Consent for Blood Transfusion and Patient Information

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Maternity Services

Good at gaining consent?
Place of birth
Management of labour
Administration of Anti-D
Definitions

- **Consent**: permission for something to happen or agreement to do something (OED)

- **Informed consent**: consent to medical procedures/treatment given by a patient after the potential risks, hazards, and benefits of the treatment have been explained
9 fundamental points of consent (GMC, 2008)

- Should be obtained at time and place that enables patients to best retain information
- Allow time for reflection before and after decisions
- Tailor approach to individual wishes, making no assumptions about information needs, levels of understanding, or about the importance patients attach to different outcomes
- Use clear, simple, and consistent language
- Give information about risk in a balanced way, avoiding bias
9 fundamental points of consent (GMC, 2008)

• Provide the likelihood and uncertainties of benefits, risks, and the side effects of each option

• Tell patients about serious adverse outcomes, even if the likelihood is very small

• Use written material and visual aids—accurate and up to date—and refer to other sources

• Check that patients understand the information they are given
Informed Consent

- Voluntary
- Informed
- Given by a person with capacity
- Taken by a practitioner adequately trained in the procedure for which the consent has been given
What about consent for Blood Transfusion?
Blood Transfusion

• “The transfer of blood components from one person (the donor) into the bloodstream of another (recipient)”

A Liquid Transplant

• Blood components are not medicines!
SaBTO

- Advisory Committee on the Safety of Blood, Tissues & Organs (a DH expert committee)
- Advises UK Ministers and Health Departments on the most appropriate ways to ensure the safety of blood, cells, tissues and organs for transfusion/transplantation
- Publishes advice and guidance, reports and statements
Background

- March 2010: SaBTO initiated a public consultation on patient consent for blood transfusion.
Why?

- **Patient Choice**: Many patients may not wish to receive a blood transfusion and/or may wish to know what the alternatives are.

- **Public Health**: Recipients may not be aware that they have received blood and then go on to donate.

- **General legal and ethical principle**: Valid consent should be obtained from a patient before they are treated.
Objectives:

- Identify the preferred option for recording consent
- Explore the potential operational impact of implementing a standardised form of consent for transfusion
- Confirm what type of information patients should receive
Key issues identified

• Not always given information on risks, benefits, and alternatives to transfusion, or the right to refuse transfusion

• Not always made aware that they have had a transfusion

• Those unaware that they have received a transfusion may go on to donate blood when they should not

• There is inconsistent practice across the UK
Action Plan

14 recommendations / 3 broad categories:

Clinical practice:
What should be done / hospital policy
Recommendations 1-6

Governance:
Review of clinical practice
Recommendations 7 -10

Education:
To help support clinical practice
Recommendations 11-14
1. Valid consent for blood transfusion should be obtained and documented in the patient's clinical record by the healthcare professional.

2. There should be a standardised information resource for clinicians indicating the key issues to be discussed by the healthcare professional when obtaining valid consent from a patient for a blood transfusion.
3. The consent standard developed by Health Improvement Scotland should be adopted throughout the UK for consent for blood transfusion
Consent for Blood Transfusion
Standard Recommended by SaBTO

The following standard, extracted from the NHS Health Improvement Scotland blood transfusion clinical standards, specifically relates to consent for blood transfusion. SaBTO recommends its use in clinical practice throughout the UK.

**Standard Statement**
The decision to transfuse is made following consideration of the potential risks and benefits of, and the alternatives to, transfusion. Where possible this is discussed between the clinician and patient (or their legal guardian) in advance of transfusion.

**Rationale**
- Treatment options (including valid alternatives to transfusion) should be discussed with the patient.
- Valid consent to treatment is an absolute requirement in all forms of healthcare.
- The principles governing the requirement for explanation and discussion, obtaining the patient’s consent and documenting this information in the case record are the same for the transfusion of blood and blood components as for any other therapeutic intervention.

**Essential Criteria**
- The patient’s records contain evidence that the reason for transfusion of blood or blood components has been explained and discussed with the patient. This includes discussion of valid alternatives to transfusion and the option to refuse.
- Leaflets explaining the risks and benefits of, and alternatives to, transfusion are readily available for patients who may require to be, or have been transfused.
- Where pre-transfusion discussion is not possible (e.g. in an emergency) there is a system, compatible with the patient’s clinical needs, to investigate and act in accordance with the patient’s treatment preferences. This includes compliance with an advance decision document.
- When pre-transfusion discussion has not taken place, the reason for transfusion (based on risks and benefits) are discussed with the patient and written information offered retrospectively.

*Background*
During 2010, SaBTO ran a consultation exercise looking at consent for blood transfusion in clinical practice. This consultation process resulted in the production of a number of recommendations, including the adoption of the NHS Healthcare Improvement Scotland consent standard for blood transfusion.

*Context*
NHS Healthcare Improvement Scotland is a health body with responsibility for supporting healthcare providers in Scotland to deliver high quality, evidence-based, safe, effective and person-centred care; and to scrutinise those services to provide public assurance about the quality and safety of that care.

Building on work previously carried out by NHS Quality Improvement Scotland and the Care Commission, NHS Healthcare Improvement Scotland’s vision is to deliver excellence in improving the quality of care and experience of every person in Scotland every time they access healthcare.

In July 2005, following a detailed scoping exercise, which formed the evidence base for transfusion standards development, a project group was established. In September 2006, following extensive consultation, their Clinical Standards for Blood Transfusion were developed and published.

*Reference*
1. NHS Quality Improvement Scotland. Blood Transfusion: clinical standards. 2006 Available at:
4. The Care Quality Commission (CQC) and the NHS Litigation Authority (NHSLA) and equivalent organisations will be made aware by SaBTO of this consent standard for blood transfusion.

5. A UK comparative audit of consent for transfusion should be carried out, facilitated by the National Comparative Audit for Blood Transfusion.
NCA 2014 Audit of Patient Information and Consent

- Patient Consent Documented 43%
- Reason for Transfusion Documented 37%
- Patients didn’t feel involved in decision 21%
6. There should be a standardised source of information for patients who may receive a transfusion in the UK
Patient Information Leaflets

• There is a list of key points that should be included in all adult patient information leaflets.
7. 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.
Don’t Forget

• Those patients who were told before an elective procedure that they “may” require a transfusion need to be told afterwards whether or not they received one!
8. SaBTO consent working group should produce good practice guidance to help identify the most effective way of providing information retrospectively when patients were unable to give prior consent
Consent for Blood Transfusion
Retrospective Patient Information – Good Practice Guidance

Executive Summary
The provision of retrospective information for patients who were not able to give valid consent prior to a blood transfusion is important for three main reasons:
- To ensure patients are aware of the treatment they have received and informed of any associated potential risks relating to transfusion
- To ensure patients who have received a transfusion know they are no longer eligible to donate blood. Patients who are not aware that they have received a transfusion may subsequently go on to donate blood they should not
- To reassure some patients who may think that they have received a transfusion, for example during surgery, when they have not

This guidance has been produced to assist organisations to establish mechanisms to ensure that retrospective information is provided to those that need it. A process flowchart (Figure 1) helps to identify which patients should be given retrospective information.

Background
During 2010, SaBTO (the Advisory Committee on the Safety of Blood, Tissues and Organs) initiated a public consultation process to review the options for undertaking valid consent for blood transfusion and the potential operational challenges involved.

Two key recommendations resulting from this consultation process were:
- Valid consent for blood transfusion should be obtained and documented in the patient’s clinical record by the healthcare professional
- Patients who have received a blood transfusion (red cells, platelets, fresh frozen plasma, cryoprecipitate or granulocytes) and were not able to give valid consent before the transfusion should be provided with retrospective information.

A SaBTO Consent for Transfusion sub-group (appendix 1) was established to look specifically at the provision of retrospective information and to produce this good practice guidance for healthcare professionals.

October 2011
Information for patients who have received an unexpected blood transfusion

Note: This leaflet should be read alongside the NHS Blood and Transplant patient information leaflet "Will I need a blood transfusion?"

While you were in hospital, it was necessary for you to receive a blood transfusion. There are many reasons why patients may need a transfusion, some of which are discussed in the "Will I need a blood transfusion?" leaflet. However do please ask a member of your healthcare team about why you needed a blood transfusion. They will be able to answer any questions you may have.

Are blood transfusions safe?
Yes, the risk that a blood transfusion may make you ill is very low. More information about any potential infection risks, and all the measures that are taken to ensure your safety, is included in the leaflet 'Will I need a blood transfusion?'

I'm a blood donor. Can I still donate?
As a precautionary measure to reduce the risk of transmitting variant Creutzfeldt-Jakob Disease (vCJD), people who have received a blood transfusion since 1980 are not currently able to donate blood.

Do I need to tell my doctor?
The hospital should include information in the discharge letter to your GP to tell them that you have had a blood transfusion, and to explain why it was carried out. The hospital should give you a copy of this letter; if they don't, you can ask the hospital for a copy.
9. UK blood services should have an ongoing programme for educating patients and the public about blood transfusion as part of their respective Better Blood Transfusion strategies.
Patient Blood Management

• Evidence-based
• Multidisciplinary approach
• Optimising the care of patients who might need a blood transfusion.
• Puts the patient at the heart of decisions
• Ensure that they receive the best treatment
• Avoid the inappropriate use of blood and blood components.
Why does it matter?

• Improves care
• Reduces inappropriate transfusion
• Ensures availability where there are no transfusion alternatives available
10. Learn Blood Transfusion e-learning should be promoted

11. The feasibility of developing a module specific to consent should be explored

A module on consent has been developed and is now available on the LearnBloodTransfusion website: [www.learnbloodtransfusion.org.uk](http://www.learnbloodtransfusion.org.uk)
12. Completion of the LearnBloodTransfusion e-learning package should be included in undergraduate curricula

The learning objectives for the principles of consent should include consent for blood transfusion
• The majority of blood transfusions go to elective patients where there is time to discuss transfusion and the alternatives available.

• It is very important that you find time to give your patient a leaflet and discuss with them the risks and benefits of receiving a blood transfusion.
Key issues

- Discuss indications, benefits, risks and alternatives
- How transfusion is administered and importance of positive patient identification
- Provide the patient with written information
- Document the discussion in the patient’s clinical records
- Ensure patient knows that can no longer donate
Local Resources

- Transfusion Practitioner
- Transfusion Laboratory Staff
- Hospital Transfusion Committee
- YOUR Trust Transfusion policy
- The Patient Blood Management Team
- Regional Transfusion Committee

Web based Resources

- www.transfusionguidelines.org
- ww3.access-24.co.uk
- http://hospital.blood.co.uk
- www.blood.co.uk
- www.learnbloodtransfusion.org.uk

Patient information can also be found at NHS Choices at: http://www.nhs.uk and via Facebook, Twitter and You Tube
The keys to Informed Consent are Information and Communication