Blood Matters

Transfusion Newsletter - Autumn/Winter Special

Are you Putting Patient Lives & Your Registration At Risk?

- Before collecting a blood component from the lab —have you checked the blood has been prescribed by a qualified member of staff?
- It is YOUR responsibility as part of mandated pre administration checks to ensure a prescription is DOCUMENTED and VALID.
- The prescription is where you will find all the essential information to ensure that the RIGHT BLOOD is given to the RIGHT PATIENT in the RIGHT WAY.
- Ensure that you have DOCUMENTED your acknowledgement of the prescription by 'signing off' the transfusion in ERecord.

SHOT

Serious Hazards of Transfusion

If you would like any additional training or have any concerns or questions, please don't hesitate to contact the Transfusion Practitioner Team who will be happy to help.

The latest annual SHOT report showed out of 193 clinical errors relating to 'Right Blood Right Patient' that year, over 21% of them were linked to prescription errors!!!

Transfusion Practitioner Team

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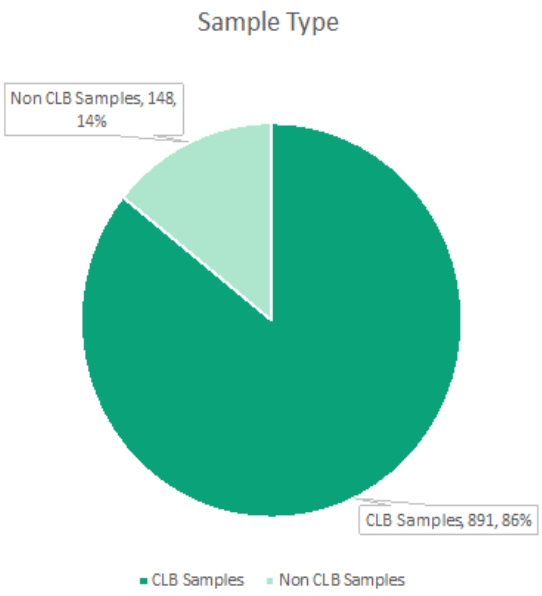
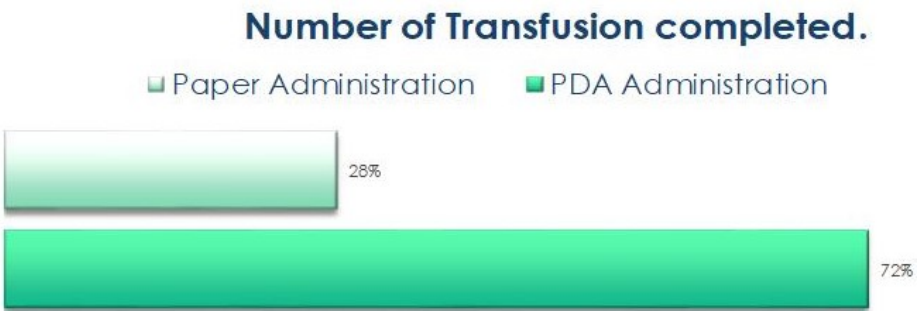
Electronic Sampling & Administration

As most areas across the Trust are now using the electronic transfusion system for both sampling and administration of blood components, the Transfusion Practitioner team have been assessing compliance in monthly 'snapshot' audits.

Thanks to your collaboration and positivity towards clinical progress the Trust is now **86% compliant in electronic sampling and 70% compliant in transfusion.**

We are hoping once the system is 'live' in theatres, this figure will improve significantly benefitting both clinical and laboratory staff.



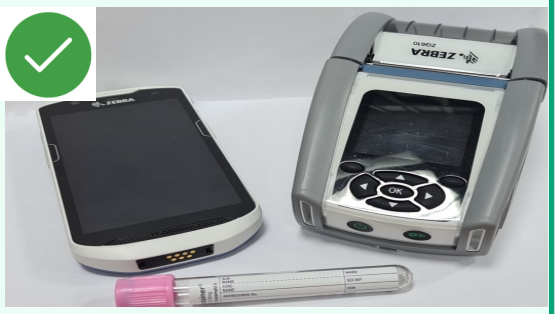


A breakdown of compliance by area and directorate is also available, please ask your matron, clinical educator or cascade trainer if you would like to see how your area is performing.

Dont Bleed your Patient Twice Please Remember...

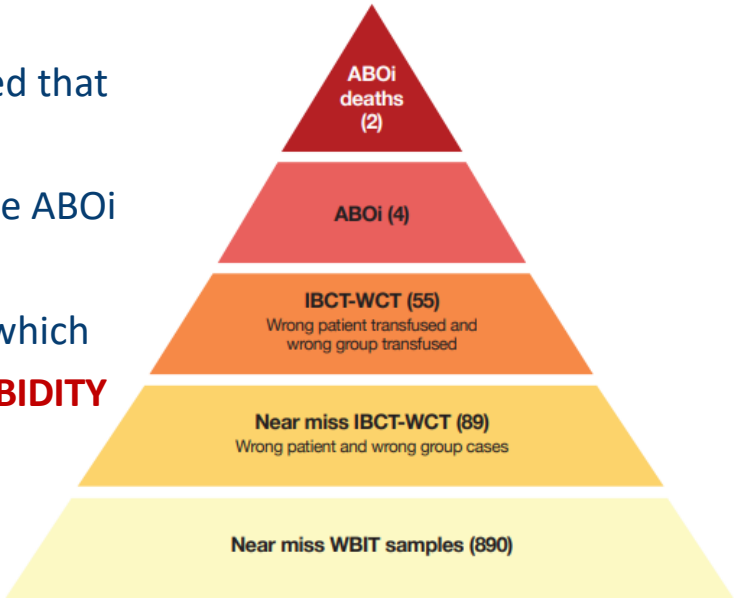
ONLY stickers produced via the portable printer using the 'collect samples' option can be placed on the sample tube.

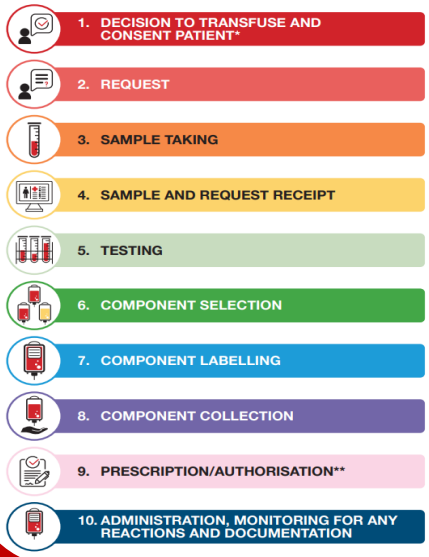
Any samples with an **ERECORD STICKER** stuck to the sample will automatically be **DISCARDED!**



Safe Transfusion

The latest SHOT report highlighted that in 2022 there were a total of **SIX ABO incompatible transfusions**. Five of the ABOi transfusions were a result of clinical collection and administration errors which resulted in **ONE case of MAJOR MORBIDITY and TWO patient DEATHS.**





There are **10 key steps** in the transfusion continuum, where every individual involved in the process is critical to ensuring a safe transfusion. Due to the complexity of the process, it is easy to comprehend the critical stages in which mistakes can be made. However, they also act to emphasise the areas where potential errors can, and are, detected due to staff diligence and MDT working.

Give blood

As the festive season draws ever closer, we urge you to consider the potentially life saving gift of donating blood this year- and even better—it's free to do!

To find out how you can donate and learn more about the people you could help, visit: Home - NHS Blood Donation

However you may celebrate the upcoming season, the Transfusion Team would like to wish you all a very happy and safe holidays and we hope that you get some time with the people you care for.