



Irish Blood Transfusion Service

Seirbhís Fuilaistriúcháin na hÉireann

Document Detail

Type: RCI IBTS FORM
Document No.: IBTS/RCI/FORM/0001[1]
Title: **REQUEST FOR TRANSFUSION REACTION INVESTIGATION**
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Status: CURRENT
Effective Date: 24-Aug-2021
Expiration Date: 25-Aug-2027

Document Detail

Review

Review: IBTS DOC PERIODIC REVIEW

<u>Level</u>	<u>Owner Role</u>	<u>Actor</u>	<u>Sign-off By</u>
1	DOCUMENT CONTROLLER	REBECCA WALDEN	REBECCA WALDEN
2	RCI WRITER IBTS	AISLING COSTELLOE	AISLING COSTELLOE
3	RCI REVIEWER IBTS	JANET MURPHY	JANET MURPHY
3	MEDICAL HEAD OF DEPT NBC	KIERAN MORRIS	KIERAN MORRIS
3	RCI HEAD OF DEPT NBC	EDEL SCALLY	EDEL SCALLY
4	QUALITY ASSURANCE REVIEWER IBTS	COLIN O'LEARY	COLIN O'LEARY

Review: IBTS DOC REVIEW AND APPROVAL

<u>Level</u>	<u>Owner Role</u>	<u>Actor</u>	<u>Sign-off By</u>
1	DOCUMENT CONTROLLER	DEBBIE MAC RORY	DEBBIE MAC RORY
2	RCI WRITER IBTS	RUTH CLEARY	RUTH CLEARY
3	RCI HEAD OF DEPT NBC	EDEL SCALLY	EDEL SCALLY
3	RCI REVIEWER IBTS	EDEL SCALLY	EDEL SCALLY
4	QUALITY ASSURANCE REVIEWER IBTS	COLIN O'LEARY	COLIN O'LEARY

Review: IBTS DOC REVIEW AND APPROVAL

<u>Level</u>	<u>Owner Role</u>	<u>Actor</u>	<u>Sign-off By</u>
1	DOCUMENT CONTROLLER	DEBBIE MAC RORY	DEBBIE MAC RORY
2	RCI WRITER IBTS	RUTH CLEARY	RUTH CLEARY
3	RCI HEAD OF DEPT NBC	AISLING COSTELLOE	AISLING COSTELLOE
3	RCI REVIEWER IBTS	AISLING COSTELLOE	AISLING COSTELLOE
4	QUALITY ASSURANCE REVIEWER IBTS	COLIN O'LEARY	COLIN O'LEARY

Review: IBTS DOC PERIODIC REVIEW

<u>Level</u>	<u>Owner Role</u>	<u>Actor</u>	<u>Sign-off By</u>
1	DOCUMENT CONTROLLER	BECKY WHITE	BECKY WHITE
2	RCI WRITER IBTS	CONOR GALVIN	CONOR GALVIN
3	RCI REVIEWER IBTS	MEGAN GALLAGHER	MEGAN GALLAGHER
3	MEDICAL HEAD OF DEPT NBC	KIERAN MORRIS	KIERAN MORRIS
4	RCI HEAD OF DEPT NBC	CONOR GALVIN	CONOR GALVIN
4	QUALITY ASSURANCE REVIEWER IBTS	REBECCA WALDEN	REBECCA WALDEN

Change Orders

Changes as described on Change Order: Change Order No.

Change Orders - Incorporated

Changes as described on Change Order: Change Order No.
IBTS/CO/0482/20

REQUEST FOR TRANSFUSION REACTION INVESTIGATION

Change Description:

1. Revise IBTS/DIAG/SOP/0063, create new IBTS/RCI/SOP/ AND IBTS/RCI/FORM. Expire BT – 0311. RCI to create new RCI SOP, MRTC to retain DIAG SOP 0063, removal of references to MRTC in new RCI SOP.
2. Update Smart train roles, referenced procedures and Training Requirements
3. Addition of Statutory Requirements in Section 1
4. Review and condense main body of Section 5
5. Reference to new IBTS/RCI/FORM where appropriate (applicable only where RCI acts as HBB)
6. Remove process flow from Section 5 and creation of new process flow in attachments.
7. Removal of Attachment 6.2 and re-format Attachment 6.2 (formerly Attachment 6.3). Identical and matching changes for IBTS/DIAG/SOP/0063, MRTC

Reason for Change:

1. As part of CC342/19 separation of shared SOPs.
2. Periodic review of the SOP involved updates to Smart Train roles, referenced procedures and training requirements.
3. Statutory requirements were not listed in previous versions.
4. Section 5 required some re-wording and clarification to improve the readability of the procedure.
5. To replace the use of BT – 0311.
6. Process flows should be captured as an attachment.
7. Attachment 6.2 was removed due to repetition.

Change order No.:

IBTS/CO/0482/20

Referenced Documents

IBTS/RCI/SOP/0074

SmartSolve Roles

RCI SMS NBC
RCI MS NBC
RCI THOD NBC

Training Type

Staff Trained in Previous version	New Staff
Previously trained on BT – 0311 Read Only	Read Only

SmartSolve Document Category

Category	Mobile	Cryobiology	Website	GDP
Yes / No	No	No	Yes	No

REQUEST FOR TRANSFUSION REACTION INVESTIGATION

Irish Blood Transfusion Service NBC Tel: 01 432 2800 Fax: 01 432 2930

Please contact the RCI laboratory at the IBTS **as soon as possible** to inform them of a transfusion reaction:

Please complete this form and provide the following:

1. 7ml Post Transfusion EDTA sample (Children 2mls)
2. 7 ml Clotted sample (Children 2mls)
3. Completed BT7 or BT345 form
4. Used Sealed Blood packs and giving set

Patient and Hospital Information			
Patient Surname		Patient Forename	
Patient Address			
Date of Birth		Hospital Number	
Hospital		Gender	
Consultant		Contact number	
Underlying diagnosis:			
Reason for transfusion:			
Product Information			
Please tick Implicated Product: Red Cells <input type="checkbox"/> Platelets <input type="checkbox"/> Plasma <input type="checkbox"/> Other <input type="checkbox"/>			
Please specify Unit number implicated:			
Unit numbers already transfused: 1. 2. 3.			
Transfusion Event Information			
Date & Time of Implicated Transfusion: ____/____/____ at ____ Hours			
Interval between commencement of transfusion and reaction: ____ Hours			
Approximate Volume of blood transfused: ____ ml			
Description of Transfusion reaction Symptoms <i>please tick boxes</i>			
Baseline Temperature before the commencement of transfusion: ____ °C			
Temperature change from baseline: > 1.5°C <input type="checkbox"/> <1.5°C <input type="checkbox"/> No Change <input type="checkbox"/>			
BP ↑: mm Hg <input type="checkbox"/> BP ↓: mm Hg <input type="checkbox"/> Tachycardia <input type="checkbox"/>			
Rigors <input type="checkbox"/>	Facial Oedema <input type="checkbox"/>	Chest Pain <input type="checkbox"/>	Back Pain <input type="checkbox"/>
Shortness of Breath <input type="checkbox"/>	Vomiting <input type="checkbox"/>	Rash <input type="checkbox"/>	Cough <input type="checkbox"/>
Haemoglobinuria <input type="checkbox"/>	Cyanosis <input type="checkbox"/>	Pain @ IV site <input type="checkbox"/>	Jaundice <input type="checkbox"/>
Urticaria <input type="checkbox"/>			
History of Pyrexia in previous 24 hours: Yes <input type="checkbox"/> No <input type="checkbox"/>			
History of previous transfusion reaction*: Yes <input type="checkbox"/> No <input type="checkbox"/>			
*If Yes, please state date if known: _____			
Other relevant information:			
Report completed by: _____ Date: _____			
Doctor's Name: _____ MCRN: _____ Bleep No: _____			