

# Administration and consent

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# Introduction

- Who are the British Committee for Standards in Haematology and what do they do?
- BCSH guideline development process
- Some of the key blood administration recommendations related to nurse authorisation
- 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.com](http://www.bcshguidelines.com)

# What do the BCSH do?

- Primary purpose:
  - 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
  - Involves all relevant stakeholders
  - Reviewed by a wide spectrum of UK haematologists who act as 'sounding boards'

# Purpose and objectives

- Provide national guidance on:
  - Pre transfusion blood sampling
  - Prescription / Authorisation
  - Requesting
  - Collection
  - Administration of blood components to
    - Adults, children and neonates
- Individual Trusts incorporate this guidance into their local and regional policies, protocols and practice

# Key recommendations

- Keep it simple
  - Try to avoid complexity and concentrate on the key steps
- 3 key principles which underpin every stage of the blood administration process:
  - Patient identification
  - Communication
  - Documentation

# Positive patient identification

- At every step in the process
  - Sampling and request form
  - Authorisation
  - Collection
  - Administration

# Communication

- Clear and concise
  - Clinical staff
  - Laboratory staff
- Policies to minimise risks
  - Written
  - Verbal
  - Electronic



# Documentation

- All paper work to be identical to that noted on the patients ID band
  - First name
  - Last name
  - Unique number
  - Date of birth

# What do you need to document?

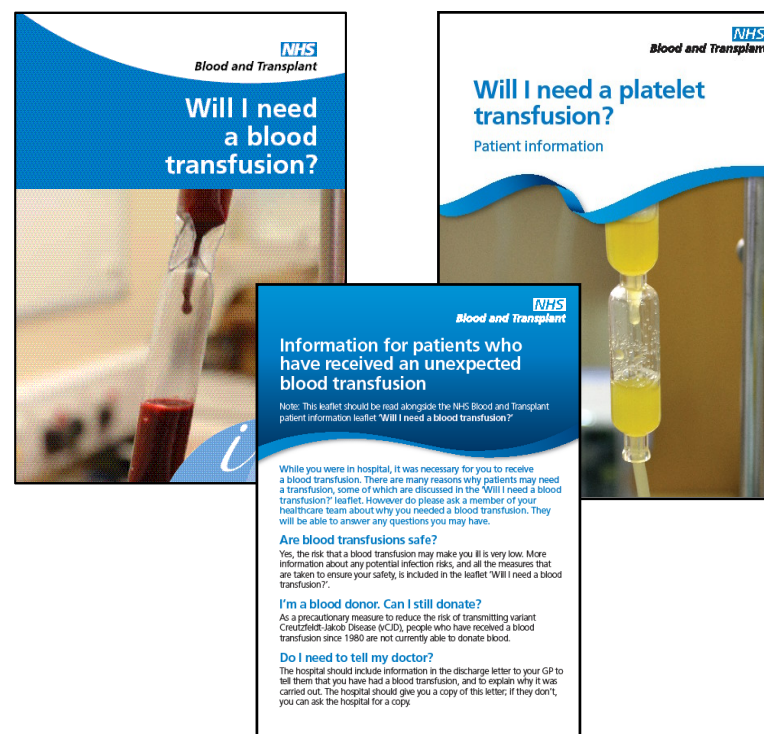
- Clinical indication for transfusion
- Relevant blood results
- Date:
  - Decision made to transfuse
  - Transfusion should be administered (if different)
- Blood component required – type and amount
- Specific requirements
- Patient information given
  - Reason, risk, benefits and alternatives
- Consent to proceed
- If the transfusion had the desired effect
- Management and outcome of any transfusion reactions or adverse event
  - Note: The clinical management of transfusion reactions is a separate BCSH guideline

# Consent

- Consent can be defined as  
“...a patient’s agreement for  
a health professional to  
provide care.”
- SaBTO the Advisory  
Committee on the **S**afety of  
**B**lood, **T**issues and **O**rgans
  - Asked to look at consent in  
2009
  - Consultation exercise in  
2010
  - Recommendations  
published in 2011

# Consent recommendations

- Valid consent should be gained
  - document in the patients notes
- Retrospective information
- Modified consent form for the long term multi-transfused

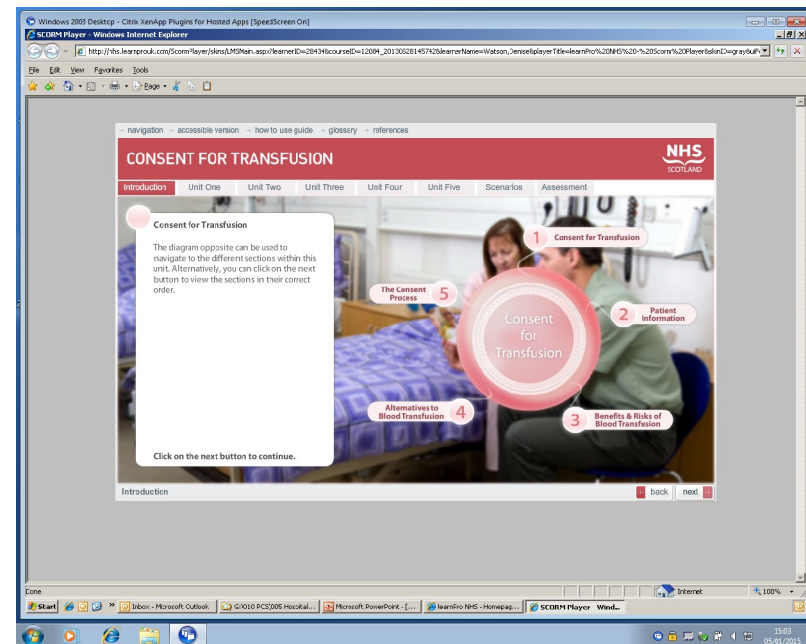


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# LBT - Consent module

- Consent for transfusion
- Patient information
- Benefits and risks of blood transfusion
- Alternatives to blood transfusion
- The consent process



<http://www.learnbloodtransfusion.org.uk/>

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# National Comparative Audit

- Patient Information and Consent (2014)
  - 164 sites, 2784 cases audited
  - 81% had documentation of the clinical indication
  - 43% had documentation of patient consent which was largely verbal
    - 80% obtained by doctors
  - 38% received information on risks
  - 8% received information on alternatives

# Decision to transfuse

- The decision to transfuse must be:
  - Based on a thorough clinical assessment of the patient and their individual needs
  - Made by trained and competent staff

# Requests for blood transfusion

- Patient identifiers
- Date required and reason
- Components – type and amount
- Specific requirements
- Sign the request form
- Note your telephone number / bleep
- Zero tolerance
- Extra care if telephone request
- Discuss with laboratory / clinical staff if unsure



# Authorisation

- Ideally by the person making the decision to transfuse
- Written on:
  - Prescription sheet for IV fluids or
  - Specific transfusion document / pathway
- Consider:
  - Rate of infusion
  - Diuretic cover
  - Weight of patient

**NHS Blood and Transplant**

## Blood Transfusion Size Matters!

Transfusion Associated Circulatory Overload (TACO) is a known cause of transfusion-related morbidity and mortality<sup>1</sup>

Transfusing a volume of 4ml/kg will typically give a Hb rise of 10g/L and should only be applied as an approximation for a 70-80kg non-bleeding patient.<sup>1,2</sup>

**Before Transfusion**

- ✓ Document the rationale for the decision to transfuse.
- ✓ Document the patient's weight.
- ✓ Document the target Haemoglobin (Hb) level.
- ✓ Calculate the number of units required.
- ✓ Clinically re-assess the patient after each red cell unit transfused.

Note: The average volume of an adult red cell unit is 280mL.

1. British Society of Haematology. Assessment of Adverse Effects of Blood Components. 2012.  
2. NHS Guidelines for Transfusion in Neurology. Adherence to Adverse Effects of Blood Components. 2012.

**NHS Blood and Transplant**

## SINGLE Unit Blood Transfusions reduce the risk of an adverse reaction

### Don't give two without review

**THINK!**

- Is your patient symptomatic?
- Is the transfusion appropriate?
- What is the haemoglobin trigger level?
- What is the patient's target haemoglobin level?

**Each unit transfused is an independent clinical decision**

**DO!**

- ✓ Clinically re-assess the patient after each unit transfused.
- ✓ Only one unit should be ordered for non-bleeding patients.
- ✓ Document the reason for Transfusion.<sup>1</sup>

1. British Society of Haematology. Assessment of Adverse Effects of Blood Components. 2012.

# Administration

- Usual rates:
  - Red cells: 1½ to 2 hours per unit
  - Platelets: 30 minutes per ATD
  - FFP: 30 minutes per unit
  - Cryo: 30 minutes per unit

Note:

Transfusion should be completed within 4 hours of removal from temperature controlled storage

# Case from SHOT 2013

- **Day 1:**
  - Patient with AML seen at 20:00 and prescribed 1 unit of RBCs. Hb 40 g/L (ED)
- **Day 2:**
  - 02:30 transferred with inadequate handover to ward. Nurse assumed blood had been given, and ED assumed blood bank would phone when blood was ready
  - 09:00 consultant haematology review; Hb 36 g/L; assumed and wrote in notes that 1 unit of RBCs given in ED, but had not

## Case from SHOT 2013 (cont'd)

- 16:30 transferred to another hospital, reviewed and started on chemotherapy at 17:04
- 19:46 acutely unwell, fever, tachycardia and hypoxic. Prescribed antibiotics but not given until 23:50
- 19:50 started 4 units FFP for coagulopathy

# Case from SHOT 2013 (cont'd)

- **Day 3:**
  - 00:10 a unit of RBCs given, 28 hours after prescribed
  - 02:00 concern about increased RR, CXR
  - 06:30 pulmonary oedema from fluid overload (3240mL input over 24 hours)
  - Transferred to ITU
  - 4 hour delay in further FFP transfusion after prescription
- **Day 4:**
  - Death due to primary illness (AML)

# SaBT0

Advisory Committee on the Safety of  
Blood, Tissues and Organs

<https://www.gov.uk>

Consent documents:

[www.transfusionguidelines.org.uk](http://www.transfusionguidelines.org.uk)



BCSH Guidelines

[www.bcsghguidelines.com](http://www.bcsghguidelines.com)

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# Any Questions?

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