**Audit of Overnight Red Blood Cell Transfusion, Weston General Hospital (WGH)**

Dr Sarah Mabbutt, Dr Philip Robson, Mrs Louise Jefferies

**Background:**

The Serious Hazards Of Transfusion report, 2005, recommends that transfusion at night (20.00-0800 hours) is inherently unsafe and should be avoided unless clinically essential (1). The aim of this audit was to establish the number and appropriateness of overnight red blood cell (RBC) transfusions at WGH. Criteria for appropriate overnight RBC transfusion were a) active bleeding or haemolysis at the time of transfusion, b) low haemoglobin level giving significant symptoms (2).

**Methods:**

Case notes for all patients who received an overnight transfusion between 1st and 14th March 2012 were searched for documentation regarding the reason for transfusion.

**Results:**

There were 27 RBC transfusion episodes, 32% of all episodes, during overnight hours. 1 case was excluded. 31% (n=8) of overnight transfusions satisfied the standards, whilst in 62% (n=16) there was no acute clinical need for transfusion overnight. 8% (n=2) required transfusion for next-day discharge.

**Key messages:**

This highlighted the need for further education for doctors and nurses regarding the hazards of overnight transfusion. To encourage thought on this issue, a new transfusion prescription proforma was developed with a tick box for whether each unit prescribed needed transfusion out-of-hours. A re-audit will occur in 2013 to ensure the situation has improved.

Serious Hazards of Transfusion Steering Group. SHOT Annual Report 2005. UK; November 2006.

National Comparative Audit of Overnight Red Blood Cell Transfusion Project Group. National Comparative Audit of Overnight Red Blood Cell Transfusion. UK; January 2008.