DAT2939/3.1 – Recall Reason Information for Hospitals

Further information on recalls initiated by hospitals (due to Transfusion Reactions and Visual Abnormalities), and those recalled by NHSBT.

Please note:

- If the unit is not transfused, there will be no follow up letter and the recall event can be closed.
- For those events where a recall letter will be sent, they will be emailed to the Transfusion Laboratory Manager, Transfusion Practitioner and Consultant Haematologist responsible for Transfusion.
- We aim to send a letter within 4 - 6 weeks however further testing may result in delay in which case an interim letter will be sent.
- Confirmatory testing will not provide information in a timeframe that is useful for the management of the patient.
- For any unused/partially used components(s), submit FRM5219 – Customer Credit Request Form. Use 'REC' as the credit code and select the appropriate reason under the drop-down section for 'Comments/Reason' for the recall.
- See 'INF1210 – NHSBT Component Recall Process' for summary.

Hospital Recall Reason	Information	Action If Recalled Unit Transfused	Follow up
Transfusion Reaction	If a patient had an acute transfusion reaction e.g., TRALI or bacterial contamination, other patients may be at risk from components from the same donation. Hospitals are asked to contact NHSBT immediately so that associated units can be recalled.	Monitor patient for up to 24 hours. If no adverse reaction occurred, no further action required. If suspected transfusion reaction, discuss with local haematologist who can contact an NHSBT consultant via your local Hospital Services Department.	Letter sent following completion of investigation. If suspected bacterial infection, the letter will usually be within 4 – 6 weeks. A suspected TRALI may take longer.

Granulocytes	If any visual abnormality is identified within this component, please contact NHSBT for further advice

Hospital reported Visual Abnormality				
Component	**Abnormality Type**	**Information**	**Action if recalled unit transfused**	**Follow up if transfused**
RBC	• Clotted • Discoloured • Sticky • Haemolysed in the pack	Visually abnormal units suspected of bacterial contamination are **returned for investigation** to the MSL Bacteriology laboratory within NHSBT. Any associated components are recalled to prevent transfusion.	Monitor patient for up to 24 hours. If no adverse reaction occurred, no further action is required. If suspected transfusion reaction, discuss with local haematologist who can contact an NHSBT consultant via your local Hospital Services Department.	Letter sent following inspection and/or confirmatory results within 4 - 6 weeks.
Platelet	• Discoloured • Turbid (cloudy) • Large clumps/aggregates			
Visual Abnormality - Other If unit is requested to be returned; it is visually examined at NHSBT but **not sent** to NBL for investigation. If the unit does not need to be returned to NHSBT; once reported you can discard the component on site and claim a credit.				
RBC	• White flakes only • Lipaemic (fatty)	Other visual abnormal units not suspected of bacterial contamination	None	None, recall event can be closed
FFP **CRYO**	• Icteric (discoloured) • Lipaemic (fatty) • White flakes (clumping, aggregates)			
Platelet	• White deposit • Small flakes • Residue			

NHSBT Recall Reason	Information	Action If Recalled Unit Transfused	Follow up
Bacterial Screening	A sample from each platelet component is monitored for bacteria during their shelf life. When there is an alert after the platelets (or associated components) have been issued, confirmatory tests are performed (may take up to 4 weeks). Most alerts are false positives or clinically insignificant bacteria.	Monitor patient for up to 24 hours. If no adverse reaction occurred, no further action is required. If suspected transfusion reaction, discuss with local haematologist who can contact an NHSBT consultant via your local Hospital Services Department.	Letter sent following confirmatory results, usually within 4 - 6 weeks.
Donor Information	Additional information provided by donors post donation e.g., flu, sickness, infection, travel. These events are usually extremely low risk to the patient.	None, unless donor has developed Chicken pox, Shingles, Hepatitis A, Measles, Rubella, in which case NHSBT will contact you with further advice.	None, recall event can be closed.
Microbiology Reactive	If a donation tests positive for mandatory testing, MHRA requires a recall of in-date components from the previous donation. This is a precaution while the current donation is sent for confirmatory testing. Most of these investigations do not confirm an infected donation.	None*	None, recall event can be closed.
Transfusion Microbiology Lookback	Possible post transfusion-transmitted (non-bacterial) infection has been reported to NHSBT from a hospital. A lookback exercise is performed to identify implicated donations.	None*	None, recall event can be closed.
Quality Defect	Non-compliance with NHSBT quality system.	None*	None, recall event can be closed.
Non-UK Plasma	Non-UK plasma supplier recalls the unit.	None*	None, recall event can be closed.

* Under rare circumstances, NHSBT Clinical Support Team will make contact if further action is required