Are Patients being consented for transfusion?

South West Regional Transfusion Committee

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Introduction

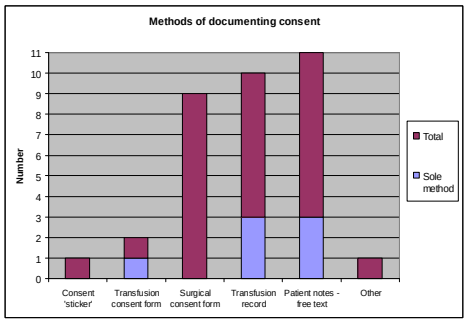
The Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) published a report and recommendations on *Patient Consent for Blood Transfusion* in October 2011. These standards were subsequently included in the *Patient Blood Management* (PBM) document released by NHS England in July 2014. The South West Regional Transfusion Committee (SWRTC) agreed to audit compliance against these standards within the region at a meeting in 2015

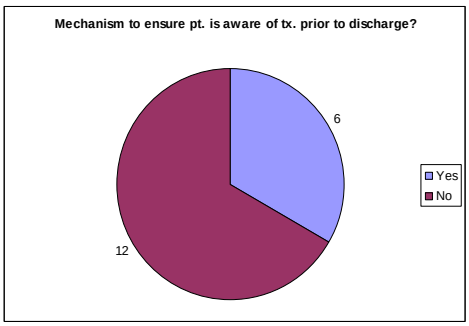
Method

A short questionnaire was developed by the Regional Transfusion Team. This asked if consent was documented and if yes where this was recorded. It also asked if consent was checked prior to discharge and if the consent process was audited. This was distributed to Transfusion Practitioners (TPs) in all trusts/hospitals within the region.

Results

All 17 NHS trusts and one independent hospital responded. Every trust/hospital stated that patient consent for transfusion was obtained and documented. Free text in the patient's notes was the most common approach and used by 11 trusts/hospitals. 11 trusts/hospitals used more than one method. 1/3rd (6/18) trusts/hospitals had a mechanism to ensure consent prior to discharge although this was mostly passive and relied on the provision of patient information leaflets. ½ trusts/hospitals said that the consent process was audited although this was usually as part of a National Comparative Audit or individual departments only.





Discussion

Every institution appeared to be doing some kind of consent for transfusion. Most trusts/hospitals appear to have more than one way of documenting consent. This makes the process more flexible but also makes auditing more difficult.
Free text in the patient's notes is the most common method of documenting consent. Surgical consent for a procedure appears to relied upon to indicate transfusion consent. It is unclear how well informed consent for blood transfusion is obtained in this situation.
Patient information leaflets are used to support the process of retrospective consent. This may be a 'passive' handing over of information.

Conclusions

Consent for blood transfusion was stated to occur in all of the trusts/hospitals in the South West who responded the survey.

The methods used for documenting consent were highly variable.

Free text in notes was the most widely cited method – would this practice be supported and better managed with the use of a consent sticker?

Only $^1/_3$ of trusts/hospitals identified a process for retrospective consent. Only 2 respondents indicated local documentation to support this.

Audit of the consent process was performed in only a minority of trusts/hospitals in the South West

Recommendations

The South West Regional Transfusion Committee to develop a consent sticker for use in trusts/hospitals in the region.
Trusts/hospitals should have a robust process to ensure that patients who have received blood are informed prior to discharge.
Trusts/hospitals should include audit of consent for blood transfusion as part of their local ongoing transfusion audit programme.

For further information contact katy.cowan@nhsbt.nhs.uk
The SWRTC website can be accessed at www.transfusionguidelines.org.uk/Index.aspx?Publication=RTC&Section=28&pageid=1062