

ACTION PLAN - PATIENT CONSENT FOR TRANSFUSION

RECOMMENDATION	ACTION	BY WHOM	TIMELINE
Valid consent for blood transfusion should be obtained and documented in the patient's clinical record by the healthcare professional	Recommendation to be included in all policies for consent and blood transfusion	Recommendation is directed to all those providing blood transfusion and managing patients who may need transfusion	Timeframe for implementation to be agreed by each organisation's Hospital Transfusion Committee (or equivalent group)
2. There should be a modified form of consent for long term multi-transfused patients, details of which should be explicit in an organisation's consent policy	Recommendation to be included in all policies for consent and blood transfusion	Recommendation is directed to all those providing blood transfusion and managing patients who may need transfusion	Timeframe for implementation to be agreed by each organisation's Hospital Transfusion Committee (or equivalent group)
3. There should be a standardised information resource for clinicians indicating the key issues to be discussed by the healthcare professional when obtaining valid consent from a patient for a blood transfusion	Publication of an information resource of the key issues to be discussed by the healthcare professional when obtaining valid consent from a patient for blood transfusion	NHS Blood and Transplant Appropriate Use of Blood Group	Information resource to be available on the Better Blood Transfusion Toolkit on the UK Blood Transfusion and Tissue Transplantation Services website in October 2011 www.transfusionguidelines.org
4. Patients who have received a blood transfusion and who were not able to give valid consent prior to the transfusion should be provided with information retrospectively	Recommendation to be included in policies for consent and blood transfusion	Recommendation is directed to all those providing blood transfusion and managing patients who may need transfusion	Timeframe for implementation to be agreed by each organisation's Hospital Transfusion Committee (or equivalent group)

5. SaBTO consent working group should produce good practice guidance to help identify the most effective way of providing information retrospectively when patients were unable to give prior consent	Publication of good practice guidance for provision of retrospective information when patients were unable to give prior consent for a blood transfusion	SaBTO Blood Transfusion Consent Group	Good practice guidance for provision of retrospective information to be available on the UK Blood Transfusion and Tissue Transplantation Services website in October 2011 www.transfusionguidelines.org
6. There should be a standardised source of information for patients who may receive a transfusion in the UK	Publication of generic information for inclusion in each of the UK Blood Services' patient information leaflets for blood transfusion	UK Better Blood Transfusion Network	Included in 2012/13 work plan
7. The consent standard developed by Health Improvement Scotland (formerly NHS Quality Improvement Scotland) should be adopted throughout the UK for consent for blood transfusion	Publication of a standard for patient consent for blood transfusion for use in the UK	SaBTO Blood Transfusion Consent Group	Consent standard to be available on the UK Blood Transfusion and Tissue Transplantation Services website in October 2011 www.transfusionguidelines.org
8. The Care Quality Commission (CQC), NHS Litigation Authority (NHSLA) and equivalent organisations in Northern Ireland, Scotland and Wales should be aware of the consent standard for blood transfusion recommended by SaBTO	SaBTO to promote awareness of the recommended standard for patient consent for blood transfusion with the CQC and NHSLA (and equivalent organisation in Northern Ireland, Scotland and Wales)	SaBTO Blood Transfusion Consent Group	Link to consent standard on Better Blood Transfusion Toolkit to be shared with relevant organisations after SaBTO 2011 public meeting
9. A UK comparative audit of consent for transfusion should be carried out, facilitated by the National Comparative Audit of Blood Transfusion (a collaborative between the Royal College of Physicians and NHS Blood and Transplant)	A UK comparative audit of patient consent for blood transfusion to be included in the National Comparative Audit work plan	National Comparative Audit of Blood Transfusion Team	Included in 2012/13 audit plan

10. Depending on the role envisaged for Healthwatch, the potential role of patient groups in providing active oversight should be explored	Establish links with relevant patient groups to enable them to be better informed and promote the standards patients should expect when being consented for transfusion	The National Blood Transfusion Committee in England Patient Involvement Working Group	Included in 2011/12 work plan
11. UK Blood Services should have an ongoing programme for educating patients and the public about blood transfusion as part of their respective 'Better Blood Transfusion' strategies	Programme for educating patients and the public about blood transfusion should form part of the UK Blood Services Better Blood Transfusion Teams' strategic plans	UK Better Blood Transfusion Network	To be included in 2012/13 work plans
12. Use of www.learnbloodtransfusion.org.uk e-learning package should be promoted by the UK Blood Services and Royal Colleges for all staff involved in the blood transfusion process	Reference to the learnbloodtransfusion e-learning package should be included in the relevant Royal Colleges' educational programmes	The National Blood Transfusion Committee in England and equivalent groups in Northern Ireland, Scotland and Wales	Ongoing action
13. Completion of www.learnbloodtransfusion.org.uk e-learning package should be included in all undergraduate curricula. Reference to consent for blood transfusion should be included in the undergraduate curriculum as part of the learning objectives outlined for the principles of consent	Reference to the learnbloodtransfusion e-learning package and consent for blood transfusion should be included in all relevant undergraduate curriculum.	The National Blood Transfusion Committee in England and equivalent groups in Northern Ireland, Scotland and Wales	Ongoing action
14. The UK Better Blood Transfusion Network should explore the feasibility of developing a new module specific to consent and blood transfusion as part of its 2011/12 work plan	Module on patient consent for blood transfusion to be included in the learnbloodtransfusion e-learning package	UK Better Blood Transfusion Network	Included in the 2012/13 learnbloodtransfusion elearning development plan