

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Policy for the Collection and Delivery of Blood Products from Blood Transfusion Laboratory to the clinical areas.

Effective: January 2011

Review: January 2013

1. Introduction.

It has been reported in the Serious Hazards of transfusion report (SHOT 2003) that 40% of the errors occur during the collection and administration of blood products. The Blood Safety and Quality Regulations 2005 state that hospitals must ensure that the cold chain is observed at all times. That is 'ensuring that storage conditions are observed at all times, including during transportation.' 'The cold chain starts from the receipt of the blood from the blood centre to the time the unit is transfused or otherwise disposed of.' This policy is to advise staff in the correct procedure for the collection and delivery of blood products from the Blood Transfusion Laboratory to the clinical area. It will outline the responsibilities of those involved in the procedure.

2. Authorised Staff:

All staff must be competency assessed every Two years and have yearly updates by the Transfusion Nurses/Blood Transfusion staff. Training occurs within the departments or during staff inductions.

- a) Porters.
- b) Registered nurses.
- c) Health care assistants.

3. Request:

3.1 Telephone Request to the Porters:

The following patient information **must** be given to the porters. This will be written on a 'porters slip' if the blood is urgent please emphasise this to the porters when the request is made. If the blood is urgent the blood transfusion laboratory should be telephoned expressing the urgency of the transfusion.

First Name
Surname
Date of Birth
Medical Record Number (MRN)
Ward where product is to be delivered
Product required
Number of units required

3.2 Requests for Ward Staff to Collect:

If a member of the ward staff is requested to collect blood/blood products they **must** have written identification e.g. notes or any documentation with the patient's details.

3.3 Request for Unconscious / Unknown Patients:

In accident and emergency departments where the patient has no identification the following will be accepted

MRN
Unknown Male/Unknown Female.

4. Collection:

All Blood Products units with the exception of Human Albumin Solution (HAS), Anti-D injections, PCC and Novo seven will be delivered in a *Red Transport Box with Cool Packs*

4.1 Red Blood Cells Fresh Frozen Plasma Octaplas Cryoprecipitate:

Check that the blood product unit required is available by checking the following:

- 4.1.1 Look in the red box in the issue room for a 'signing out form' If the 'signing out form' is not available go to the laboratory and ask a member of staff for help and advice.
- 4.1.2 Check the information on the 'signing out form' is the same as the identification details given by the ward
- 4.1.3 Take the blood product unit from the fridge. The blood products are stored in alphabetical order (Surname) then expiry date order for that patient.

NB. Always take the unit in order on 'signing out form'
- 4.1.4 Check the patient details on the unit tag with the identification details given by the ward.
- 4.1.5 If correct, check the donation number is the same on the unit tag and the 'signing out form'.
- 4.1.6 Sign and record the date, time, clinical area where the blood product is to be taken to on the 'signing out form' for each individual unit adjacent to the unit details.
- 4.1.7 Place blood in a Red Transport box with Cool Packs, ensure that the lid is correctly Zipped around the box.
- 4.1.8 Replace the 'signing out form' in alphabetical order back into the red box in the issue room.
- 4.1.9 Deliver immediately to the clinical area.

4.2 Platelets:

Platelets are collected directly from the laboratory.

Ask a member of the laboratory staff for the platelets:

NB. Platelets are not to be transported in the same box as any other Blood Products

- 4.2.1 The laboratory staff should 'hand over' the platelet unit and the 'signing out form'
- 4.2.2 Check the information on the 'signing out form' is the same as the identification details given by the ward
- 4.2.3 Check the details on the unit tag with the identification details given by the ward.
- 4.2.4 If correct, check the donation number is the same on the unit tag and the 'signing out form'.
- 4.2.5 Sign and record the date, time, and clinical area where the Platelets are to be taken to on the 'signing out form' for each individual unit adjacent to the unit details.
- 4.2.6 Place Platelets in a Red Transport box, without cool packs, ensure that the lid is correctly zipped around the box.
- 4.2.7 Replace the 'signing out form' in alphabetical order back into the red box in the issue room.
- 4.2.8 Deliver immediately to the clinical area.

**4.3 Collection Of Batch Products For Named Patients:
Human Albumin Solution (Has)
Anti-D Injections
Pcc (Beriplex)
Novo Seven**

Batch products are collected directly from the laboratory.

Ask a member of the laboratory staff for the required batch product.

NB. Batched Products do not require transporting in a Grey box.

- 4.3.1 The laboratory staff should 'hand over' the batch product and the 'signing out form'.
- 4.3.2 Check the information on the 'signing out form' is the same as the identification details given by the ward
- 4.3.3 Check the details on the unit tag with the identification details given by the ward.

- 4.3.4 If correct, check the donation number is the same on the unit tag and the 'signing out form'.
- 4.3.5 Sign and record the date, time, and clinical area where the blood product is to be taken to on the 'signing out form' for each individual unit adjacent to the unit details.
- 4.3.6 Replace the 'signing out form' in alphabetical order back into the red box in the issue room

5. Delivery:

5.1 Delivery of Products to the Clinical Areas:

On receipt of the blood products a member of the ward staff must check that the correct product has arrived by:

- 5.1.1 Opening the box to ensure the correct product has been delivered
- 5.1.2 Check the name of the patient to on the unit to ensure it is for the correct patient.
- 5.1.3 Reseal the Red box and sign the porters' slip, ensuring the date and time is also recorded.
- 5.1.4 The porter retains the slip and places it in a collection box situated in the porter's room/theatres. The collection box is changed by a member of the laboratory staff monthly.
- 5.1.5 The product, if not a batch product, delivered is to be kept in the Red box until ready for use.

Once the blood product has been used, telephone the porter to collect the transport box.

All blood products should be administered in accordance with the Blood Transfusion Policy.

If in doubt about any of the above contact a member of the laboratory staff

The policy will be reviewed by the Transfusion team.
31/1/2013

1. Personnel

Compliance with the above policy will be monitored by the following personnel;

- Dr. J.P. Wallis (Consultant Haematologist)
- Miss. Y Scott (Blood Bank Manager)
- Mrs. S Whitehead (Blood Transfusion Nurse)
- Mrs. S Avery (Blood Transfusion Nurse)
- Mr. I Mellors (Quality Manager Haematology)

2. Background

The Department of Haematology is required to comply fully with the standards for Blood Transfusion and Medical Laboratory practice against which it is regularly and independently inspected by external assessors. Accreditation status is awarded on the basis of the inspection findings and the accreditation status is published in the public forum.

The department is inspected by Clinical Pathology Accreditation (UK) Ltd. on a bi-annual basis against international standards ISO 15189 (Quality Management) and ISO17025 (Medical Laboratory Practices).

The department is required to submit an annual compliance report to the Medical and Health Regulatory Agency (MHRA) stating it's compliance with blood bank and blood transfusion regulations and with British and European Law governing blood bank practices (Blood safety and quality regulations 2005 and Blood safety and quality [amendment] regulations 2006).

The department of Haematology has been externally inspected by both organizations in 2008 and currently holds full and unconditional accreditation.

3. Regulation requirement

The department of Haematology is required under regulations to have clearly identified management structures in place with clear professional clinical direction in all of its areas of activity. This role in blood transfusion practice is filled by Dr J P Wallis (Consultant Haematologist). The services offered have to meet the requirements of its services users and there should be adequate space, suitable equipment, staff training programs in place, non-conformance systems management review systems, document control and quality management systems in place, and functional systems for self audit and reflective learning.

4. Audit and self regulation

The department of Haematology has a documented training programme for all staff groups within the Trust who are responsible for the distribution of blood components from the Transfusion Laboratory to clinical areas (this includes porters, Nurses, ODP's, Clinicians and Laboratory Personnel). The department is required to assess competence in these

areas and implement corrective action where there is a failure to meet required standards. The competence assessment process is carried out by the personnel listed in point 1 above. The assessment processes are continuously occurring and cover a 3 year period before reassessment. Reassessment will occur immediately where poor performance is detected by non-compliance audit processes.

5. Non-compliance processes

The department of Haematology undertakes 'real time' non-compliance audit. Non-compliances are recorded and investigated immediately within the department. The Transfusion Nurses, Blood Bank Manager and laboratory staff will carry out initial investigations. The non compliances are signed by the Blood Bank Manager, The Operational Manager and finally signed off by the Quality Manager.

All non compliances are discussed at bi-weekly Transfusion non-compliance meetings between the Blood Transfusion Nurses, Blood Bank Manager and Quality Manager. Further investigations and corrective action plans are formulated and implemented through this group.

Non-compliances are escalated as required to Trust Risk Management (reported through DATIX), Serious Hazards of Transfusion (SHOT) and MHRA as appropriate. The latter two are dependant on severity and are done to meet legal requirement.

The Trust has a Blood Transfusion Committee which meets 3 times a year and is chaired currently By Dr. I Warnell (Consultant Anaesthetist). Non compliances and incidents are also raised at this forum.

6. Audits and Reports

All non-conformities and non-compliances are included in the Annual Management review which is written by the Quality Manager. This document is displayed in the department and is also send to Clinical Pathology Accreditation (UK) Ltd. [CPA] annually as part of ongoing accreditation requirement. The Non compliance reports are also sent to Trust Risk Management.

The department carries self audit activity against a predetermined and scheduled programme. This is carried out by all members of Laboratory staff and Blood Transfusion Nurses and the Quality Manager holds all final reports. The audits are used as the base for data collection which is statistically analyzed and the data incorporated into the final reports. All parts of the transfusion processes are monitored by this proc

**THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A**

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Collection and Delivery of Blood Products from Blood Transfusion Laboratory to the clinical areas	Policy Author:	Susan Whitehead
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)	No	Policy lays out the correct procedure for collecting and delivering all Blood Products
	• Race *	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender *	No	
	• Culture	No	
	• Religion or belief *	No	
	• Sexual orientation including lesbian, gay and bisexual people *	No	
	• Age *	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems *	No	
	• Gender reassignment *	No	
	• Marriage and civil partnership *	No	
2.	Is there any evidence that some groups are affected differently?	No	Policy applies to all groups
3.	If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?	No	
4(a).	Is the impact of the policy/guidance likely to be negative? (If "yes", please answer sections 4(b) to 4(d)).	No	No, ensures Correct checking procedure
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	None	N/A
4(d).	Can we reduce the impact by taking different action?	N/A	N/A

Comments:	Action Plan due (or Not Applicable):
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Name and Designation of Person responsible for completion of this form: Susan Whitehead (Transfusion Nurse) Date:24/1/2011.....

Names & Designations of those involved in the impact assessment screening process Susan Whitehead (Transfusion Nurse) Sara Avery (Transfusion Nurse):.....

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.