Blood Matters

Blood Transfusion Newsletter - Volume 1

Vol 1. April - June 2019

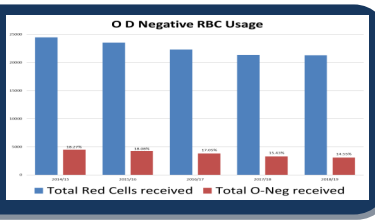
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Welcome to the 1st edition of Blood Matters. This newsletter is produced for the Newcastle Upon Tyne Hospitals by the Hospital Transfusion Team (HTT). The HTT meets monthly and reports to the Trust Hospital Transfusion Committee. This group is responsible for developing strategy for and monitoring compliance with policy.

This newsletter is one of the initiatives to help promote any new information concerning blood transfusion, to highlight any recurring errors/incidents and to advertise training sessions/seminars

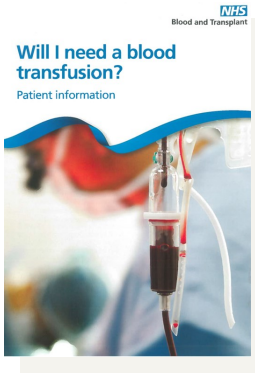
Patient Blood Management

One of the initiatives implemented by the HTT in 2015 was to reduce the usage of O-Neg red cells. We've managed to reduce our O-Neg usage from 18% to 14% of our total red cell usage. This is a great achievement but there is still more work to be done.



Patient Information Leaflet

The NHSBT has provided a leaflet to be given to patients at the point of gaining consent whilst obtaining samples for transfusion.



Please contact the transfusion laboratory if you require any leaflets for your ward/clinical area.

Paediatric Red Cell Exchange

This month has seen the first automated red cell exchange procedure carried out. A 12 year old patient with sickle cell anaemia has been receiving monthly blood transfusions since she had a stroke at the age of 5 years. The aim of regular blood transfusion is to prevent further stroke by keeping the sickle haemoglobin percentage at low levels to prevent the blood from sickling.

Regular blood transfusion causes excess iron to accumulate which can damage the heart, liver and other organs when regular transfusions are given over a long period of time. Automated red cell exchange uses equipment that removes the sickle blood and replaces it with sickle negative donor blood. This is performed using a double-lumen portacath. This dramatically reduces the degree of iron overload, preventing long term complications which can include liver cirrhosis, heart failure and endocrine organ failure.

The automated red cell exchange program has been set up by Sister Julie Guest and the paediatric apheresis team and the first exchange took place on GNCH Ward 4.

Blood Transfusion Cascade Training

The blood transfusion cascade training day might be for you!

Our cascade trainers:

- Assist in training staff in obtaining samples for transfusion and/or administering transfusion products.
- Assist in investigations/retraining when things don't go to plan.
- Cascading updates in transfusion to clinical staff.

The upcoming training dates for this year are:
(NB: This is a full day course)

Monday 16th September – RVI

Wednesday 20th November – Freeman

For more information and to book a place please contact the Transfusion Practitioners:

hospitaltransfusionteam@nuth.nhs.uk

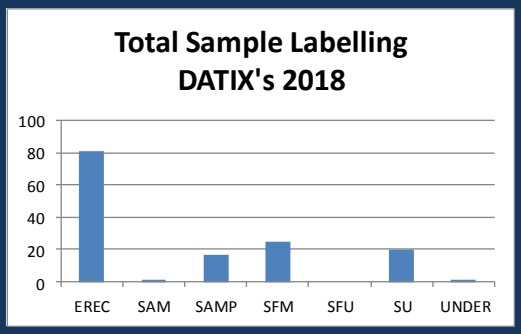
Do You Know?

Changes have been made to training and competency requirements for Blood Transfusion.

The e-Learning packages have now changed to the national package and are now available on ESR, just search for Blood Transfusion and complete the relevant Units. For further information on which modules you need to complete and for the updated competency documents please visit:
www.newcastlelaboratories.com/lab_service/transfusion

Do You Know?

In Blood Transfusion the MOST common DATIX incident types are Wasted products, Traceability Issues and Sample labelling.



EREC	eRecord / Addressograph label on sample
SAM	Specimen Accepted by Heam/Imm/Biochem Consultant
SAMP	Other Sample / Form Issues
SFM	Sample & Form Mismatch
SFU	Sample & Form Unlabelled
SU	Samples Unlabelled
UNDER	Underfilled Specimen

Sample Acceptance and Rejection

The Blood Transfusion laboratory follows strict guidelines on sample labelling.

Here is a list of Do's and Don'ts for sample/request form labelling:

- **Do positively identify the patient by asking them to state their name and date of birth.**
  - **In-Patients – information on the wristband MUST match the information given by the patient.**
  - **Out-Patients – information in the notes MUST match the information given by the patient.**
- **Do label samples next to the patient e.g. bedside and hand write the sample tube**
- **Do sign the declaration on the request form as this is a legal requirement.**
- **Don't stick addressograph or eRecord labels on transfusion sample tubes. They can be used for the request form.**
- **Don't pre-label sample tubes.**

Rejection Criteria

Samples will be rejected in the following circumstances:

- **The minimum essential information is missing from the sample or request.**
- **The sample and request form information do not match.**
- **The sample is unlabelled or otherwise unsuitable (e.g. wrong tube type, addressograph or eRecord label on sample).**

The laboratory will allow certain minor amendments to be made and will contact the individual stated on the declaration. Amendments MUST be made by the individual who originally took the specimen and they must bring some patient documentation with them, e.g.: patient notes or a letter from the notes containing the patient's demographics – This documentation MUST NOT be an addressograph label.

Please follow the policy: http://nuth-intranet/apps//policies/operational/Samplecollectionandacceptance201901.pdf for further information if required.

Feedback Welcome

Please send any feedback to
hospitaltransfusionteam@nuth.nhs.uk

Please also use this email for any non-urgent transfusion queries.

Newcastle Laboratories

www.newcastlelaboratories.com