Transfusion Complications in Patients with Haemoglobin Disorders - Previous Recommendations

Year first made	Action	Recommendation
2013	**Hospital haematologists and transfusion teams**	Any case of suspected hyperhaemolysis should be reported (for hospitals served by NHSBT) to the National Health Service Blood and Transplant (NHSBT) red cell immunohaematology (RCI) consultant or consultant on call at the local Blood Centre as soon as possible to enable real-time data collection and diagnosis
2013	**Haemoglobinopathy audit group**	A national review of shared care arrangements could be performed as part of the forthcoming haemoglobinopathy audit
2012	**Hospitals supplied by NHSBT: Hospital Transfusion Teams, Transfusion Laboratory Managers with the support of their Chief Executive Officers**	In previous reports, it was identified that electronic access to the blood group and antibody information from reference laboratories by hospital transfusion laboratories would be helpful when managing the transfusion support of complex patients, particularly if patients are treated in different hospitals and/or different geographical areas. This system is in the process of being implemented by the NHSBT and is known as SP-ICE. The success of such a system in delivering safer patient care is dependent on a number of factors: • That hospitals use common patient identifiers such as NHS number (or equivalent) when sending samples to reference laboratories • Those hospitals allow their patient data to be entered on the system, which is provided by an NHS organisation and used by other NHS organisations to improve the safety of the transfusion support of individual patients • That hospitals train all transfusion laboratory staff to use the system, including those providing an out-of-hours service
2011	**Manufacturers of hospital IT systems, Trusts/Health Boards/Hospitals, Hospital**	Clinicians must ensure that a haemoglobinopathy diagnosis is transmitted to the transfusion laboratory every time a patient is admitted and from every speciality area. There should be a mandatory field on the transfusion request whether paper or electronic to ask about haemoglobin disorders

	Transfusion Teams (HTTs)	
2011	**CMO's National Blood Transfusion Committee (NBTC) with patient support groups**	The warning card system for patients needs to be simplified so that people with haemoglobin disorders carry a single source of information about their diagnosis, red cell phenotype and any irregular antibodies. Patients need to be educated to present this information at every hospital contact
2011	**Education subgroup of the NBTC**	As people with haemoglobin disorders may attend any specialty, all core curricula for medical training should ensure that adequate education takes place about these disorders with particular attention to their transfusion needs