PROCEDURE FOR BLOOD COMPONENTS/PRODUCTS PRE-ADMINISTRATION CHECKS AND TRACEABILITY

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Document Revision History

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Edition 01	New document	25th June 2007
Edition 02 CRL7755 CRL7756 CRL7754 CRL7753 CRL7752 CRL6198 CRL2710 CRL2282 CRL2257 CRL2152 CRL1097	1. Merged HP-A-BTR-ADMINTRACESTJ into HP-A-BTR-ADMINTRACE. 2. Included reference to the use of BloodTrack TX, instead of traceability labels, in some areas for the fating of units. 3. Clarified the responsibilities of doctors, nurses, midwives, BSc student midwives and student midwives with RGN qualification regarding the administration of anti-D in section 0.2, as described in the 'memo re IV competency' (active date 20-04-09) and the memo 'Agreement regarding extension of BSc Midwifery student's participation in the blood transfusion chain to include intramuscular administration of anti-D' issued 29-3-10. 4. Added sections 0.3 Related Documents and 0.4 Abbreviations. 5. Added an explanation about how to check compliance with the 72 hour rule in section 1.3. 6. Included 'the transfusion of a unit of red cell concentrate should not exceed 4 hours from the time the unit was removed from controlled storage' in section 1.4. 7. Added the pre-administration checks required for batch products to section 1.4. 8. Clarified how a transfusion should be managed if it has been delayed and a unit is out of controlled storage for more than 30 minutes in section 1.5. 9. Added in section 1.6 that when emergency blood is taken, the blood transfusion laboratory in MWRHL needs to be informed 10. Included reference to batch products, which may be issued by the blood transfusion lab in an emergency situation as 'Emergency Blood' instead of on a named patient basis in section 1.6. 11. Included details of the process for the collection and transport of traceability labels back to the blood transfusion laboratory in section 1.7, which were previously described in HP-A-BTR-COLLECTTRACE. 12. Removed points 2.4.7 and 2.4.8, as they are more appropriate in HP-A-BTR-MONITORDISP.	5th February 2013

0 INTRODUCTION

0.1 BACKGROUND

0.1.1. The EU Blood Directive requires that evidence of the final fate of every blood component/product is retained and accessible for at least 30 years.
0.1.2. The Mid-Western Area Hospitals provide traceability labels on all blood components/products to comply with statutory requirements.
0.1.3. The traceability label is used by the laboratory to record the final fate of each unit of blood component/product issued for transfusion in areas where Blood Track TX is not in use.
0.1.4. In areas where Blood Track TX is being used, the unit fate is automatically uploaded to the Blood Track Manager in the blood transfusion laboratory and the fate of the unit is subsequently recorded on iLAB.

0.2 *RESPONSIBILITIES*

0.2.1. It is the responsibility of the laboratory staff to attach the traceability label with the patient's identity details to the blood component/product issued for that patient.
0.2.2. It is the responsibility of appropriately trained nursing/midwifery staff to perform and record the pre-transfusion observations and identification checks outlined in this document.
0.2.3. It is the responsibility of 2 appropriately trained persons to perform the bedside check, both of whom must sign the administration section of the record of transfusion support (ROTS).
0.2.4. A doctor or nurse/midwife/student midwife with RGN qualifications can perform the bedside checking procedure if they are registered with the appropriate regulatory body; are IV competent and have attended the appropriate haemovigilance training.
0.2.5. BSc midwifery students cannot be the second checker in the pre-administration checking procedure of anti-D as they are not registered practitioners.
0.2.6. Third and fourth year BSc midwifery students may administer prophylactic anti-D under the direct supervision of the registered midwife who is acting as their instructor, provided that the BSc midwifery student has attended appropriate haemovigilance education.
0.2.7. If anti-D is administered by a 3rd or 4th year BSc midwifery student, it is the responsibility of both the student and their registered midwife instructor to sign a single "checked and administered by:" area in the administration section of the ROTS and it is the responsibility of the second registered midwife acting as the second checker to sign the other "checked and administered by:" area.
0.2.8. Prophylactic anti-D can only be administered intravenously by a clinician who has attended the appropriate haemovigilance education.
0.2.9. It is the responsibility of the person who commences transfusion of the blood component/product to:
- Detach the peelable section of the compatibility label and place it in the space provided in the administration section of the ROTS
- Complete, sign and tear off the traceability label and place it in the traceability label box for return to the blood transfusion laboratory.

0.2.10. If anti-D has been administered by a BSc midwifery student, the traceability label should be signed by the student and it must also be co-signed by the registered midwife instructor.
0.2.11. It is the responsibility of the person taking down the unit to ensure the peelable section of the compatibility label is placed in the ROTS and the traceability label has been detached.
0.2.12. It is the responsibility of the blood transfusion laboratory staff to record the fate of the blood component/product on the laboratory information system (iLAB).
0.2.13. It is the responsibility of the CNM/CMM to ensure that this procedure is adhered to on the ward and to ensure that outstanding traceability labels are returned to the blood transfusion laboratory promptly.
0.2.14. It is the responsibility of the haemovigilance officer to collate and review traceability non conformances, i.e. where the fate of a blood component/product is outstanding.

0.3 DEFINITIONS

0.3.1. N/A

0.4 *ABBREVIATIONS*

0.4.1	ROTS	Record of transfusion support
0.4.2	MRN	Medical record number
0.4.3	CNM	Clinical nurse manager
0.4.4	CMM	Clinical midwife manager
0.4.5	HVO	Haemovigilance officer
0.4.6	iLAB	Laboratory information system (formerly known as APEX)
0.4.7	CMV	Cytomegalovirus
0.4.8	B/Hs	Bank holidays
0.4.9	ADON	Assistant director of nursing
0.4.10	M/S	Medical Scientist

0.5 RELATED DOCUMENTS

0.5.1.	HP-A-BTR-COLLECTION	Procedure for the manual collection/return of blood components/products from/to controlled storage.
0.5.2.	HF-A-BTR-ROTS	Record of Transfusion Support
0.5.3.	HF-A-BTR-ROTSTX	Record of Transfusion Support *(for BloodTrack TX)*
0.5.4.	HP-A-BTR-MONITORDISP	Procedure for monitoring patients during administration of blood and blood components and disposal of transfusion packs.
0.5.5.	HF-A-BTR-ANTIDRECORD	Record of Transfusion Support for anti-D
0.5.6.	LF-A-BTR-ISSUEEM	Issue form for blood/blood products for emergency use
0.5.7.	HF-A-BTR-BLDCOMPREG	Blood component/product collection register
0.5.8.	HP-A-BTR-BLOODTRACKTX	Use of BloodTrack Tx for blood sample collection and blood component/product administration

1 PROCEDURE

1.1 *IN THE BLOOD TRANSFUSION LABORATORY*

1.1.1. The transfusion request is processed in the laboratory, where the compatibility/traceability label is printed, checked and attached to the blood component/product issued for that patient.

1.2. *COLLECTION OF BLOOD COMPONENTS/PRODUCTS*

1.2.1. The collection of blood components/products is described in the 'Procedure for the manual collection/return of blood components/products from/to controlled storage (HP-A-BTR-COLLECTION)'.

1.3. *THE BEDSIDE CHECKS IN THE CLINICAL AREA*

1.3.1. If BloodTrack Tx is being used, refer to 'Use of BloodTrack Tx for blood sample collection and blood component/product administration' (HP-A-BTR-BLOODTRACKTX).

1.3.2. If BloodTrack TX is not in use, it is essential that 2 appropriately trained staff perform the specified checks at the patient's side (**never** remotely from the patient) before starting the infusion.

1.3.3. Inspect the blood component/product for leaks, clots, clumping or discolouration.

1.3.4. Check the component has not passed its expiry date/time.

1.3.5. Ask the patient to state their full name and date of birth and verify these details against the identity band worn by the patient.

1.3.6. If the patient is unable to participate in the identification process, check the details on the identity band(s) and verify the patient's identity with another member of staff.
1.3.7. Patients must never receive a blood component/product in the absence of a fully completed identity band(s).
1.3.8. Outpatients at the Mid-Western Regional Maternity Hospital do not require an identity band for administration of anti-D and are therefore the exception to this policy.
1.3.9. Check that the patient identification details (name, DOB and hospital number) are identical on the identity band(s), the compatibility label on the blood component/product, the compatibility report form, the patient's medical notes and the prescription.
1.3.10. Ensure that for each individual blood component/product prescribed, a separate prescription panel is used and completed fully (including the patient's name, hospital number and the date for which the transfusion is prescribed).
1.3.11. When the massive/emergency transfusion section of the ROTS is being used, ensure that the patient's name, hospital number and DOB are recorded in the appropriate section.
1.3.12. When administering a unit of red cell concentrate, ensure that it will be infused within 72 hours of the specimen collection date and time stated on the compatibility report form.
1.3.13. The only exceptions to the 72 hour rule are placenta praevia patients and neonates.
1.3.14. Check that the ABO/Rh (D) group and the donation number are identical on both the Irish Blood Transfusion Service (IBTS) label and the compatibility label on the blood component/product; and that both labels are identical to the compatibility report form.
1.3.15. If the patient's ABO and/or Rh (D) group on the compatibility report form is not identical to that of the blood component, the compatibility report form should state that the unit is "Non group specific, suitable for transfusion"; if this statement does not appear on the compatibility report form, do not proceed with the transfusion, but phone the blood transfusion laboratory for advice immediately.
1.3.16. Check the ABO and Rh (D) group against any historic transfusion records available in the medical notes, the ROTS and the laboratory information system, iLAB.
1.3.17. Check the prescription for any special requirements (e.g. CMV negative and/or irradiated blood components or apheresis platelets) and ensure that the component/product meets those requirements.
1.3.18. When administering non-group specific batch products (such as albumin, immunoglobulin, anti-D etc.) the lot number, unit number (the blue/white barcode sticker) and expiry date on the product must be checked against the lot number, unit number and expiry date on the compatibility label and the compatibility report.
1.3.19. If any discrepancy is found during the bedside checks, do **not** transfuse the blood component/ product, but rather, contact the blood transfusion laboratory for advice.
1.3.20. If the checking process is interrupted, stop and start the checking procedure again.
1.3.21. Record date, start time and pre-transfusion vital signs in the administration section of the ROTS.
1.3.22. Do not leave the patient until the transfusion has commenced.

1.4. *ONCE THE TRANSFUSION HAS COMMENCED*

1.4.1. The transfusion of a unit of red cell concentrate should not exceed 4 hours from the time the unit was removed from controlled storage.
1.4.1. If BloodTrack Tx is in use, refer to 'Use of BloodTrack Tx for blood sample collection and blood component/product administration' (HP-A-BTR-BLOODTRACKTX).
1.4.2. If the checks are satisfactory and the transfusion commences, the peelable section of the compatibility label, which contains the unique donation number, is placed in the space provided in the administration section of the ROTS.
1.4.3. The traceability label is torn from the compatibility label along the perforated line.
1.4.4. The nurse/midwife/doctor prints their name (not the patient's name), signs their name and records the date and time the transfusion commenced on the traceability label.

1.4.5. The traceability label must be completed if the patient receives any of the blood component/product.

1.4.6. If a blood product/component is transfused when a patient is in transit to another hospital, the ROTS and traceability label must still be completed, but the traceability label must be returned to the originating hospital.

1.4.7. The traceability label is placed in the traceability box located at the nurses/midwives station on each ward/clinical area.

1.5. *IF THE TRANSFUSION IS POSTPONED/DELAYED*

1.5.1. If it is necessary to postpone/cancel the transfusion, the unit of red cell cencentrate should be returned to controlled storage within 30 minutes from the time it was removed.

1.5.2. If a unit of red cell concentrate is out of controlled storage for more than 30 minutes and the likelihood is that it will not be transfused within 4 hours, 'For Discard' should be written on the unit.

1.5.3. Blood intended for discard must never be returned to controlled storage; instead, contact the Blood Transfusion laboratory for advice.

1.5.4. Do not remove the traceability label if the blood component/product is not transfused.

1.5.5. If the transfusion has been cancelled, a line should be drawn through the prescription panel(s) in the ROTS, which should be initialled and dated.

1.5.6. If the transfusion has been delayed (e.g. line had to be re-sited etc.), but the unit is out of controlled storage for more than 30 minutes, the unit of red cell concentrate must **not** be refrigerated, but may still be transfused until up to 4 hours from the time it was removed from controlled storage. [Note: the transfusion must be completed (or stopped if incomplete) within 4 hours of the unit being removed from controlled storage regardless of what time the transfusion began.]

1.6. *EMERGENCY O Rh (D) NEGATIVE BLOOD & BATCH PRODUCT TRANSFUSIONS*

1.6.1. If it is necessary to use the emergency O Rh (D) negative blood, inform the Blood Transfusion Laboratory in the MWRHL immediately, so that it can be replaced.

1.6.2 Confirm the blood group on the front of the pack is O Rh (D) negative and that it has not passed its expiry date.

1.6.2. Inspect the pack for any leaks, clots, clumping or discoloration.

1.6.3. Check that the ABO and Rh (D) group and donation number are identical on both labels on the unit and that both labels are identical to the ABO and Rh (D) group on the compatibility report form.

1.6.4. During a massive haemorrhage, the blood transfusion laboratory may issue the batch products, fibrinogen concentrate and factor VIIa, as 'RGH Emergency Blood' instead of to a named patient.

1.6.5. In the MWRHL and MWRMH, emergency albumin (5%) is also available in the blood fridge.

1.6.6. The traceability label accompanying any emergency O Rh (D) negative blood or emergency batch products must be signed and dated and attached to the "ISSUE FORM FOR BLOOD COMPONENTS/ PRODUCTS FOR EMERGENCY USE ONLY" (LF-A-BTR-ISSUEEM), which must be completed by the prescribing doctor and left in the 'traceability labels' box for collection.

1.7 *PROCESS FOR THE COLLECTION OF TRACEABILITY LABELS*

1.7.1. In areas where the Blood Track Tx is not used to fate units, the completed traceability labels are collected from the 'traceability labels' box at the nurses/midwives station on each ward/clinical area and transported to the blood transfusion laboratory in the Mid-Western Regional Hospital Limerick, as summarised in table 1.

TABLE 1: TRACEABILITY LABEL COLLECTION & TRANSPORT IN THE MID-WESTERN AREA				
Site:	**Day:**	**Collected by:**	**Transported to MWRHL lab by:**	**Transported in:**
MWRHL	Mon.-Fri.	Porters	Porters	n/a
	Sat., Sun., B/Hs	n/a	n/a	n/a
MWROH, Croom	Mon.-Fri.	CNM/acting CNM	Van / Taxi	Designated pouch
	Sat., Sun., B/Hs	CNM/acting CNM	Taxi	Designated pouch
MWRMH	Mon.-Fri.	Porters	Van / Taxi	Designated pouch
	Sat., Sun., B/Hs	n/a	n/a	n/a
Milford Care Centre	Mon.-Fri.	Ward Manager/designee	Taxi	Envelope
	Sat., Sun., B/Hs	n/a	n/a	n/a
Barrington's Hospital Ltd.	Mon.-Fri.	Laboratory staff	BHL Courier/Taxi	Envelope
	Sat., Sun., B/Hs	n/a	n/a	n/a
St. John's Hospital	Mon.-Fri.	HVO/designee	Taxi	Envelope
	Sat., Sun., B/Hs	n/a	n/a	n/a
MWRH, Ennis	Mon.-Fri.	Porters	Van	Envelope
	Sat., Sun., B/Hs	n/a	n/a	n/a
MWRH, Nenagh	Mon.-Fri.	Nursing staff take labels to ADON office at the end of the day, where they are collected by lab staff the next morning.	Courier	Envelope
	Sat., Sun., B/Hs	n/a	n/a	n/a

1.8 *TRACEABILITY LABEL RETURN TO THE BLOOD TRANSFUSION LABORATORY*

1.8.1. When the traceability label is returned to the blood transfusion laboratory, the unit is fated on iLAB as transfused to the patient identified on the label.

1.8.2. The traceability label is attached to the original request form and archived for at least thirty years.

1.8.3. In areas where Blood Track TX is used to record and monitor transfusions, the unit fate is automatically uploaded to the Blood Track Manager in the blood transfusion laboratory and the units are subsequently fated on iLAB.