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We Can't Implement the Two Sample Rule!

How can it be implanted?

- ◆ When a patient attends a clinic for the first time and it is decided that an operation or procedure is necessary, take a Group and Antibody screen sample. This will ensure one historic group on the patient's transfusion history.
- ◆ When the patient attends pre op clinic within seven days of an operation, take a sample, if sample timing allows. If sample timing does not allow, arrange for patient to come back and have second sample taken within permissible time period or on admission.
- ◆ When issuing a transfusion report on first time patients, state:

"first presentation: A check group sample will be required should this patient require blood transfusion"

In emergency situations inform the Doctor immediately if a second sample is required, do not wait until blood is required

- ◆ When speaking to Medical staff don't ask for a "second sample", ask for a "confirm group sample". There is a lot less resistance this way!

1 In order to succeed, engagement of ALL staff, Laboratory and Medical is essential, especially those in Emergency Care, be sure to emphasise reasoning, giving examples if necessary. With a little determination and patience the two sample rule can be implemented successfully and with little inconvenience to patients, medical staff and blood transfusion staff.

We cannot implement the rule because:

"They will take two samples at the same time and keep one back in case they need it"

2 Ensure two sample rule is covered on transfusion training and they are fully aware of why it is required. Make them aware of the potential consequences if they do that, to both the patient and themselves. If it did become a persistent problem consider using a different colour sample tube obtainable only from the laboratory as a last resort.

"We will not be able to cope with the increased workload"

3 Recent audits show over 90% patients requiring red cells already have an historic group on record. Increase workload is minimal to the extent of not being noticeable. Second sample may allow "Electronic Issue" in situations where a full crossmatch may have been necessary therefore saving time.

"There would be a delay in providing blood in an emergency"

Emergency blood is always available. Stress need to take confirm sample before giving any emergency blood.

"There will be an increase in use O Rh (D) Neg"

4 This did not happen, there are very few occasions where the patient did not have an historic group and there was not sufficient time to supply to confirm group sample

"We cannot supply two samples on Neonate/Paediatrics they are very difficult to bleed"

One of the sample collection requirements are already not available for Neonate/Paediatrics: you cannot ask them their Name and Date of Birth. Recent findings by a study in the North East shown that there were more WBIT incidents in Paediatrics than in any other speciality.

Once an initially sample has been received only a very small amount is required to perform a confirm group.

By Barry Chesterson, Senior BMS

In this issue:

We Can't implement the Two sample Rule!

By: Barry Chesterson, Senior BMS, Transfusion, Warrington and Halton NHS Foundation Trust

'Single Unit Transfusion —Is this the way forward?'

By: Dr A Allameddine, Consultant Haematologist, Pennine Acute Hospitals NHS Trust

'Transfusion Awareness Day'

By: Sharron Jackson, Transfusion Practitioner, The Christie NHS Foundation Trust

'Transfusion Crossword'

By Elaine Wain, Transfusion Practitioner, Ysbyty Gwynedd, Bangor

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Single Unit Transfusion Is this the way forward?

Blood resources are limited and provision is reliant on the availability of volunteer donors. Maintaining an adequate blood supply is a real challenge due to the declining number of people willing to donate. Last year 2.1 millions units of blood were collected in the UK from about 1.6 millions donors. Although the donor base is adequate to meet the current demand, it is expected that this will be a real challenge for the future.

Patient Blood Management, a recent initiative by the NHSBT, is a patient-focused multidisciplinary model aiming to deliver better patient outcomes through the effective conservation and management of patients whilst avoiding the use of allogeneic (donor) blood. The use of restrictive transfusion triggers and implementation of a single-unit transfusion policy could be the way forward to achieve this.

Historically and despite a lack of studies, most guidelines recommend double-unit transfusions, while only a few, including more recent guidelines, recommend single-unit red cell transfusions in the absence of active bleeding. Recent data suggests that a single-unit transfusion is safe and can considerably reduce the total red cell requirement. A study by Berger et al (Haematologica 2012) showed that a change from a double to single-unit red cell transfusion policy is safe, associating this with a 25% reduction of red cell transfusions, and at the same time only a moderate increase in workload for the health care professional for haematology and oncology patients. This finding demonstrates that the long-standing dogma that two units are necessary for an adequate haemoglobin increase must be critically revised.

The Pennine Acute Hospitals NHS Trust intends to change their policy for hospitalized patients without active bleeding from double to single-unit RBC transfusions. This will involve issuing one unit of red cells at a time from the Hospital Blood Bank. The single-unit transfusion policy will be established in all hospital wards with the exception of intensive care units, emergency wards and theatres. More than one RBC unit will be issued if explicitly prescribed by the treating physician (e.g. in cases with active bleeding).

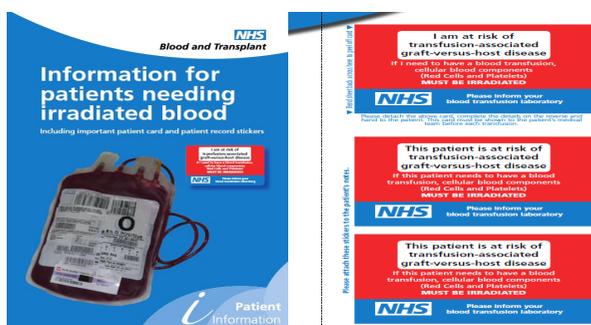
It is anticipated that by implementing a single-unit transfusion policy a saving of up to 25% of red cell issues will be made.

**By Dr A Allameddine,
Consultant Haematologist**



Special Requirements

Some patients are at risk of Transfusion Associated Graft-Versus Host Disease (TA-GvHD), these patients will carry an alert card given to them at diagnosis by the medical team responsible for their care. Irradiated blood components are required for these patients, always inform your Hospital Blood Bank of these patients if you see this card.



Transfusion Quiz Answers

- Across:** 2 Overload, 6 Retrospective, 9 Competent, 10 Platelets, 11 Prothrombin, 12 Consent, 13 Date of Birth
Down: 1 Tranexamic acid, 3 Red Cells, 4 Pyrexia, 5 Regulations, 7 Special, 8 Hand Written, 9 Coldchain



The Christie NHS Foundation Trust

'Transfusion Awareness Day'

By Sharron Jackson, Transfusion
Practitioner

The Christie NHS Foundation Trust hosted a transfusion awareness day which was held on the 10th of June 2013 in celebration of 'National Blood Week' and the new campaign 'Right Patient Right Blood'.

The day was a huge success with 164 patients, relatives, visitor's and staff joining Sharon Jackson the Transfusion Practitioner and Bill, Syed, Steve and Adam from the Jehovah's Witness community to discuss and

Each stand provided information on different topics. Blood donation provided the biggest interest from the visitors and relatives to the day.

The Jehovah's Witness information and community members had interest from patient's looking for alternatives to transfusion.

The Transfusion Practitioner and Medical Illustration developed a rolling video and audio for individuals to listen to while browsing the stands. Patient interviews also played providing the attendee with personal accounts of the transfusion process and/or pathway and treatment from a patients perspective.

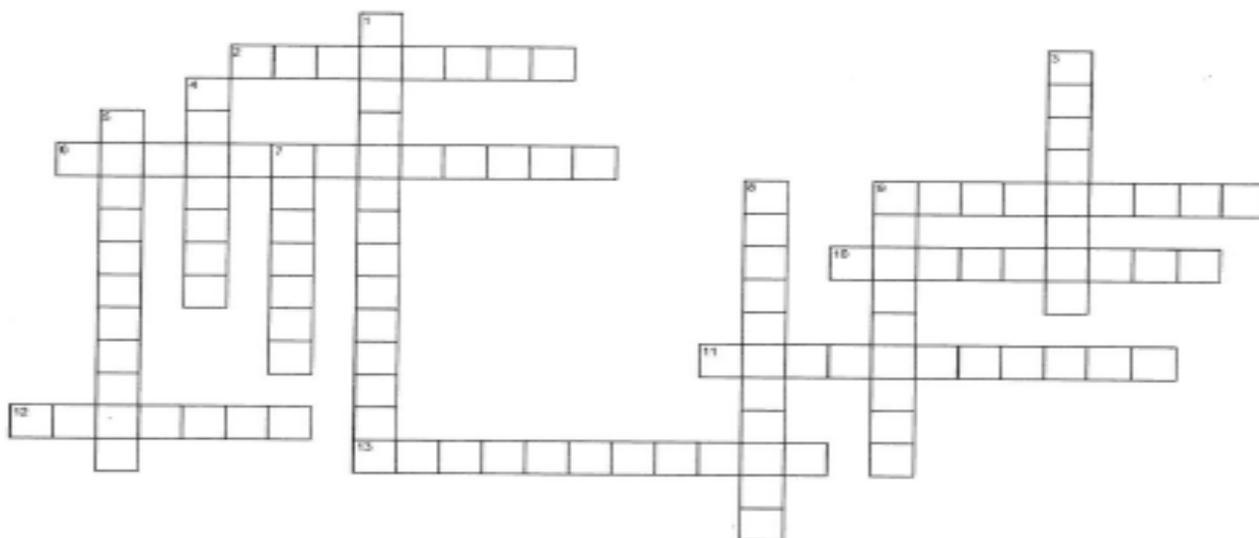


Special thanks to the following for making the day so successful:

- ◆ **Thelma Gowenlock;** volunteering services, who worked tirelessly meeting and greeting.
- ◆ **Anne Murtagh;** Medical Illustration Manager who assisted with photos and videos
- ◆ **Sean Boulton;** Estates Office (specialist services) who provided the 'muscle' moving stands etc.
- ◆ **Jayne Addison;** NHSBT, Patient Blood Management Practitioner who provided support and information

Transfusion Crossword – Can you do it?

By Elaine Wain, Transfusion Practitioner



ACROSS

- 2 Complete the sentence 'Transfusion Associated Circulatory?'
- 6 What consent is obtained if the patient is unconscious at the time of transfusion?
- 9 All staff must be deemed when dealing with any blood components
- 10 These are needed to initiate the clotting mechanism
- 11 The INR test for monitoring a patient on warfarin therapy is calculated using thetime
- 12 This must be obtained prior to the transfusion taking place
- 13 A mandatory identifier required on a transfusion sample

DOWN

- 1 What initial medication should be considered in massive haemorrhage?
- 3 Cells that carry oxygen
- 4 This symptom could indicate a transfusion reaction
- 5 Complete the sentence 'Blood Safety and Quality2005'
- 7 CMV and irradiated components are commonly known as '..... requirements'
- 8 If bedside technology is not available, all transfusion samples must be
- 9 A term used to indicate that blood is kept at the optimum temperature

(Answers on page 2)

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