

## **Guidelines for the Blood Transfusion Services**

### **4.6: Records**

<http://www.transfusionguidelines.org/red-book/chapter-4-premises-and-quality-assurance-at-blood-donor-sessions/4-6-records>

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It is strongly recommended that all records pertaining to donor and donation identity be entered and maintained in an electronic format which can be accessed readily by approved and qualified personnel, and in a manner which preserves donor confidentiality in accordance with legal requirements. Machine-readable systems for identifying donors and donation derivatives are also recommended. Initial documentation – for example on session records – may be made manually and archived for the required period in law, with relevant portions transcribed electronically whenever convenient operationally.

#### **4.6.1: Donor session records**

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The session venue, the date and the identity of all donors attending must be recorded.

The relevant medical history of all donors must be documented for any donors who are deferred or withdrawn, and the full details including the reasons must be recorded.

All donations must be recorded including type collected (blood or component(s)) and the reason for any unsuccessful donations.

The records should allow identification of each important step associated with the donation.

All adverse reactions must be recorded together with the action taken. Full details of any other incidents, including those only involving staff, must be recorded.

These records should be used for the regular compilation of statistics and review by those responsible for the organisation and management of blood collection sessions.