Blood Matters

Blood Transfusion Newsletter - Volume 4

The Newcastle upon Tyne Hospitals NHS Foundation Trust

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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 new information concerning blood transfusion, to highlight any recurring errors/incidents and to advertise training sessions/seminars.

Cascade Training

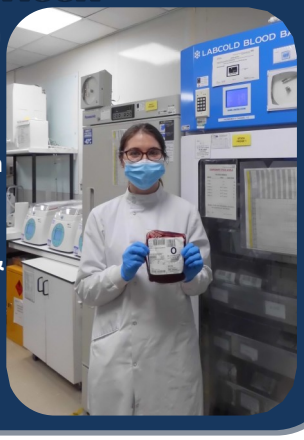
Our cascade training sessions will be restarting soon!!

This will be delivered via a new virtual format which we hope will make the course more accessible while still providing the necessary content to a satisfactory standard.

We will start to contact our waiting list but if you are interested in becoming a cascade trainer please email us at nuth.hospitaltransfusionteam@nhs.net

Transplant Week

It's National Transplant Week! In 2019 Newcastle Upon Tyne Hospitals performed 74 heart/lung and 32 liver transplants with vital transfusion support provided by the Transfusion Lab. That's 615 units of blood, 167 pools of platelets & 804 units of FFP issued around the clock by our transfusion team.



ALERT

The aim of antibody screening is to determine the presence of antibodies of clinical significance. When the antibody screen is positive, further testing is required to identify the responsible antibodies. This enables the laboratory to select suitable units should transfusion be required. Reporting of a positive antibody screen also serves to alert the clinician to possible delay in the supply of compatible blood.

Did you know there is a method of checking whether individuals have antibodies pre- surgery by checking on e-record? They are highlighted by an 'alert' , below their name on powerchart or, if you scroll to Antibody Screen under Results you can see if they have antibodies, plus how long it will take to cross match . For any further information you can contact the lab

Spotlight on the lab

I graduated from Lancaster University in 2016 with a BSc (Hons) in Biomedical Science. I originally trained in Microbiology before moving to Newcastle where I started working as a Biomedical Scientist (BMS) in Haematology and Transfusion at the RVI. After completing the IBMS Specialist Diploma, I moved to the Freeman in 2018 and this is where I currently work as a Specialist BMS.

My work requires contribution to a continuous 24/7, 365 days a year service. The role involves testing patient samples for blood groups and atypical antibodies and ensuring blood and blood products, including FFP, platelets and cryoprecipitate, are issued to patients. Given the wide range of specialist services offered at NuTH, patients can often have complex transfusion needs, including haemato-oncology, ECMO and transplantation, and I enjoy the challenges associated with this. It can be particularly stressful when patients are bleeding but we are well equipped to deal with these scenarios. One of the most memorable shifts for me was a nightshift at the RVI when the Major Haemorrhage Protocol was activated and rolled until 24 major haemorrhage boxes had been issued. This equates to 96 RBC, 96 FFP and 24 platelets!

Emily—BMS

Paperlite Update

To avoid the risk of over transfusing a patient, it is extremely important that all transfusion events are correctly documented and accessible as part of the patient record.

All transfusions should be recorded on the appropriate Blood Transfusion Pathway form, which is available within the Paper Vault (duplex printing should be used to print double-sided).

Once complete, The Blood Transfusion Pathway form should be kept with the patient and included as part of their temporary paper documentation.

In line with *paperlite* policy, the temporary paper documentation should be sent to Medical Records on a weekly basis, or on discharge of the patient.

All Blood Transfusion Pathway forms MUST be separated and urgently hand delivered to Medical Records on the respective site. The Medical Records Team will immediately scan each form so that each transfusion event becomes viewable as part of the patient electronic record in Document Store.

Before authorising any transfusion to a patient it is important to check both the electronic record in Document Store and the temporary paper documentation for previous transfusion history.

For any additional information, please contact the Transfusion Practitioners on either 48852 or 48853 in the first instance.

Patient Blood Safety: Specimen Labelling for Transfusion

From January 2021 Blood transfusion will no longer accept amendments to be made for minor errors in the specimen labelling process. Any error made will lead to the rejection of the sample and the need for a new sample to be obtained.

Any person involved in any part of the Blood transfusion process MUST have completed: Relevant e-learning and competency assessment.

ID right to save a life

- Patient should be positively identified before the sample is taken
- Ask the patient to state their full name and date of birth
- Check the details match the patient's ID wristband EXACTLY

Informed consent

Informed consent for blood transfusion must be obtained and documented in the patient's clinical record by the clinical team prior to sample being taken. As part of the consent process a standardised patient information leaflet should be given to the patient outlining risks and benefits of blood transfusion.

Attention to detail now saves time later

- MRN, Surname, Forename, DOB must be on the transfusion request form (Handwritten/eRecord/ addressograph label accepted)
- Check all details on the request form are correct
- MRN, Surname, Forename, DOB must be clearly HANDWRITTEN on sample tube.
- The Declaration MUST be signed by the person taking the specimen.

The request form and sample labelling should all be completed at the patient's bedside. When you leave the bedside no further changes/additions should be made to the sample or the request form.

If in any doubt STOP and make additional checks before restarting the process!

Feedback Welcome

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

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

Newcastle Laboratories

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