Safety, Quality & Standards Directorate

Department of
Health, Social Services and Public Safety

An Roinn
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Your Ref:
Our Ref: HSC(SQSD) 30/2007
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Chief Executives of Health & Social Care Trusts
For cascade to: Heads of Blood Banks and Transfusion Committees
Medical Directors
Chief Executive of HSS Boards
Chief Executive of the Northern Ireland Blood Transfusion Service
Regional Haemovigilance Cor-ordinator
Chief Executive of RQIA
For cascade to: Independent Hospitals/Hospices/Clinics and relevant Regulated Services
Chief Executive (designate) HSCA
Regional Director of Public Health

Dear Colleagues

RE: SAFER PRACTICE NOTICE – "RIGHT PATIENT, RIGHT BLOOD"

Introduction

With the formation of the new Health and Social Care Trusts, this provides an opportunity to highlight the contents of the National Patient Safety Agency's Safer Practice Notice **Right Patient, Right Blood(14),** available on www.npsa.nhs.uk/site/media/documents/2009_0316FEB06_V20_WEB.pdf

The Department endorses the principles outlined in this Notice which was designed to improve the safety of blood transfusions and to promote strict checking procedures at each stage of the blood transfusion process. This Safer Practice Notice is part of a broader national initiative, which is being taken forward collaboratively through the National Blood Transfusion Committee, the Serious Hazards of Transfusion (SHOT) and the National Patient Safety Agency.

The key messages identified in this Safer Practice Notice are applicable to health and social care and independent sector organisations. The NPSA website has a number of electronic resources available which will assist in implementation.

Action

HSC and Independent Sector organisations should have:

1. Agreed to and started to implement an action plan for competency based training and assessment for all staff involved in blood transfusions;
2. Ensured that the compatibility form (or equivalent) and patient notes are **not** used as part of the final check at the patient's side;
3. Systematically examined local blood transfusion procedures using formal risk assessment processes;
4. Bar codes or other electronic identification and tracking systems for patients, samples and blood products;
5. Photo-identification cards for patients who undergo regular blood transfusions; and
6. Labelling system of matching samples and blood for transfusion to the patient concerned.

All organisations should have an action plan in place by **8 October 2007**, with actions completed by **2 June 2008**.

Monitoring implementation

Progress towards implementation will be co-ordinated through the Northern Ireland Regional Transfusion Committee.

Organisations need to be aware of this Safer Practice Notice, in order to assist in complying with criteria 5.3.1(f)(9), 5.3.2 and 5.3.3(f) of the *Quality Standards for Health and Social Care* (safe practice in the use of blood and blood products, learning from adverse incidents and implementation of evidence based practice through guidance, for example, NPSA). These Quality Standards underpin clinical and social care governance reviews in health and social care organisations.

Independent sector organisations, where blood transfusions are administered, will also wish to provide evidence to the Regulation and Quality Improvement Authority that implementation is complete **by 2 June 2008.**

Yours sincerely

Maura Briscoe
Director, Safety, Quality and Standards Directorate