Summary of Incidents Related to Transplant Cases - Previous Recommendations

Year first made	Action	Recommendation
2012	**Clinical transplant teams; Transfusion Laboratory managers, Hospital Transfusion Teams**	To minimise transfusion errors, a written transplant programme detailing key dates and blood group information, should be developed for each transplant recipient. This should be sent, with written confirmation of receipt, to the transfusion laboratory in the hospital where the transplant is being undertaken, the shared care centre and its transfusion laboratory
2012	**The BCSH Transfusion Task Force; the British Society of Blood and Marrow Transplantation (BSBMT)**	Guidelines should be developed that cover the procedures, particularly communication protocols, necessary for managing transplant patients, especially where ABO/RhD mismatched transplants have been given. This should be a standard for all transplant centres