

## GUIDANCE FOR CLINICAL STAFF TO SUPPORT PATIENT CONSENT FOR BLOOD TRANSFUSION

### Patient may require Blood / Blood Component Transfusion

Patients receiving a blood transfusion (red cells, platelets or plasma) whether for a medical or surgical cause should be informed of the indication for the transfusion including risks, benefits and alternatives. A record of this discussion should be documented in the patient's clinical records.

Ideally the decision to transfuse should be made with the patient or parent/carer in advance of any planned transfusion.

In the emergency setting, the information will need to be given retrospectively.

### Prospective Information

Valid consent\* should be obtained prior to any planned transfusion and documented in the patient's clinical record.

\*Valid consent entails the provision of information on risks, benefits and alternatives available before asking the patient to give consent. This does not have to include a signature from the patient.

### Retrospective Information

Patients treated in emergency setting where it was not possible to obtain valid consent pre-transfusion.

Patients who were told pre-procedure (e.g. pre-operatively) that they *might* require a transfusion then need to be informed whether they did/did not receive a transfusion.

### Key issues to be discussed when obtaining valid consent

1. The following information should be discussed:
  - Type of blood / blood component
  - Indication for transfusion
  - Benefits of the transfusion
  - Risks of transfusion
  - Possible alternatives to transfusion
  - How the transfusion is administered and the importance of correct patient identification
  - Inform patient that following a blood transfusion they can no longer be a blood donor.
2. Provide written information.
3. Check if patient needs time to consider or requires further information.
4. Document the discussion in the patient's clinical records.

### At discharge

1. If patient has had a transfusion, ensure that they have been informed.
2. Record information about the transfusion in the discharge summary, also stating that the patient has been informed.

## Resources

This guidance applies to the transfusion of all blood components (**red cells, white cells, platelets, fresh frozen plasma & cryoprecipitate**) and should be used by healthcare organisations to strengthen the consent processes already in place.

Specific guidance should also be used to ensure that alternatives have been considered for blood and blood components e.g. pre-operative iron therapy, intra-operative cell salvage where appropriate for avoidance of red cell transfusion and prothrombin complex concentrate in place of FFP for warfarin reversal.

### Adverse events

Clinical teams involved with the prescribing and administration of blood and components must be aware of adverse events that can be associated with transfusion including prompt recognition and management ([www.shotuk.org](http://www.shotuk.org)). These include:

Incorrect Blood Component Transfused (IBCT)	Inappropriate, Unnecessary, Under/Delayed Transfusion (IandU)
Acute and Haemolytic Transfusion Reactions (ATR and HTR)	Transfusion-Transmitted Infection (TTI)
Transfusion-Associated Circulatory Overload (TACO)	Transfusion Associated Acute Lung Injury (TRALI)
Transfusion-Associated Dyspnoea (TAD)	Transfusion Associated Graft-versus-Host Disease (TA-GvHD)
Post Transfusion Purpura (PTP)	

Clinicians should refer to the HPA website ([www.hpa.org.uk](http://www.hpa.org.uk)) to get the latest information on the risks of transmissible infections. Current guidance from the HPA states that the risk of getting hepatitis from a blood transfusion in the UK is currently (January 2011) about 1 in 670,000 for hepatitis B and 1 in 83 million for hepatitis C. The chance of getting HIV (Human Immunodeficiency Virus) infection is about 1 in 5 million or HTLV (Human T-Lymphotropic Virus) infection is about 1 in 18 million.

Although the risk of getting variant Creutzfeldt-Jakob Disease (vCJD) from a blood transfusion is probably very low with a single blood transfusion, the risk of any infection will increase with each additional blood component.

### Long-term transfusion-dependent patients

Long-term transfusion-dependent patients will need modified consent. This should where possible include an initial discussion at the start of a transfusion regime with a regular update including appropriate information regarding the benefits and risks of transfusion and specific relevant issues e.g. iron overload, risk of allo-immunisation including haemolysis risks (red cells) and platelet refractoriness (HLA antibodies), infective risks and other transfusion reactions.

### Other information

Where needed, patients should be provided with contact details of key specialists for further discussion around blood transfusion issues relevant to their specific clinical diagnosis e.g. hospital transfusion practitioner, local haematologist or other clinician such as anaesthetist, surgeon or obstetrician.

The Trust website can be used to provide information for patients about consent and safe blood transfusion.

### Useful websites

<a href="http://www.transfusionguidelines.org.uk">www.transfusionguidelines.org.uk</a>	<a href="http://www.blood.co.uk">www.blood.co.uk</a>	
<a href="http://www.nhs.uk/conditions/blood-transfusion">www.nhs.uk/conditions/blood-transfusion</a>	<a href="http://www.nhshealthquality.org">www.nhshealthquality.org</a>	<a href="http://www.shotuk.org">www.shotuk.org</a>
<a href="http://www.hpa.org.uk">www.hpa.org.uk</a>	<a href="http://www.bcshguidelines.co.uk">www.bcshguidelines.co.uk</a>	<a href="http://www.sign.ac.uk/guidelines/">www.sign.ac.uk/guidelines/</a>

**Patient information leaflets are available from :** [www.hospital.blood.co.uk](http://www.hospital.blood.co.uk)