Blood Administration Guidelines

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on behalf of

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Blood Administration Guidelines

- Who are the BCSH and what do they do?
- BCSH guideline development process
- Some of the key blood administration recommendations related to nurse authorisation

  (adults, routine, non urgent / emergency, red cells)
- SaBTO Consent for Blood Transfusion

Who are the BCSH?

- The British Committee for Standards in Haematology (BCSH) is a sub-committee of the British Society for Haematology (BSH).

The BCSH consists of 4 Task Forces:

- Haemato-oncology
- General Haematology
- Haemostasis and Thrombosis
- Blood Transfusion

www.bcshguidelines.org

What do the BCSH do?

- The primary purpose of the BCSH is to provide up to date advice on the diagnosis and treatment of haematological disease by the production of evidence based guidelines.
- Guidelines are drafted by writing groups following specific guideline writing procedures.
- This procedure endeavours to involve all relevant stakeholders and ensures review of draft guidelines by a wide spectrum of UK haematologists who act as 'sounding boards'.

Adapted from BCSH Process for Guideline Development

Approval for guideline development from BCSH

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Writing group members identified and agreed by BCSH

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Literature review

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Draft guideline produced

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Draft guideline reviewed by the BCSH Transfusion Taskforce

Not Approved → Re-draft guideline → (back to Draft guideline reviewed by the BCSH Transfusion Taskforce)

↓ Approved

Draft guideline reviewed by the Sounding Board

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Major changes needed?

Yes → (back to Draft guideline reviewed by the BCSH Transfusion Taskforce)

↓ No

Make minor alterations as required

↓

FINAL VERSION

Adapted from the BCSH Procedure for Guideline Development (www.bcshguidelines.com)

Purpose and objectives

- Provide national guidance on:
  - Pre transfusion blood sampling
  - Prescription
  - Requesting
  - Collection
  - Administration of blood components to
    - Adults, children and neonates
- Note: The clinical management of transfusion reactions is not included (a separate BCSH guideline is being developed)
- Provide the basis for the development of standardised local and regional policies, protocols and practice

Some key recommendations…

Keep it simple

- try to avoid complexity and concentrate on the key steps, especially patient identification.

3 key principles which underpin every stage of the blood administration process:

- Patient identification
- Communication
- Documentation

Positive patient identification

At **every** stage of the transfusion process

Blood sampling

Blood collection

Patient details on request form

Right results for the right patient at the right time

Blood administration

Patient details on authorisation / prescription sheet

Communication

- Clear and unambiguous communications between all involved in the transfusion process, including all clinical and laboratory staff and any other support staff, is essential.
- Organisations should have local policies to minimise the risk of misinterpretation or transcription errors in all communications, whether written, verbal or electronic.

Documentation

- All paperwork relating to the patient must include, and be identical in every detail with, the minimum patient core identifiers contained on the patient's identification band.
- Full and complete documentation at all stages
- E.g. transfusion care pathways

Decision to transfuse

The decision to transfuse must be based on a thorough clinical assessment of the patient and their individual needs

and documented in the patient's clinical notes

Pre-transfusion documentation requirements:

The clinical indication for transfusion

- Relevant pre-transfusion indices (e.g. FBC, coagulation screen)
- The date the decision for transfusion was made and the date the transfusion should be administered (if different)
- Blood components to be transfused and their volume / dose
- Patient information given (reason, risk, benefits, alternatives) and consent to proceed
- Any special requirements to transfusion e.g. CMV-ve / irradiated

Consent for Blood Transfusion

SaBTO

Advisory Committee on the Safety of Blood, Tissues and Organs

SaBTO = Advisory Committee on the **Sa**fety of **B**lood, **T**issues and **O**rgans

Advise Ministers of the UK Government (and the Devolved Administrations) on the most appropriate ways to ensure the safety of blood, cells, tissues and organs for transfusion / transplantation

2009 – SaBTO asked to look at 'Consent for Blood Transfusion'

2010 – Consultation exercise

October 2011 – recommendations announced

Informed consent – what is it?

- Consent can be defined as "…a patient's agreement for a health professional to provide care."

- Informed (or valid) consent can be defined as "an ongoing agreement by a person to receive treatment, undergo procedures or participate in research, after the risks, benefits and alternatives have been adequately explained to them."

SaBTO Consent for Transfusion

Valid consent for blood transfusion should be obtained and **documented in the patient's clinical record by the healthcare professional**
(as per BCSH Blood Administration Guidelines 2009)

Patients who have received a blood transfusion and who were not able to give valid consent prior to the transfusion should be provided with
information retrospectively

There should be a **modified form of consent for long term multi-transfused patients**, details of which should be explicit in an organisation's consent policy

Standardised Information resource

Training and education

- Patients and public
- Healthcare professionals

LearnBloodTransfusion

Governance: NHSLA / CQC

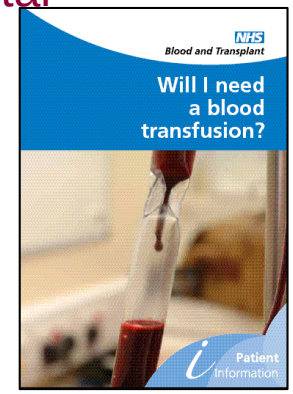
Patient information and consent

Wherever possible, a trained and knowledgeable practitioner should inform the patient (and/or those with parental responsibility) of:

- The reason for
- The risks
- The benefits
- And the alternatives to transfusion.

- Timely and easy to understand
  Patient Information – written and verbal

- Documented in the patient's clinical notes.



Requesting and Authorisation

Requests for blood transfusion

The ‘request’ constitutes the mechanism of communication with the transfusion laboratory, asking them to prepare and issue a component for administration

- Clinical staff can discuss transfusion requirements with laboratory staff
- The person making the request should be:
  - trained and competent
  - locally authorised
  - in possession of the relevant information about the patient
- The name of the person making the request should be clearly indicated on the written or electronic request form (plus telephone number)
- Extra care if telephone request – document and be aware of possible communication or transcription errors

Requests for blood transfusion

- The details on the request form and the sample tube are the only direct contact between the clinical area and the blood transfusion laboratory – the accuracy and completeness of this information is therefore of vital importance – zero tolerance is recommended

•As a minimum, the request should:

Positive patient ID

- contain the patients core identifiers (NB: also gender)
- patient diagnosis and any significant co-morbidities relevant to the transfusion
- provide a clear, unambiguous reason for transfusion. Terms such as ‘pre-op’, ‘anaemia’ or ‘low Hb’ alone are not acceptable
- state when the transfusion will take place and the level of urgency
- the location of the patient and where the blood will be transfused (if different)
- any other relevant information (e.g. known antibodies, previous blood transfusion reactions, any known pregnancies)
- What type of component is required and number of units
- Any clinical special requirement (e.g. CMV –ve, irradiated)

Written authorisation / prescription

- Blood components should only be prescribed by an appropriately trained, competent and locally authorised registered practitioner, using an approved prescription sheet for intravenous fluids or on a special transfusion documentation record.

- NOTE: be aware of aware of possible communication / transcription errors (e.g. telephone results, results for another patient).

- Ideally, to prevent communication or transcription errors, blood components should be prescribed by the registered healthcare professional making the decision to transfuse.

Written authorisation / prescription

- The prescription should include the following information:
  - ✓ patient core identifiers
  - ✓ date (and time if appropriate) the blood component is required
  - ✓ type of blood component to be administered
  - ✓ any clinical special transfusion requirements (e.g. irradiated, CMV negative, blood warmer required).
  - ✓ number of units (or volume) to be transfused
  - ✓ time over which each unit is to be transfused
  - ✓ Any special instructions (e.g. concomitant drugs required, e.g. furosomide)
  - ✓ Signature of the prescriber

NOTE: take care with terminology / abbreviations

Written authorisation / prescription

Red Cells

- For routine administration, there is extensive experience of safely administering a red cell unit over 90-120 minutes per unit
- Patients less tolerant of increased blood volume should be transfused more slowly with careful haemodynamic monitoring. For **some** patients it may be appropriate to give a diuretic.
- Note: SHOT reports relating to small adults being over-transfused
- Transfusion should be completed within 4 hours of removal from temperature controlled storage

Post transfusion documentation

Management and outcome of any transfusion reactions
or adverse events

An indication of whether or not the transfusion had the desired effect (e.g. post transfusion increment in Hb or improvement in patient symptoms)

What about day case patients??

???? Questions ????

BCSH Guidelines

www.bcshguidelines.org

SaBTO

Advisory Committee on the Safety of Blood, Tissues and Organs

www.dh.gov.uk/ab/SaBTO/index.htm

Consent documents:
www.transfusionguidelines.org.uk