Avoidable, Delayed and Undertransfusion (ADU) - Previous Recommendations

Year first made	Action	Recommendation
2011	**Hospital Transfusion Committees (HTCs)**	Hospital Transfusion Committees (HTCs) should review the arrangements for the management of aortic surgery in line with the Vascular Society Quality Improvement Programme http://www.aaaqip.com
2011	**Transfusion Laboratory Managers, Pathology Directors**	Hospital laboratories should review their arrangements for fire and other alarms regarding emergency telephone calls and the delivery of results and blood products
2011	**Transfusion Laboratory Managers. Clinical Risk Managers. Medical Directors**	Trusts should review the arrangements for management of massive blood transfusion and to ensure that practice drills take place. Hospitals/Trusts/Health boards should develop practice drills for activation of major haemorrhage protocols to ensure that all staff know what to do in an emergency
2011	**General practitioners, Hospital doctors, Medical Schools, Hospital Transfusion Teams (HTT)**	Blood transfusion is not an appropriate treatment for iron deficiency. Elderly patients are particularly at risk for transfusion-associated circulatory overload. Iron deficiency must be diagnosed and treated with iron supplements
2010	**Leads/directors of pathology**	Every Trust/hospital must ensure compliance with CPA standards when giving telephoned results, in obtaining confirmation of the correct transmission
2010	**HTCs**	Every Trust must review its major haemorrhage protocol to ensure that it meets the recommendations of the NPSA Rapid Response Report 'The transfusion of blood and blood components in an emergency' NPSA/2010/017
2010	**HTCs, clinical governance committees**	All nurses and midwives making the clinical decision and providing the written instruction for blood component transfusion must operate within a governance framework ratified by the Trust and be aware of their professional accountability.

2010	**Clinical governance committees**	Handover information must include the decisions that have been taken with respect to transfusion support and the laboratory tests that have been requested
2009	**Risk management boards, HTCs, HTTs**	Staff working with paediatric patients must be trained and familiar with paediatric prescribing regimens and dose calculation for children. A specially designed prescription chart for paediatrics may assist this.
2009	**Royal Colleges**	Junior doctors must not be expected to clinically evaluate potentially bleeding patients if they are insufficiently experienced. Senior colleagues need to be involved in the decision to transfuse and the evaluation of patients with unexpected results. Doctors need to differentiate chronic anaemia from acute blood loss. BMS requests for repeat samples must be heeded.
2009	**POCT teams and manufacturers**	Blood gas machines must not be used for Hb estimation unless they are designed and calibrated to produce accurate, reproducible results.
2009	**HTCs**	Haematology laboratories need protocols for dealing with out of range results, including trending and delta checks, films and asking the Haematologist. Potentially erroneous results should not be communicated to clinicians either verbally or as unverified results on the computer system. New samples should be requested, with an explanation, but the incorrect result should not be given.
2008	**NBTC**	Trainee doctors in all hospital specialities must receive sufficient transfusion medicine education to be comfortable and safe in the clinical and laboratory assessment of anaemic and bleeding patients, and to be able to use blood components optimally to manage them
2008	**Trust CEOs**	A culture shift in the clinical arena is required so that when a doctor feels unable to handle a clinical scenario, requesting and obtaining appropriate help is easy, and negative judgement is avoided.