

Blood for obstetric emergencies

Standard operating procedure (SOP) | OBS-SOP-002

Document type	Standard operating procedure (SOP)
Title	Blood for obstetric emergencies
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Prepared by	{{roles.quality_lead.name}}, Quality lead
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Effective date	{{document.effective_date}}
Next review	{{document.review_date}} (12 months, or sooner after any incident or change)
Replaces	None (new document)
Standards and criteria supported	Standard 12 (Obstetrics and Gynaecology), criterion 12.4
Evidence basis	E-006, E-009
Status of this document	Recommended best-practice model. A hospital may adopt, adapt or replace it with an equivalent that meets the same criteria.

At a glance: what to do

1. A defined route to a blood bank or transfusion service is in place for obstetric emergencies.
2. The route is tested each year, with the time to blood recorded.
3. Emergency release follows BLD-SOP-006 when full compatibility testing cannot wait.
4. A woman who may need blood is typed and screened on admission.

Stop and get help straight away if: a haemorrhage occurs with no defined route to blood.

1. Purpose

To make sure blood is available within minutes for obstetric haemorrhage (12.4).

2. Scope

Applies to	Clinical and support staff in the hospital
Locations	All wards, clinics and departments of {{facility.legal_name}}
When	Whenever the activity described is carried out
Does not apply to	Activities covered by another document listed in section 15

3. Definitions and abbreviations

Term	Meaning in this SOP
Clinical lead	The doctor or nurse in charge of the area at the time

4. Background and rationale

To make sure blood is available within minutes for obstetric haemorrhage (12.4).

5. Responsibilities

Role	Duties in this SOP	Competence needed
Lead obstetrician	Owns the route and the test	Clinician
Blood bank or transfusion lead	Confirms supply and tests the route	Scientist

6. Equipment, materials and resources

Item	Specification or standard	Check before use
Records and forms named in this document	Current version	Checked before use

7. Safety and infection prevention

- Stop and call for help if a patient is at immediate risk. Do not delay urgent care to complete paperwork.

8. Before you start

- Confirm the forms and equipment named in this document are available and current.

9. Procedure

Follow the steps in order. Where a step says "If", take the action for the case that applies. Do not skip a step. If a step cannot be done, use section 11 and section 12.

Step	Action	How to do it	Key point
1	Define the route.	• Write the route to the blood bank, with the contact and the time to blood.	Route written.
2	Type and screen.	• Type and screen each woman at risk on admission.	Typed on admission.
3	Test.	• Test the route each year and record the time to blood.	Tested, timed.

Decision points

- No decision points in this procedure.

10. Special situations

Situation	What to do
Out of hours	Follow the same steps. Use the on-call contact on the wall of the area.

11. Problems and escalation

- Any serious problem goes to the duty clinical lead at once and to the clinical director the same day.

12. Monitoring and compliance

What is checked	Target	How often	Who	If the target is missed
Route tests done each year	100%	Yearly	Blood bank or transfusion lead	Escalate to medical director

13. Records

Record	Where it is kept	Kept for
Record named in this document	Patient record or the area file	{{facility.records_retention_years}} years

14. Training and competence

- Staff are trained in this document at induction and refreshed each year, with a recorded competency check.

15. Related documents

ID	Title	Relationship
BLD-SOP-006	Emergency release of blood (existing, reused)	Procedure
BLD-FRM-002	Blood request and issue record (existing, reused)	Record

16. Evidence

ID	Source and status
E-009	Based on the WHO recommendations for the prevention and treatment of postpartum haemorrhage (2012).
E-006	ASF Policy Framework v1.2. Adapted.
E-009	ASF Expert Committee consensus.

EC = ASF Expert Committee consensus. Items marked EC are reviewed by the Committee each year.

17. Change history

Version	Date	What changed	Approver and signature
1.0	{{document.effective_date}}	First version	Pending Expert Committee approval