

### Adverse Events Related to Anti-D Immunoglobulin - Previous Recommendations

Year first made	Action	Recommendation
2011	Hospital Transfusion Laboratories, Hospital Transfusion Committees Trust/ Hospital/Health Board Chief Executive Officers (CEOs)	All organisations involved in the issue and administration of anti-D Ig must ensure that their systems are robust with respect to issue, receipt and recording, and should audit their systems with a view to increasing the safety and security of the process
2011	Hospital Transfusion Laboratories, Hospital Transfusion Committees Trust/ Hospital/Health Board Chief Executive Officers (CEOs)	Kleihauer tests that suggest a transplacental haemorrhage of >2mL, or that give equivocal results, should be referred for flow cytometry at the earliest opportunity  Laboratories performing Kleihauer screening must participate in external quality assessment schemes
2010	Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of General Practitioners	All healthcare professionals involved in the issue and administration of anti-D Ig must complete the anti-D modules in the Learn Blood Transfusion e-learning programme.
2010	HTCs	If there is any doubt as to the true RhD status of a patient, or whether anti-D detected in an antibody screen is of immune or prophylactic origin, and these questions cannot be quickly resolved, then prophylactic anti-D Ig should be administered rather than place the patient at risk by withholding it.
2009	HTCs	Trusts must ensure that there is representation from midwives and obstetricians on hospital transfusion committees, with the aim of jointly drawing up straightforward local protocols for the request, issue and use of anti-D based on well-established national guidance.
2009	HTCs, Trust CEOs	Cases of late administration, omission, or inappropriate administration of anti-D immunoglobulin must be the subject of internal follow-up within trusts via established governance mechanisms.

<b>2008</b>	<b>HTCs</b>	Trusts should ensure that robust systems under overall control of the hospital transfusion laboratory are in place, to ensure that anti-D Ig is issued on a named patient basis, to ensure appropriate use and to meet traceability requirements.
<b>2007</b>	<b>Consultant haematologists with responsibility for transfusion, HTCs, HTTs</b>	D-typing should be performed by the routine methodology available in the hospital transfusion laboratory, not by emergency techniques which may not be as robust.
<b>2007</b>	<b>NBTC, NHSBT Appropriate Use of Blood Group, IBMS, BBTS, BCSH, Royal Colleges of Midwives, O&amp;G, GPs</b>	Obstetricians and midwives must be familiar with the national guidance for routine antenatal anti-D prophylaxis and the rationale behind it. National guidance regarding all anti-D prophylaxis should be standardised. There is a need for clear and unambiguous advice to ensure that all hospitals are able to develop local guidelines that reflect national consensus.
<b>2007</b>	<b>Trust CEOs, consultant haematologists with responsibility for transfusion, HTCs, HTTs</b>	There should be clinical follow up and retesting in six months of patients in whom anti-D administration has been delayed or omitted. The outcome should be reported to SHOT as well as internally within the Trust.