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<td><strong>Policy Number</strong></td>
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<tr>
<td><strong>Author(s)</strong></td>
<td>Dr Annette Nicolle</td>
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<td>Dr Shilpa Ramesh</td>
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<td>Karen Nesbitt</td>
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<tr>
<td><strong>Sponsor</strong></td>
<td>Hilary Lloyd, Director of Nursing, Midwifery and Quality</td>
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This policy supersedes all previous issues.
## Version Control

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<td>24/04/2013</td>
<td>Dr Annette Nicolle Dr Bozman, Dr Sally Evans</td>
<td>Hospital Transfusion Committee</td>
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TRANSFUSION POLICY FOR NEONATES AND CHILDREN

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Transfusion policy for neonates and children

1. **Introduction**

   Neonates and children should not be regarded as small adults. They sometimes require specific blood components that need to be requested through the NHS Blood and transplant authority (NHSBT). They also require different pre-transfusion test in the first 4 post-natal months as they are unable to produce allo-antibodies at this young age. This policy is in place to ensure that current clinical guidelines are followed when transfusing neonates and children.

2. **Policy Scope**

   *The purpose of this policy is to provide specific advice for clinical staff treating neonates and any child under 16 years. It does not replace information in the main Transfusion Policy, RM 36 but provides additional advice on dosage and special requirements*

3. **Aim of the policy**

   This policy aims to provide staff with information about recommended transfusion thresholds, pre-transfusion testing, selection of specific products, such as irradiated blood, according to current guidelines.

4. **Duties - roles and responsibilities**

   4.1 The Trust Board
   
   To support the Hospital Transfusion Committee and transfusion practitioners in their role in promoting safe transfusion practice in neonates and children

   4.2 The Hospital Transfusion Committee (HTC)
   
   - To provide an evidence based policy based on national guidelines
   - To monitor the appropriate use of blood components
   - To monitor practice through audit
   - To support the Transfusion practitioners in their role

   4.3 The Clinical staff
   
   - To maintain competency in blood transfusion
   - To promote the appropriate use of blood through observing the Haematology Guidelines, HTC recommendations and Trust policy
   - To discuss the risks and benefits of transfusion with the patient and/or parents and obtain verbal consent whenever possible
   - To prescribe blood components appropriately
   - To maintain patient safety throughout the transfusion process
   - To report any adverse events to the Transfusion laboratory as soon as possible

   4.4 Laboratory Staff
   
   - To maintain competency in blood transfusion practice
   - To promote the effective use of blood through compliance with this policy and the Hospital policy for Blood transfusion
5.0 Definition of terms

- **ABO, RhD**: Refers to patient blood groups
- **ATG**: Anti-thymocyte Globulin
- **BCSH**: British Committee for Standards in Haematology
- **CMV**: Cytomegalovirus
- **CLD**: Chronic lung disease
- **CPAP**: Continuous positive airways pressure ventilation
- **DAT**: Direct Antiglobulin test (Coombs test)
- **ET**: Exchange transfusion
- **FiO2**: Percentage of inspired oxygen
- **HDN**: Haemolytic disease of the new born
- **HEV**: Hepatitis E Virus
- **HLA-matched**: Matched to recipient’s tissue type
- **HPA**: Human platelet antigen
- **HTC**: Hospital Transfusion Committee
- **IAT**: Indirect Antiglobulin test (indirect Coombs test)
- **IUT**: Intra uterine transfusion
- **IVH**: Intraventricular Haemorrhage
- **NAIT**: Neonatal alloimmune thrombocytopenia
- **NHSBT**: NHS Blood and Transplant authority

6. Transfusion policy for Neonates and Children

All blood components are covered by this policy.

6.1 **Patient Identification**

ALL inpatients must wear an ID wristband for identification purposes.

*Please refer to the Patient Identification policy, RM40 for further details*

6.1.2 **Once infant is over 4 months old the pre-transfusion testing requirements are the same as for adults: see Transfusion Policy for Adults**

6.3 **Pre transfusion testing for neonates and infants within the first 4 post-natal months.**

Wherever possible, samples from both the mother and infant should be obtained for initial ABO and RhD group determination.

Investigations for the Maternal sample:
- ABO/Rh and Antibody screen

Investigations for the Infant sample:
- ABO/Rh (carried out twice)
- DAT
- If maternal sample absent, screen infant’s serum for atypical antibodies by IAT (Diamed)

*A positive DAT on the neonate’s red cells or an atypical red cell antibody in maternal or neonatal sera suggests possible HDN. In such cases serological investigations will be necessary to allow selection of appropriate blood.*
6.4 Cross-matching

- If patient less than 4 months old with no (maternal) antibodies present, DAT is negative and there have been no previous transfusions, a serological crossmatch is NOT required.
- Blood will not be selected for electronic crossmatch if maternally derived ABO antibodies are present in the neonate’s plasma. ABO-identical adult blood transfused to an infant with maternal anti-A or anti-B may haemolyse, even if the pre-transfusion DAT is negative, due to stronger ABO antigen expression on adult cells.
- After the post natal age of 4 months, compatibility tests should be carried out in accordance with national guidelines for pre-transfusion testing in adult practice (BSH, 2012).

6.4.1 Take at least 2 blood spots for screening tests (sickle cell disease, cystic fibrosis etc) prior to transfusing blood.

6.5 Irradiation of blood products for Neonates, Infants and Children

Universal irradiation of blood products for neonates, infants and children is NOT required eg cardiac surgery, acute leukaemia, common viral infection, HIV. However it is MANDATORY in certain circumstances.

For full guidance please refer to BSH Guidelines on the use of Irradiated Blood Components 2010

- All blood and platelets for intrauterine transfusions (IUT) should be irradiated.
- All blood for neonatal exchange transfusions (ET) should be irradiated if there is a previous history of IUT or if donation comes from first- or second- degree relative. For other neonates requiring ET, irradiation is recommended provided it does not cause undue delay.
- Neonates who have received a previous IUT of either red cells or platelets should receive irradiated blood products until 6 months after their expected delivery date (40 weeks gestation).
- All HLA-matched platelets or donations from first- or second- degree relative must be irradiated
- It is not necessary to irradiate red cells for routine “top-up” transfusions of premature or term infants unless there is a prior history of IUT, or the donation has come from a first- or second- degree relative
- All children with Hodgkin lymphoma at any stage of the disease should have irradiated red cells and platelets for life
- All children with aplastic anaemia receiving immunosuppressive therapy with ATG (and/or alemtuzumab) should receive irradiated blood products
- All children with severe T lymphocyte immunodeficiency syndromes should receive irradiated blood products from the time the diagnosis is first suspected, whilst further diagnostic tests are undertaken. In cases of uncertainty a clinical immunologist should be consulted.

6.6 Selection of blood products for Neonates, Infants and Children

6.6.1 NHSBT first introduced hepatitis E virus (HEV) screened components for selected patients on 14 March 2016 following a recommendation from the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO).
- From 1 November 2017 all blood components issued by NHSBT are HEV negative with the exception of some very rare phenotypes held by the Frozen Blood Bank.
6.6.2 Red Cells

- Neonate’s own ABO and RhD group or an alternative compatible ABO and RhD group
- Compatible with any ABO or atypical red cell antibody present in the maternal or neonatal plasma
- Leucodepleted (all red cell units are leucodepleted)
- CMV negative (not essential if emergency situation)
- Blood less than 1 week old (not a guideline, however please select freshest unit)
- Paediatric split packs are available from NHSBT (each pack contains approx 40-50mls if only small volume needed)
- The amount of blood required should be included on the request form (it is calculated from infant’s weight) NB: The initial 20mls will be discarded so account for this when ordering packs.
- A full unit can be given if blood requirement is >100mls. (Surplus will be wasted)

6.6.3 Fresh Frozen Plasma

- Neonates with significant coagulopathy should receive a recommended dose of 15 mls/kg of FFP

Prothrombin time >18 seconds
Activated partial thromboplastin time >42 seconds
- In the absence of bleeding FFP may not be required unless the neonate or child is to undergo a significant bleeding challenge eg. surgery
- Correction of the prolonged coagulation screen is unpredictable and should be re-checked following administration of FFP at dose of 15mg/kg.
- Consideration should also be given to replacing Vitamin K
- A stock of neonatal non-UK MB (methylene blue) treated FFP is available in the Transfusion laboratory and from NHSBT. This should be use first-line for all neonates and children under the age of sixteen before issuing adult FFP units.

Points to consider:
- FFP should NEVER be used as simple volume replacement and it is not clearly superior to crystalloids or colloids in the management of neonatal hypotension
- Routine administration to preterm infants for prevention of periventricular haemorrhage (PVH) should be avoided.

6.6.4 Platelets

Platelets for neonatal transfusion
- ABO identical or compatible and Rh identical or compatible
- HPA compatible in infants with alloimmune thrombocytopenia
- Infused in a volume of 10-20mls/kg (ask for APHERESIS)
6.7 Clinical indications for transfusion of blood components

6.7.1 The NHS Executive Circular HSC2002/009 “Better blood transfusion: appropriate use of blood” is as applicable to children as it is to adults.

The decision to transfuse depends on clinical judgement, taking into account the child’s general condition, the presence or absence of bleeding and whether or not there are signs of haematological recovery.

6.7.2 For children with aplastic anaemia, red cell transfusions are usually reserved for symptomatic patients with Hb values less than 70g/l since sensitisation as a result of large numbers of transfusions reduces the chance of a successful outcome.

6.7.3 Red Cells

_Suggested transfusion thresholds for the administration of red cells to infants less than 4 months old_

<table>
<thead>
<tr>
<th>Consider transfusion</th>
<th>Transfuse at</th>
</tr>
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<tbody>
<tr>
<td>Anaemia in the first 24 hours</td>
<td>Hb 120g/l</td>
</tr>
<tr>
<td>Cumulative blood loss in 1 week, neonate</td>
<td>10% blood volume</td>
</tr>
<tr>
<td>Neonate receiving intensive care</td>
<td>Hb 120g/l</td>
</tr>
<tr>
<td>Acute blood loss</td>
<td>10% blood volume</td>
</tr>
<tr>
<td>Chronic oxygen dependency</td>
<td>Hb 110g/l</td>
</tr>
<tr>
<td>Late anaemia, stable patient</td>
<td>Hb 70g/l</td>
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Using Haematocrit thresholds to guide transfusion may be preferred by some clinicians. The following thresholds are taken from the Newcastle Neonatal Services Guidelines (Gateshead is a part of the Northern Neonatal Network).

6.7.3.1 Transfuse for Haematocrit <35-40%

- Infants requiring mechanical ventilation
- If receiving >35-40% supplemental oxygen (stable babies with CLD in FiO2 > 35% or in more than 0.2L/min oxygen will often tolerate haematocrit >30%

6.7.3.2 Transfuse infants at Haematocrit <30%

- CPAP
- If receiving supplemental oxygen (up to 35%)
- Problematic apnoea of prematurity
- Sustained tachycardia or tachypnoea
- Poor weight gain despite adequate calories
- Breathlessness or going off feeds
- If undergoing surgery

6.7.3.3 Asymptomatic babies or babies in nursery

- It is important to check the reticulocytes count before considering transfusion
- Transfuse infants with Hct less than or equal to 20% even if asymptomatic if reticulocyte count is <100000/ml
6.8 Platelets

6.8.1 Suggested transfusion thresholds for the administration of Platelets for infants less than 4 months old

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Neonate with major bleeding</td>
<td>&lt;100 x 10⁹/l</td>
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<tr>
<td>Preterm or term neonate, with bleeding &lt;1000g and &lt;1 week old Clinically unstable (high ventilation requirements or fluctuating BP/hypovolaemia) Previous major bleeding tendency (e.g., grade 4 IVH) Concurrent coagulopathy Surgery or exchange transfusion NAIT (see below)</td>
<td>50 x 10⁹/l</td>
</tr>
<tr>
<td>Sick preterm or term infant, not bleeding non-bleeding neonate in first week of life NAIT (see below)</td>
<td>30 x 10⁹/l</td>
</tr>
<tr>
<td>Stable preterm or term infant, not bleeding</td>
<td>20 x 10⁹/l *</td>
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</table>

* this threshold is taken from the BSH guidelines. There are paediatric guidelines which recommend platelet transfusion in all infants with a platelet count <30 x 10⁹/l. The threshold used should be at the discretion of the treating consultant.

6.8.2 Children with thrombocytopenia

Consider platelet transfusion if
- Low platelets <10 x 10⁹/l (N.B. Not in ITP)
- Platelet count <20 x 10⁹/l with one or more of the following:

DIC: (Always seek medical advice from a Haematology Consultant first)
Severe mucositis
Anticoagulant therapy
Platelets likely to fall <10 x 10⁹/l before next evaluation
Risk of bleeding due to local tumour infiltration

6.8.3 Neonatal Alloimmune Thrombocytopenia:
- Refer to Haematology Consultant and NBS
- NHSBT may request samples from neonate and mother
- HPA 1a/5b negative platelets required (random donor platelets only if no compatible platelets available)
- High dose intravenous immunoglobulin.
- In such patients, a minimum platelet count of 30x10⁹/l is recommended. Paediatric guidelines recommend transfusion threshold of 50 x 10⁹/l for non-bleeding patients and 100 x 10⁹/l if major bleeding.
6.9 Component volume and specification for red cell and platelet transfusions

6.9.1 Top-up transfusion: Red Cells

Desired Hb (g/l) - actual Hb x weight (kg) x 3
(Usually 10 to 20 ml/kg)

Rate approx 5ml/kg/hr

No red cell exchange transfusions, intra-uterine blood transfusions (IUT) or extra-corporeal membrane oxygenation (ECMO) take place on site at the Queen Elizabeth Hospital. All neonates/infants requiring such advanced support are transferred to either the Great North Children's Hospital, Royal Victoria Infirmary or Freeman Hospital, Newcastle upon Tyne for specialist care in the Fetal Medicine Unit or Paediatric Intensive Care Units.

The specific blood product requirement for these procedures is detailed in the appendix for information purposes only.

6.9.2 Top-up transfusion: Platelets

Children under 15kg: 10-20ml/kg

Children over 15kg: single apheresis unit

ALWAYS REQUEST APHERESIS UNITS FOR TRANSFUSION TO CHILDREN

7 Training and competency assessment

See the Trust training needs analysis

8 Diversity and Inclusion

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat staff reflects their individual needs and does not unlawfully discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010). This policy aims to uphold the right of all staff to be treated fairly and consistently and adopts a human rights approach. This policy has been appropriately assessed.

9 Process for monitoring compliance with the policy

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<td>National audit</td>
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<tr>
<td>MHRA</td>
<td>Compliance report</td>
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<td>Continual surveillance</td>
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<tr>
<td>Ad hoc</td>
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10 Consultation and review of this policy

This policy has been written in consultation with the relevant experts and approved by the Hospital Transfusion Committee (HTC). The policy will be reviewed every two years and when new guidelines become available to ensure compliance with current legislation.

11 Implementation of this policy

This policy will be circulated by the Trust secretary as detailed in OP27 policy for the development, management and authorisation of policies

12 References


BSH. Guidelines for pre-transfusion compatibility procedures in blood transfusion laboratories. Transfusion Medicine, 2012; 23(1): 1-33


Blood Transfusion policy RM36, Gateshead Health NHS Foundation Trust
Pre-transfusion testing for neonates and infants within first 4 post natal months

**Maternal sample:** ABO/Rh and Antibody screen.

**Infant sample:**
- ABO/Rh (carried out twice)
- DAT (carried out on neonates red cells)
- If maternal sample absent, screen infants serum for atypical antibodies by IAT (Diamed)

**Group selection**
- Neonates own ABO and RhD group or an alternative compatible ABO/RhD group.
- Compatible with any ABO or atypical red cell antibody present in maternal or neonatal plasma
- Not appropriate to include neonates for electronic crossmatch, if maternal antibodies are present.

**Crossmatching**
- Neonates less than 4 months old with no maternal antibodies and a negative DAT - No crossmatch is required

*Serological crossmatch required if...*
- Maternal antibodies are present
- Positive DAT
- Child older than 4 months
- Previous transfusions

**Selection of blood products for Neonates, Infants and Children**
- **Leucodepleted** (all red cell units are leucodepleted)
- **CMV negative** (not essential if emergency situation)
- **Blood less than 1 week old** (not a guideline anymore, however please select if available)
- Paediatric Split packs are available from NHSBT (each pack contains approx 40-50mls if only small volume needed)
- The amount of blood required should be included on request form (it is calculated from infants weight) NB: The initial 20mls are usually wasted so account for this when ordering packs.
- A full unit can be given if blood requirement is >100mls or if the request is
13 Appendix 2

No red cell exchange transfusions, intra-uterine blood transfusions (IUT) or extra-Corporeal membrane oxygenation (ECMO) take place on site at the Queen Elizabeth Hospital. All neonates/infants requiring such advanced support are transferred to either the Royal Victoria Infirmary or Freeman Hospital, Newcastle upon Tyne for specialist care in the Fetal Medicine Unit or Paediatric Intensive Care Units. Please telephone the RVI Blood bank (282 4335) to inform them of the transfer and the mother’s blood group if available.

For completeness the specific requirements are listed below:

13.1 Exchange Transfusion

Volume depends on clinical indication - refer to guidelines and clinicians request eg single or double volume exchange

- Term Infant
  - 80-160mls/kg
- Pre term infant
  - 100-200mls/kg

13.1.1 Red cells for Exchange Transfusion

- Group O or ABO compatible with maternal and neonatal plasma, Rh D negative (or Rh D identical with neonate)
- Negative for any red cell antigens determined by maternal antibody status
- Crossmatch compatible with maternal plasma
- 5 days old or less
- CMV negative
- Irradiated
- Transfused within 24 hours of Irradiation
- Irradiation is essential if infant has had previous IUT and is recommended for all exchange transfusions.
- Irradiation for ET in the absence of IUT is not essential if this would lead to clinically significant delay.
- Blood should be warmed to 37°C immediately prior to transfusion.
- (see section 2 for volume)

13.2 Intrauterine Transfusion (IUT)

- Always contact Consultant Haematologist
- Always liaise with NHSBT
- Refer to guidelines for further information (Blood Bank file 2, Guideline Y)
- The red cell transfusion programme starts as late as possible before hydrops develops, to enable the pregnancy to advance to a safe gestational age (36-37 weeks)
- Volume calculated:
  Desired HCT – fetal HCT \* fetoplacental blood volume
  Donor HCT – desired HCT

13.2.1 Red Cells for IUT (available from NHSBT)

- Group O (low titre haemolysin) or ABO identical with foetus (if known) and Rh D negative
- K negative blood is recommended but not essential.
- IAT-crossmatch compatible with maternal serum and negative for relevant antigen(s) determined by maternal antibody status.
- Blood less than 5 days old in CPD anticoagulant
- CMV negative
- Irradiated
- HCT below 0.75
- Warmed to 37°C immediately prior to transfusion
- Transfused at a rate of 5-10ml/min
- (see section 2 for volume)

13.3 Platelets for IUT

- Group O negative (low titre haemolysin) or group specific/compatible if known.
- Human Platelet specific alloantigen (HPA) compatible with maternal antibody
- Preferably Apheresis
- Irradiated
- CMV negative
- Warmed to 37°C immediately prior to transfusion
- Transfused at a rate of 1-5ml/min
- Volume calculated:

\[
\text{Desired platelet increment} \times \text{fetoplacental blood volume} \\
\text{Platelet count of concentrate}
\]

13.4 Extra Corporeal Membrane Oxygenation (ECMO)

- ECMO is highly specialised respiratory support in which there is a high risk of intra-cranial haemorrhage.
- This procedure is normally carried out at the Freeman Hospital
- Blood products are specific and should always be obtained from the NHSBT.
- Inform a Consultant Haematologist immediately if this procedure has been requested.
- Consult BCSH guidelines for further information.
Ordering blood in an Emergency for Paediatrics/Neonates

This procedure should only be followed in an EMERGENCY. Where time allows paediatric units will be sourced from the NHSBT by the laboratory and are the preferred transfusion option.

Contact Blood Transfusion Immediately on ext 6543 (Bleep 2082)
- Inform Transfusion staff of the clinical situation
- Ask for the “Paediatric Emergency Unit”
- Where possible provide patient identification (Hospital number, name, DOB)
- You will be asked for the name of the clinician taking responsibility for the uncross-matched blood
- Send a group and screen sample at the earliest opportunity
- Contact the porters ASAP via PorterTrac to collect the unit

Blood is required urgently – hospital number available for blood bank

Blood is required urgently – no hospital number

You will receive 3 paediatric red cell packs (O Negative) labelled as “Paed Emergency” and stickered with the patient ID

You will receive 3 paediatric red cell packs (O Negative) labelled as “Paed Emergency” with an accompanying form to complete.

After the transfusion has been administered sign the traceability label and return it to the Transfusion lab via the POD system

After the transfusion has been administered, fill in the accompanying form provided with the unit and sign the traceability label, returning all to the Transfusion lab via the POD system

Communication to the laboratory is vital. If more blood/products are required liaise with Blood Transfusion ASAP (ext 6543). Full blood count should also be considered.

Version 1.1 Authors JC, LC, SR, KN, Ratified by HTC Dec 2017