Documentation for Transfusion

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ANNP Authorisation Education Event

Documenting Transfusion

- “Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is Not an optional extra to be fitted in if circumstances allow.” NMC 2009

- 3 different hospitals. Different documentation

- Local policies do differ slightly

- “The use of specifically designed transfusion care pathways or combined transfusion prescription and monitoring charts to record this information is encouraged.” BCSH 2009

Documenting and verifying patient identity

- “All paperwork relating to the patient must include, and be identical in every detail to, the minimum patient core identifiers contained on the patient’s identification band.” BCSH 2009

- **Patient core identifiers are:** Last name, first name, date of birth, unique identification number (preferably NHS,CHI or HSC number)

Documenting the prescription

- Prescription Chart/ Transfusion Pathway
- Has the Prescription been correctly documented?
- Must be accurate and complete

Documenting the clinical indication for transfusion

- Pre transfusion documentation
- “The minimum dataset to be recorded in the patients clinical records should contain documentation of the reason for transfusion (clinical and laboratory data), details of the information provided to the patient (risks, benefits and alternatives to transfusion) and consent to proceed.” BCSH 2009

Documenting vascular access

- Correct type of vascular access
- Size of vascular access
- Condition and appearance of site
- All documented on VIP charts-**Visual Infusion Phlebitis**

Documenting administration

- Wristband
- Details on the prescription/transfusion pathway
- Blood compatibility tag attached to the blood

- Do they all match exactly? And have you documented these checks?

Documenting additional medication

- Are there any further instructions or medications to be given and has this been correctly documented?
- Separate prescription chart
- Nursing staff administering the blood must be aware of any medications or special instructions

Documenting patients clinical status

- The patients clinical status should be monitored and documented throughout the transfusion, for every unit transfused.

- If you have already identified a potential risk ensure its documented

- Previous reaction
- At increased risk of TACO

Documenting the patients response

- Any complications or adverse reactions
- Any treatment required and the response to the treatment
- The amount of blood transfused

Documenting parents understanding

- Decision to transfuse- rational and valid consent
- Who was present during the discussions and which member of staff spoke to them
- Any concerns from the parents
- Did you feel they understood the potential risk, benefits and alternatives

Any Questions?

Thank you