

Irradiation of blood components for the prevention of transfusion-associated graft-versus-host disease

RIGHT COMPONENT TO RIGHT PATIENT SURVEY

Presented by
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Irradiated Blood Components

Right Blood to Right Patient

The BCSH Guidelines on gamma irradiation of blood components for the prevention of transfusion-associated graft-versus-host disease (1996) states:

- *Gamma irradiation is currently the only recommended method for TA-GVHD prevention.
Leucodepletion by current filtration technology is inadequate for this purpose.*
- *For at-risk patients, all red cell, platelet and granulocyte transfusions should be irradiated.*

SHOT report 2005 - incidents / reports related to irradiated blood components

Actual incidents	106
Near miss reports	45

SHOT recommendations in 2004 and 2005 have emphasised that:

Mechanisms must be put in place for appropriate and timely communication for information regarding special transfusion requirements

Robust systems for noting patients' special requirements should be developed together with a policy of empowering patients to be more aware of their own special needs

Irradiated Blood Components – Right Blood to Right Patient Survey

The survey was sent to hospitals in England, Wales, Northern Ireland and Scotland (via the blood services).

In England, the results were collated by the RTC administrators.
In Wales, Northern Ireland and Scotland results were collated by the blood services.



Country	Responses received
England (inc North Wales)	136 (133 / 3) - 122 NHS 14 Private
Wales	8
Northern Ireland	4
Scotland	15
Total	163

2 private hospitals responded that they did not use irradiated blood products.

Therefore the results given are for **161** responses.

Who receives irradiated blood components?

	Yes n=161	Policy
Allograft	151 (93.8%)	125 / 151 (82.8%)
Autograft	153 (95.0%)	124 / 153 (81.0%)
Purine Analogues	158 (98.1%)	126 / 158 (79.7%)
Hodgkins	154 (95.6%)	127 / 154 (82.5%)

Variation in duration

Purine Analogues - Duration

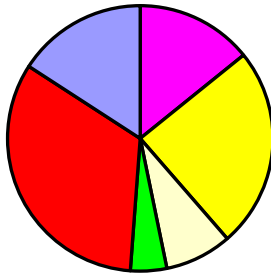
n=124



- 3 months (2)
- 6 months (17)
- 1 year (4)
- 2 years (5)
- Indefinitely (90)
- Other (7)

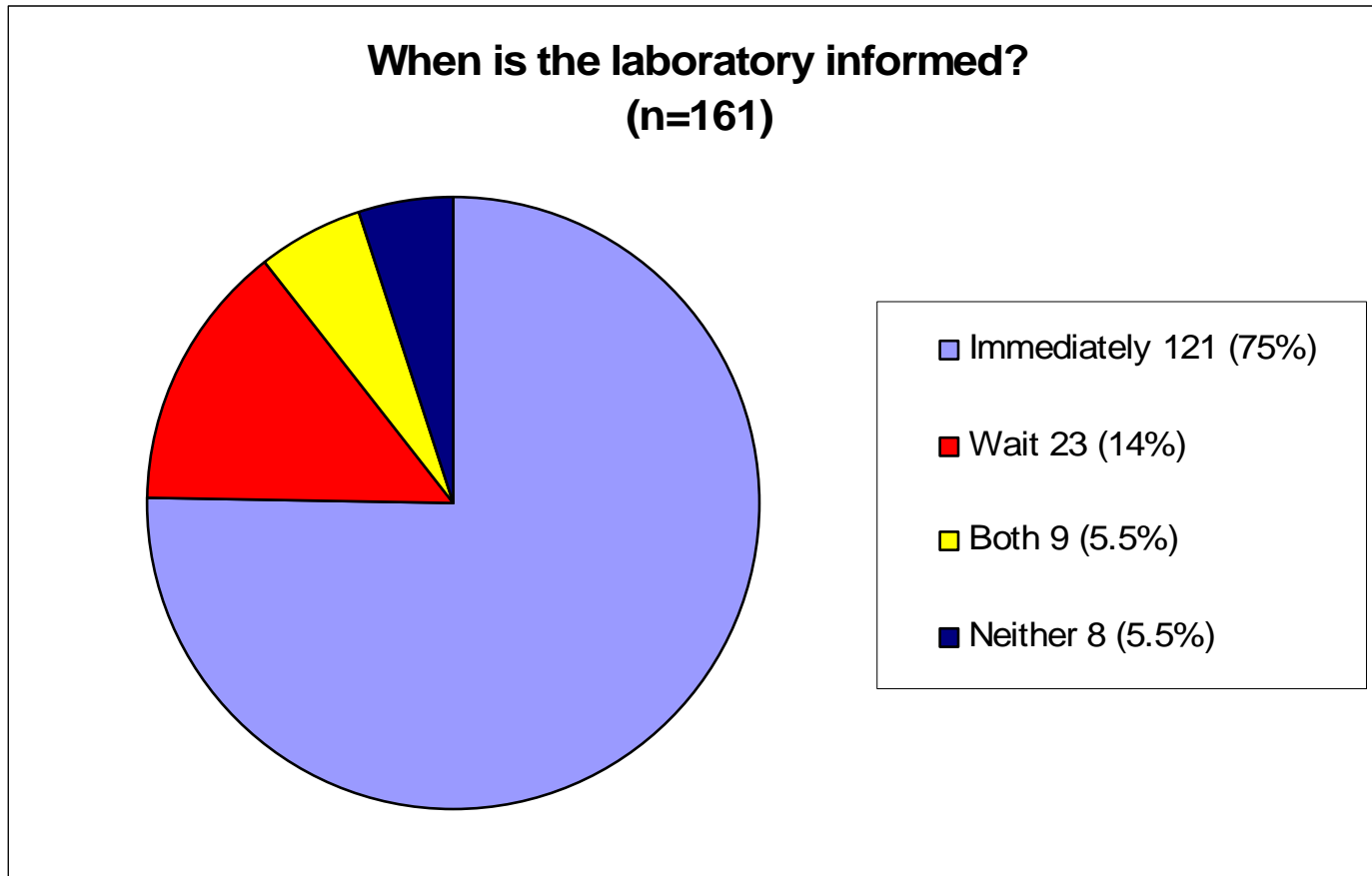
Allogeneic - Duration

n=119

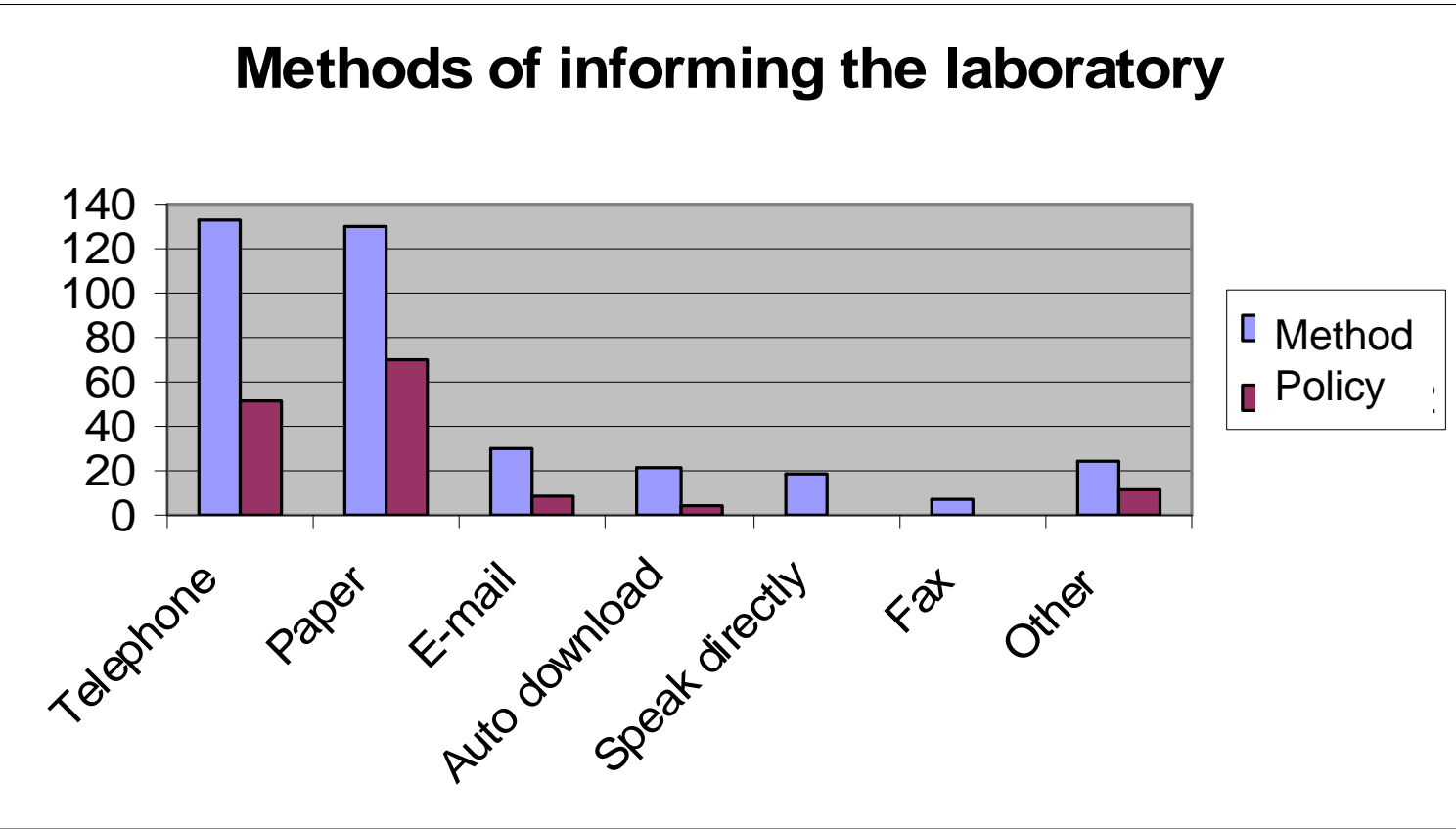


- 3 - 6 months
- 6 months
- 1 year
- 2 years
- Indefinitely
- Other

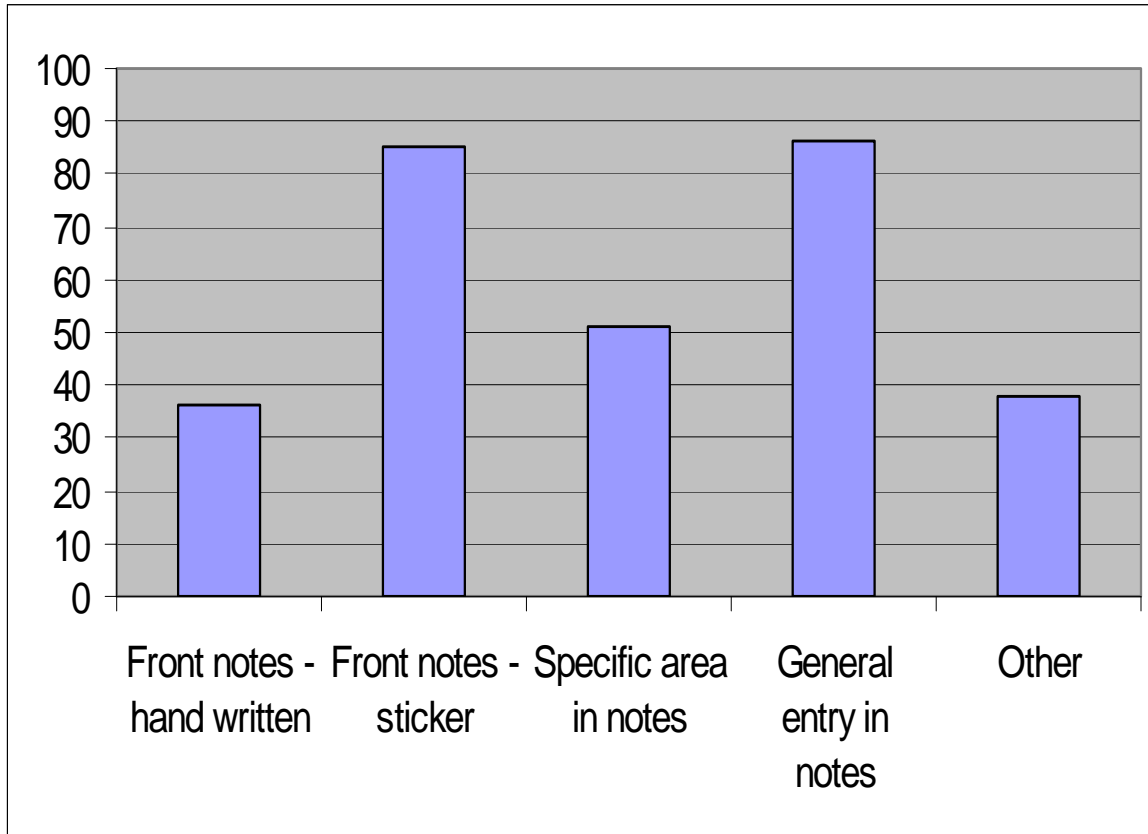
When is the laboratory informed?



How is the laboratory informed?



How is the requirement for irradiated blood components recorded?

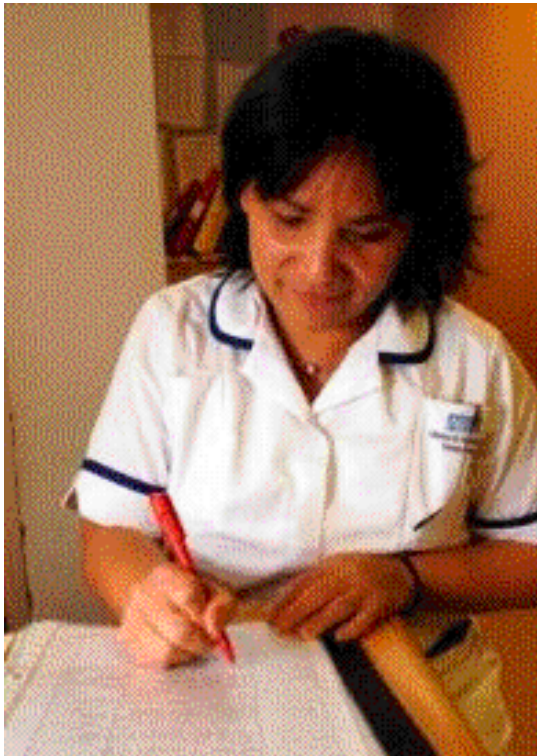


58 (36%) not identifiable on front of notes

31 (19%) general entry in notes only
no specific documentation area

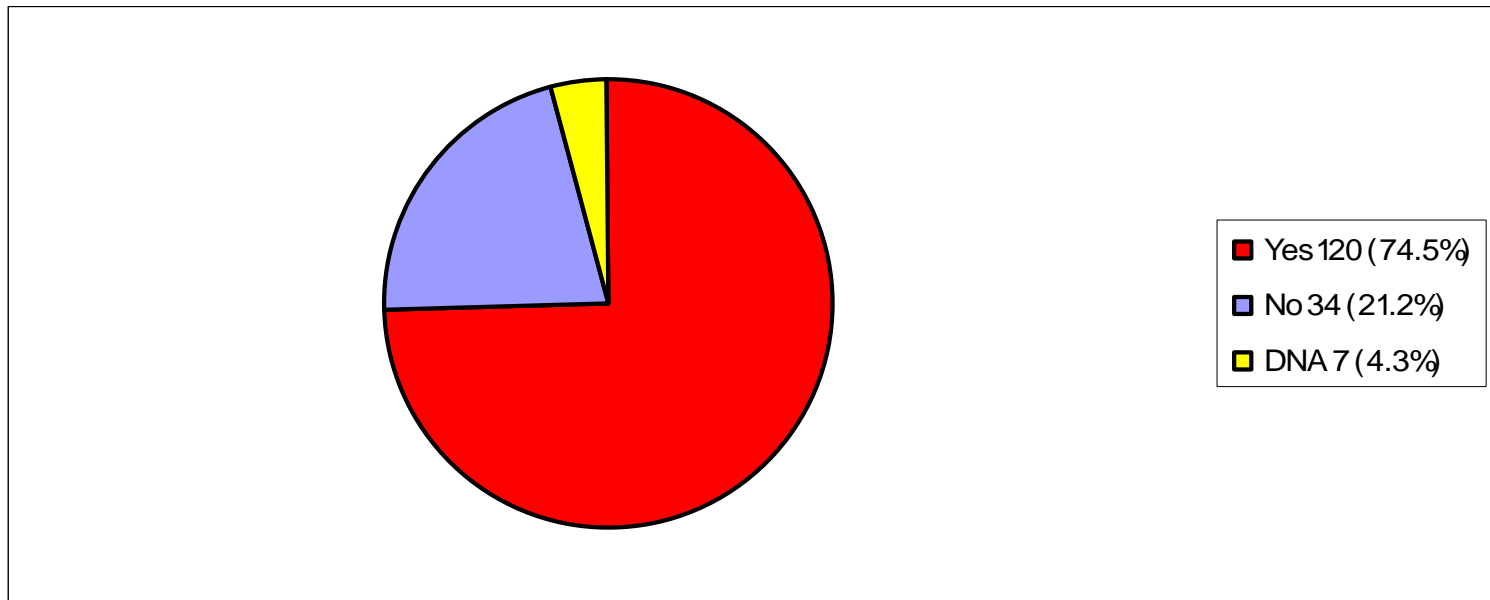
14 (9%) No entry in medical notes

What about the nursing notes?



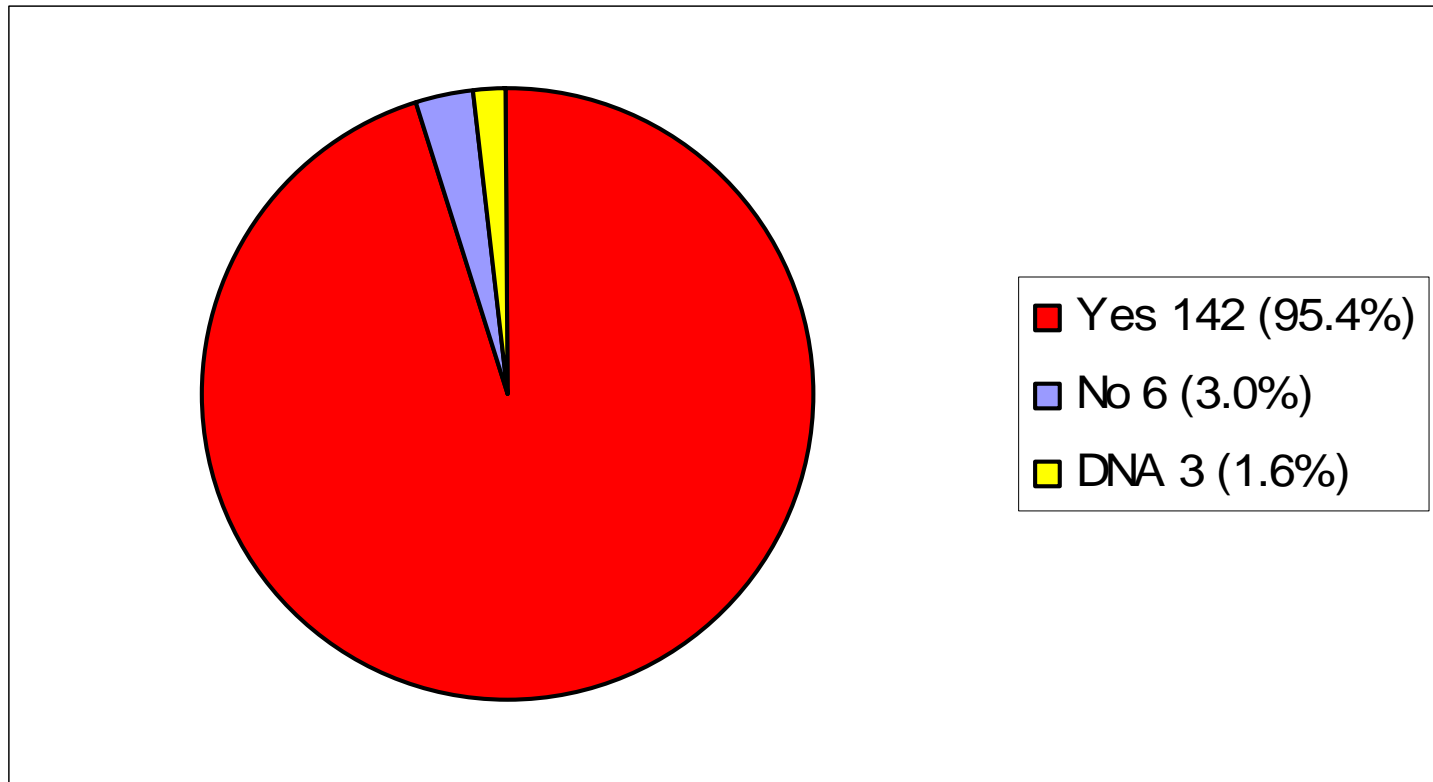
Only 42 / 161 (26.7%) stated that there was a specific area of the nursing documentation where the requirement for irradiated blood components is documented.

Does your hospital blood administration policy state that 'special requirements' must be checked as part of the final bedside check?



Does the laboratory IT system 'flag up' the need for irradiated blood components?

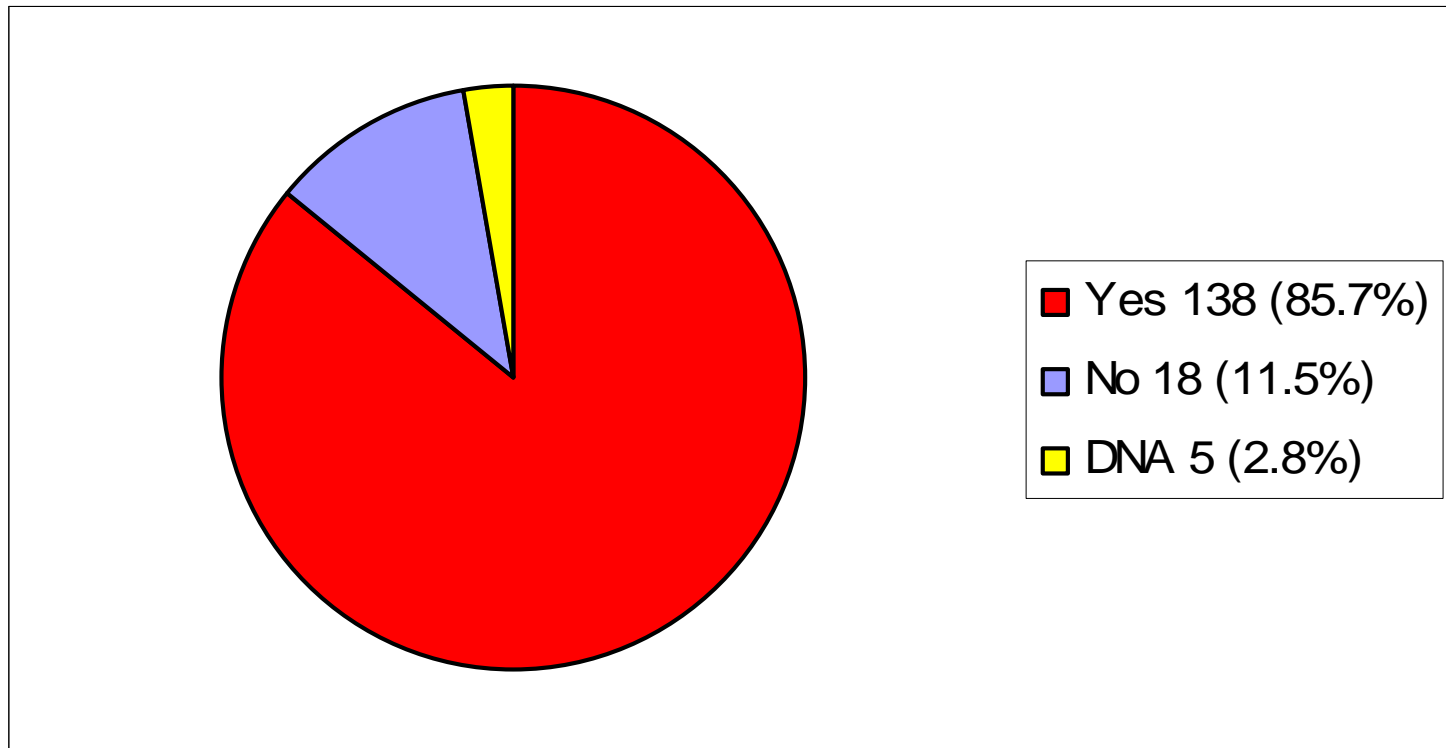
n=161





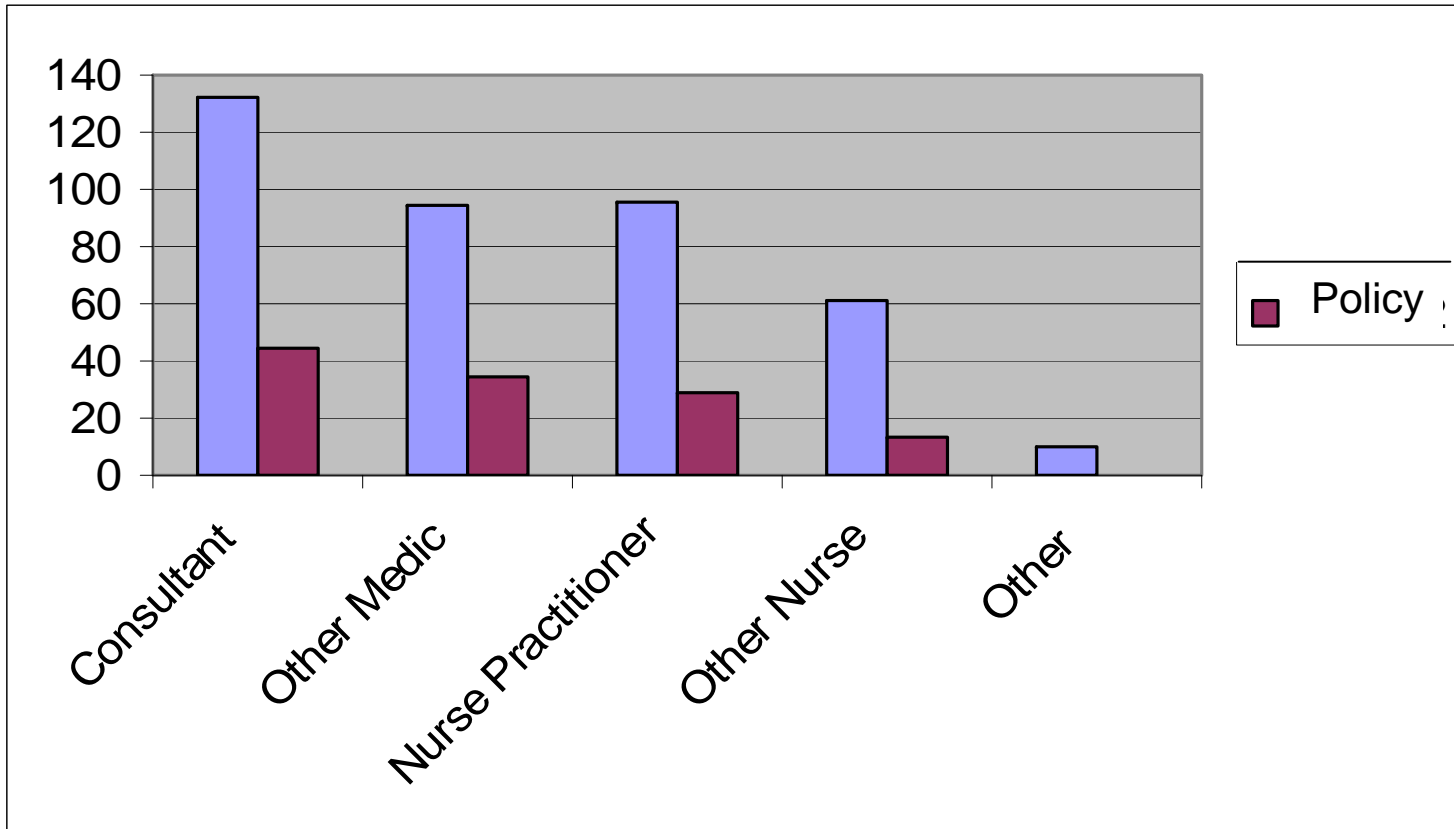
Are patients informed that they need irradiated blood components?

n=161



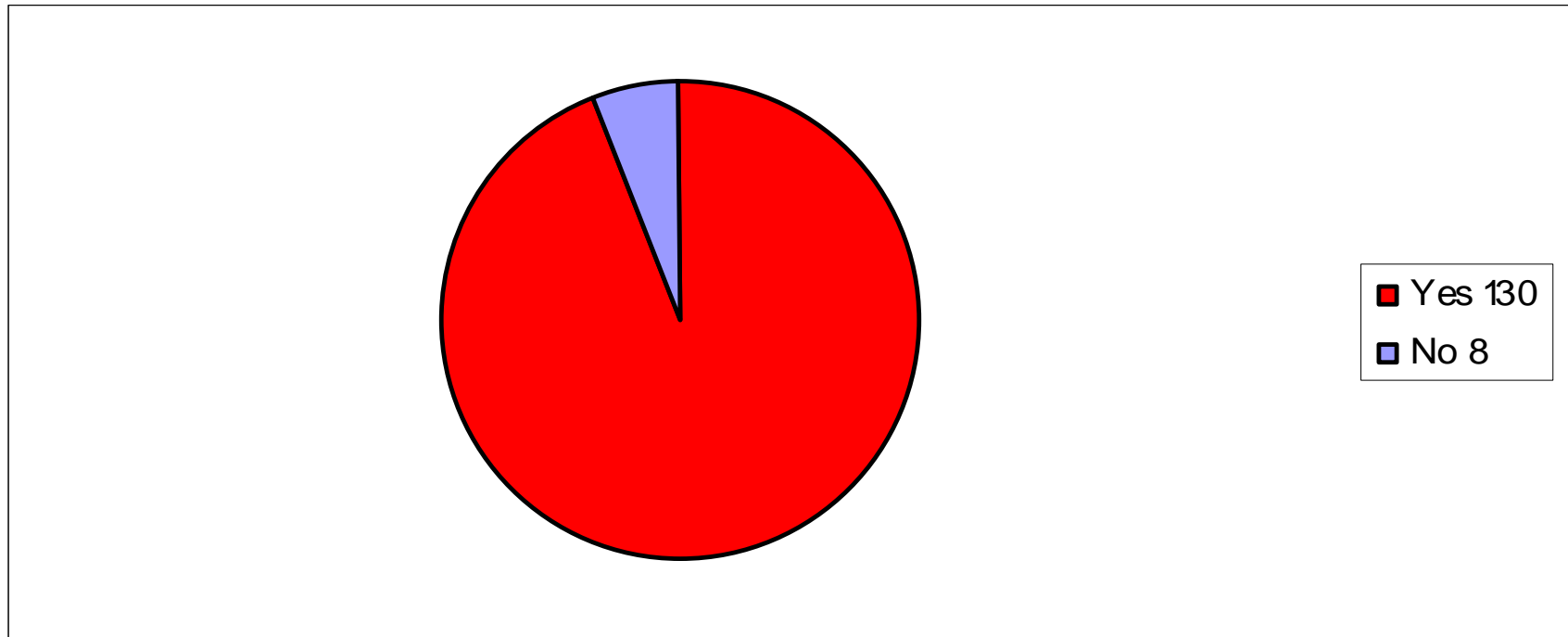
Who informs patients?

n=138 (patients are informed)

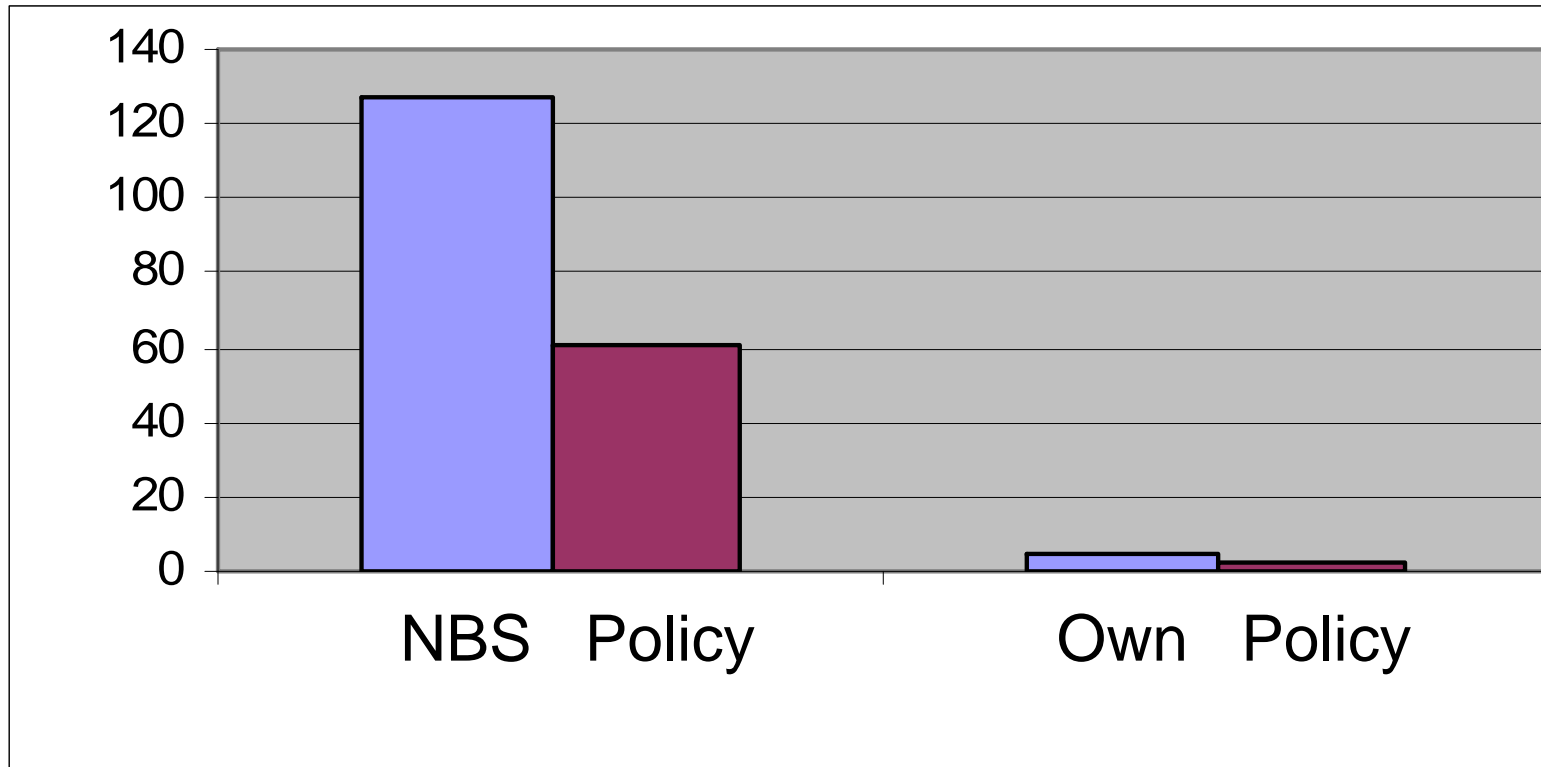


Are patients given any written information?

n=138 (patients are informed)

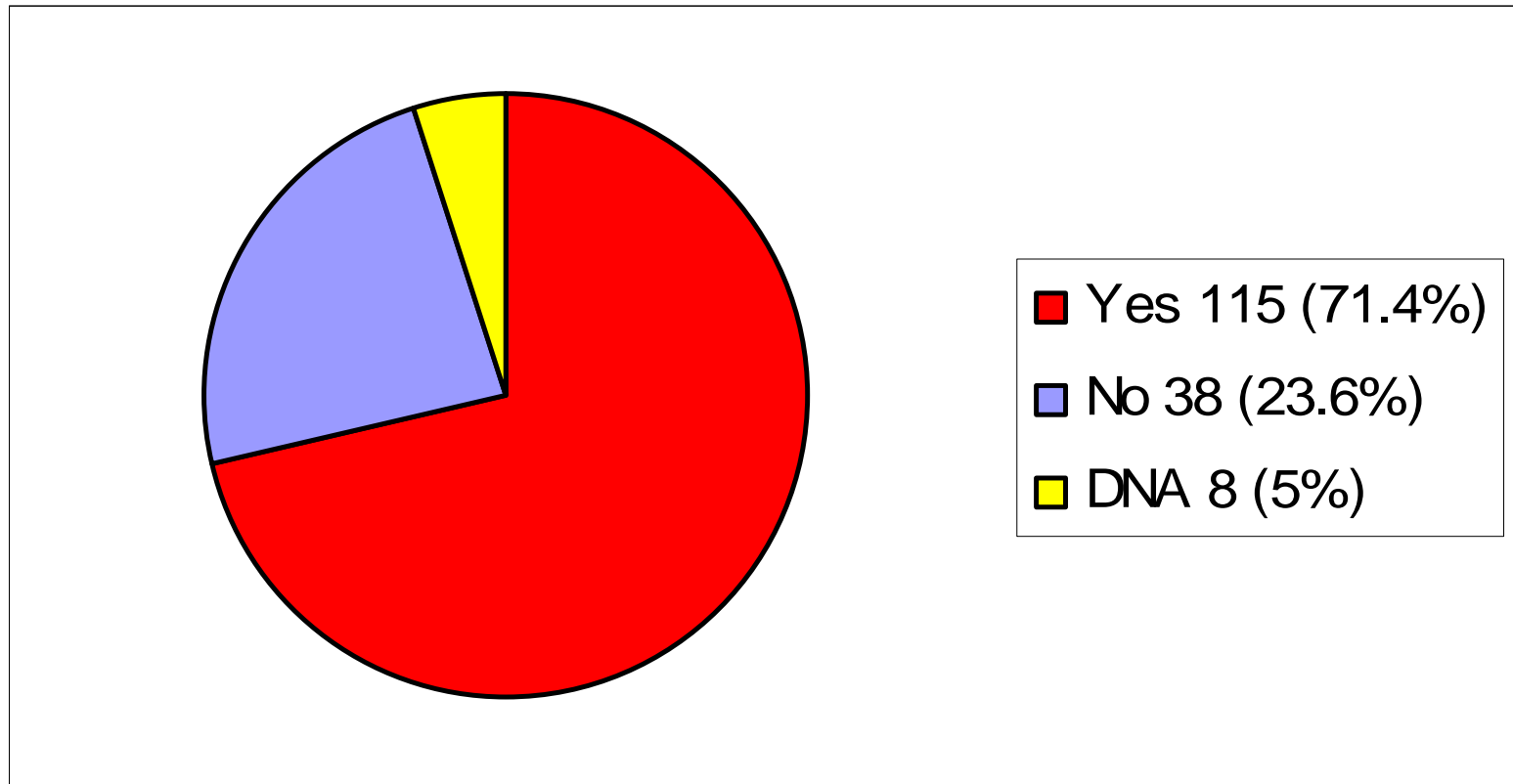


What written information is used?

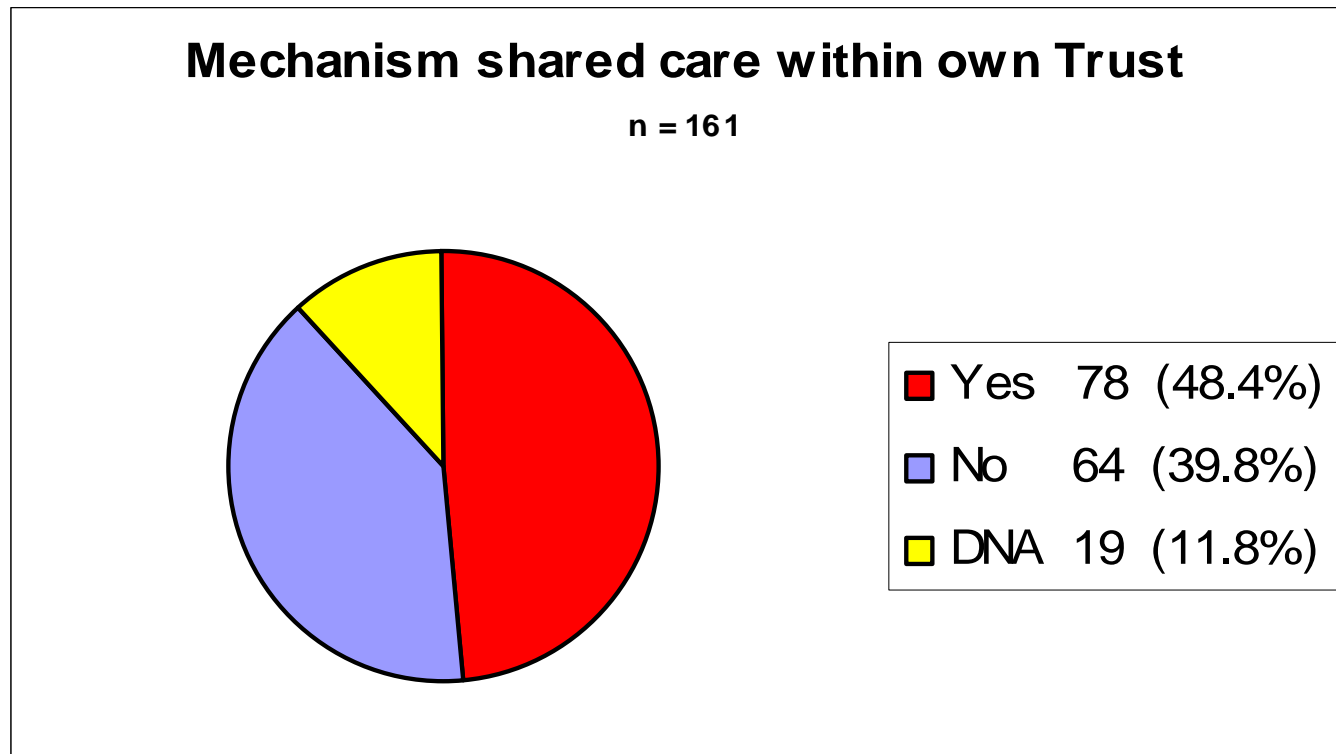


Are patients given an alert card to carry?

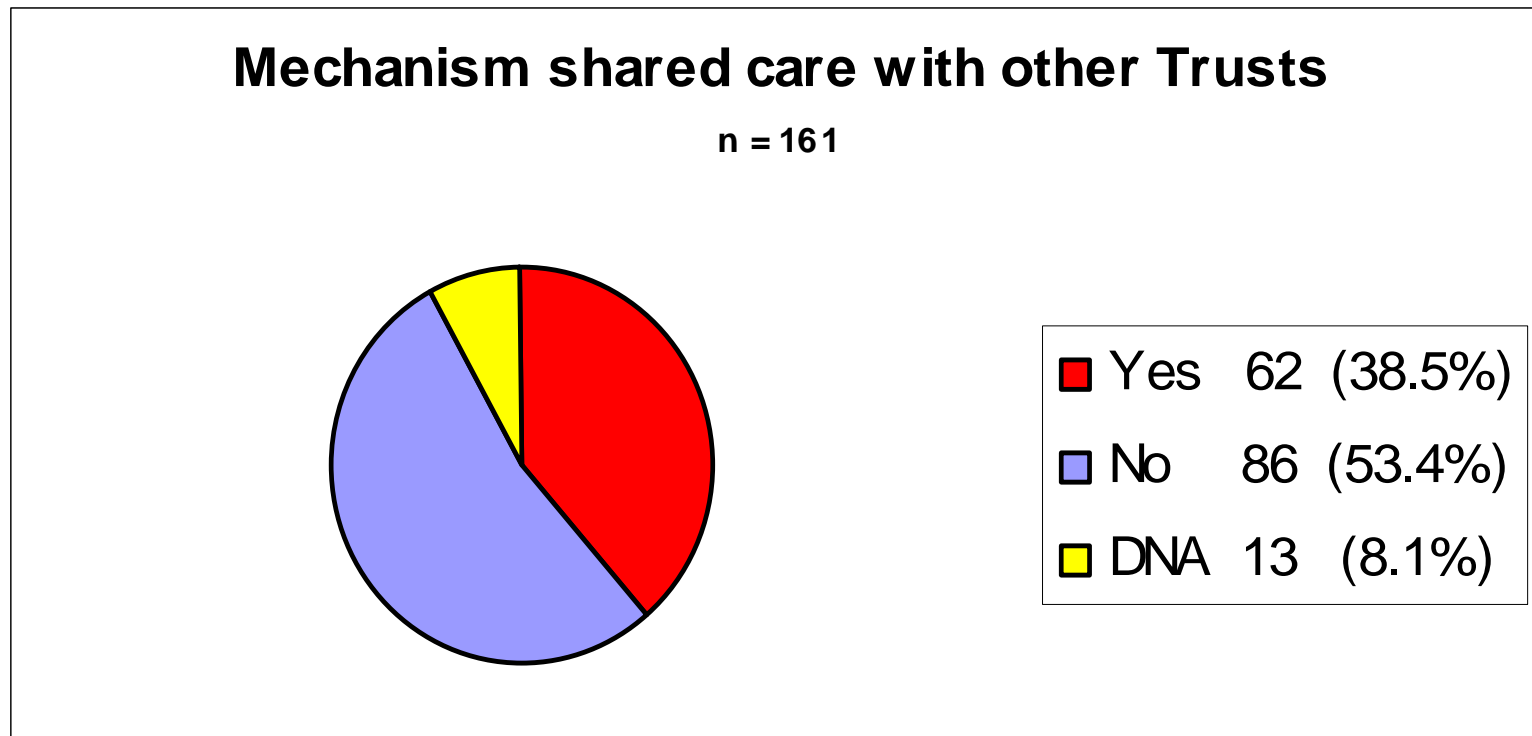
n=161



‘Shared care’: do you have a mechanism for informing other departments / hospitals within your Trust?



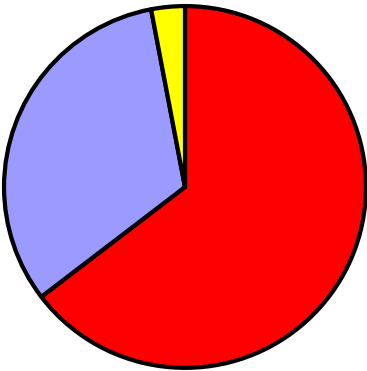
'Shared care': do you have a mechanism for informing other Trusts?



Failures of the mechanisms in place

Failures within own Trust

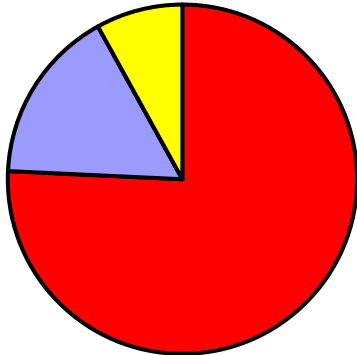
n = 161



■ Yes 104

Actual incidents / near misses

n = 161

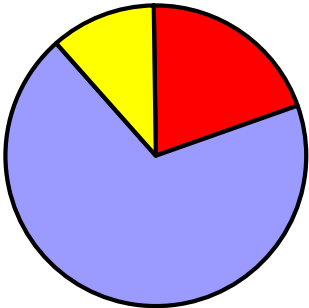


■ Yes	122 (75.8%)
■ No	26 (16.1%)
■ DNA	13 (8.1%)

Failures of the mechanisms in place

Failures from own Trust to other Trusts

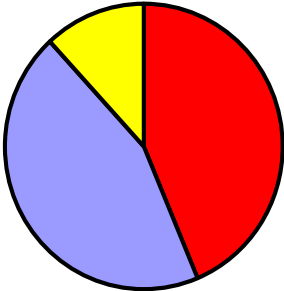
n = 161



■ Yes 32 (19.9%)

Failures from other Trusts to own Trust

n = 161



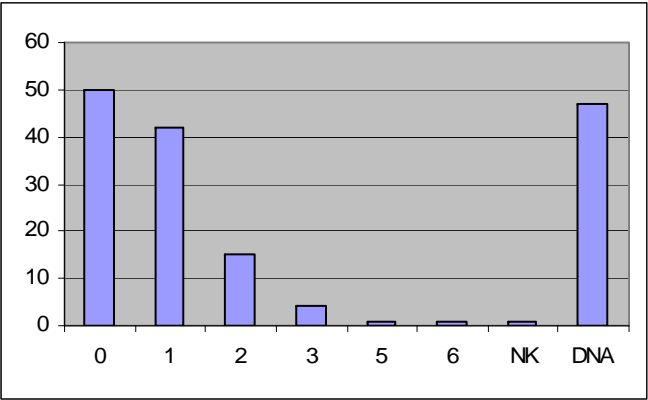
■ Yes 70 (43.5%)

■ No 72 (44.7%)

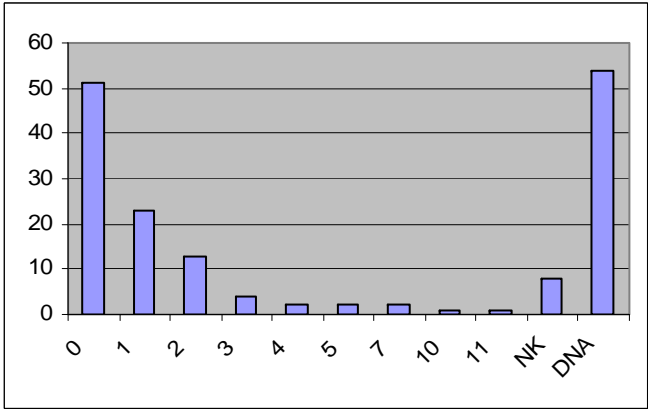
■ DNA 19 (11.8%)

How many incidents have occurred?

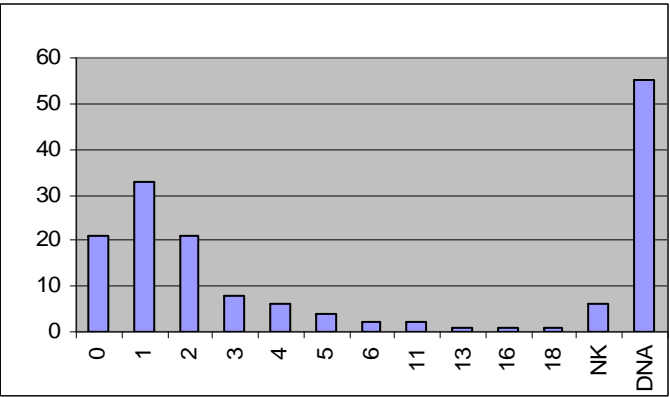
12 months actual



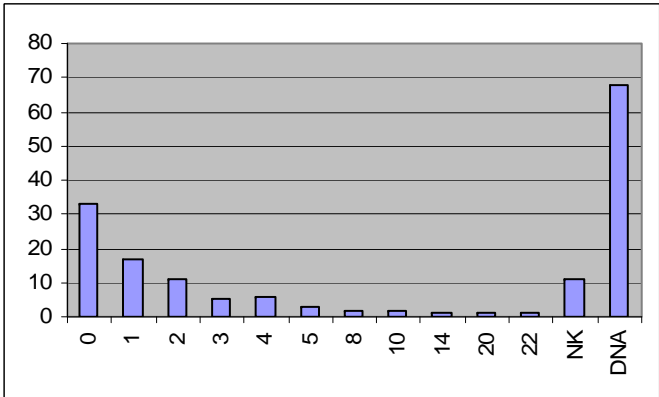
12 months near miss



5 years actual



5 years near miss



Additional comments

“Very poor in practice”

‘Time scales vary and are dependant on clinician’

‘This survey has exposed how woefully inadequate our policy is..’

‘poor documentation’

‘Main system failure is failure to notify blood bank’

‘No formal mechanisms.....’

**National and regional reports are
being produced....
available soon**

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