North East Regional Transfusion Committee

Guideline for the authorisation of Platelets by Nurse Authorisers caring for Adult Haematology and Oncology patients

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Target audience:	NHS Foundation Trusts in the North East Region

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1. Introduction

A collaborative project was undertaken by NHS Blood and Transplant and the Scottish National Blood Transfusion Service to investigate the "prescribing" or more properly "authorisation" of blood transfusions by nurses and midwives. Section 130 of the 1968 Medicines Act has been amended by Section 25 of the Blood Safety and Quality Regulations 2005 (SI 2005 no 50). In effect this means that Blood and Blood Components (Red Cells, Platelets, Fresh Frozen Plasma and Cryoprecipitate) are excluded from a legal definition of medicinal products and therefore cannot be "prescribed" by any practitioner. There is therefore no legal barrier to nurses authorising a blood transfusion. Following wide consultation a Governance Framework was developed to support this role developement.

2. Purpose

In responding to the changing needs of patients and clinical practice, some senior and experienced nurses have been considered in authorising blood transfusions. This guideline only applies to Haematology / Oncology Nurse Specialists and Chemotherapy Day Unit staff as identified by the Consultant Haematologist / Oncologist.

It is expected that the patient will benefit due to:

(i) A reduced delay in the decision to transfuse

(ii) A reduced delay in authorising the transfusion

(iii) The decision to transfuse will be made by an experienced nurse who has an in depth knowledge of the patients undergoing regular transfusion.

This guideline establishes the criteria and assessment framework required for the authorisation of platelets by nurse authorisers. This guideline will ensure that the assessment is transferrable, on agreement with their Consultant Haematologist / Oncologist, for staff moving to any Trust within the North East region. If staff move around the region, the decision to authorise blood components will be made when both the consultant and nurse feel happy to do so.

3. Definitions

The Delegator will be the Consultant Haematologist / Oncologist responsible for the care and treatment of an individual Haematology / Oncology patient.

The Delegate is the Nurse who will authorise the blood component.

Delegation will be agreed by the Director of Nursing and the Consultant Lead for the Haematology Department. Delegation is planned through agreed and accepted clinical practice.

4. Duties

Consultant Haematologist / Oncologist

(i) The Consultant Haematologist / Oncologist is responsible for monitoring the patient's progress.

(ii) The Consultant Haematologist / Oncologist is responsible for drawing up a clear plan of treatment for patients requiring transfusion of platelets.

(iii) The Consultant Haematologist (MRC Path haematology or equivalent) / Oncologist will act as mentor and assessor, and must be up to date with mandatory transfusion training.

Nurse Authoriser

(i) The nurse will approach a Consultant Haematologist / Oncologist as a mentor and assessor.

(ii) The nurse will be responsible for gaining adequate knowledge and experience prior to assessment and must be up to date with mandatory transfusion training.

(iii) The nurse will demonstrate competence according to the competency document.

5. Training

In order for the nurse authoriser to apply for the training they must have at least 3 years experience relevant to transfusion, approval and support from their Consultant Haematologist / Oncologist.

The nurse authoriser must attend the education day provided by the North East Regional Transfusion Committee and completes the assessments within one month.

The training will include:

(i) Overview of components

(ii) Transfusion reactions

(iii) Significance of antibodies and appropriate blood selection

(iv) BCSH administration guidelines, documentation and reporting of incidents

(v) Legal requirements

(vi) Appropriateness, indications for transfusion and Hb triggers

(vii) Scenarios

6. Equality Impact Assessment

To be undertaken once the guideline has been approved by the NE RTC.

7. Monitoring Compliance with the Document

(i) Nurses' authorisations of platelets will be reviewed by individual Trust Transfusion Committees through audit of compliance.

(ii) Non-compliance by the nurse authoriser will be dealt with as per local Trust policy.

8. Standards/Key Performance Indicators

Patients receiving a platelet transfusion, in accordance with this policy, will not experience any time delays due to the authorisation of the blood component. The

authorisation of blood components will be audited both locally and regionally. The regional results will be fedback to the Regional Transfusion Committee.

9. References

1. Blood Safety and Quality Regulations, 2005, (SI No50)

2. Fullbrook S, (2007), Professional Behaviour, British Journal of Nursing, 6, 16, 3, 180-181

3. Pirie, E and Green, J (2009), A Framework to Support Nurses and Midwives Making the Clinical Decision and Providing the Written Instruction for Blood Component Transfusion. http://www.transfusionguidelines.org.uk/docs/pdfs/BTFramework-final010909.pdf

4. Pirie, E and Green, J (2007), Should Nurses Prescribe Blood? Nursing Standard June, pages 21, 39, 35-41

5. The Medicines Act, 1968, (DH 1968)

6. The Queen Elizabeth Hospital, King's Lynn

Appendix A - Checklist for the Review and Approval of Procedural Documents

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or standard?		
2.	**Rationale**		
	Are reasons for development of the document stated?		
3.	**Development Process**		
	Is the method described in brief?		
	Are individuals involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
4.	**Content**		
	Is the objective of the document clear?		
	Is the target population clear and unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
	Are the references cited in full?		
	Are local/organisational supporting documents referenced?		
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate, have the joint human resources/staff side committee (or		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	equivalent) approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
8.	**Document Control**		
	Does the document identify where it will be held?		
	Have archiving arrangements for superseded documents been addressed?		
9.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?		
	Is there a plan to review or audit compliance with the document?		
10.	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so, is it acceptable?		
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?		

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name		Date	
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	
Signature			

Acknowledgement: Cambridgeshire and Peterborough Mental Health Partnership NHS Trust

Appendix B - Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Race		
	• Ethnic origins (including gypsies and travellers)		
	• Nationality		
	• Gender		
	• Culture		
	• Religion or belief		
	• Sexual orientation including lesbian, gay and bisexual people		
	• Age		
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems		
2.	**Is there any evidence that some groups are affected differently?**		
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**		
4.	**Is the impact of the document/guidance likely to be negative?**		
5.	**If so, can the impact be avoided?**		
6.	**What alternative is there to achieving the document/guidance without the impact?**		
7.	**Can we reduce the impact by taking different action?**		

If you have identified a potential discriminatory impact of this procedural document, please refer it to [*insert name of appropriate person*], together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact [*insert name of appropriate person and contact details*].

Appendix C - Version Control Sheet

Version	Date	Author	Status	Comment

Appendix D - Plan for Dissemination of Procedural Documents

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Acknowledgement: University Hospitals of Leicester NHS Trust

Title of document:			
Date finalised:		**Dissemination lead: Print name and contact details**	
Previous document already being used?	**Yes / No (Please delete as appropriate)**		
If yes, in what format and where?			
Proposed action to retrieve out of date copies of the document:			
To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Format (i.e. paper or electronic)**	**Comments:**

Dissemination Record - to be used once document is approved

Date put on register / library of procedural documents:		**Date due to be reviewed:**	

Disseminated to: (either directly or via meetings, etc.)	Format (i.e. paper or electronic)	Date disseminated:	No. of copies sent:	Contact details / comments: