

Learning Points for Clinical Staff

Learning Point	Notes/Action
<ul style="list-style-type: none"> • Develop training programme of all clinical staff involved in the transfusion process. Only trained personnel to be permitted to collect and administer blood and monitor patients undergoing transfusion. • Involvement of medical director and clinical directors in the training of specialist trainee doctors and junior doctors, including cascading via grand round and clinical governance structures. • It is important when reviewing any incident that investigators examine the events leading to the error to determine if improvements to the process, procedure or system can be made. • Group O platelets can cause acute haemolytic reactions even when tested and labelled negative for high-titre haemolysins. They should only be used for non-group O patients (particularly paediatric patients) as a last resort, and should not be kept by hospitals as stock. • Acute reactions are often difficult to classify, particularly when laboratory tests are not undertaken, and when the patients is seriously ill. • Education of all relevant staff in the recognition of transfusion reactions and in appropriate intervention, investigation and documentation. • Transfusion reactions should be reported to the hospital transfusion team immediately, so that appropriate investigations can be undertaken • Highlight wristband identification policy to all admitting areas and ward nursing staff. Audit compliance with policy. • Raise awareness of blood/platelet transfusion procedures at senior nurses' meeting, and via the risk group and governance structure. • When PTP (Post Transfusion Purpura) is suspected there should be referral to a platelet reference laboratory for relevant investigations - Clinicians need to maintain awareness of this rare but treatable complication of transfusion. 	

Learning Points for Laboratory Staff

Learning Point	Notes/Action
<ul style="list-style-type: none"> • Manual processes are more prone to error. During process validation ensure that manual procedures and interventions are kept to a minimum and that appropriate checks are in place at weak, manual points of a process. • Competency assessment in ABO/D typing should include detection and interpretation of mixed field reactions. • Training and competency assessment in the laboratory must cover basic manual checking procedures to ensure that these are second nature at a time when automation and computerisation will have lessened experience and practice in these basic skills. • Laboratories must ensure that robust systems are in place for highlighting 'outstanding' work on a patient, for example positive antibody screen awaiting identification, group and screen not complete. • Competency-based training for laboratory staff must include staff who work out of hours, both those staff who do not work routinely in transfusion and those who do, and must apply to locum members of staff. • A laboratory quality system, as required by the Blood Safety and Quality Regulations, must include internal incident reporting mechanisms and appropriate, documented, corrective actions. • Transfusion laboratories must have thorough search strategies when looking for patient histories in order to find and reconcile multiple entries for a patient – see the section on laboratory errors related to IT. • A laboratory quality system must include process validation. The process of recording special transfusion requirements within the transfusion laboratory should be validated and must be kept as simple as possible. • Competency assessment of staff working in the transfusion department must include competencies in the provision of blood for specific groups of patients and in understanding the importance and use of 'special requirement' flags. • Ensure implementation and monitoring of a comprehensive quality system covering blood component handling and storage to meet the requirements of the Blood Safety and Quality Regulations. • If the patient has been transfused within the last 3 – 14 days, a fresh sample should be taken within 24 hours of the next transfusion, in line with BCSH guidelines. • Kidd antibodies are often difficult to detect, and more sensitive techniques may be required to confirm the identification. 	