Non-Medical Authorisation Course

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East Midlands Regional Transfusion Committee

Authorising, Prescribing & Sampling

Janice Smith

Matron Transfusion Specialist

Chesterfield Royal Hospital NHS

NHS Foundation Trust

Aims of this session

To discuss and understand:

- Authorising blood / blood products
- Prescribing of blood / blood products
- Sampling requirements

Authorisation Practice

- Non-medical practitioners/nurse specialists may only authorise blood components in their specific clinical area and are responsible for their own actions.

- The non-medical practitioners/nurse specialists will undertake the extended role solely within their clearly defined clinical transfusion guidelines for their area of practice.

Authorisation Practice

- This area of competence is not transferable to any other areas within the Trust / Organisation

- They must ensure they keep themselves up-to-date with the policies and procedures associated with Blood Transfusion and maintain their competency to authorise transfusion.

It is essential to:

- Explore alternatives to blood component transfusion
- Only authorise blood components if it will be of benefit to the patient
- Ensure the patient has given informed consent for transfusion and that this is documented in the patient notes
- Document the reason for authorising blood component transfusion

It is essential to:

- Refer cases to Clinical Teams with the relevant expertise where there is doubt or concern about authorising transfusion.
- Contact a registered medical practitioner without delay if any adverse reaction or event is suspected and comply with local policy and procedure.

Prescribing

- Prescribing requirements may vary between Trusts
  - Electronic or paper?
- Ensure you are prescribing for the correct patient. Core identifiers are a MUST:
  - First name, Last name, DOB, Unique patient ID no.
- Specify component required & amount
- Any “special requirements” ? e.g. irradiated
- Are concomitant drugs required? e.g. diuretic
- Specify rate / duration of transfusion

Questions around prescribing

- Timing of transfusion
- Rate decisions
- Special requirements?
- Nurse authoriser versus nurse prescriber & concomitant drugs
- Management of adverse events

Requests to the laboratory

- Clear communication with the labs is key!
- They are your friends & have a vast amount of knowledge
- Local policy may be electronic or written
- Caution if requesting over the phone . . .
- Be aware of:
  - patients with known antibodies as they may be difficult to crossmatch
  - or who have “special requirements” as provision may take longer

Requests to the laboratory

- Ensure all requests include:
  - full patient ID (4 identifiers)
  - location of patient
  - exact details of product required
  - amount required & any special requirements
  - details of any previous reactions
  - any recent pregnancies or transfusions
  - reason for transfusion
  - when is the product required?

Sampling requirements

- What is the “2 sample rule” all about?
- Why does Blood Bank reject so many samples?
- Sample labelling requirements:
  - Positive patient ID
  - Labelling at the bedside, don’t pre-label
  - You take the sample, you label the bottle
  - Stickers or hand written?
  - 4 identifiers, signature, date, time & location

Common errors

- Decisions made on another patient's results
- Diluted samples
- Not using most current result
- Transfusion indication not clear
- Patient history not reviewed or considered
- Poor clinical documentation
- Failure of positive patient ID
- Poor knowledge re transfusion process
- Transcription errors
- Not using lab based result

Wrong blood in tube (WBIT)

- Woman grouped 10 years ago at CRH, A⁻ tve
- Seen in pre-assessment, re-grouped O⁻ tve
- Presumed error in pre-assessment, patient re-sampled
- Repeat grouping undertaken: O⁻ tve
- Sampling error had been made 10 years ago and wrong data held on the system

Reported to SHOT

Failure to give irradiated blood

- Haematology patient on a surgical ward requiring transfusion.
- Dr questioned whether patient should receive irradiated products and contacted Blood Bank.
- Blood Bank reviewed history and found no flags or alerts on their system.
- Discussed with Haematology Consultant who confirmed patient did require irradiated products.
- Patient had already received non-irradiated blood earlier that day.

Reported to SHOT

Failure to inform the laboratory about specific requirement for irradiated components

- A 67 year old man had been treated for chronic lymphocytic leukaemia (CLL) at another hospital with fludarabine
- At initiation of treatment at the second hospital no notification was made to the transfusion laboratory until he had received 10 units of non-irradiated components
- Several different haematology doctors had requested the transfusion on different occasions
- The hospital transfusion policy was amended to require the requestor to check for specific requirements

A pregnant woman fails to receive CMV negative red cells

- A pregnant woman (gestation 19 weeks) was having a liver transplant
- The red cells requested and transfused were not CMV negative because the blood transfusion laboratory was unaware the patient was pregnant
- The requestor did not select CMV negative or indicate that the patient was currently pregnant on the request form
- This was discovered when pregnancy was documented on the second request form after the initial red cells had already been administered
- There was no historical record in the transfusion laboratory for this patient

Wrong twin transfused

- Pre-term twins being managed on NNU
- Twin A had required previous transfusions and was O_2 dependent. Twin B more stable.
- Routine result rung through from the lab regarding twin B; Hb 74g/L
- Initially recorded correctly, but then the Nurse reconsidered and thought she had documented for the wrong twin as twin B less O_2 dependent and no previous transfusions.
- Notes amended, twin B's results now in twin A's notes
- Electronic record not reviewed by Dr prior to transfusion
- The following night, Nurse rechecked both twin's Hb and was concerned to find that twin A had an Hb of 171g/L , twin B's was 74g/L
- Twin A had received an unnecessary transfusion

Reported to SHOT

Summary

- Authorise blood / blood products only for patients within your agreed sphere of practice and knowledge boundaries
- Ensure you prescribe clearly, based on up-to-date, accurate results & correct information
- Samples and requests must be correctly labelled and provide all the required information.