# Guidance Notes on completion of Massive Haemorrhage Spreadsheet - June 2012

The Spreadsheet has been designed for use across the region to enable regional audit including benchmarking. The intention is that individual trusts/hospitals can collect the data onto the spreadsheet for their own use and use the same tool to submit data for regional analysis. This will hopefully prevent duplication of work. When submitted at a regional level to the regional transfusion committee the columns on date of birth and hospital number would be deleted in the copy sent to the RTC to comply with the Caldicott priniciples.

## Presentation

**1. Case number-**assigned locally by hospital, on each sheet to ensure details transcribed correctly **Hospital Number**- local identifier
**2. Hospital Number**- local identifier
**3. Date of birth**- date of birth of patient (dd/mm/yyyy)
**4. Age group-** select age group that patient fits in.
**5. Date of Massive Haemorrhage-** Date massive haemorrhage occurred (dd/mm/yyyy)
**6. Time of bleed-** Time massive haemorrhage diagnosed (24 hour clock hh:mm)
**7. Emergency / Elective**- Was the haemorrhage an emergency presentation or occurring secondary to a planned procedure?
**8. Location-**location where massive haemorrhage occurred/presented e.g. Emergency Dept, theatre.- choose from list or specify other
**9. Pathway activated**- was the hospital/trust massive haemorrhage pathway activated yes / no
**10. Lab informed**- was the transfusion laboratory notified in the agreed manner yes / no
**11. Grade of person making decision to activate pathway-** choose from list or specify other
**12. Speciality of person activating pathway-**choose from list or specify other
**13. Presentation of bleed**- Presentation of bleed i.e. gastrointestinal, obstetric (tick main presentation)
**14. Final Diagnosis-** patients final diagnosis i.e. duodenal ulcer, PPH (free text)
**15. Trauma Call-** If it was a trauma case was a call put out for the trauma team, select from list.

## Blood products used-adult

**16. Case number**
**17. Time to emergency/ flying squad O negative blood (if used)-** Time in minutes from activation to transfusion of emergency O neg.
**18. Time to red cells (excluding emergency O neg)-** Time in minutes from activation to transfusion of red cells other than emergency O neg.
**19. Emergency O Neg-** Total amount of emergency O Neg blood / "flying squad blood" ordered in the first 24 hours and total amount actually transfused. Answer in units (0 if none was required)
**20. Red Cells-** red cells ordered in first 24 hours and red cells actually transfused in the first 24 hours-excluding initial emergency use of O Neg (if this had been required). Answer in units (0 if none)
**21. Platelets-** platelets ordered and transfused in the first 24 hours. Answer in total number of adult doses (0 if none)

**22. FFP-** FFP ordered and transfused in the first 24 hours. Answer in total number of units (0 if none)
**23. Cryoprecipitate-** Cryoprecipitate ordered and transfused in the first 24 hours. Answer in pooled donor units(0 if none)
**24. Cell Salvage-**Was cell salvage used in the first 24 hours (yes or no), and if so howmuch (mls).
**25. Wasted O Neg-** number of units of O neg blood wasted. (0 if none). Split into avoidable and unavoidable wastage. **Avoidable** includes products that were not used and were not suitable for use in other patients or where there was product mismanagement i.e. cold chain not maintained **Unavoidable**. includes products that for whatever reason were not used in that particular case of major haemorrhage but were suitable to be used on other patients or where management was appropriate (i.e FFP defrosted and delivered but not transfused as patient dies).

**26. Wasted RC-** number of units of Red cells wasted excluding emergency O neg (0 if none)
**27. Wasted Plts-** number of units of platelets wasted (0 if none)
**28. Wasted FFP-**number of units of FFP wasted (0 if none)
**29. Wasted Cryo-** number of units of cryoprecipitate wasted. (0 if none)

## Blood products used-paediatric

**The columns on useage of products and wastage are then duplicated (on a further sheet) to allow separate entry of Paediatric usage in mls. Please use these columns if the products were calculated on a weight basis (as would be normal in paediatric population/ <16 yrs old). Leave blank if not, i.e. adult population (if paediatric columns are used then leave previous adult columns blank).**

## Laboratory

**30. Case number**
**31. Was fibrinogen checked**- Yes / no / unknown- on initial bloods following activation of pathway.
**32. TEG/Rotem-** was TEG or Rotem used in the management of the case yes / no / unknown
**33. Hb-** Closest laboratory result following haemorrhage- ideally should be within an hour of massive haemorrhage pathway activation (g/dL)
**34. Plt count-** Closest laboratory result following haemorrhage- should be within an hour of major haemorrhage pathway activation ($x10^9$/L).
**35. Fibrinogen-** Closest laboratory result following haemorrhage- should be within an hour of major haemorrhage pathway activation (g/L).

**36. Other clotting parameters-** results following activation of pathway- normal, abnormal, not tested, unknown.

**The next set of lab results i.e. 2nd should be the first available after 24 hours.**

## Adjuncts

**37. Adjuncts-**
Use of tranexamic acid- with tranexamic acid also asked if this was administered within 3 hours of bleed and also dose given (1g iv stat followed by 1g over 8 hours infusion or other)
**38. rVIIa, PCC, fibrinogen concentrate**.- options of yes, no or unknown
**39. Other adjuncts-** Specify if other adjuncts used i.e specific factor products, DDAVP, protamine
**40. Risk Factors-**Patient use of warfarin, aspirin, clopidogrel, heparin, known bleeding disorder (congenital or acquired), liver disease, other- options of yes, no or unknown.
**41. Complications-**Transfusion reaction, Thrombosis, organ failure, other or none.
**42. Complication please specify-** Specify complication
**43. ITU/HDU-** Was the patient admitted to a critical care setting
**44. Lab stand down-** Was the laboratory informed of stand down
**45. 24 hr Survival-** Was the patient alive at 24 hours, discharged, transferred or deceased
**46. 30 day survival-**Was the patient alive at 30 days, discharged, transferred or deceased
**47. Cause of death-** What was the cause of death stated
**48. Appropriate Activation-** Was this activation of the pathway thought to be appropriate- decision as per hospital transfusion team/committee?
**49. Were there any reportable incidents-** Yes or No**,** with free text column for further detail i.e. record things that went well, delays etc.

A further sheet is available to allow hospitals to add customised columns for their own records.

*When the spreadsheet has been completed for the intended period and a copy is sent to NHSBT it is important to delete the columns with hospital ID number and date of birth on the copy forwarded to preserve anonymity.*