Paediatric Cases - Previous Recommendations

Year first made	Action	Recommendation
2012	**Hospital Transfusion Teams, British Maternal and Fetal Medicine Society**	Hospital transfusion teams and clinical specialists should review local protocols and communication pathways for emergency provision of blood for fetal and neonatal transfusion
2012	**Hospital Transfusion Teams, Accident and Emergency Department Leads**	Appropriate paediatric transfusion volumes and prescriptions should be the focus of ongoing education in hospitals, particularly in situations of emergency transfusion, such as accident and emergency departments
2011	**HTTs and clinical users of blood**	A significant number of paediatric acute transfusion reactions (ATRs) followed prophylactic platelet transfusions; this underlines that it is important to ensure that prophylactic platelets are given according to guidelines.
2011	**HTTs and haematologists**	Paediatric ATRs where there are severe allergic reactions should be investigated in conjunction with allergy specialists (British Committee for Standards in Haematology (BCSH) ATR guidelines).
2011	**HTTs and clinical users of blood**	SHOT requests that hospitals continue to report cases of possible transfusion-associated necrotising enterocolitis (NEC) in order to provide more representative information on the nature and extent of this possible reaction in the UK.
2010	**RTCs, HTCs, HTTs, pharmacists**	2009 recommendation on the need for local consideration of the design of prescription charts was reiterated
2010	**HTTs, hospital transfusion laboratories, consultant haematologists with**	Laboratory staff competency on the issues surrounding neonatal and infant pre-transfusion compatibility testing should be targeted during training, particularly given the relatively low frequency of paediatric work in many laboratories. The revised BCSH guidelines on compatibility testing will clarify the requirements for

	responsibility for transfusion	neonates.
2009	**HTCs, HTTs, pharmacists**	The correct prescription of paediatric transfusions is vital and an area of recurrent errors. Local consideration should be given to the design of paediatric prescription charts in order to facilitate the correct prescription of both blood component volumes/rates and clinical special requirements
2009	**HTCs, HTTs, RCH, RCM, NMC**	Nursing staff involved in paediatric transfusion must be sufficiently skilled and competent in the use of pumps/blood infusion devices, appropriate transfusion volumes/rates, and the need for special requirements in order to reduce these types of errors. These aspects should be included in their transfusion training as required by the BSCH (2009) guidelines on the administration of blood component.
2008	**HTTs**	Clinical staff should be encouraged to report all ward-based reactions and events including possible TACO and TRALI and neonatal ATR cases.
2007	**HTT , hospital transfusion laboratories and consultant haematologists with responsibility for transfusion**	Laboratory BMSs must be aware of special component requirements in patients under 16, and routine checking for additional flags should be carried out based on the date of birth.
2007	**HTT and clinical users of blood**	Prescribing for paediatric patients should be carried out only by those with appropriate knowledge and expertise in calculating dosage and administration rates for this group
2007	**HTT and clinical users of blood**	Special requirements are more common in paediatric patients, because of the range of congenital and malignant conditions for which they may be hospitalised, and particular care is needed to ensure that documentation, handover, communication and bedside checking are effective and comprehensive.