Cambridge University Hospitals NHS
NHS Foundation Trust

Patient Consent for Transfusion

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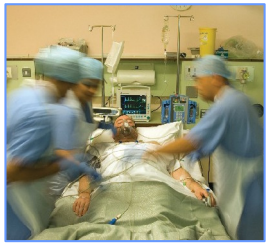

Overview of consent

- Millions of people receive transfusions each year
- Addenbrookes Sept 2012: 2296 components were issued
- Are these patient's fully aware of risks, benefits & alternatives?
- Cell salvage?
- At present no legal requirement to obtain consent for blood transfusion
- Already mandatory in some countries

Blood and Blood Products Transfusion Consent

Facility:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

A. Interpreter / cultural needs

An Interpreter Service is required? ☐ Yes ☐ No

If *Yes*, is a qualified Interpreter present? ☐ Yes ☐ No

A Cultural Support Person is required? ☐ Yes ☐ No

If *Yes*, is a Cultural Support Person present? ☐ Yes ☐ No

This consent primarily includes intravenous or central venous line infusion of fresh blood and blood products, red cells, platelets and plasma (e.g. fresh frozen plasma and cryoprecipitate)

Start Date of Transfusion Eg. 10/01/2008	
Approximate end Date of Transfusion. Eg. 20/06/2008. *A new consent is required after 12 months from start of transfusion.*	

B. Why am I having a transfusion?

Your doctor has recommended that you have a transfusion of blood or blood products, which are from volunteer donors. Blood is collected and screened by the Australian Red Cross Service.

A transfusion is necessary to replace a part of your blood and is given to either;

- replace red blood cells to treat or prevent anaemia, improve oxygen transport and relieve symptoms of dizziness, tiredness or shortness of breath or

C. Risks of blood and blood products transfusion consent

Most common reactions to fresh blood or blood products that are being transfused are:

- high temperature
- rash, itching and hives
- feeling a bit unwell.

Rare risks are:

- having too much blood/fluids giving you shortness of breath.
- haemolysis, the abnormal breakdown of red blood cells.

S BINDING MARGIN

Background

- Embedded principle in GMC that patient should receive valid consent before receiving medical treatment.
- 2000 NHS plan: informed consent must be sought from all NHS patients.
- DoH set up Good Practice in Consent initiative, Blood is often an additional procedure during a course of treatment so was given no specific guidance.

SaBTO

- Advisory Committee on the Safety of Blood, Tissues & Organs advises on the most appropriate way to ensure safety of blood, cells tissues and organs for transfusion/transplantation
- March 2010: public consultation initiated on patient consent for blood transfusion:
- Objectives of consultation:

1. Identify preferred option for recording consent
2. Potential operational impact of implementing consent
3. What type of information should patient's receive

Background to consent

- General legal & ethical principle that valid consent should be obtained from a patient before they are treated.
- Audits by SaBTO identified practice of obtaining any consent for blood transfusion is highly variable.
- Findings:

1. Risks, benefits & alternatives and right to refuse transfusion are not always given to patients
2. Patients may not be aware they have had a transfusion and may go on to donate blood when they should not.
3. General inconsistent practice across the UK

Addenbrooke's and consent

- HTC (Hospital transfusion Committee) looked at how to implement the recommendations:
- 3 groups were identified:

1. Surgical patients (surgical procedure specific forms) not all will need to mention blood transfusion.
2. Medical patients who receive multiple treatments as part of a treatment plan
3. 'Ad Hoc' transfusions (eg medical patient is found to have anaemia on admission)

Initial steps

- Group 1 (surgical patient): Existing consent form to be amended to include box to be ticked if transfusion is likely. Additional tick box to confirm patient leaflet has been read by patient. Is this enough?
- Group 2 (Medical patients): Procedure specific consent form with review date)
- Group 3 (Ad hoc): Record in patient's notes

Consent Form

Open inguinal hernia surgery

For staff use only:
Hospital number:
Surname:
First names:
Date of birth:
NHS no: _ _ _ / _ _ _ / _ _ _ _
Use hospital identification label

d) any extra procedures that might become necessary during the procedure such as:
☐ Blood transfusion ☐ Other procedure (please state)

.....

.....

The following information leaflet has been provided:

Open inguinal hernia surgery

Version, reference and date: **Version 4, CF136, June 2012**

or ☐ I have offered the patient information about the procedure but this has been declined.

3 This procedure will involve:
☐ General and/or regional anaesthesia ☐ Local anaesthesi

Medical Patients

- Patients on long term treatments such as Thalasseamia
- Transfusion consent form to be developed
- Yet to be decided how long consent will be valid and review period
- What happens if they are admitted for surgery? Should they be re-consented, not part of their ongoing treatment (Platelets & FFP different from ‘top up of red cells’)

Ad Hoc audit July 2012

- Week audited July
- 138 patients had transfusion (red cells)
- 21 (15%) were unlikely to have signed any form of consent which may indicate transfusions.
- 2 patients as examples:

1. Patient B had an endoscopy, signed a generic consent (Blood transfusion box NOT ticked) for his endoscopy. 6hrs later had maleana which required 2 units.
2. Patient C had a catheter replaced caused blood loss, no formal consent. Documented in notes that catheter replaced and that blood was needed. No evidence of risks, alternatives & benefits.

Challenges

- Who is responsible for obtaining and recording consent?

1. Medic prescribing the blood? (Medic who prescribes should be aware of the indication for giving blood)
2. Nurse in pre-admission clinic (knowledge & time) is patient leaflet enough as a resource for patient and person obtaining consent.
3. Is there a responsibility that consent is checked before giving blood?
4. Benefits & risks of transfusion will vary depending on individual clinical situation.
5. Are tick boxes on form enough? Should all risks & benefits be listed on consent form?
6. Yet another form in patient's notes (to be ignored if separate consent)

Patient Information

Cambridge University Hospitals NHS
NHS Foundation Trust

Haematology Department

Your questions about blood transfusion answered

A leaflet for patients and their relatives

Why might I need a blood transfusion?

Blood transfusions are given to replace blood lost in surgery, major accidents, childbirth, or to treat anaemia (lack of red blood cells).

http://hospital.blood.co.uk/library/patient_information_leaflets/leaflets/index.asp

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Patient Information Leaflets

All files are stored in a PDF format and require Adobe Acrobat Reader

Electronic Ordering

NHSBT leaflets may be ordered directly from the distribution hub operated by access 24

Usernames and Passwords are held by your Customer Services Team. Contact your RTC Administrator or Customer Services Administration Office (01865 381042) if you require any assistance.

Will I need a blood transfusion?
More information on: Why you might need a blood transfusion, the risks and benefits and how will you feel during a blood transfusion.
Leaflet is also available in English/Welsh
Albanian, Arabic, Bengali, Chinese, Croatian, Farsi, French, Greek, Gujarati, Kurdish, Pashto, Polish, Punjabi, Serbian, Somali, Turkish, Urdu, Vietnamese.

Information for patients needing irradiated blood
More information on: Why is irradiated blood needed? Do all types of blood need to be irradiated? Does irradiation damage the blood?
Leaflet is also available in English/Welsh
Albanian, Arabic, Bengali, Chinese, Croatian, Farsi, French, Greek, Gujarati, Kurdish, Pashto, Polish, Punjabi, Serbian, Somali, Turkish, Urdu, Vietnamese.

Iron in your diet

Contact Us

Site Map

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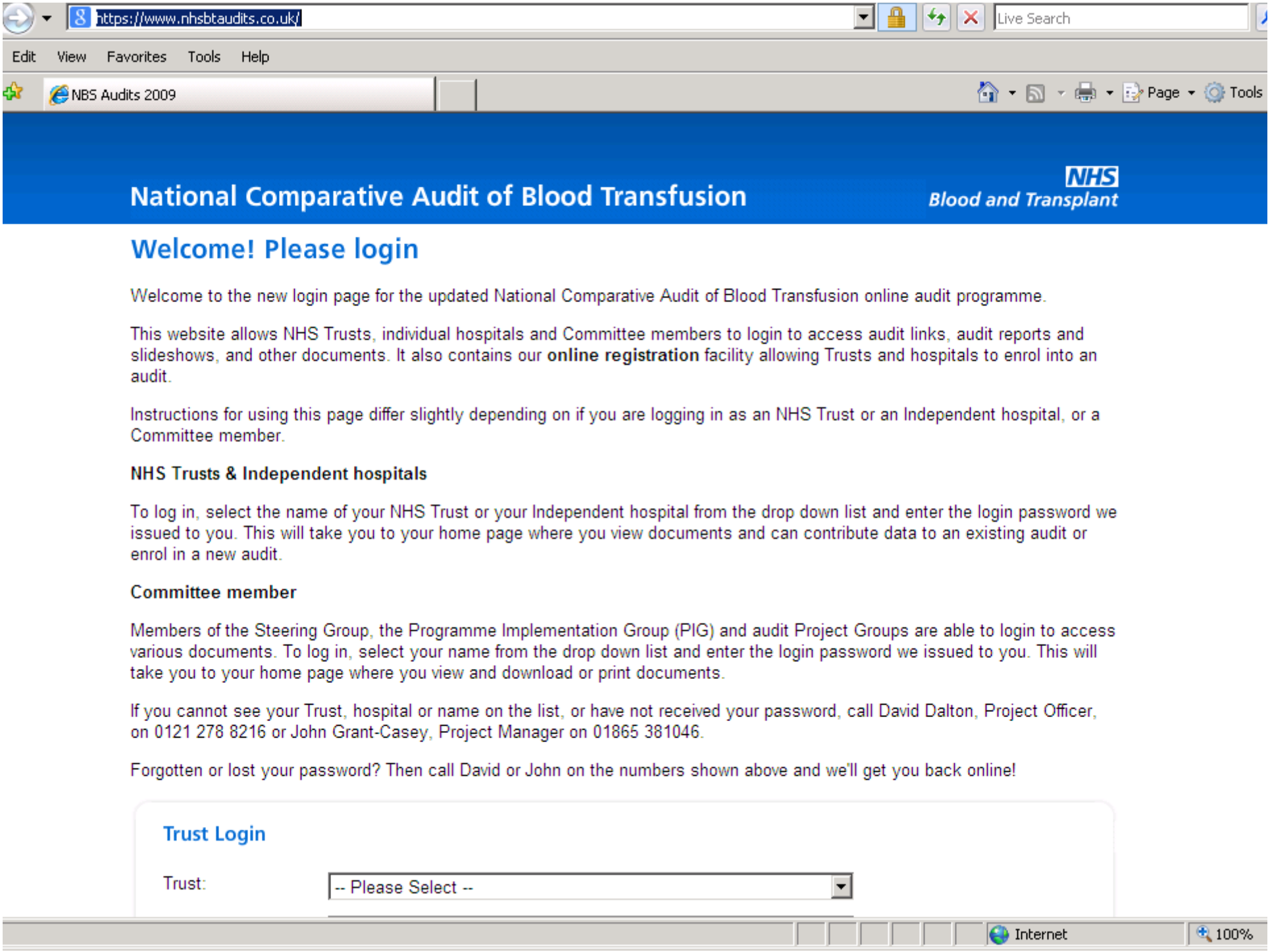
Internet 100%

National Comparative Audits

- Why audit?

- Blood is vital to the delivery of healthcare in the UK.
- Blood safety & safety of transfusion practices are a core element of patient safety.
- In order to obtain quality improvements, we have to measure our practice against existing standards
- National and Regional audit provides the opportunity to benchmark against others to drive improvement.
- Forthcoming audits:
- Sample labelling Winter 2012
- Consent audit Spring 2013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Committee member
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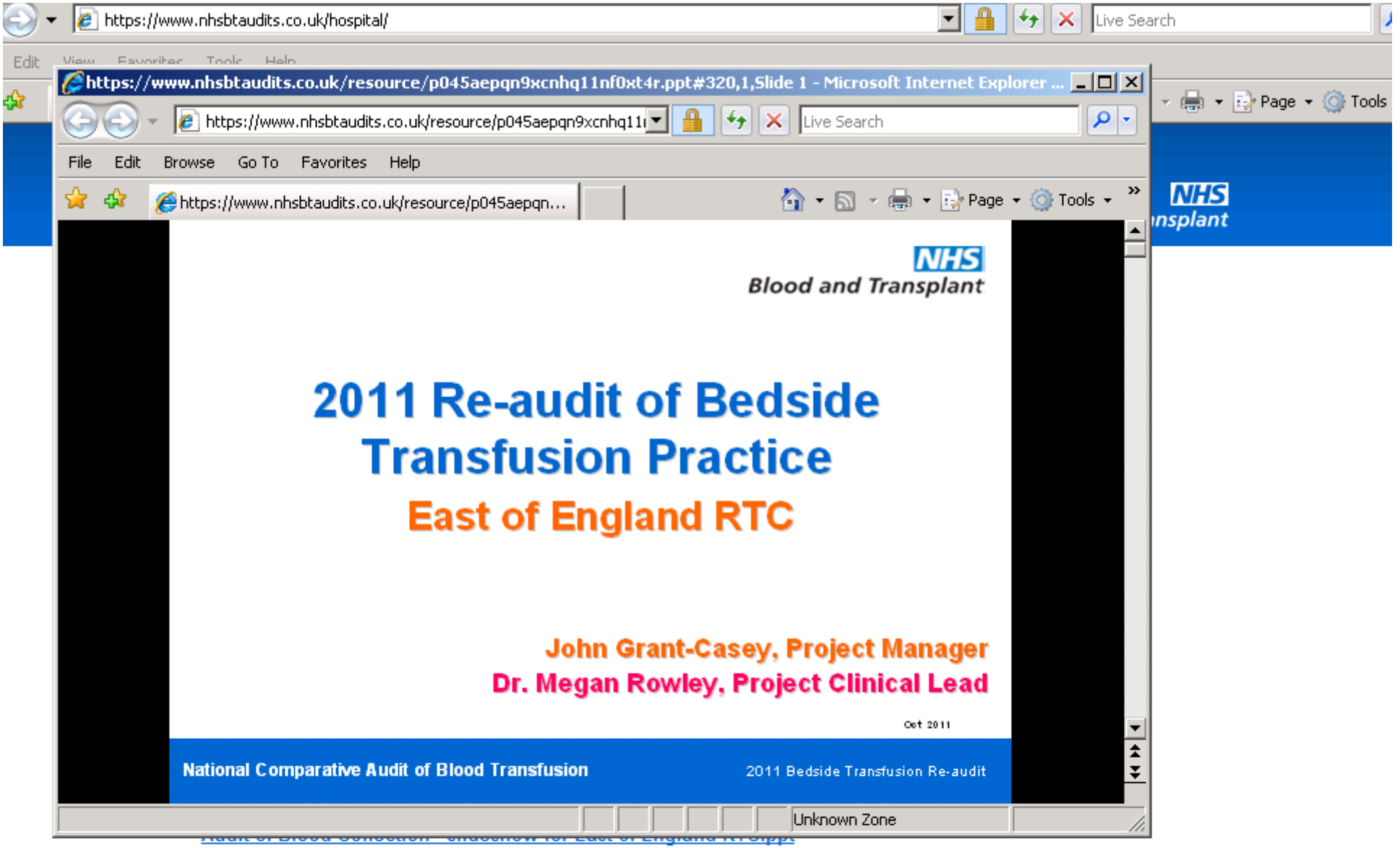

2008 Bedside Transfusion re-audit slideshow

2008 Bedside Transfusion re-audit slideshow for East of England RTC.ppt

Annual Reports

National Comparative Audit of Blood Transfusion Annual Report 2011 - 12.pdf

Audit Programme

NCABT News - April 2011.pdf

Aim of the Audit

- Are the recommendations from 2009 BCSH guidelines for the administration of blood components at the bedside being followed?
- Has there been any improvement in practice from previous audits?
- Audit objectives:

1. Presence of patient identification wristband
2. Completemess & accuracy of wristband
3. Reason for lack of wristband
4. Have observations been recorded before, during & after the completion of the transfused unit?

Who took part?

- 182 sites both independent & NHS
- 94% of East of England eligible Trusts
- 9250 transfusions nationally
- Audit Standards:

1. Patient having the blood transfusion is wearing a wristband
2. Wristband contains: Forename, Surname, DOB & NHS/Hospital number
3. Patient identity Is checked using wristband and verbally prior to administration

Audit standards contd..

4. TPR & BP baseline
5. TPR & BP are measured after 15 minutes
6. TPR & BP are measured at the end of the transfusion

- Sites were asked to audit 40,50 or 60 units depending on their red cell usage
- 1,2 & 3: ‘Never Event’ Patient receives an ABO incompatible unit or wrong treatment because they were not wearing a wristband.
- 4,5 & 6: Undetected transfusion reaction. Eg: If standard 4 is missed, it is more difficult to evaluate the significance in a rise in temperature

Standards 1, 2 & 3

- Nationally 97.3% of patients were wearing a wristband, Regionally 98.9%.

- Conclusions:
- Children & neonates were less likely to be wearing a wristband.
- Example: Neonate has 2 wristbands attached to cot, one saying baby (transfusion sample was sent on this wristband), and one saying full name.

Standards 4, 5 & 6

- 4: Pre obs 85% of patients had pre-obs performed.
- Regionally: 92.5%
- 5: Obs after 15 minutes: 87% had them within 30 minutes from the start of the transfusion.
- Nationally 48% at 15 minutes
- Regionally 47% at 15 minutes
- 6: Obs at the end of each transfused unit: 84% Nationally
- Regionally 84%

Important messages

- No Wristband, No transfusion; no exceptions

- If the wristband is taken off or is illegible – put another one on before proceeding.
- An alternative ID system MUST have four core identifyers and MUST be attached to the patient
- If patient (or parent) refuses, the risk of proceding with the transfusion must be evaluated and recorded in the notes

Important messgaes contd..

- Observations:
- Pre- transfusion observations are essential in order to detect a change during or after the transfusion. Good practice states that blood should not be collected until the observations have been performed.
- Early observations(15 minutes) are needed to detect any acute transfusion reactions.
- Post transfusion observations should be carried out prior to the discharge of day patients and contact information should be provided for the patient to use in case they feel unwell following the transfusion.

Any Questions?

Innovation and **excellence** in health and care