Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Blood Transfusion Policy

Pre-Administration

This procedural document supersedes: PAT/T2 v.6 – Blood Transfusion Policy

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Approved by:	Hospital Transfusion Committee
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Target Audience:	Trust wide; all staff involved in the transfusion process

Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
Version 1	25 June 2021	• This is a new procedural document, please read in full.	Gill Bell – Chief Biomedical Scientist Transfusion

Contents

1. INTRODUCTION

Errors in the requesting, supply and administration of blood lead to significant risks to patients.

Errors either in the collection or labelling of the sample for blood grouping and compatibility testing, or in the laboratory, or to failure of the final pre-transfusion checks account for a number of patient deaths in the UK each year.

The incidence of `wrong blood in tube' episodes has changed little over several decades. This contrasts with the dramatic reductions in other hazards of transfusion such as viral transmission. The introduction nationally of the "**2 Sample Rule**" whereby two separate samples are taken and tested prior to routine transfusion should help to address this.

Variation in the practice of the administration of blood is remains increasingly evident from audit, both local and national and from the annual Serious Hazards of Transfusion (SHOT) reports. Consequently the Trust is committed to the use of competency assessment of all staff involved in the transfusion process.

2. PURPOSE

This policy is based on recognised guidelines and provides the Trust with local procedures for the ordering and administration of blood products and the management of transfused patients.

3. DUTIES AND RESPONSIBILITIES

- All staff involved in the transfusion process must be aware of this policy.
- All staff involved in the transfusion process should understand their role and responsibilities.
- Role specific training requirements must be met; the competencies are mandatory.
- Ensure transfusion is appropriate and alternatives have been explored.
- All transfusion documentation must be completed.
- Recognise and manage transfusion reactions.
- Always report untoward transfusion events / reactions to Blood Bank and by Datix.
- Recognition of Massive Haemorrhage; activate the Massive Haemorrhage protocol.

4. PROCEDURE

- All samples must be handwritten and labelled to include surname, forenames, date of birth, district (D) number / NHS number, (identification numbers from other hospitals are **not** acceptable), date and ward. **6 ml** of blood is required for grouping and crossmatching (pink top EDTA). Addressographs may be used on request forms, **do not use Addressograph Labels on Samples.** Both the sample and request form **must** be signed by the person taking the sample.

- Urgent requests must also be telephoned to the Blood Bank. Do not write "ASAP" for time required. The sample and request form must be brought directly to Blood Bank and presented to a member of blood bank staff

- Blood products must be prescribed on blood prescription sheet **WPR26564**.

- When a unit of blood is transfused to a patient the sticker from the blood tag must be signed by two nursing or medical staff one with responsibility for the actual administration of the blood. The start and finish time must be recorded and the sticker attached to the prescription sheet. The tear off tag must have the “patient identity confirmed by:” box filled in and then this tag must be returned to Blood Bank immediately.

- It is extremely important that the units of blood are transfused in expiry date order. Some
  units of blood will have a shorter expiry time and must be used before other units; some of the requested units may indeed not be needed and can then be returned and used for other patients. Blood products must not be removed from the Blood Bank until you are ready to start the transfusion, the pre-transfusion checks must have been performed and ensure that the patient has adequate venous access.

- Transfusion of should be commenced within 30 minutes of collection. If after the blood is collected a problem arises which prevents immediate transfusion, the unit must be returned to the Blood Bank within 30 minutes of collection and Blood Bank staff informed. There have been instances of blood being left on the ward for hours and having to be discarded. Such wastage of this valuable resource must be avoided.

- Each unit of blood should be used within four hours of removal from the blood fridge. It is essential that medical / nursing staff check that the drip is running satisfactorily; and if it isn't, that this is rectified in order that the unit of blood may be given within the required time.

- Recognise trigger and activate pathway for management of massive haemorrhage; if you

need emergency uncrossmatched i.e. Emergency group O blood or group specific where possible) you need to consider activating the Massive Haemorrhage protocol. Communication with the Blood Bank is essential to ensure blood products are made available as quickly as possible.

Patients Lacking Capacity:

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the Extranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

4.1. POSITIVE IDENTIFICATION OF PATIENTS AND SAMPLE COLLECTION

Key Recommendations:

- Positive patient identification at all stages of the transfusion process is essential.
- Where possible, patients (and for children; those with parental responsibility) should have the risks, benefits and alternatives to transfusion explained to them in a timely and understandable manner.
- Samples are to be taken by trained member of staff with a valid competency in venepuncture.
- The request form must be completed in full (Addressograph labels may be used).
- The sample tube must be labelled immediately after the blood has been taken (at the patient's bedside), sample tubes must not be pre-labelled. Addressograph labels cannot be used.
- Blood Bank has a zero tolerance policy on incorrectly labelled samples and/or request forms.

4.1.1. Positive identification of the patient is essential and is based on:

- Direct questioning of the patient - by asking them to state their surname, first name and date of birth. This must always be done where the patient is judged capable of giving an accurate, reliable response. Staff should never lead the patient, the answer yes is not sufficient to establish correct identification.
- Checking the details on the patient's identification wristband, match those on the request form. All in-patients and all patients undergoing a transfusion must have an ID band complying with the Trust's Patient Identification Policy.
- All patients including unconscious and unknown patients must have a patient identification number and an ID wristband with this number. When additional details become available the Blood Bank must be informed but details must not be changed mid incident.
- No wristband – no transfusion.

Positive identification of the patient must occur prior to:

- Venepuncture
- Transfusion of blood and blood products

4.1.2. Sample Collection

- Samples are to be taken by a trained member of staff with a valid competency in venepuncture.
- All patients being sampled must be positively identified. Sample tubes should not be pre-labelled.
- **The collection of the blood sample from the patient into the sample tubes and the sample labelling should be performed as one continuous uninterrupted event, involving one patient and one trained and competent healthcare worker only, samples to be labelled at the bedside using information taken from the patient's ID wristband.**

4.1.3. The Request Form

The request form must be completed in full (Addressograph labels may be used) and include:

- Full name - surname and forename
- Hospital number and/or NHS number may be used - Hospital numbers from other hospitals are not acceptable as they do not uniquely identify the patient on CaMIS. The NHS number must be available for the issue of blood products using Bloodhound
- Date of birth
- Patients location

- Consultant
- Number and type of blood products required
- Date and time required
- Patient's diagnosis / clinical details (include pregnancy status)
- Reason for the request (clinical indication) including most recent haemoglobin and or platelet count if applicable, include date tested
- Any special requirements (e.g. Irradiated, HLA matched, CMV or HEV negative)
- Date and time bled
- Gender
- Requestors name and signature
- The request form should be signed by the person drawing the sample
- Date of last transfusion
- Any known antibodies
- If pregnant within the last 6 months and Rh D negative please state the dates and doses of any prophylactic Anti-D immunoglobulin administered during this pregnancy

4.1.4. The Sample

- Addressograph labels must not be used
- The patient must be positively identified at the time a sample is taken
- The sample tube must be labelled immediately after the blood has been taken (at the patient's bedside), sample tubes must not be pre-labelled
- Never copy details from the request form onto sample tubes

The sample tube must be labelled with the following details taken from the ID band:

- Full name - surname and forename
- District number, NHS number, Hospital numbers from other hospitals are not acceptable
- Date of Birth
- Gender
- Signature of person taking the blood sample
- Ward or Clinical area
- Date sample taken
- Time sample taken

4.1.5. The Unconscious and or Unknown Patient including Major Incident Patients

- The minimum identification for an unconscious unknown patient is the district number and the gender of the patient. Follow the Trust protocol for the identification of unconscious patients. This level of identification is essential even for use of the emergency group O blood packs.

- Avoid changing the details of the unknown patient mid incident / acute treatment; this would result in samples with the new details being required to obtain further blood products. The original wristband must be left in place until all merges are complete, this will mean two wristbands may be in place for a short time.

- Wristbands must not be removed if you intend to continue transfusing blood products labelled with the original details. Either complete their infusion with the original wristband in place and use this for all checks or return unused products to Blood Bank.

4.1.6. Incorrectly labelled samples or request forms

- The Blood Bank has a zero tolerance policy on this and **will not** accept any sample where the request form and/or sample are inadequately or incorrectly labelled.

- A substantial number of requests arrive with labelling or request form errors. This can contribute to serious errors and delays in blood product provision. In clinical emergency situations group O blood will be available for the patient while the sampling and labelling process is repeated correctly.

Samples and forms cannot be amended, even in a clinical emergency a new sample and form must be provided

4.2. PRESCRIBING AND REQUESTING BLOOD PRODUCTS

Key Recommendations:

- Patients must be given information regarding the risks/benefits and alternatives to transfusion, including the option of no transfusion.
- Blood products should only be prescribed when the clinician is satisfied that the risk of not transfusing is likely to be greater than the risk of transfusing.
- Blood products can be prescribed by a doctor or an appropriately trained and approved senior nurse. The requirement for training / completed competencies includes Locum / agency staff.
- Serological studies should be performed using blood collected no more than 3 days in advance of the actual transfusion when the patient has been transfused or pregnant within the preceding 3 months.

- Where there has been no transfusion or pregnancy within the preceding 3 months, the sample is valid for up to 7 days.
- A second sample should be requested for confirmation of the ABO / D group of a first time patient prior to transfusion, where this does not impede the delivery of urgent red cells or other components

4.2.1. Contacts

Blood Bank

- DRI 644044
- BDGH 572452

The Hospital Transfusion Team

- Blood Bank Manager DRI 644031
- Transfusion Practitioner **Contact via Switchboard**
- Consultant Haematologist **Contact via Switchboard**

4.2.2. Consent

Patients have the right to know about the treatment being offered and the available alternatives. This should be done in a timely and understandable manner. It is essential to follow the Trust policies on consent; these are available on the intranet.

- Patients must be given information regarding the risks/benefits and alternatives, including the option of no transfusion. This should be recorded in the patient notes, this is the responsibility of a doctor; however, signed consent is not required.
- It is helpful to provide patients with an information sheet outlining the risks and benefits of blood transfusion. For example, NHS Blood & Transplant produce a number of patient information leaflets; these are available from the Transfusion Practitioner.
- If a patient refuses a transfusion the Doctor in charge of the patient and Blood Bank should be informed and any blood product on the ward immediately returned to the Blood Bank.

It is recommended that the following information is documented in the case notes using blood prescription sheet **WPR26564:**

- The discussion with the patient. (Details of the information provided to the patient)

- Reason for transfusion (clinical and laboratory data)
- The administration of the transfusion and any complications
- The clinical outcome
- Consent to proceed
- If unable to obtain consent prior to transfusion, document retrospective patient notification

Wherever consent is not possible i.e. in an emergency or for an unconscious patient, the decision to treat must be documented in the patient's medical notes detailing why the transfusion is judged to be in the best interests of the patient. Any known advance directives, DNAR decisions and consultations regarding the patient's rights under the mental capacity legislation must be taken into account and included in the entry in the notes.

In addition, if a patient is unable to give consent prior to transfusion they should be provided with information retrospectively to comply with SABTO recommendations (Oct 2011).

Post Transfusion; complete patient discharge list and inform GP, transfusion episodes should be recorded in the discharge summary.

4.2.3. Patient Blood Management

Good patient blood management (PBM) can be described as management of the patient at risk of transfusion so as to minimise the need for allogeneic transfusion.
Blood products should only be prescribed when the clinician is satisfied that the risk of not transfusing is likely to be greater than the risk of transfusing.

Questions to think about before prescribing a transfusion:

- Have you acted on an up to date result?
- Have you reviewed the clinical condition of your patient?
- Is your patient symptomatic?
- Is the transfusion appropriate? Is intervention required?
- Is transfusion the only appropriate intervention?
- Is your patient <50Kg? Be aware there is an increased risk of TACO – transfusion associated circulatory overload.
- What volume should be transfused? Guidelines recommend a one unit transfusion

then review before prescribing further units for non-bleeding patients.

- Are the blood products prescribed on blood prescription sheet WPR26564
- Have you documented in the medical notes why you made the decision to transfuse?
- Does the patient have the mental capacity required to be able to make an informed decision regarding the transfusion?
- Have you discussed the need for transfusion with the patient, and advised them of all known risks and obtained informed verbal consent?

4.2.4. Prescribing Blood Products

- Blood can be prescribed by a Doctor or **authorised** non-medical staff e.g. midwife or nurse with the appropriate NMA training / competencies completed. This includes the organisational competency based package for prescribing blood and blood products. Competencies are recorded on Oracle Learning Management (OLM). The requirement for training / completed competencies includes Locum / agency staff.

- Red cells (this may be expanded to include Platelets following approval by the Hospital Transfusion Team) can also be prescribed within a controlled framework for select patient groups by an appropriately trained and approved senior nurse providing the following are adhered to:

  The nurse must:

  - Work in an area of clinical practice where making the clinical decision to transfuse and authorising blood components is relevant.
  - Have the Trust's written permission to undertake the NHSBT Non-Medical Authorisation of Blood Components course (a programme for senior nurses and midwives who are working towards making the clinical decision and providing the written instruction for blood component transfusion as part of service development).
  - Have an identified clinical mentor to support learning in practice.
  - Have notified the Hospital transfusion Team. (Please note that the above will be verified by NHSBT with the Trust via our Transfusion Practitioner)
  - Have completed the organisational competency based package for prescribing blood and blood products. Competencies are recorded on Oracle Learning Management (OLM).

- All staff prescribing must be aware of the risks / benefits of transfusion.
- All prescribers of blood products must have the appropriate training / competencies.
- All prescribers must have completed and follow both local and national guidelines; failure to do so may result in requests being rejected.
- The prescription for blood and blood products must be signed and dated by the prescriber on the appropriate blood prescription sheet (WPR26564).
- It is essential that the prescription sheet contains the patient identification details surname, first name, date of birth, patient identification number.
- It is essential that all documentation provides a unique identification of the patient

The prescription must document the following:

- Consent obtained
- Retrospective notification of transfusion if consent not obtained.
- What components are to be transfused
- Date of transfusion
- The volume/number of units to be transfused
- The rate of transfusion for red cells is usually 1.5 - 2 hours. Transfusion must be completed within 4 hours of removal from the Blood Fridge or authorised sealed blood product transit box.
- The rate of transfusion is 20 - 30 minutes for an adult therapeutic dose of platelets / bag of fresh frozen plasma (FFP) or Cryoprecipitate.
- Any other special instructions or requirements e.g. Irradiated, HLA matched, CMV or HEV negative products required and the reason. Blood Bank must be made aware of any special requirements prior to transfusion.
- Requirement for any concomitant drugs.
- Any adverse reactions

4.2.5. Requesting Blood Products

- Blood can only be **requested** by a Doctor or **authorised** non-medical staff e.g. midwife or nurse with the appropriate training / competencies completed. The requirement for training / completed competencies includes Locum / agency staff.

- All telephone requests **must** be followed by a written request form, failure to do so will result in a delay in blood product provision.

Requesting HLA Matched Products for Renal Transplant Patients

Only patients with confirmed live donors require HLA matched products. This is required to maintain the match between the live donor and the recipient. The provision of HLA matched products can take 3-5 working days and will require timely planning with Blood Bank.

4.2.6. Timing and viability of Blood Bank samples

Where there has been no transfusion or pregnancy within the preceding 3 months, the sample is valid for up to 7 days. See *Table 1* for summary of sample validity.

Table 1. Working limits for use of stored whole blood for pre-transfusion testing

Patient Type	Sample Stored at 4°C
Patient transfused or pregnant in last 3 months	Up to 3 days
Patient not transfused and not pregnant in last 3 months	Up to 7 days

4.2.7. The Two Sample Prior To Transfusion Rule

First Sample

- This can be an historical sample i.e. >7 days old or taken on the same day as the 2nd sample.

Second Sample

- Must be a separate venepucture event with new patient ID checks performed.
- Must be sent to the laboratory site which will perform the blood issue. Ideally this would be performed by a different member of staff but this is not mandatory.

General principles

This national recommendation is based on the evidence from –

- The BEST studies as referenced in BCSH Guidelines for pre-transfusion compatibility procedures in blood transfusion laboratories.
- National data from the IBCT and the Near Miss chapters in recent SHOT reports (SHOT, 1996 to 2010) – 386 cases of “wrong blood in tube” (WBIT) were reported as near misses in

2010.

- Local data confirms an unacceptable number of WBIT cases among patients where it can be detected due to having a historical group on record.

Those taking samples for transfusion need to understand that the second sample is required due to the possibility of inadequate patient identification and labelling errors which lead to an unacceptable risk of WBIT and potentially a never event.

The two samples must be taken independently of one another. Incidents have reported of the two samples being taken at the same time and one "saved" to send to the transfusion laboratory at a later time with a false time of venepuncture, this is a severe breach of the rules and could result in a "never event" should this lead to the transfusion of ABO incompatible red cells.

4.2.8. Urgent Situations

A second sample must be obtained and tested before issue of **group specific red cells**.

The urgency of the situation is always considered, as delays in provision of blood could compromise patient outcome, therefore in an urgent situation when it is not possible to obtain a second sample, **group O red cells will be issued until a second sample is received and tested**.

4.3. ADMINISTRATION OF BLOOD PRODUCTS AND TRACEABILITY

Key Recommendations

- Final check must be conducted next to the patient by the same trained and competent licensed healthcare professional who administers the component.
- All patients receiving a transfusion must be positively identified.
- All patient core identifiers on the patient's identification wristband must match the details on the blood component label.
- All blood components should be administered using a blood administration set with integral mesh filter.
- All transfusions should be completed within 4 hours of leaving temperature controlled storage.

4.3.1 Staff Administrating Blood Components

Blood components are excluded from the current legal definition of medicinal products and the requirement for prescription by a registered medical practitioner but are viewed as medicines for administration purposes. Blood components should only be

administered by a licensed professional such as doctor (GMC registered), or a nurse holding current registration of the NMC Professional Register as a Registered General Nurse (RGN), Registered Sick Children's Nurse (RSCN), Registered Midwife (RM) or Operation Department Practitioner (ODP) who has completed the organisational competency package in Receipt/Administration of blood and blood products. Competencies must be recorded on OLM.

4.3.2. Receipt of Blood Products in the Clinical Area

- The blood group and unit number of the blood product must be **identical** to that described on the attached blood tag label.
- The blood or blood component must be checked for compliance with any special requirements as specified on the prescription sheet e.g. Irradiated, CMV negative.
- The blood or blood component must be checked to ensure that it has not and will not have passed its expiry date during the transfusion period i.e. in date at the start and end of transfusion.

4.3.3. Inspection of Blood or Blood Products

It is essential that staff administering blood or blood products inspect each unit prior to transfusion and return the unit to the Blood Bank if any defects are found.

The inspection should pay attention to:

- The integrity of the pack by checking for leaks at the port or seams.
- Evidence of haemolysis in the plasma or at the interface between red cells and plasma.
- Evidence of unusual discoloration or turbidity.
- The presence of large clots.

4.3.4. Responsibility for the Identity Check of the Patient and the Blood Product

Although two members of staff may be involved in the checking procedure it is recommended that one member of staff should be **responsible** for carrying out the identity check of the patient **and** the unit of blood at the patient's bedside. The responsible member of staff must be a doctor, or a nurse holding current registration of the GMC Professional Register as a Registered General Nurse (RGN), Registered Sick Children's Nurse (RSCN) or Registered Midwife (RM) providing they are signed off for IV drug administration.

In certain clinical areas the second checker may be a Nursing Associate providing they have completed the required transfusion competencies. Check this is permitted before second checking.

4.3.5. The Final Bed Side Check

This is **ESSENTIAL** and is based on**: Tag & Bag, Tag & Wristband Checks**

Only the labelled blood product and the patient's wristband are to be used as part of the final bedside check, **NOT the prescription sheet.**

Always start with direct questioning of the patient to establish positive identification. In the case of patients who are judged capable of giving an accurate reliable response ask their surname, first name and date of birth. Checking this information against the wristband is **mandatory**.

- Check the details on the patient's wristband match the blood tag label:

  The surname, first name, gender, date of birth and unique identification number must be identical with the blood tag label attached to the blood component.

- Check the blood tag label is attached to the correct bag by checking the donation number, product type and blood group of both matches.

- Any discrepancies identified by these checks should be reported to Blood Bank **immediately** and the transfusion delayed until clarification of any point is made.

- The transfusion of blood and blood components should begin as soon as possible.

- The minimum identification for an unconscious unknown patient is the NHS or hospital number and the gender of the patient. Follow the Trust protocol for the identification of unconscious patients.
- The prescription sheet must be readily available during the transfusion. The ideal location may vary from one clinical area to another, but a local policy should exist defining this location. The report must then be filed in the medical notes following completion.

4.3.6. Traceability

The return of the blood tags is mandatory and a legal requirement under the Blood Quality & Safety Act (BSQR 2005).

- The completed detachable blood tag **must immediately** be returned to Blood Bank following the completed transfusion. This is to enable full traceability and to ensure the Trust fulfils its legal requirements as defined by BSQR 2005.
- The peel off sticker from the blood tag must be attached to the prescription sheet (WPR26564).

- The start and finish time of the transfusion must be recorded on the blood prescription sheet (WPR26564).
- The efficacy/ outcome/ benefit of this transfusion must be recorded in the patient's notes.

4.3.7. Documentation of Transfusions

Full documentation of transfusions is mandatory and a legal requirement under BSQR 2005.

Documentation in the Patients Notes:

A permanent record of the transfusion must be held in the patient's medical notes by completing a blood prescription sheet (WPR26564), with the following information:

- Start and finish time of the transfusion on the blood prescription sheet.
- The indication for the transfusion.
- The type and number of blood products used.
- The efficacy/ outcome/ benefit of this transfusion must be recorded in the patient's notes.
- The occurrence and management of any adverse effect.
- The peel off sticker from the blood tag must be attached to the prescription sheet.
- The sheets used for nursing observations during the transfusion.

Documentation to be returned to Blood Bank:

The return of the tags is mandatory and a legal requirement.

The completed detachable blood tag must be returned to Blood Bank immediately following transfusion to enable full traceability and ensure the Trust fulfils its legal requirements as defined by BSQR 2005.

4.4. COLLECTION AND RETURN OF BLOOD PRODUCTS

Clear documentation of the blood audit trail is mandatory and a legal requirement under the Blood Quality & Safety ACT (BSQR 2005)

Key Recommendations:

- Before collection, ensure the patient is ready to start the transfusion, baseline observations have been taken and the patient has venous access.

When collecting the blood component from the Blood Bank or blood refrigerator:

- Bloodhound blood tracking system is used to control blood product collection.
- Ensure the person collecting components has been Bloodhound trained and has a valid competency.
- Take authorised documentation containing the patient's core identifiers and bar coded NHS number e.g. an addressograph label. This must still be done if **Teletrack** is used to organise collection.
- Check core patient identifiers with the label on the blood component.
- Core patient identifiers, date and time of collection and staff identification details must whenever possible be recorded using Bloodhound. If Bloodhound fails or room temperature products are collected, staff must use the Blood Register to sign out each unit removed with the date and time.
- The component should be delivered to the clinical area and given directly to the staff responsible for transfusion without delay.

4.4.1. Staff authorised to collect Blood Products

- **Only** staff that have been **fully trained and have had a competency assessment to use Bloodhound** can collect products from the Blood Bank / Blood fridges.
- Bloodhound blood collection training is provided from a trained assessor in your clinical area. If training or reassessment is required this should be arranged through your manager. Reassessment is required 2 yearly. Collection training must be recorded on OLM, managers must ensure that their staff have a valid competency if they need to collect blood products as part of their role and to ensure service provision.

Collection of Blood Products from a Bloodhound controlled Blood Fridge:

- Collection can be arranged using the Teletrack system **however**, the staff member removing the blood from the Blood Bank must have information including the patient's full name, date of birth and district number.
- The **blood product** identification details on the bag (blood group and donation number and expiry date) must also be checked with the details on the compatibility label (blood tag) attached to the unit.
- **It is extremely important that the units of blood are transfused in expiry date order**. This is because some units of blood will have a shorter expiry time and must be used before other units.

4.4.2. Receipt of Blood Products on the Ward

The blood **must** be **immediately** handed to the person responsible for administrating the transfusion and **NOT** left on the Nurses station.

Note: Blood must only be stored in designated Blood Bank fridges and not in the ward, drug or domestic fridges.

4.4.3. Returning Blood Products

Unboxed Single Units:

- Blood and blood products should be transfused as soon as possible after delivery to the ward / clinical area i.e. within 30 minutes of leaving the blood fridge
- If after collection of the blood a problem arises which prevents immediate transfusion, the unit must be returned to Blood Bank **within 30 minutes of collection.**

Boxed Units e.g. unused:

- The transit box containing the units should be handed directly to a member of Blood Bank Staff.
- Units can be stored in a cool box, unopened, for up to **2 hours** before being returned to Blood Bank. Once the box is opened the transfusion must be completed within 4 hours.

There have been instances of blood being left on the ward/clinical area resulting in wastage of this valuable resource, this must be avoided.

Blood Products returned for disposal:

- If blood has been out of the fridge for more than 30 minutes and there is no prospect of its immediate use i.e. the unit to be transfused within 4 hours, the hospital blood bank should be informed. The blood must be returned to the blood bank for disposal due to the risk of bacterial growth and breach of the cold chain regulations.
- The blood product for disposal must never be placed in a Blood Bank fridge; it must always be handed directly to a member of Blood Bank staff.

5. TRAINING/ SUPPORT

Role specific competencies are in place. Staff must have the relevant competencies to perform a transfusion related task / procedure e.g. venepucture, collection of blood products, administration of blood products and prescribing blood products. Competencies are recorded on OLM. Advice regarding the relevant competencies is available from the Transfusion Practitioner.

6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

- The Hospital Transfusion Team will ensure that systematic audit and review of the transfusion process is undertaken and will report outcomes to the Hospital Transfusion Committee.

- This will include participation in the programme for national comparative audit of blood transfusion as well as local and regional audits.

- The Hospital Transfusion Committee will review all serious adverse transfusion events / reactions which must be notified direct to blood bank staff in addition to the Trust's incident reporting system; Datix.

7. DEFINITIONS

All defined within the document.

8. EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment for All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 1)

9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- PAT/PA 19 Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS)

- PAT/PA 28 Privacy and Dignity Policy

- PAT/T 8 Specimen and Request Form Labelling Policy

- PAT/PS 7 Patient Identification Policy

- PAT/PA 2 Consent to Examination or Treatment Policy
- PAT/PA 24 Transfer of Patients and their Records

10. DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

11. REFERENCES

This policy is written in accordance with the following guidelines and policies: **BSH Guidelines**

- Use of Platelet Transfusions 2016
- Transfusion for Fetuses, Neonates and Older Children 2016
- Haematological Management of Major Haemorrhage 2015
- Use of Anti-D Immunoglobin for the Prevention of Haemolytic Disease of the Fetus and Newborn 2014
- Management of Anaemia and Red Cell Transfusion in Adult Critically Ill Patients 2012
- Pre-transfusion Compatibility Procedures in Blood Transfusion Laboratories 2012
- Investigation and Management of Acute Transfusion Reactions 2012
- Use of Irradiated Blood Components 2020
- Administration of Blood Components 2017
- The Estimation of Fetomaternal Haemorrhage 2009
- Spectrum of Fresh-Frozen Plasma and Cryoprecipitate products 2018

APPENDIX 1 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	**Division**	**Assessor (s)**	**New or Existing Service or Policy?**	**Date of Assessment**
Blood Transfusion Policy – Pre-Administration	Pathology	Gill Bell	New Policy	14.06.2021

1) Who is responsible for this policy? Name of Care Group/Directorate: Pathology

2) Describe the purpose of the service / function / policy / project/ strategy? The policy provides the Trust with local procedures for pre-administration of blood products.

3) Are there any associated objectives? Legislation, targets national expectation, standards – Yes compliance with BSQR 2005, BSH & NICE guidelines.

4) What factors contribute or detract from achieving intended outcomes? Lack of compliance

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

. **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation]

6) Is there any scope for new measures which would promote equality? [any actions to be taken

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	**Affected?**	**Impact**
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	**Outcome 2**	**Outcome 3**	**Outcome 4**	

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form - see CORP/EMP 27.

Date for next review: June 2024

Checked by: Atchuta Bobbili **Date: 14.06.2021**