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Royal Cornwall Hospitals NHS Trust

# Delays and the Laboratory

Stephen Bassey


NHS
National Patient Safety Agency

# Rapid Response Report 3

From reporting to learning

10 September 2007

## Emergency support in surgical units: Dealing with haemorrhage

NHS
National Patient Safety Agency

# Rapid Response Report

NPSA/2010/RRR017

From reporting to learning

21 October 2010

## The transfusion of blood and blood components in an emergency

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Contents lists available at ScienceDirect

Transfusion Medicine Reviews

journal homepage: www.tmreviews.com

Optimal Dose, Timing and Ratio of Blood Products in Massive Transfusion: Results from a Systematic Review

Zoe K. McQuilten [a,b,*], Gemma Crighton [a], Susan Brunskill [c], Jessica K. Morison [a], Tania H. Richter [a], Neil Waters [a], Michael F. Murphy [c], Erica M. Wood [a]

## Mortality from trauma haemorrhage and opportunities for improvement in transfusion practice

S. J. Stanworth[1], R. Davenport[3], N. Curry[2], F. Seeney[4], S. Eaglestone[3], A. Edwards[5], K. Martin[4], S. Allard[6], M. Woodford[5], F. E. Lecky[6] and K. Brohi[3]

*BJS* 2016; **103**: 357–365


# The Prospective, Observational, Multicenter, Major Trauma Transfusion (PROMMTT) Study

## *Comparative Effectiveness of a Time-Varying Treatment With Competing Risks*

*John B. Holcomb, MD; Deborah J. del Junco, PhD; Erin E. Fox, PhD; Charles E. Wade, PhD; Mitchell J. Cohen, MD; Martin A. Schreiber, MD; Louis H. Alarcon, MD; Yu Bai, MD, PhD; Karen J. Brasel, MD, MPH; Eileen M. Bulger, MD; Bryan A. Cotton, MD, MPH; Nena Matijevic, PhD; Peter Muskat, MD; John G. Myers, MD; Herb A. Phelan, MD, MSCS; Christopher E. White, MD; Jiajie Zhang, PhD; Mohammad H. Rahbar, PhD; for the PROMMTT Study Group*

JAMA SURG/VOL 148 (NO. 2), FEB 2013 WWW.JAMASURG.COM

bjh guideline

# A practical guideline for the haematological management of major haemorrhage

**Beverley J. Hunt,[1] Shubha Allard,[2] David Keeling,[3] Derek Norfolk,[4] Simon J. Stanworth,[5] Kate Pendry[6] and on behalf of the British Committee for Standards in Haematology**

*[1]Department of Haematology, GSTT, St Thomas' Hospital, [2]Department of Haematology, Royal London Hospital, London, [3]Oxford Haemophilia and Thrombosis Centre, Oxford University Hospitals, Churchill Hospital, Oxford, [4]Department of Haematology, Leeds Hospital, Leeds, [5]NHSBT/Department of Haematology, John Radcliffe Hospital, Oxford, and [6]Patients' Clinical Team, NHSBT, Manchester, UK*

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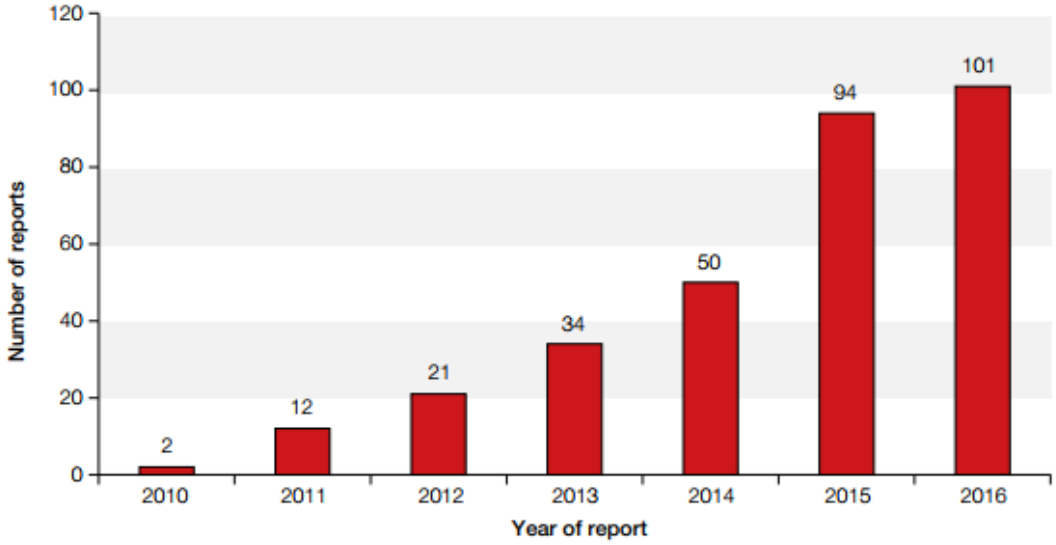
**Figure 11a.1:** Delayed transfusion reports by year 2010-2016



How long to get ABO compatible red cells

- 41% >15 min
- 24% >20min
- 12% >30min
- 2 samples

TRANSFUSION PRACTICE

# Exposure to ABO-nonidentical blood associated with increased in-hospital mortality in patients with group A blood

*Menaka Pai,[1,2] Richard Cook,[3] Rebecca Barty,[1] John Eikelboom,[2] Ker-Ai Lee,[3] and Nancy Heddle[1,2]*

**TRANSFUSION** Volume 56, March 2016

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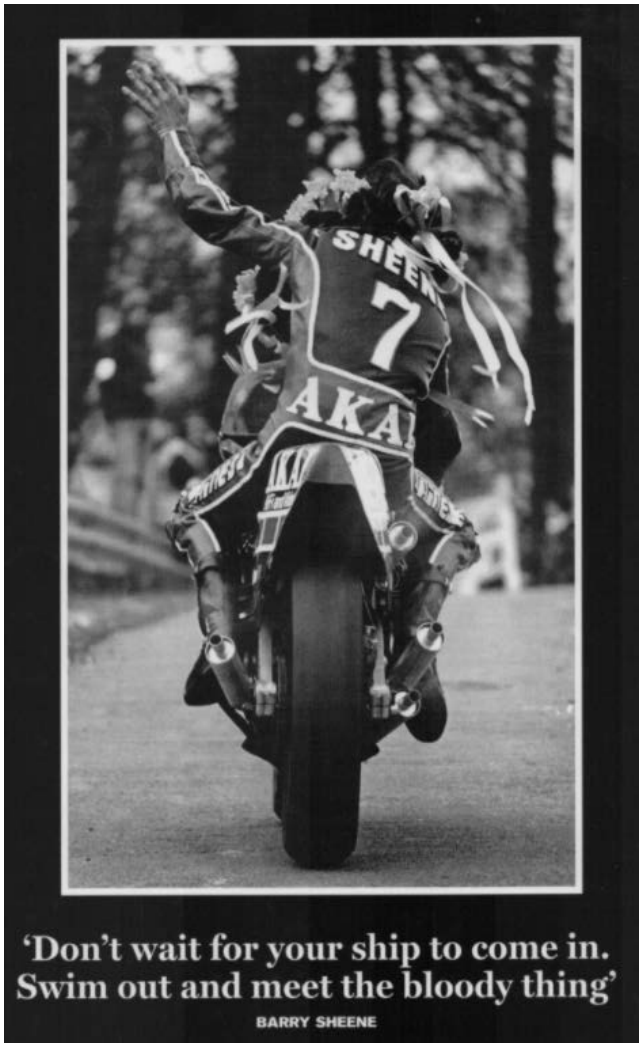
- Flawed decision making
- Target fixation
  - Ab panels & crossmatching
  - Not performing the right tests
  - Sample validity
- Communication, clarity and confirmation
  - Log comms for handovers

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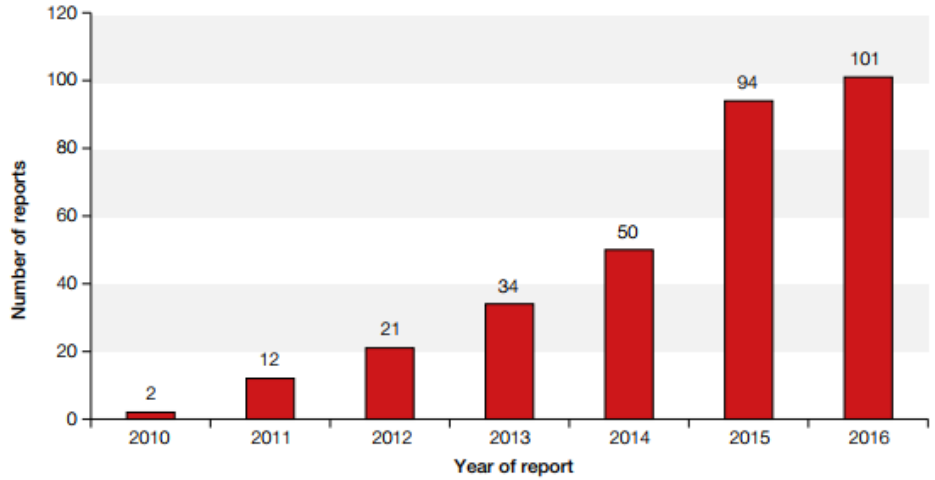
- Shroud waving
- Understanding the ‘sharp end’
- Clinically what are the alternatives?
- Running out of haemoglobin is always fatal

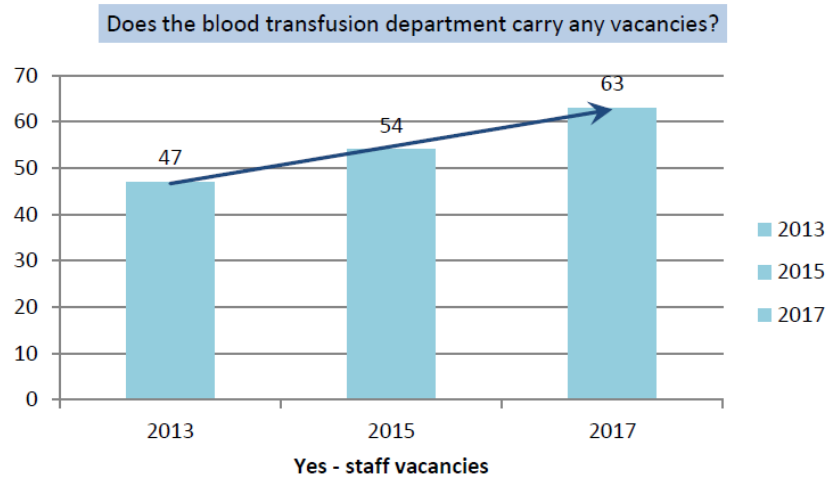
- Calling for help
- Predicting usage
- Ordering ahead

- Practice
- Practice
- Practice

- Staff training, education and confidence
- Joined up thinking in the lab
- Not relating results form the rest of the lab
- Over-reliance on automation and electronic issue

Figure 11a.1: Delayed transfusion reports by year 2010-2016



NHS Improvement

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Home > Resources > Pathology networks

# Pathology networks

We have identified 29 potential pathology networks, allowing for the transformation of pathology services into a series of networks across the country.

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- Information vaccum
- Use of salvage (FFP/Cryo/Plts needs ↑)
  - Following protocols for coag
- Code red / MHP
- Samples not always taken
- Reaction to PoC results

- Access to blood fridge
- Sample checking in theatres – do you know what clinicians check?
- Speed of infusion

- MHP activation is a two-way street
- There should be no secret code
- Check for ‘red stuff out/red stuff in’ thinking

# The simple stuff…

Keep everyone informed

- What do you want and for whom?
- How much?
- Why?
- Where?
- When?
- Repeat it
- Record it

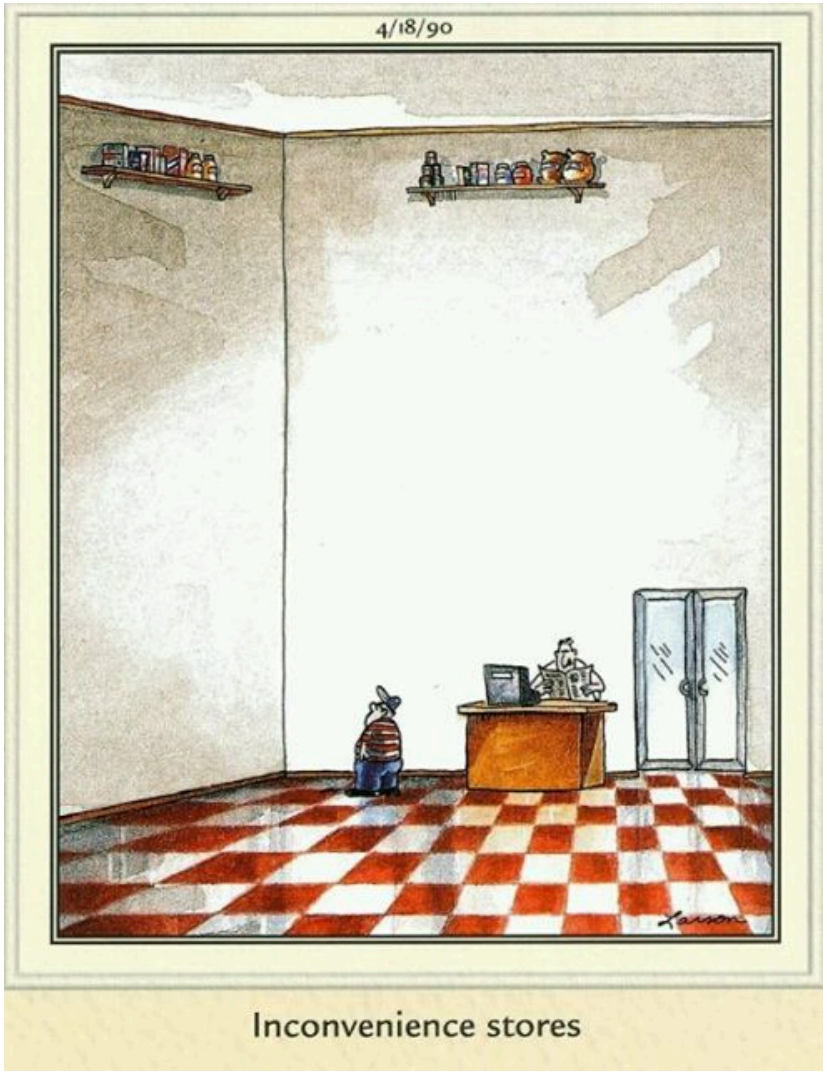
# The simple stuff…

Keep everyone informed

- Is it achievable?
- In full?
- In part?
- Not at all?
- What's the alternative?

# The not so simple stuff…

- Where's the sample?


4/18/90
Inconvenience stores