North West Anglia NHS Foundation Trust

Transfusion Related Adverse Events Report Form
Version 11

Document Type:	Form		
Central Index Number:	C0160a – Associated document of C0160		
Document Owner: (Name, job title and email)	Emily Rich, Lead Transfusion Practitioner, emily.rich3@nhs.net		
Division:	Family and Integrated Support Services Division		
Directorate/CBU:	FISS - Pathology		
Scope (please select)**:**	☑ Trust wide	☐ Specific staff group:	
Standards and Legislation and key related documents:	British Society for Haematology 2023 – Guideline on the investigation and management of acute transfusion reactions		
Specialty Meeting Approval:	FISS - Hospital Transfusion Committee	**Date:**	18 September 2019
CBU Meeting Approval:	N/A	**Date:**	Enter date

Additional Approval *(if required)*:				
PSC - *Tick* ☐	**D&TC** - *Tick* ☐	**TIPCC** - *Tick* ☐	**Safeguarding Committee** - *Tick* ☐	**ELD** - *Tick* ☐
Enter date	Enter date	Enter date	Enter date	Enter date

First-Level Approval: (Divisional Leadership Board)	FISS Divisional Leadership Board	**Date:**	28 April 2026
Second Level Approval: (*if required* – please consult sect. 6.4 of the Trust Wide Document Control Policy)	Quality Governance Operational Committee	**Date:**	8 August 2019
Review Date:	28 April 2029		
Target Audience:	Staff across all sites		
Trust Partnership Group Approval:	N/A	**Date:**	Enter date
Date archived:	*For Corporate Governance Compliance Team use only* Click or tap to enter a date.		

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AUTHOR'S CHECKLIST

Document Title:	Transfusion Related Adverse Events Report Form
Central Index Number:	C0160a

Must be completed when reviewing existing published documents only

Before beginning the process of reviewing and updating an existing document, please take the below into consideration and answer the questions in the drop-down boxes in the Y/N column:

Considerations for all documents		Y/N	Action	
			"Yes"	"No"
1.	Is the document still required?	Yes	Please see question 2.	Arrange document removal with Exec Director/Chair of DLB and forward to the relevant compliance team.
2.	Has there been any change in guidance or national policy since the previous version?	No	Please see question 4.	Please see question 3.
3.	**REVIEW DATE ROLL ON:** Where there has been no major[1] change to the document, can it be approved without having to go through all relevant committees (including those in chronological order)?	Yes	Exec Director/Chair of the DLB to approve new review date by email*. *(see version control summary/page 3)* The following information must be sent to the relevant compliance team: 1. Evidence of review date approval (*email). Non-Clinical Compliance Team Clinical Compliance Team	Please see question 4.
4.	Can the document be approved at first-level only? (Please refer to section 6 of the Trust-wide Document Control Policy)	Yes	Proceed with review and **first-level only** approval processes.	Proceed with review and both first and second-level approval processes.

[1] As defined in section 7.3 of the Trust-wide Document Control Policy

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VERSION CONTROL SUMMARY

Version:	Page/Section of Document:	Description of change: (List all amendments made to the document. "Review" or "Update" is not sufficient information.)	Date Exec Director/Chair of DLB approval for RDRO:	Date approved:	Date published:
10.1	1	Telephone number for Transfusion Practitioner changed	28.06.2023	N/A	19.07.2023
11	Appendix A	Adjusted format of form and added additional symptoms to document	28/04/2026	N/A	28/04/2026

If a document is being updated in line with actions following a serious incident, patient safety incident or Never Event, please state this in the 'Description of change' column.

DOCUMENT CONTRIBUTORS

Please list the details of all who contributed to the development of this document.

Name	Job Title	Version Contributed to
Emily Rich	Lead Transfusion Practitioner	Version 11

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Note: On completion of the document please update the auto-contents by selecting the table, followed by **Update Table** and **Update entire table**.

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1. INTRODUCTION

1.1 This form is designed to guide staff dealing with suspected moderate or severe transfusion reactions. Mild reactions can be managed locally.

1.2 It includes contact numbers for the Transfusion Laboratories, Haematologists and Transfusion Practitioners.

1.3 It includes details of tests to request, and symptoms to document.

2. PURPOSE

2.1 To ensure that suspected transfusion adverse reactions are investigated in a rapid and robust way.

3. SCOPE

3.1 All staff involved in the transfusion of blood products and blood components.

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APPENDIX A: TRANSFUSION RELATED AVERSE EVENTS REPORT FORM

Contact Numbers	
Peterborough Transfusion Laboratory	Tel 8451/2 Bleep 1151 (out of hours)
Hinchingbrooke Transfusion Laboratory	Tel 6157 Bleep 1257 (out of hours)
On-Call Haematologist	Bleep via switchboard
Transfusion Practitioners	Via Teams or (204) 8480/8422

If suspecting a moderate or severe reaction please request tests below on ICE and send to transfusion **immediately** with this completed Transfusion Related Adverse Events Report Form

Remains of all donor bags		Group and screen		FBC and retics	
Coagulation screen		U&E, LFT, LDH			
Blood cultures (if sepsis suspected)		First urine post reaction (if haemolysis suspected)		IgA and serial mast cell tryptase at 0, 3h, and 24 hr **(on advice of Consultant Haematologist only)**	
If Transfusion Associated Circulatory Overload (TACO) or Transfusion Related Acute Lung Injury (TRALI) are suspected arrange a chest X-Ray and notify the Transfusion Laboratory immediately.					

Patient Details			
Surname		D.O.B	
Forename		Hospital Number	
Ward/area		Consultant	
Did the unit, patient details and paperwork all match?			

Temperature	Baseline		At time of reaction	
Blood pressure	Baseline		At time of reaction	
Pulse	Baseline		At time of reaction	
Respiratory rate	Baseline		At time of reaction	
O2 sates	Baseline		At time of reaction	
Other symptoms (tick)	Chills or Rigors		Headache	
	Soft tissue swelling		Vomiting or nausea	
	Urticaria/hives		Rash	
	Breathlessness		Productive cough	
	Wheeze		Pain at IV site	
Other *(please record details)*				

Transfusion Details		Volume transfused	
Unit Number		Type of product	
Date & Time transfusion commenced			
Date & Time of onset of symptoms			

Form completed by			
Print name		**Signature**	
Date		**Time**	
Telephone/bleep		**Datix number**	

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APPENDIX B: PHARMACY QUALITY ASSURANCE CHECKLIST

Pharmacy Quality Assurance Checklist for all Medicine-Related Clinical Policies, Procedures and Guidelines

This form must be completed by the appropriate designated pharmacist for all policies, procedures and guidelines relating to medicines prior to being submitted to the Drugs and Therapeutics Committee.

Title of Document:			**Central Index Number:**
1.	**Document particulars:**	**Yes / No / N/A**	**Comments (as necessary)**
	Is the document written in clear, unambiguous language?		
	Does the document also apply for Hinchingbrooke Hospital/ Peterborough City Hospital/ Stamford Hospital?		
	If the answer to the above question is YES, has the relevant pharmacist at the cross site location been contacted for their input? **(Please indicate name of person contacted in comments)**		
2.	**Evidence Based**		
	Are the product(s) on the Formulary? If non-formulary then please submit Formulary request/Business case.		
	Have indications been clearly reviewed?		
	Are the medicines, hospital supply only?		
	Have doses of medication been clearly reviewed?		
	Are definitions in the document clearly explained?		
	Are roles and responsibilities in the document clearly explained?		
	Are the products listed in the document licensed, unlicensed or off license? If unlicensed then please complete unlicensed form.		
	Are there any Patient Safety Alerts/MHRA Alerts/NICE guidance associated with the document?		
	Is there any specific ordering or storage requirements with the product(s) in the document?		
	Are there any cost implications with the product(s) in the document?		
	Is there any supporting evidence to support the document? **(References should be checked and updated)**		
	Are there measurable standards to support the monitoring of compliance? **(Audit table applicable to policies only)**		
3.	**Pharmacist Compliance Approval:**		
	Name:		
	Signature:		
	Role:		
	Date:		

Please return completed form to the Pharmacy Medicines Governance Team.

Pharmacy Medicines Governance – updated December 2022

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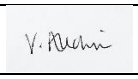
APPENDIX C: QUALITY ASSURANCE CHECKLIST

CORPORATE GOVERNANCE COMPLIANCE OFFICER'S USE ONLY

		Y/N/ n/a	COMMENTS (to author for amendments)
1	**Title of document**		
	Is the title clear and unambiguous	Y	
2	**Type of document (e.g. procedure, guidance)**		
	Is it clear whether the document is a procedure, guideline, SOP?	Y	
3	**Introduction**		
	Are reasons for the development of the document clearly stated?	Y	
4	**Content**		
	Are all sections of the front cover completed correctly?	Y	
	Is the document in the correct Trust approved format?	Y	
	• Paragraphs numbered consecutively	Y	
	• Headers: only on front page to contain logo	Y	
	• Footers: on every page except front page	Y	
	Has the Author's Checklist (pg. 2) been fully updated?	Y	
	Are the Version numbers correct in the title, summary and the footers?	Y	
	Has the Version Control Summary (pg. 3) been fully updated with changes?	Y	
	Has the Document Contributors section (pg. 3) been completed?	Y	
	Are the objectives/aims clearly stated?	Y	
	Does this document concern the handling, moving or storage of personal identifiable or commercially sensitive information? If yes, has a Summary Privacy Impact Assessment been completed?	N/A	
5	**Evidence Base**		
	Is the type of evidence to support the document explicitly identified?	Y	
	Are associated documents referenced?	Y	
6	**Approval Route**		
	Has email approval been received for change of review date only?	Y	
	Does the document identify which committee/group will approve it?	Y	
	Does the document meet the criteria for Second Level approval or Information Only?	Y	For information

If answers to any of the above questions is 'no', then this document is not ready for approval, it needs further review.

It is vitally important that documents are forwarded to the Corporate Governance Compliance Team after every amendment and approval meeting to ensure the most up-to-date version is held by the team at all times.

CORPORATE GOVERNANCE COMPLIANCE TEAM:		
1.	Date comments returned to author by Compliance Lead:	
2.	Date of Corporate Governance Compliance Team approval:	17.04.2026
3.	Name of Compliance Lead:	Viv Allchin 

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Please do not delete any of the below approval sections.
If certain sections are not applicable to the document's journey, please enter 'N/A'

SPECIALTY APPROVAL MEETING: Hospital Transfusion Committee			
On approval, Chair to sign below and send the document and the minutes from the approval committee to the Corporate Governance Team. **To aid distribution all documentation should use electronic signatures and be sent electronically wherever possible.**			
Chair's Name	[illegible]	**Date**	18/09/2019
Signature			

CBU APPROVAL MEETING: Enter name of CBU meeting			
On approval, Chair to sign below and send the document and the minutes from the approval committee to the Corporate Governance Team. **To aid distribution all documentation should use electronic signatures and be sent electronically wherever possible.**			
Chair's Name	***Not applicable***	**Date**	Enter date
Signature			

ADDITIONAL APPROVAL MEETINGS: Complete all that apply			
On approval, Chair to sign below and send the document and the minutes from the approval committee to the Corporate Governance Team. **To aid distribution all documentation should use electronic signatures and be sent electronically wherever possible.**			
Select Meeting.		Select Meeting.	
Chair's Name		**Chair's Name**	
Date	Enter date	**Date**	Enter date
Signature		**Signature**	
Select Meeting.		Select Meeting.	
Chair's Name		**Chair's Name**	
Date	Enter date	**Date**	Enter date
Signature		**Signature**	

FIRST-LEVEL APPROVAL: FISS Divisional Leadership Board			
On approval, Chair to sign below and send the document and the minutes from the approval committee to the Corporate Governance Team. **To aid distribution all documentation should use electronic signatures and be sent electronically wherever possible.**			
Chair's Name	DR. TIM JONES	**Date**	28/04/2026
Signature	[signature]		
Please confirm if document requires Second-Level **approval** or it is to be submitted for **information only**. Please see section 6.4 of the Trust's Document Control Policy.		☐ **APPROVAL**	
		☐ **INFORMATION ONLY**	

SECOND-LEVEL APPROVAL: Quality Governance Oversight Committee			
On approval, Chair to sign below and send the document and the minutes from the approval committee to the Corporate Governance Team. **To aid distribution all documentation should use electronic signatures and be sent electronically wherever possible.**			
Chair's Name	KANCHAN REGE	**Date**	08/08/2019
Signature	[signature]		

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