

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 Safety Briefing

On the 30<sup>th</sup> of September we'll be running a patient safety briefing on incorrect blood components transfused and near misses. The sessions will be at both the RVI and Freeman at 12:00 and 12:30. If you are involved in the transfusion process at any stage we'd highly recommend you attending one of the sessions!

## Harvey's Gang

Harvey's Gang was set up to show children that need significant laboratory support, around the labs. This helps to visually explain the work that is involved with processing blood samples and also provides the patient and their family members with an insight into why it can sometimes take so long for blood results to come back.

Harvey's Gang



We were delighted to welcome Sam and his mum to the Blood Sciences Lab for a visit! Sam had a heart transplant in 2016 and has to have his bloods checked regularly to make sure everything is working. He was really excited to wear his lab coat and watch how we process his blood!

Sam booked his samples in, did some pipetting and then went to biochemistry. Sam enjoyed looking at all the probe arms moving and loved being in the cold room, especially on a day like today, we even showed him the new analyser that is about to be used! In Haematology, we showed him how the machines work and what blood looks like down the microscope, Sam loved the purple lymphocytes! Finally in transfusion, we looked at what different blood groups looked like in tubes.

Welcome to Harvey's gang Sam!

For any further information or to arrange a visit please email to [harveysgang@nuth.nhs.uk](mailto:harveysgang@nuth.nhs.uk)



## Do You Know?

The National Blood Service has released a video on how to correctly label samples for Blood Transfusion.

If you head over to YouTube and search for: Pre Transfusion Blood Sampling Process by Patient Blood Management England you'll be able to watch it!

## Spotlight on the lab

The Blood Sciences laboratory is open 24/7 but did you know about staffing levels?

One of our Biomedical Scientists (BMS) recalls a busy night shift: *"I was on nights, halfway through maintenance of an analyser when a baby was crashed on to ECMO. I received a phone call asking for products, for a film to be looked at and a TEG sample to be analysed. I asked them to give me an order of priority and it was only at that point did the ward realise I was by myself"*.

On a night shift there's only one BMS in Blood Transfusion and Haematology and one in Biochemistry. The HCSA is trained to assist but some procedures can only be completed by the BMS.

On a night shift, think to yourselves, does this need to be ordered now?

## An unexpected flood!

On the afternoon of Friday 31st May the Freeman laboratory was presented with a very unique situation. A significant flood within the laboratory occurred due to a ruptured hot water pipe which necessitated the temporary closure of the Blood Sciences laboratory.

Blood Transfusion temporarily moved to a satellite location at NCCC36 from which we were able to issue emergency units of blood and still continue transfusion support for two transplants cases in progress in theatre as well as urgent cases across the rest of the hospital.



# Trust Transfusion Changes

- With paperlite coming, the transfusion documents you would normally get will be available in the document repository section on E-Record and will be scanned into electronic records following discharge of the patient.
- The Braun pump has now began rolling out, these new pumps, with the appropriate giving set are suitable for use in the administration of blood products in accordance with manufacturers guidelines. Contact your clinical educator if training is required.

## Obtaining a Sample for Blood Transfusion

In May 2018 a new Blood Transfusion Request form was introduced. Recently we completed an audit on the use of the new form and on the introduction of the consent sticker, showing that we obtained an overall 65.84% for the day.

The Advisory Committee on the Safety of Blood, Tissues and Organs released guidelines that all patients should be given information on the risks and benefits of transfusion to enable them to consent to being transfused if required. In 2015, an audit showed that only 33% of samples received from patients had the consent recorded in their notes.

The image displays the 'BLOOD TRANSFUSION Request Form' from the Newcastle upon Tyne Hospitals NHS Foundation Trust. The form is divided into several sections, each highlighted by a blue callout box:

- Patient demographics:** Includes fields for Name, Sex (M/F), Date of Birth (DOB), Phone (Cell/NO/Yes), and Consultant.
- Declaration:** A red-bordered section containing a declaration statement and a signature line for the person taking the blood sample.
- Patient History:** A section with multiple-choice questions regarding previous transfusions, pregnancies, and medical history (e.g., HIV, Hepatitis, Sickle Cell).
- Prescription information:** Includes fields for Diagnosis, Operation (date/type), and Urgent/Non-urgent status with reasons.
- Special Requirements:** A section with checkboxes for specific transfusion needs like 'Intraoperative transfusion' or 'Exchange transfusion'.
- Consent Complete, Peel out, Place in notes:** A yellow 'Record of Consent' sticker with a signature line and date field.
- Order code NUTH229:** A box at the bottom right of the form.

The recommendation from the Hospital Transfusion Committee was *“Transfusion team to revisit the transfusion request form and the introduction of a clearly visible sticker to be stuck in patients notes when a transfusion information leaflet has been given.”* From the audit findings it would suggest the overall consent process is up to 65.84%. Whilst this is great, there is still room for improvement. One of the recommendations from the audit and supported by the HTC is *“All directorates should move over to the new blood transfusion request form to improve compliance with the consent process”*

### Feedback Welcome

Please send any feedback to  
[hospitaltransfusionteam@nuth.nhs.uk](mailto:hospitaltransfusionteam@nuth.nhs.uk)

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



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