NORTH EAST & YORKSHIRE
REGIONAL TRANSFUSION COMMITTEE

Transfusion Bulletin
North-East & Yorkshire RTC

New Year Edition 2025

Message from the Regional Transfusion Chair, Ric Procter

"Happy New Year to you all"

Another year has passed in our region, and I take pride in the work being delivered by teams across the patch. Despite the pressures faced on staffing levels and clinical priorities, every team still finds time to engage with our quality improvement projects and sharing the best practice undertaken. The function of the RTC would not be possible without this commitment.

It is a privilege to chair the region and thank you all for continuing to progress transfusion safety and appropriate blood use.

I hope you have all had some time off with friends and family, away from the pressures of work. I look forward to the New Year and hope you find the content of this regional update valuable. If you have any suggestions for inclusion in the next safety update, or lessons learnt from safety incidents, then please forward them to Janice.Robertson@nhsbt.nhs.uk

NBTC Rolling Education Programme

Plasma and Platelets - London RTC
Wednesday 22 January 2025

RCI (compatibility, urgent transfusion in tricky patients) - Midlands RTC
Thursday, 06 February 2025

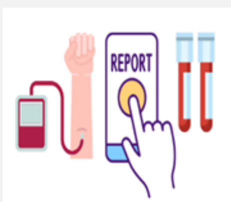
Mums, Babies and Blood – East of England RTC
Wednesday 12 Feb 2025

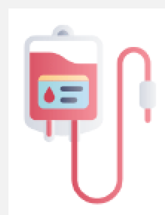
Details of 2025 events and additional resources produced by the PBM teams are available via https://nationalbloodtransfusion.co.uk/education

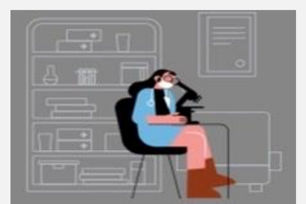
Transfusion 2024 and Transfusion Transformation Strategy update
November 2024
A brief summary of Transfusion 2024 activity and an introduction to the Transfusion Transformation strategy for the next 5 years Recommendations | National Blood Transfusion Committee

Coming soon from the PBM team

- Updated Blood Transfusion Training (BTT) eLearning modules
- Fit to Donate – A PBM and Blood Supply collaboration raising awareness around the importance of donor health
- Baby Blood Assist app under development
- Updated PBM website with enhanced accessibility







To keep up with all the latest news, follow us on **PBM England X:** @PBM_NHS
To view videos and resources from our regional events, subscribe to the **PBM England YouTube channel:** https://www.youtube.com/c/PatientBloodManagementEngland

TRANSFUSION RESEARCH AND PAPERS

The impact of different doses of oral iron supplementation during pregnancy: a pilot randomized trial. Blood Advances.

Re-evaluating treatment thresholds in patient blood management: Female patients experience more perioperative anaemia and higher transfusion rates in major elective surgery.

Tranexamic acid versus placebo to prevent bleeding in patients with haematological malignancies and severe thrombocytopenia (TREATT): a randomised, double-blind, parallel, phase 3 superiority trial

Use of Intravenous Albumin A Guideline From the International Collaboration for Transfusion Medicine Guideline.

Summary of relevant points in the 2024 National Comparative Audit of Bedside Transfusion Practice (Re-audit). Full report 2024-bedside-transfusion-audit-report-final.pdf

7% of sites reported no bedside transfusion checklist

- If a checklist is used it is not mandatory in a number of sites
- 4% of cases stated that no check on details matched a patient name band

3.5% checks were not carried out at the bedside

- Space, noise, distractions and busy staff were all contributory factors
- Distant checks are perceived to be of benefit but risk incorrect patient identification

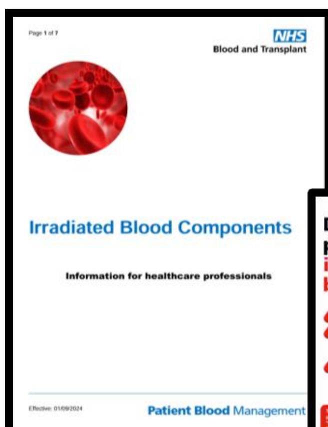
Staff were aware of being watched, and despite this still had a concerning knowledge gap

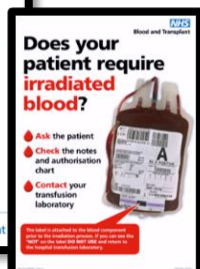
- <1% staff stated they had received no training at all
- 4.4% unsure if they had been trained

The recommendations include

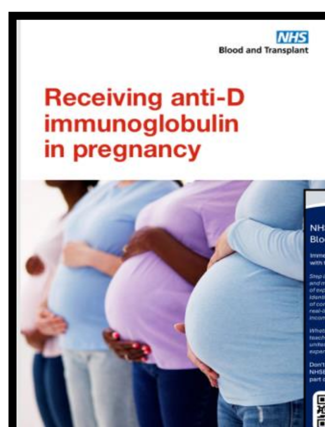
- Bite sized 2-3 yearly reminders on why and what the key bedside checks are
- Ensure every hospital has a pre-transfusion checklist available
- Empower patients to view the ID band step as a positive process they control
- Consider prompts to ensure that equipment and patients are in the right place before blood collection to avoid interruption etc
- Top-down dissemination from nursing governance along with ward level huddles. The process needs embedded in day-to-day activity.

Recently launched





irradiated-factsheet-1924.pdf (nhsbtdbe.blob.core.windows.net)



Receiving anti-D immunoglobulin in pregnancy leaflet (nhsbtdbe.blob.core.windows.net)

Sharing learning & good practice

We all know how important the sharing of learning from incidents / audit, best practice and new ideas can be to help us keep improving patient care and quality. Please send us any contributions you have for our next newsletter.

Whether it's transfusion or PBM related, key audit findings, a new project, or success story, get in touch by contacting our RTC Administrator Janice.Robertson@nhsbt.nhs.uk so we can share it with the region.

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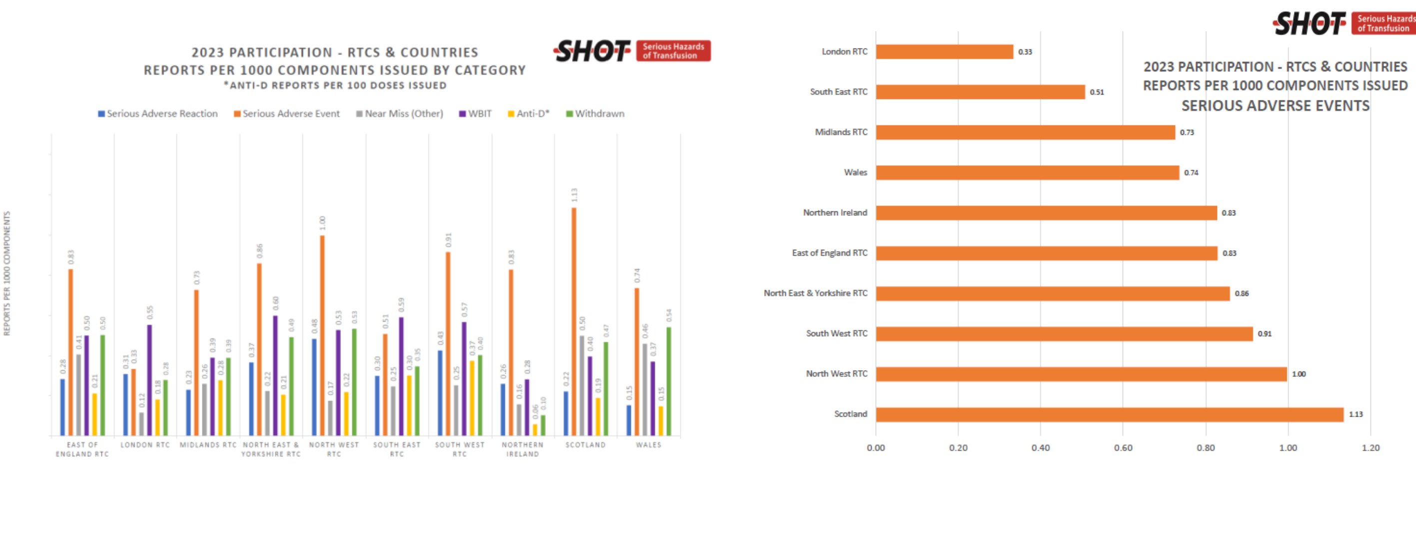
Transfusion Safety Updates

An overview of the reports submitted to SHOT, since reporting began in the category, definitions, relevant resources and recent recommendations can be accessed via this link: https://www.shotuk.org/resources/current-resources/data-drawers/



SHOT Bites

https://www.shotuk.org/resources/current-resources/shot-bites/

New SHOT Bites

SHOT Bite No. 29:
Differences of reporting errors related to anti-D Ig and immune anti-D

SHOT Bite No. 30:
Post-Transfusion Purpura

SHOT Bite No. 31:
The role of Sp-ICE in preventing Haemolytic Transfusion Reactions

SHOT Bite No. 32:
SCRIPT

Picture credit: SHOT

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Transfusion Safety Updates

Shared Learning from Incidents – Calderdale & Huddersfield

At the Trust there are several computer systems in place, BloodTrack is used for blood sampling and the administration of blood components/products. This has enabled the Trust to move away from the traditional 2-person check to a one person check as BloodTrack is used as the second checker. Unfortunately, the Trust does not have electronic prescribing, and blood transfusion prescriptions are still managed entirely on paper. Transitioning to electronic prescribing is the Trusts next step and this would enhance patient safety, efficiency, and compliance with modern healthcare practices.

Patient X required a blood transfusion, the doctor completed the blood transfusion prescription chart, prescribed one unit of red blood cells to be transfused over 3 hours.

BloodTrack was used and the correct process was followed. The staff nurse caring for patient X read the handwritten blood transfusion prescription chart to administer the red blood cells over 30 minutes. The doctor had written the time as 3° and not 3 hours. The staff nurse did not question the transfusion time as the patient had previously had transfusions over 30 minutes. The staff nurse set the infusion pump and the red blood cells were transfused over 30 minutes.

Date	Blood Component	Are special requirements needed? State requirements or N/A	Volume	Rate	
23/8/24	1 unit of P.RBC	N/A	1 unit	3°	Name Signature
					Name Signature

When the transfusion was complete it came to light the red blood cells had been transfused over 30 minutes and not 3 hours which the doctor advised had been prescribed. The doctor explained and apologised to patient X for what had happened. Patient X was reviewed by the doctor, and their vital signs were monitored for the following hour. No harm came to patient X. The ward sister and staff nurse caring for patient X also made their apologises.

A Datix was completed, and the incident was reported to SHOT. **Following the investigation the Transfusion Care Pathway was escalated to the medical team and learning shared regarding using correct words and not abbreviation on the transfusion prescription chart, this was communicated Trust wide.** It was also reiterated to the staff nurse and nursing team if something is unclear to check with the prescriber.

Patient X has received a number of transfusions since this incident occurred and the correct process has been followed.