CONTROLLED DOCUMENT

University Hospitals Birmingham NHS Foundation Trust

Blood Transfusion Policy			
Type of Document	Policy		
Purpose	The policy describes the framework and principles required to deliver best transfusion practice.		
Controlled Document Number	14	**Version Number**	8.0
Document Sponsor	Chief Medical Officer		
Document Lead	Chair of the Hospital Transfusion Group		
Policy Status	Ordinary	**Ratification Body**	Group Executive Team
Date Ratified	23/06/2025	**Review date**	23/06/2028
This Policy is essential reading for:	All staff involved in the transfusion process		
Information for:	Any other staff with an interest		
What has changed since the last version of this controlled document?	• The policy has been transferred into the current format used by the Trust.		

University Hospitals Birmingham NHS Foundation Trust

POLICY ON A PAGE Blood Transfusion Policy	
Key things to know	• While transfusion is typically considered to be 'safe', there persists ongoing risks associated with administration of blood and where possible, the use of blood should be avoided, utilising Patient Blood Management to optimise patients prior to planned procedures or during ongoing treatment and transfusing only where compliant with Trust indications for transfusion. • Following recommendations from the Infected Blood Inquiry and external review of Trust procedures, all decisions to transfuse must be documented clearly with specific rationale for the indication to ensure that when adverse events occur, there is clear evidence that the use of blood was appropriate and proportionate. • The steps involved with the administration of blood (section 7) must occur in line with Trust procedures to reduce the possibility of errors which could cause harm to patients, and all staff performing these processes must have completed the relevant training and competency based on their job role. Where processes involve the use of staff ID verification to enable access to a system, the sharing of ID details is treated as a disciplinary matter.
Advice and guidance	transfusion.practitioners@uhb.nhs.uk
Training	A detailed Training Needs Analysis can be found in Appendix B

The above summary highlights the main points for all users. For specific details please refer to the main document which follows.

Table of Contents

Version History

Version	Title	Issue Date
5.0	Blood Transfusion Policy	31/01/2012
6.1		22/12/2017
7.0		18/12/2020
7.1		11/04/2024

Details of Associated procedures which enact this policy, and those which provide ancillary information can be found here.

1. Policy Statement

1.1. The purpose of this policy and its associated documents is to ensure that University Hospitals Birmingham NHS Foundation Trust (the 'Trust') delivers all aspects of the transfusion process safely. This will be achieved through the following objectives which ensure the Trust complies with The Blood Safety and Quality Regulations 2005 (BSQR 2005).

2. Policy Objectives and the Standards that measure them

2.1. The Blood Transfusion Policy and associated procedures are in place and staff are aware of them.

Standard A: The Policy is communicated according to a communications plan.

2.2. Procurement and Provision are conducted appropriately.

Standard B: Materials used in blood transfusion are appropriately procured, stored and are available on a timely basis.

2.3. Staff involved in the transfusion process are appropriately trained. This is set down in the Training Needs Analysis (Appendix B).

Standard C: All members of staff who are involved in the transfusion process must be trained and competency assessed according to the Trust's blood transfusion procedures specific to their role.

2.4. The use of blood is minimised.

Standard D: Patients who may require transfusion are optimised to minimise the need for allogeneic blood whilst ensuring the best clinical outcome.

2.5. Blood is rapidly provided when clinically appropriate.

Standard E: Transfusion of red cells, plasma, platelets and cryoprecipitate must be supplied within pre-determined time frames for transfusion to patients with life-threatening haemorrhage.

2.6. Consent is obtained prior to transfusion.

Standard F: Informed consent is obtained prior to transfusion.

2.7. Risks associated with transfusion are minimised.

Standard G: Blood transfusion carries significant risks and the clinical team responsible for the patient must adhere to the Trust procedures for managing a patient undergoing transfusion to ensure that a risk and benefit assessment has been completed, and the right blood is administered to the right patient, at the right time, for the right reason.

2.8. A Governance process is in place to manage the activity.

Standard H: All incidents occurring during the transfusion process are reported, reviewed, investigated, followed up and lessons learned.
Standard I: A group with governance responsibilities is in place, with Terms of Reference.

3. Scope

3.1. In Scope: This policy applies to all members of staff including students, locums, bank and agency staff and staff employed on honorary contracts who are involved at any stage of the transfusion process in the Trust, on or off the premises.

3.2. Out of Scope: Anyone not involved in the blood transfusion process.

4. Definitions

4.1. Definitions are listed in Appendix C.

5. Legal Framework

5.1. Blood Safety and Quality Regulations (BSQR) (2005) set the standards for quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components. Aspects of the regulations apply to 'blood establishments' (the UK Blood Services) and hospital transfusion laboratories. The Blood Safety and Quality (amendment) Regulations 2006/2013 further amend the BSQR 2005 (SI 2005/50) ("the principal regulations") to make a number of changes to the provisions governing the operation of hospital transfusion laboratories.

5.2. These changes relate specifically to traceability requirements and notification of adverse reactions and events and introduce community standards and specifications relating to a quality system for blood establishments. The Medicines and Healthcare Products Regulatory Agency inspect using the BSQR and issue a licence to the Trust transfusion laboratory to issue blood, only if the regulatory requirements are met.

5.3. The Trust has specific duties under the following sections of BSQR (2005) and discharges them through the application of this policy:

Section 9:	Hospital blood bank requirements
Section 10:	Requirement for hospital blood banks to provide information to the Secretary of State
Section 11:	Service of notices relating to hospital blood banks
Section 14:	Disclosure of information by blood establishments and hospital blood banks
Section 15:	Inspections, etc.
Part 4:	Storage, transport and distribution conditions for blood and blood components
Part 5:	Quality and safety requirements for blood and blood components.

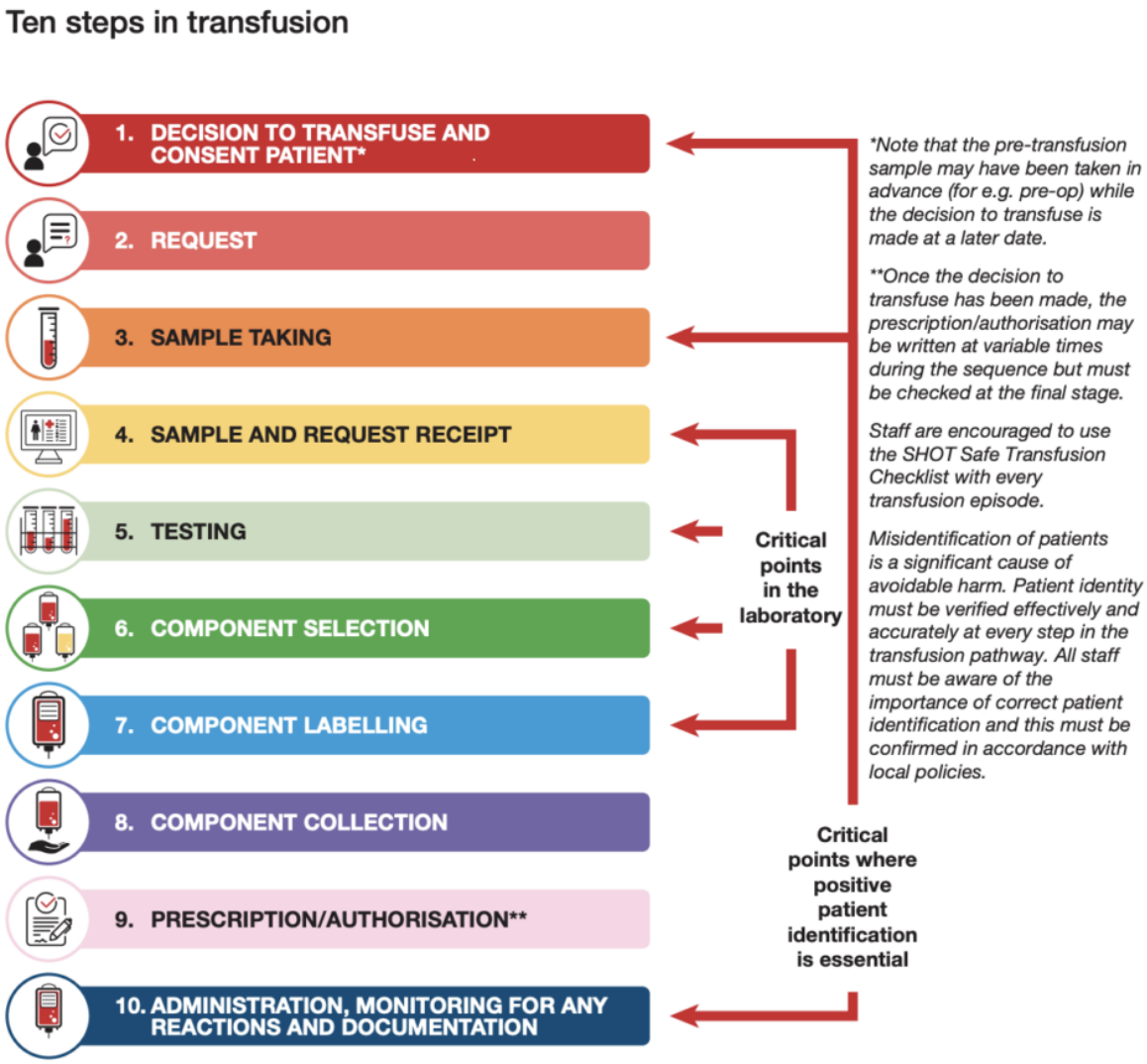
6. Policy Framework

6.1. This section describes the broad framework for the Blood Transfusion Policy. Detailed instructions are provided in the associated procedural documents. The Hospital Transfusion Group (HTG) shall approve all Trust controlled documents associated with this policy, and any amendments to such documents, and is responsible for ensuring that such documents are compliant with this policy. The chair of the HTG shall provide final written confirmation that the document has been approved.

6.2. Documents originating outside of the hospital transfusion team but relating to any part of the transfusion process will be presented to the HTG for approval.

7. The Transfusion Process

The Serious Hazards of Transfusion have set out ten steps in the transfusion process, this can be seen below in the following diagram:



Ten steps in transfusion - Serious Hazards of Transfusion

8. Procurement and Provision

Standard B: Materials used in blood transfusion are appropriately procured, stored and are available on a timely basis.

8.1. Procurement of Blood Components

8.1.1. Laboratory Services on behalf of the Trust are responsible for the procurement of blood components. Such materials will only be procured from organisations that comply fully with the United Kingdom BSQR (2005). Blood components will ordinarily only be procured from NHS Blood and Transplant, with the exception of imported pooled solvent detergent frozen plasma (Octaplas).

8.2. Procurement and Maintenance of Blood Storage Devices

8.2.1. The procurement and validation to BSQR of all blood storage devices is managed by the Hospital Transfusion Teams (HTTs). Replacement of existing devices and purchase of new equipment is managed through laboratory change controls. The Transfusion Laboratory Managers (TLMs) are responsible for ensuring all procured equipment complies with BSQR.

8.2.2. Requests for purchasing satellite blood storage devices must be made via the HTT, who will assess the need for this additional equipment to be procured, installed and maintained, and will make a recommendation to the HTG where a final decision will be made. Following successful application, the HTT will assist the requesting department with implementation.

8.3. Maintenance

8.3.1. Periodic preventative maintenance, reactive maintenance and associated temperature monitoring and mapping of blood storage devices and compliance with BSQR is managed by the HTTs. This may involve third party companies who are required to hold the relevant United Kingdom Accreditation Service (UKAS) accreditation.

8.3.2. The Head Biomedical Scientist (BMS) is responsible for ensuring maintenance of all laboratory equipment and blood storage devices used in the transfusion process complies with BSQR.

8.4. Procurement of articles used in the administration of blood

8.4.1. Ordering of equipment (such as but not limited to pumps or blood warmers) and disposables used for the administration of blood components is the responsibility of the clinical area where the blood is administered. These will be ordered through the Trust's procurement team. The HTT will advise whether particular items are suitable for use and with which blood components.

8.5. Provision of appropriate blood components

8.5.1. The transfusion laboratory will provide the most appropriate blood component based on the patient's requirements, current stock availability and urgency.

8.5.2. The clinician responsible for each patient's care will provide the necessary clinical information in order to inform the transfusion laboratory's choice of component.

8.5.3. Full traceability is a requirement of BSQR. The clinician administering the component is responsible for recording the use of the specific blood component and returning traceability information as detailed in the procedures for administration of blood components.

8.6. Supply of blood in times of shortage

8.6.1. When an emergency situation occurs and the supply of blood is likely to be outstripped by demand, the Emergency Blood Management Group (EBMG) will be activated in accordance with the Emergency Blood Management Plan. The circumstances under which the EBMP is activated, responsibilities of the transfusion team, site and executive teams and functions of the EMBG are set down in the EBMP.

8.7. Monitoring of cold chain

8.7.1. Blood must be collected and transported correctly from blood storage devices and administered to the patient or placed back into blood storage devices within agreed timeframes, as outlined in the procedures for administration of blood components and procedure for collection of blood components. This is a requirement of the BSQR and components for which appropriate storage cannot be verified will be discarded.

8.8. Laboratories

8.8.1. The transfusion laboratories are run in accordance with BSQR (2005) as enforced by MHRA and are accredited to ISO 15189:2012 by UKAS. Periodic inspections will be carried out by UKAS and short notice non-periodic inspections will be carried out by MHRA; all areas of the Trust will co-operate with these.

9. Minimising the need for blood

Standard D: Patients who may require transfusion are optimised to minimise the need for allogeneic blood whilst ensuring the best clinical outcome.

9.1. All patients identified as at risk of needing a blood transfusion must be assessed by medical staff or Healthcare Practitioner (HCPs) working to the expanded practice protocol to authorise blood components.

9.2. The HTG oversee the implementation of patient blood management recommendations, including the 2015 Blood Transfusion NICE Guidelines (NG24). Directions from the HTG are actioned by the HTTs and may include the development of Trust guidelines and monitoring of compliance to such guidelines. This will include diagnosis and treatment of anaemia, thrombocytopenia and deranged coagulation so as to avoid transfusion where there are appropriate alternatives.

10. Ensuring rapid provision of blood when clinically appropriate

Standard E: Transfusion of red cells, plasma, platelets and cryoprecipitate must be supplied within pre-determined time frames for transfusion to patients with life-threatening haemorrhage.

10.1. The procedure for provision of blood to patients with life-threatening haemorrhage is laid down in the Blood Transfusion; Major Haemorrhage Procedure (MHP) and Urgent and Massive Transfusion for adults and children over the age of 28 days.

10.2. Blood components for use in an emergency for patients of unknown blood group are in limited supply and the Trust has a responsibility to ensure their judicious use.

10.3. The TLMs are responsible for ensuring the laboratory services support appropriate blood use by way of appropriate laboratory procedures for rapid issue of blood, strategic storage of suitable blood at locations around the Trust and rapid processing of samples for patients with life-threatening haemorrhage.

10.4. The HTG is responsible for ensuring appropriate procedures are in place to guide appropriate use, training to these procedures is undertaken and for monitoring their use. This may include reporting back to NHS Blood and Transplant.

11. Consent

Standard F: Informed consent is obtained prior to transfusion.

11.1. Informed patient consent must be obtained and clearly documented in the patient's clinical record before any transfusion takes place. Where the patient is unable to consent, the clinician must ensure that no advance decision is in place precluding the use of blood components and enter into the patient's notes the decision to transfuse being made in the patient's best interest.

11.2. The patient has the right to consent to or decline a transfusion which should occur following discussion with a healthcare professional competent in consent for blood transfusion.

11.3. The Trust's Consent to Examination or Treatment Policy sets out guidance on consent and should be used in conjunction with the risks, benefits, and alternatives detailed in the procedure for prescribing and requesting blood. Specific guidance for the management of patients who decline blood transfusion for any reason, including on religious grounds, is described in the Procedure for the Management of Refusal of Blood Components and Products; including the Care of Jehovah's Witnesses.

12. Minimising the risks associated with transfusion

Standard G: Blood transfusion carries significant risks and the clinical team responsible for the patient must adhere to the Trust procedures for managing a patient undergoing transfusion to ensure that a risk and benefit assessment has been completed, and the right blood is administered to the right patient at the right time for the right reason.

12.1. All patients for whom a blood transfusion is felt to be clinically indicated must be assessed by medical staff or HCPs working to the expanded practice protocol to authorise blood components. They must conduct and document a risk and benefit analysis as part of the decision to transfuse which must be documented in the patient record. All staff involved in the transfusion process must be trained in, and adhere to, the Trust transfusion procedures listed in this document in order to minimise the risks associated with any transfusion given.

12.2. Patients must be accurately identified as set down in the Trust Policy for Identification of Patients to ensure their identity is correctly assigned and this identity is confirmed at every stage of the transfusion process.

12.3. Staff performing any part of the transfusion process must adhere to the associated Trust procedure for the element they are performing.

13. Adverse events

Standard H: All incidents occurring during the transfusion process are reported, reviewed, investigated, followed up and lessons learned.

13.1. All incidents during the blood transfusion process must be reported on the Trust's incident reporting system.

13.2. All incidents, including near misses, relating to the blood transfusion process are investigated by Transfusion Practitioners (TPs) and reviewed by Lead Transfusion Practitioners (LTPs) with clinical support from the transfusion consultants as needed. Significant or recurring issues are escalated to the HTTs and reviewed by the HTG (which includes representation from the Clinical Risk and Patient Safety Team) on a quarterly basis. Incidents reported to the HTG must include all NHS England Never Events, any incidents that have triggered a Trust Root Cause Analysis, any Serious Adverse Events and Reactions as defined by the MHRA and any incidents linked by recurrent themes or evolving trends. Inclusion of incidents in the latter categories will be at the discretion of the lead TP and transfusion consultant.

13.3. Serious Adverse Events and Reactions as set down by the MHRA are also reported by the LTPs and TLMs (or delegated to sufficiently qualified professionals) to MHRA as part of the Trust's licence conditions and Serious Hazards of Transfusion (SHOT) as a voluntary contribution.

13.4. The unintentional transfusion of ABO-incompatible blood components is an NHS England Never Event and must be escalated immediately according to the Trust's Reporting and Management of Safety Events Policy. Members of the HTTs and HTG will co-operate with any investigations undertaken by the Trust relating to transfusion incidents.

13.5. The HTTs and HTG will make recommendations based on information presented in the incident reports, in order to reduce the risk of further incidents. These will be enacted by the HTTs.

13.6. Transfusion-related incidents and any subsequent actions are presented to Group Clinical Quality Management on a six-monthly basis by the chair of the HTG or a nominated deputy.

14. Governance and Assurance

14.1. The governance of this policy is carried out by the HTG which is constituted with a Terms of Reference. These are detailed in document TRA.R002 which is accessible on the Pathology domain of Q-pulse 5.

14.2. Assurance regarding compliance with this policy will be provided by the chair of the HTG to the Trust board, as set down in their duties. This takes the form of a biannual report summarising the information set down in the monitoring criteria in Appendix A. The full monitoring requirements, leads, process and timeframes are also set down in Appendix A.

15. Duties

15.1. Chief Medical Officer

15.1.1. The Chief Medical Officer is the Sponsor of this policy and will approve this document and ensure that associated documents are compliant with this policy.

15.2. Chair of the HTG

15.2.1. Providing assurance to the Board of Directors' that blood transfusion is carried out across the Trust according to the policy.

15.2.2. Ensuring that the HTG is conducted according to the Terms of Reference.

15.2.3. Receiving assurance from the Clinical Service Lead for Laboratory Haematology, or the Consultant Clinical Lead for Transfusion (CCLfT), that the actions of HTG/HTT have been implemented.

15.2.4. Approving all procedural documents associated with this policy and introducing and ensuring appropriate changes in practice.

15.2.5. Reporting to and feeding back from the Regional Transfusion Committee as appropriate in relation to the activities of the HTG.

15.3. Site Directors, General Managers, Clinical Service Leads, Site Directors of Nursing, Matrons and Supervisors of Midwives

15.3.1. Incorporating the Blood Transfusion Policy and its associated procedures into Trust working practices.

15.3.2. Ensuring staff implement and adhere to the policy and the associated procedures.

15.3.3. Ensuring protected time is allocated for staff to attend training for transfusion as per the Blood Transfusion Role Specific Training Needs Analysis.

15.3.4. Supporting the implementation of clinical guidelines relating to blood transfusion and in line with this policy.

15.4. Chairs of the Hospital Transfusion Team (HTT)

15.4.1. Ensuring the HTT is conducted according to the Terms of Reference.

15.4.2. Oversee the day-to-day implementation of this policy.

15.4.3. Ensuring the HTT enact the instructions of the HTG.

15.4.4. Report the actions of the HTT to the HTG. This may be delegated to the appropriate HTT members.

15.5. Clinical Service Lead for Laboratory Haematology

15.5.1. Has overall clinical responsibility for implementing the actions of the HTG/HTTs, which may be delegated to the CCLfT.

15.6. Consultant Clinical Leads for Transfusion

15.6.1. The Trust has two Consultant Clinical Leads for Transfusion (CCLfT); one covering QEHB and one covering BHH, GHH and SH sites.

15.6.2. The appropriate lead provides day-to-day direction of the service in association with the Head BMS, TLMs and other consultant haematologists and TPs. The CCLfT will usually be the chair of the HTT at the relevant site. CCLfT may provide oversight and supervision cross site when appropriate.

15.7. Individuals involved in the transfusion process

15.7.1. A detailed description of duties and responsibilities of individuals involved in each step of the transfusion process is set down in each specific Trust procedure.

16. Associated Documents

16.1. Documents which are directly linked to this policy:

Version	CDN	Title	Issue Date
8.1	35	Blood Transfusion - Emergency Blood Management Plan	17/03/2020
1.0	CG1379	Blood Transfusion: Procedure for Prescribing and Requesting of Blood Components	11/2022
1.5	CG253	Clinical Guideline for Indications for Transfusion of Blood Components	12/2024
1.3	CG1320	Blood Transfusion; Major Haemorrhage Procedure (MHP) and Urgent and Massive Transfusion for Adults and Children Over the Age of 28 Days	08/2024
1.0	CG1428	Procedures for Administration of Blood Components	08/2023
8.0	428	Procedure for the Management of Refusal of Blood Components and Products; including the Care of Jehovah's Witnesses	10/08/2023
2.0	CG976	Clinical Guideline for the Management of Transfusion Reactions	03/2023
3.0	CG227	Severe Anaemia	06/2024
1.0	1373	Procedure for Collecting, Transporting & Returning Blood Components (HGS)	12/08/2022
8.0	424	Procedure for Collecting, Transporting & Returning Blood Components (QEH)	12/08/2022
4.0	EPP922	EPP To Enable Registered Healthcare Practitioners to Authorise Blood Component Transfusion	12/2024

16.2. Documents which provide ancillary information regarding this policy:

Version	CDN	Title	Issue Date
5.2	382	Policy for Identification of Patients	14/02/2025
8.0	181	Reporting and Management of Safety Events Policy	29/04/2025
8.0	24	Consent to Examination or Treatment Policy	29/04/2025

17. References

17.1. Legislation/Regulatory guidance

- Requirements for Training and Assessment in Blood Transfusion. National Blood Transfusion Committee. 2016.
- Guidelines for Blood Transfusion. National Institute for Clinical Excellence. 2015
- Patient Blood Management. National Blood Transfusion Committee. 2014.
- Guidelines for the Blood Transfusion Services in the UK 8th Edition. Joint UKBTS/HPA Professional Advisory Committee. 2013. (BSQR (2005) guidelines)
- The Impact of the Blood Safety and Quality Regulations 2005 on Hospital Transfusion Laboratories. NHS Operational Impact Group. 2005.
- Never Events List – NHS Improvement 2018

18. Implementation, Monitoring, and Training

18.1. This policy will be available on the Trust's Intranet and external Internet site. The policy will also be disseminated through the management structure within the Trust and communicated according to a communications plan.

18.2. The monitoring of this policy can be found in Appendix A.

18.3. The specific training required for clinical staff is set down in the blood transfusion role specific Training Needs Analysis (Appendix B). The Training Needs Analysis for laboratory staff is managed via the laboratory quality management system based on the role and grade of the staff member.

Appendix A Monitoring Matrix

What is being monitored	Who prepares the report?	Which meeting or Group is it reported to?	How often is it reported?	Where are concerns escalated to?
Standard A: The Policy is communicated according to a communications plan.				
A communications plan is in place	Included in report to HTG	HTG committee	As required	Hospital Transfusion Group
Standard B: Materials used in Blood Transfusion must be appropriately procured, stored and be available on a timely basis.				
The transfusion laboratories function according to BSQR 2005	HBMSs CSL	Pathology Board HTG	Annual	Clinical Support Services (CSS) Board
	HBMSs CSL	Pathology Board	Monthly	Clinical Support Services (CSS) Board
	TLMs	HTG	Quarterly	Pathology Board
Emergency blood management arrangements are established	Chair of HTG	HTG	As per activation	Clinical Quality and Patient Safety Committee
Laboratory tests are quality controlled and assured to ensure consistent accuracy of results	TLMs	Pathology Board HTG	Quarterly	Board of Directors
		Transfusion QMM	Monthly	Pathology Board
The transfusion laboratories are practising within scope	Lead BMSs	Pathology Board	Annually	Board of Directors

for ISO 15189:2007 accreditation				
Appropriate blood is provided in a clinically acceptable timeframe	TLMs	HTG	Quarterly	Pathology Board Clinical Quality and Patient Safety Committee
Standard C: All members of staff who are involved in the transfusion process must be trained and competency assessed to the Trust's blood transfusion procedures specific to their role.				
All members of staff who are involved in the transfusion process must be trained and competency assessed to the Trust's blood transfusion procedures specific to their role.	LTPs	HTG	Quarterly	Clinical Quality and Patient Safety Committee
Standard D: Patients who may need blood transfusion are optimised to minimise the need for allogeneic blood whilst ensuring the best clinical outcome.				
Patients who may need blood transfusion are optimised to minimise the need for allogeneic blood whilst ensuring the best clinical outcome and authorisation and request of blood is performed according to procedure.	LTPs	HTG	Annually	Clinical Quality and Patient Safety Committee

Standard E: Transfusion of red cells, plasma, platelets and cryoprecipitate must be supplied within pre-determined time frames for transfusion to patients with life-threatening haemorrhage.				
Blood is issued within locally defined time periods as per SOP for each site.	TLMs	HTG Pathology Board	Quarterly	Board of Directors
Major haemorrhage protocols are managed according to the procedure	LTPs/TLMs	HTG	Quarterly	Clinical Quality and Patient Safety Committee
O D neg red cells are used appropriately	LTPs/TLMs	HTG	Quarterly	Pathology Board Clinical Quality and Patient Safety Committee
Standard F: Blood transfusion carries significant risks and the clinical team responsible for the patient must adhere to the Trust procedures for managing a patient undergoing transfusion to ensure that a risk and benefit assessment has been completed and the right blood is administered to the right patient at the right time for the right reason.				
Transfusions are carried out safely and risks to the patient are minimised	LTPs	HTG	Quarterly	Clinical Quality and Patient Safety Committee
Samples are obtained in line with the Trust Procedure for Sample Collection	LTPs	HTG	Annually	Clinical Quality and Patient Safety Committee
Blood is collected from storage in line with the Trust Procedure for the	LTPs	HTG	Annually	Clinical Quality and Patient Safety Committee

Collection and Transport of Blood Components				
Blood is administered in line with the Trust Procedures for the Administration of Blood	LTPs	HTG	Annually	Clinical Quality and Patient Safety Committee
Standard G: Informed consent is obtained prior to transfusion.				
Consent for transfusion is taken and recorded according to procedure	LTPs	HTG	Annually	Clinical Quality and Patient Safety Committee
Declaration for refusal of blood is taken and recorded according to procedure	LTPs	HTG	Annually	Clinical Quality and Patient Safety Committee
Standard H: All incidents occurring during the transfusion process are reported, reviewed, investigated, followed up and lessons learned.				
All incidents occurring during the transfusion process are reported, reviewed, investigated, followed up and lessons learned.	LTPs/TLMs	HTG	Quarterly	Clinical Quality and Patient Safety Committee
	CCLfT	Clinical Quality and Patient Safety Committee	Six monthly	Board of Directors
Standard I: A group with governance responsibilities is in place, with Terms of Reference.				
The HTG is in place and meets quarterly	Chair of HTG and CCLfT	HTG	Quarterly	Clinical Quality and Patient Safety Committee

Appendix B – Training Needs Analysis

	Blood transfusion awareness	Obtaining a sample	Administration of blood components	Collecting and returning of blood components	Anti-D	Transfusion request form Completion/ Special Requirements	Non-Medical Authorisation **(NHSBT Course)**	Cascade Trainer
Anaesthetist	✓	✓	✓					
Doctor	✓	✓	✓*		✓*			
PA	✓	✓	✓*/***					
AP	✓	✓	✓**	✓*	✓*	✓*	✓*	✓*
Registered Nurse/NA	✓**	✓**	✓**	✓*	✓*	✓*	✓*	✓*
MW	✓**	✓**	✓**	✓*	✓*		✓*	✓*
ODP	✓		✓*	✓**				✓*
Perfusionist	✓	✓*	✓*	✓**				✓*
SNA	✓	✓		✓*				
HCA/MSW		✓*		✓*				
TSW/ODA				✓**				
Phlebotomist		✓						
Porter				✓				
Update Frequency	2 Yearly	2 Yearly	2 Yearly	2 Yearly	2 Yearly	2 Yearly	Annual self-audit	Yearly

* Role/Area dependent – Opt-in for training/competency

** Role/Area dependent – Opt-out of training/competency

*** Subject to introduction of statutory registration

Appendix C: Definitions

Term	Definition
ACP	Advanced Clinical Practitioners
AP	Advanced Practitioner
BHH	Birmingham Heartlands Hospital
BMS	Biomedical Scientist
BSQR	Blood Safety and Quality Regulations (2005)
CCLfT	Consultant clinical lead for transfusion
EBMG	Emergency Blood Management Group
GHH	Good Hope Hospital
HCA	Healthcare Assistant
HCP	Healthcare Practitioner
HTG	Hospital Transfusion Group (Nationally referred to as Hospital Transfusion Committee)
HTT	Hospital Transfusion Teams
IQC	Internal Quality Control
LTP	Lead Transfusion Practitioners
MHRA	Medicines and Healthcare Products Regulatory Agency
MLA	Medical Laboratory Assistant
MSW	Midwifery Support Worker
MW	Midwife
NA	Nurse Associate
NEQAS	National External Quality Assessment Service
NMA	Non-Medical Authoriser
ODA	Operating Department Assistant/Orderly
ODP	Operating Department Practitioner
PA	Physician Associate
QEHB	Queen Elizabeth Hospital Birmingham

QMM	Quality Management Meeting
SH	Solihull Hospital
SNA	Student Nurse Associate
TLM	Transfusion Laboratory Manager
TP	Transfusion Practitioners
TSW	Theatre Support Worker
UKAS	United Kingdom Accreditation Service