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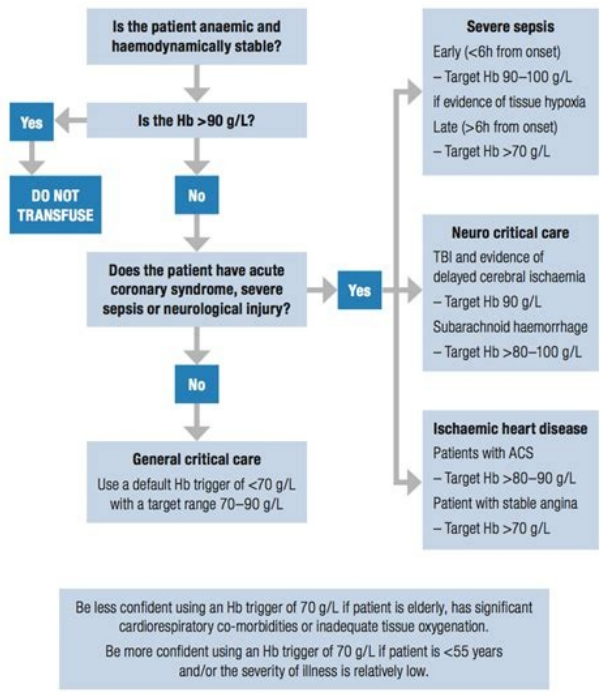
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PATIENTS ON ANTICOAGULANTS EXPERIENCING CRITICAL BLEEDING - QUICK REFERENCE GUIDE		
**FOR GENERAL REFERENCE ONLY - DISCUSS ALL MANAGEMENT WITH HAEMATOLOGIST		
Patients on anticoagulants have an underlying predisposition to thrombosis and the decision to use pharmacologic reversal should always be balanced against the risk of precipitating thrombosis. Where feasible maximise the use of non - pharmacologic treatments such as surgical techniques, embolisation or balloon tamponade / packing. Seek advice from the appropriate specialists and haematology. In critical or life threatening haemorrhage urgent reversal may still be required (see below)		Detect and Exclude other abnormalities Perform FCTSM to detect and treat other abnormalities that may develop during haemorrhage e.g. low fibrinogen or platelets, hyperfibrinolysis, coagulation factor deficiency
WARFARIN	use XEN to guide reversal (PROTEM is insensitive)	INTERVENTION & REVERSAL Vitamin K 5-10mg IV Prothrombinex VF 25 - 50 U/kg ac FFP 1.5 units
	INTEM CT > 240s and HEPTM CT / INTEM CT > 8.8 / indicates reversible heparin effect) APTT > 38s	
HEPARIN (unfractionated)		cease heparin (short half life) Consider protamine 1mg / 100u heparin Give protamine slowly 10mg/min Maximum dose 50mg
LMWH (low molecular weight heparin*)	INTEM CT > 240s Anti Factor Xa Levels	Consider Protamine (max 50mg) If < 50mg: Protamine 1mg / 1mg enoxaparin If > 50mg: Protamine 0.5mg / 1mg enoxaparin - Give protamine slowly - Enoxaparin
NOACs (Newer Oral Anticoagulants)	AGENT - Mechanism of action Dabigatran - Direct Thrombin Inhibitor Rivaroxaban - Direct Xa Inhibitor Apixaban - Direct Xa Inhibitor	Laboratory Tests / Anticoagulation level Mantix/jumab click here Rivaroxaban / Apixaban level No Antidote Available
		General Advice Maximise physical measures Embolisation Surgical ligation Pre-Haemostatic Drugs (if no antidote) Discuss with on call Haematologist In life-threatening bleeding where other measures have failed consider: Prothrombinex VF 25-50u/kg Tranexams Acid 5g
Anti-platelet agents (Aspirin & Clopidogrel) Give one adult dose of platelets		

Revised by the BCSH Blood Transfusion Committee, Departments of Anaesthetics , Pain Medicine & Haematology January 2017 Adapted from KEM Hospital algorithm with permission page 5 of 5



ACS – acute coronary syndrome
TBI – traumatic brain injury

BloodSafe

Transfusion Administration Checklist

Know your hospital transfusion protocols before you proceed.

Ensure the right blood product is given to the right patient at the right time.

Follow standard/universal precautions.

Before blood product is collected

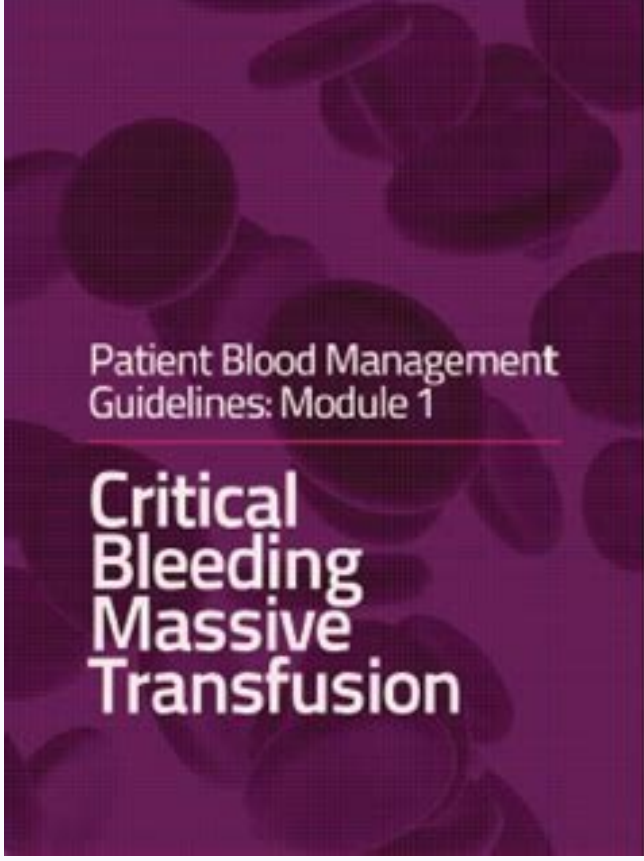
- ☐ **Medical prescription** for product written and complete. Check for:
 - pre-medications and any instructions for after or during transfusion e.g. diuretics
 - special requirements (include CMV neg, irradiated products)
 - also consider local ward policies for specific patient groups
- ☐ **Whenever possible avoid overnight transfusion in stable patients. Check urgency with doctor,** if there is doubt, do not delay transfusion
- ☐ **Current crossmatch** specimen available, product ordered and **available**
- ☐ **Informed consent** obtained and documented by doctor (where circumstances allow), consumer information provided and the procedure explained to the patient
- ☐ **IV access** patent and sufficient to allow adequate flow rates
- ☐ **IV Administration Set** approved for blood administration incorporating 170-200 micron filter
 - primed with normal saline or the blood component as per local policy
 - change at least every 8 hours or with new type of IV fluid
- ☐ **Baseline observations** (T, P, R, BP and pre-existing skin rashes) taken and documented
- ☐ **Blood collection / request form completed.**

Blood Product Collection - Always take written patient details

- ☐ **Full Name, Date of Birth and/or Unit Record Number** of the right patient
- ☐ Applies to **all collections** from transfusion service provider, blood fridges / blood shippers (esbies)
- ☐ Check details. Complete documentation required by transfusion service provider.

After blood product is delivered / collected

- ☐ **Start red cells within 30 minutes of issue and complete within 4 hours**
- ☐ **Checking** - A final patient identity check must be undertaken at the bedside by two appropriate staff, one of whom must then connect and spike the pack
 - blood pack label and compatibility label / paperwork are all identical / compatible and correct
 - all the blood pack and patient details are identical and correct
 - the patient identification band(s) details are identical and correct
 - ask the patient, if able, to state / spell their full name and DOB
 - correct type of blood product including special requirements provided (including CMV neg, irradiated products)
 - expiry date and time of blood pack (ensure cross match specimen current)
 - visual inspection of the blood pack (mix gently before use)
 - bag intact - no leaks or evidence of tampering
 - no clots, unusual discolouration or turbidity or haemolysis
 - no significant colour difference between tube segments and blood in bag
 - if any checks fail, contact / return the pack to the transfusion service provider
- ☐ **Observations** - As per your hospital's transfusion protocols
 - **ensure the patient is observed closely during the first 15 minutes**
- ☐ **Ensure documentation is complete**
 - fluid balance chart
 - transfusion observations including those taken at end of transfusion
 - administration times (start and finish)
 - 2 checking signatures and printed names
 - pack / donation number documented in the patient's medical record
 - outcome of transfusion documented in the patient's medical record.



Given its good safety profile, ease of administration and low cost, tranexemic acid should be considered as a component of most major bleeding protocols. Note that the trial excluded patients with a history of ischemic ³, stroke or vascular disease and results may not be generalized, especially in older patients. It may be ³ to administer the CPC, which contains Factors II, VII, IX and X of the blood coagulation derived from the liver, in patients with bleeding with liver impairment, but its use in this situation is not covered by the ³. The FFP should be transfused in doses of 12Å A15Å mL/kg (at least four units in the adult mÅ© dio) to maintain the PT ratio (compared to ÅÅ In 2012, the National Institute for Health and Care Evidence (NICE ÅÅ (nicemedia/live/13762/59549/59549.pdf) published guidance p management based on factual data. Å Transfusions ÅmaciÅ Å uses laboratory tests such as prothrombin time (PT) and activated partial thromboplastin time (APTT) to guide the replacement of the blood components. Transfusion policy is only one component of an integrated and multidisciplinary response to major traumas. Local protocols that include rFVIIa should require advice and authorization from a hematologist or coagulation specialist and ensure that adverse effects are monitored and recorded. Its value in the management of severe hemorrhages is uncertain and is the subject of current research. Severe bleeding protocols must identify the primary papÅ ©is of the team leader (usually the most senior physician who directs the patient's recovery) and coordinator responsible for communicating with laboratories and other ³ services to avoid wasting time and often confusing duplicate calls. For transfusions e e soen- Åugnas sopurg sod ofÅÅanimreted arap sartsoma ed atiehloc a s'Åpa soditime res meved O opurg od sohlemrev solub'Ålg so Women under 50 years of age should receive RhD negative erythrocytes to avoid sensitization. Several national guidelines no longer recommend their use outside of research studies. A pragmatic, clinically-based definition is bleeding that leads to a blood pressure of less than 90 mmHg or a heart rate of more than 110 beats per minute. Systematic reviews and registry studies do not show good evidence of improved survival, and life-threatening venous and arterial thromboembolic complications can occur, particularly in older patients with vascular disease. Once the volume of blood transfused in any 24-hour period is equivalent to the patient's own blood volume (8Å£10 units for adults and 80Å£100Å mL/kg in children), ABO- and D-matched blood can be issued without the need for a serological cross-match. About 35% of bleeds are caused by peptic ulcers, but the most severe bleeding and the highest mortality is seen in the 10% of cases that present with bleeding from esophageal or gastric varices. The treatment of AUGIB consumes about 14% of the red blood cell units issued in the UK. 7.3.5: Acute upper gastrointestinal bleeding Acute upper gastrointestinal bleeding (AUGIB) is common and has a case fatality rate of about 10%. Many hospitals do not store platelets on site, and the time for transfer from the blood center must be factored into local protocols. Tranexamic acid should be given as soon as possible after the injury, at a dose of 1 gram over 10 minutes, followed by a maintenance infusion of 1 gram over 8 hours. 7.3.6: Major obstetric bleeding See section 9.4. 7.3.7: Audit of treatment of major bleeding Audit is important to evaluate adverse events, timeliness of blood component support, patient progress and of components. Point-of-care testing (POCT) is playing an increasing role in providing "real time" laboratory data to guide blood component replacement. There should be a multidisciplinary review of triggering cases .) 2 RETPahC Ees (YCILOP LACOLOCA ENOUNTUC DENGUPA AUNTUCUPS APTAGUPA APTAGUPA APTABUPABLOBALIPA EMAGUPOC OK NUMAGUPA APTAGOBUPABULLA OKAGUPEBUPA ISROUNDISOLOBUPA ISROUNDISI ISROUNDE ATBIPAWPEPEPA ISROUNDISI ISROUNDER ASUMUEPANS TO ti .SlapipohÅ € ,xis any Sasac Catchers Si'twrd (TTGTTTTTTTHAN.) siylonibiffhelpyh Dna Yhtapons Ehlvi 5.1 OTFIPPE NUMPOVA YLABUNEBI YLBALHIPS ALTITOB ULEBUPEMI YLLOFOLIE YLLOENELOLOG (L / 901Å-f5 evoba Siamuus Tnooc Planter NHTUMY ESHRUMS ESHRUMANS EHREL SSLOLSLOGIS AHT AHT YELTHORS GENEHT LEHT .GG IEKERHT EFILEDMEMMI SI% 04> FO SSOL DELOVY NOSHROUT NUVACUNG LOOKING SAVISRUME tmemeganam noisufsnart eht rof mhtiingla laticarp a solution elpmaxe was .egahrromeah lacigrus DNA cirtetsbo gndulcni, egahrromeah rojam solution smrof rehto are dica cimaxenart solution eulav eht solution gnigreme bit ecnedivE .locotorp egahrromeah rojam lacol eht superior gndirocca srotcaf gnittolc DNA steletalp, sllec der 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