

Non-Medical Authorisation Course

Thursday 22nd October 2015

Authorising, Prescribing & Sampling



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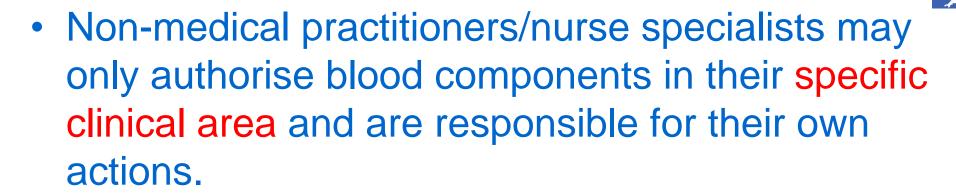


Aims of this session

To discuss and understand:

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

Authorisation Practice



 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.



- 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





- 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 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





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





- 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





- 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?





- 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





- Woman grouped 10 years ago at CRH, A-tve
- Seen in pre-assessment, re-grouped O tve
- Presumed error in pre-assessment, patient resampled
- 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





- •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

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SERIOUS HAZARDS OF TRANSFUSION



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

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SERIOUS HAZARDS OF TRANSFUSION







- Pre-term twins being managed on NNU
- Twin A had required previous transfusions and was O₂ 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 O₂ 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.