Title: **BLOOD TRANSFUSION POLICY**

Ref: 0219 Version 11
Classification: Guideline

Directorate: Laboratory Medicine

Due for Review: 15/12/2020
Document Control

Responsible for review: Consultant Haematologist and Transfusion Lead
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Ratified by: Patient Blood Management Group

Applicability: All Patients

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1 Purpose

To give clear guidelines to ensure that all transfusions within Torbay and South Devon NHS Foundation Trust are carried out following current best practice recommendations

PLEASE NOTE:

All Policies relating to laboratory procedure including sample rejection policy and compatibility testing are stored in the laboratory document control system. If access to these documents is required please contact the blood bank manager on Ext. 55241.

2 Introduction

Changes to National Guidelines and publication of NICE (National Institute for Health and Care Excellence) guidelines (NG24 Blood Transfusion) have resulted in changes to the recommended consent process for blood transfusion and an emphasis on blood conservation strategies.

This policy aims to provide a means of ensuring that all blood transfusions carried out in hospitals within Torbay and South Devon NHS Foundation Trust are performed within the requirements laid out by various bodies including NICE, British Committee for Standards in Haematology (BSCH) and the Department of Health (DoH).

In 2016 National Standards were developed from the BCSH Guideline on Administration of Blood Components 2009 and agreed through collaboration with a sounding board of Transfusion Practitioners and the relevant stakeholders in the NBTC to ensure that all staff members taking part in the transfusion process have a knowledge of practical procedural details and an in depth understanding of the rationale for the processes and the dangers in not following these.

3 Roles and Responsibilities

Blood and Blood Components may only be **prescribed** by Registered Medical Practitioners or Registered Nurses, who can demonstrate compliance with current training requirements.

Blood and Blood Components may only be **administered** by Registered Medical Practitioners, Registered Nurses, Registered Midwives, Registered Operating Department Practitioners and named Assistant Practitioners (ref: Guideline 1723 Assistant Practitioner and Adult Blood Transfusions), who can demonstrate compliance with current training requirements and have been deemed competent to the standards originally set out in NPSA SPN 14.

Blood and Blood Components may only be **collected from the Transfusion Department** by Registered Medical Practitioners, Registered Nurses, Registered Midwives, Registered Operating Department Practitioners, Nursing Auxiliaries, Health Care Assistants, Orderlies, Ward Clerks and other ancillary staff who have undertaken the necessary training and have been deemed competent to the standards originally set out in NPSA SPN 14.

DoH **Health Service Circular 2007 / 001** (Better Blood Transfusion: Appropriate Use of Blood) states: 'NHS Trusts should provide regular documented training and competency assessment in safe and appropriate transfusion practice from blood sample collection to blood administration and the monitoring of patients during the transfusion episodes (including phlebotomists, laboratory staff, porters, nurses and medical staff) in line with National guidelines.

The **Blood Safety and Quality Regulations 2005** state 'Personnel directly involved in the collection, testing, processing, storage and distribution of human blood and blood components are provided with timely, relevant and regularly updated training'.

In 2006 the NPSA, in conjunction with the NBTC and SHOT, issued a Safer Practice Notice, [**SPN14**], '*Right Patient Right Blood'.* This document detailed actions to be taken by all NHS and independent sector organisations to improve the safety of blood transfusions.
Health Service Circular 2007 / 001 (Better Blood Transfusion: Appropriate Use of Blood) states: 'NHS Trusts should provide regular documented training and competency assessment in safe and appropriate transfusion practice from blood sample collection to blood administration and the monitoring of patients during the transfusion episodes (including phlebotomists, laboratory staff, porters, nurses and medical staff) in line with National guidelines and the NPSA's Safer Practice Notice (SPN 14) Right Patient - Right Blood'

The NPSA was abolished in 2012 so a NBTC working group was formed to review the competencies and develop guidance to replace the former NPSA document.

The National Blood Transfusion Committee have now standardised the requirements for transfusion training and competency as detailed below

4 Education and Training

For all staff involved in the transfusion process Trusts must have in place a system for training, knowledge and understanding assessments to be undertaken a minimum of every 3 years (2 years for blood collection) and more frequently if deemed necessary at a local level. TSDFT has decided that to avoid any confusion all training, knowledge and understanding assessments will be undertaken a minimum of every 2 years.

- Staff must be trained and assessed as competent prior to taking part in the transfusion process.
- Individual healthcare professionals are responsible for their own practice and ensuring that their knowledge and assessments are up to date and valid and that they are practicing in compliance with local policy.
- Ward or departmental managers must establish the number of staff that need to be trained and assessed to ensure the safe and effective delivery of transfusion in their area.
- All staff participating in the transfusion process must be trained and have demonstrated competency in the parts of the process they are involved in.

4.1 Core Standards

Knowledge testing and assessment packages should reference National Standards (Appendix 1) to facilitate transferability between trusts. The Standards have been developed from the BCSH Guideline on Administration of Blood Components 2009 and have been agreed through collaboration with a sounding board of Transfusion Practitioners and the relevant stakeholders in the NBTC.
Training, testing and assessment packages should be developed from these National Standards.
They are intended to ensure knowledge of practical procedural details and an in depth understanding of the rationale for the processes and the dangers in not following these.

4.2 Training

Training may take the form of face to face training or E learning

Transfusion education sessions are held at Torbay Hospital throughout the year, to enable all relevant staff to access mandatory training in transfusion practice. Blood transfusion education sessions are held as part of the Trust Mandatory Clinical Update days, these sessions can also be booked as 'stand-alone sessions'.
Details of dates, times and venues can be obtained via the Horizon Centre.

Sessions can also be delivered directly in the clinical area, this facility is in general offered to the Community Hospitals but can also be accessed by wards on the acute site, to arrange these sessions please contact the Transfusion Practitioner.

E-learning is also available via http://www.learnbloodtransfusion.org.uk/
The same e-learning package can be accessed through the Trust's learning management system.

4.3 Competency

Following an individual's initial training, a one off practical competency assessment must be undertaken. This practical assessment need not be repeated if there is on-going satisfactory performance but should be repeated if there is a period of greater than one year out of a workplace where transfusion routinely takes place.
TSDFT have formally adopted a package of competency assessments based on these National Standards.

Please refer to Competency Framework1697 Transfusion Package Competency Assessments

Competency assessments will be carried out by Ward Managers, designated Ward Blood Champions or members of the Transfusion Team. Once assessments are complete it is the responsibility of the Ward Manager or designated ward Blood Champion to inform the Transfusion Team to enable BloodHound accounts to be activated. This Transfusion Team will also ensure that this information is added to the individuals Electronic Staff Record (ESR)

Individuals who are involved in transfusion related incidents, or who fail knowledge tests or practical assessments, should be managed in a consistent way**.**

4.4 Knowledge Assessment

Knowledge and understanding assessment should be performed at least every 2 years
Knowledge tests must be performed against National Standards and local specific processes.

4.5 Transferability of training, knowledge tests and practical assessments

Training, testing and assessments that have been undertaken against National Standards (Appendix 1) and referenced are transferable between trusts.
Evidence of compliance must be forwarded to the Transfusion Team who will ensure that this information is added to the learner's Electronic Staff record (ESR).

Transferring staff members who can demonstrate compliance with these standards will need to attend a 30 minute hands on training session on the use of BloodHound (electronic transfusion system) either with a member of the Transfusion Team or ward based Blood Champion/Ward Manager prior to having their BloodHound account activated

4.6 Management of Incidents and Poor Performance

Individuals who are involved in transfusion related incidents, or who fail knowledge tests or practical assessments, should be managed as outlined below:

- Individuals should be given two (2) attempts to pass the knowledge test and practical competency test, after which retraining must be undertaken.
- Individuals failing knowledge tests or practical assessments must not continue to practice until satisfactory performance has been demonstrated.
- The Hospital Transfusion Team should be involved in the investigation of all transfusion related incidents.

- Hospital Transfusion Teams should ensure that incident reports and investigations are available to the line managers and educational supervisors of all individuals involved in transfusion incidents
- Individuals involved in incidents may be asked to include details of the incident, and any reflection undertaken, for discussion in their annual/educational appraisal.
- Individuals involved in serious and/or repetitive incidents should undertake retraining and / or repeat assessments on the direction of the hospital transfusion team and/or line manager.

A risk assessment should be undertaken by a senior member of the team to decide whether individuals involved in transfusion incidents are allowed to continue to be involved in the transfusion process pending full investigation.

4.7 Non-Compliance with Mandatory Training, Competency or Knowledge Assessment

Any staff member who does not maintain compliance with the training, competence or knowledge assessment in line with the National Standards will have their BloodHound access suspended and MUST not take part in the transfusion process until the situation is rectified.

5 Informed Consent

Patients who may require a transfusion should have the reasons for and the risks, benefits and alternatives explained to them. All information given, written and verbal, and consent to proceed, should be clearly documented in the patient's notes.
Where appropriate, patients must be provided with the patient information leaflet 'Receiving a blood transfusion', or alternative relevant literature, produced by the National Blood Service. Issue of the leaflet to a patient must be recorded in the medical or nursing notes. PDF versions of all transfusion related patient information leaflets can be accessed through ICON

https://icon.torbayandsouthdevon.nhs.uk/areas/transfusion/Pages/patient-information-leaflets.aspx

Leaflets can be ordered, free of charge, by following the instructions

The blood transfusion consent form can be found attached to the front of the Blood Component Authorisation booklet or on the Trust's Document Library.

For patients undergoing regular transfusions consent should be obtained at the beginning of treatment, a separate consent form is not required for each transfusion.

5.1 Patients Refusing a Blood Transfusion

Please see Ref 2218 - Patients including Jehovah's Witness refusing Blood and Blood Components

6 Prescription

The prescription of Blood and Blood Components is the responsibility of the doctor or nurse practitioner. Blood and Blood Components may only be prescribed by those who are current with transfusion education requirements, please refer to Section 4 above for details.
Registered nurses or midwives who have completed the NHSBT - Non-medical Authorisation of Blood Components course may also prescribe blood and blood components.

Blood and blood components should be prescribed in accordance with national guidelines – please refer to 0234 Red Cell Transfusions Clinical Use of; 0044 Platelets Clinical Use of;

0046 Fresh Frozen Plasma Clinical Use of; and 0143 Surgical Blood Order Schedule for Elective Surgery. Guidance on dosages and infusion rates for blood components can also be found as part of the Blood Component Transfusion Record.

An accurate haemoglobin result should be obtained before any red cells are prescribed. It is recommended that this haemoglobin has been measured no more than 24 hours before the start of the transfusion episode for inpatients and no more than 72 hours for day case patients.

The decision to transfuse must be based on a thorough clinical assessment of the patient and their individual needs. The rationale for the decision to transfuse and the specific components to be transfused should be documented in the patient's notes.

The clinical assessment should include an evaluation of the patient's age, body weight and concomitant medical conditions that predispose to Transfusion Associated circulatory Overload (TACO): cardiac failure, renal impairment, hypoalbuminaemia and fluid overload. These factors should be documented in the patient's notes and should be considered when prescribing the volume and rate of the transfusion, and in deciding whether diuretics should be prescribed.

For patient's identified at risk of TACO, a written request should be made that during the administration of blood components, specific attention should be given to monitoring the patient for signs of circulatory overload, including fluid balance. The rate of transfusion should be carefully assessed, as TACO can occur after only one unit of red cells in at risk patients.

Transfusing a volume of 4ml/kg will typically give an Hb increment of 10g/l. the concept that one unit of red cells gives an Hb increment of 10g/l should only be applied as an approximation for a 70-80 kg patient. For patients of lower body weight the prescription should be reduced.

Paediatric transfusions should be prescribed in mls. This may also be appropriate for very low body weight adults, as may the use of smaller volume paediatric packs. This should be discussed with the hospital transfusion laboratory, and specific guidance given to the clinical staff administering these unfamiliar components.

Single unit red cell transfusions are recommended where possible, especially in non-bleeding patients.

All red cell units should be transfused within four hours of removal from designated temperature controlled storage.

Rate of transfusion

- For routine administration, there is extensive experience of safely administering a red cell unit over 90-120 minutes per unit.
- Patients less tolerant of increased blood volume should be transfused more slowly with careful haemodynamic monitoring.
- For some patients it may be appropriate to administer a diuretic (e.g. furosemide 20 to 40 mg orally), although this is not necessary as a routine.
- During major haemorrhage, rapid infusion (1 units over 5-10 minutes) may be required (with appropriate clinical and haemodynamic monitoring).

An indication of whether the transfusion achieved the desired effect (either post transfusion increment rates or improvement in patient symptoms) should be documented in the patient's notes. In the absence of significant on-going blood loss, further units should not be prescribed

without monitoring the patient's Hb. In patients with minor but on-going blood loss, Hb should be regularly monitored, as a minimum after every 2-3 units of red cells.

Blood and blood components should be prescribed on the Blood Component Transfusion Record. It is essential that the prescription sheet contains the patient identification details, i.e. surname, first name, date of birth and patient identification number. Ideally an addressograph label including bar-code ID should be used. The prescription **must** be legible, **IN CAPITALS** and with no abbreviations. It must be signed and name printed by the prescribing medical practitioner.

Specify:

a) The blood or blood component to be given and any special requirements (e.g. CMV sero-negative, irradiated) – please refer to 0042 CMV Negative Blood Components, 0043 Irradiated Blood Components and 1873 Hepatitis Negative Blood Components
b) The quantity, i.e. number of units or volume in mls to be given
c) The duration of each unit – please note that red cell transfusions must be completed within 4 hours of blood being removed from cold storage
d) Any special instructions (e.g. medication required before or during the transfusion)
e) The date of commencement of the transfusion, with time if known

Enter into the patient's medical notes:

a) The date
b) The indications for the use of the blood / blood component
c) The number and type of blood / blood components ordered
d) That the patient has been informed of the risks and benefits – the patient information leaflet will help facilitate this.

Post transfusion – enter into the patient's medical notes:

a) The date
b) The amount of blood / blood component transfused
c) Comments on the effectiveness of the transfusion
d) The occurrence and management of any adverse events

Timing of the transfusion

All transfusion episodes must be completed within 72 hours of start of the transfusion

Avoid transfusion at night unless it is clinically indicated, i.e. patient is actively bleeding or symptomatic. The risk of error is greater (SHOT 2003); reaction detection may be delayed and the patient is woken frequently.
Transfusions should therefore NOT be carried out between 20:00 and 08:00 unless clinically indicated.

Please note: Patients for whom transfusion between these hours has been deemed clinically indicated may be transferred between clinical areas with the transfusion in progress. This is of particular significance for transfusions that have been deemed clinically indicated in high dependency or high throughput areas such as A&E, ICU or PACU.

7 Request for Blood Transfusion

The 'Request for Transfusion' constitutes the mechanism of communication with the transfusion laboratory and is different to the prescription.
Requesting of Group and Saves or Crossmatches may only be carried out by an appropriately trained, competent and authorised practitioner in possession of the relevant information about the patient, please refer to Section 4 above for details. Information relating

to significant co-morbidities, pregnancy, previous transfusion history and patient's special requirements may have a major impact on blood provision.
The name of the person making the request should be clearly indicated on the written request form

Minimum acceptable details on the request form

As a minimum the request should contain

a. The patients core identifiers
    i. Last name
    ii. First name
    iii. Date of Birth
    iv. NHS number /Hospital Number
b. Information on the patient's diagnosis and any significant co-morbidities of relevance to transfusion
c. A clear, unambiguous reason for transfusion, terms such as 'Pre-op', 'Anaemia' or 'Low Hb' are not acceptable
d. When the transfusion will take place and the urgency of the transfusion
e. The location of the patient at the time of request, and where the blood will be transfused (if known to be different)
f. Any relevant information on other factors which influence transfusion requirements, including:
    i. Known blood group antibodies
    ii. Any previous reactions to blood components
    iii. Any known pregnancies
g. The type and volume of blood component required
h. Any information on any clinical special requirements for blood components
    i. Irradiated
    ii. CMV seronegative
    iii. HEV Negative

No amendment of or addition to patient core identifiers is allowed on the request

8 Samples for Blood Transfusion

Samples for 'Group and Save' or 'Group and Crossmatch' may only been taken by staff members who have had appropriate training and who have been deemed competent to the standards originally set out in NPSA SPN 14. Please refer to please refer to Section 4 above for details.

Refer to 1535 Venepuncture, Procedure for , 0199 Venepuncture – Competency Framework

The collection of the blood sample and the subsequent labelling of the sample tubes should be performed as one continuous, uninterrupted event at the patient's (bed) side, involving one patient and one member of staff only.

Timing of Transfusion Specimens

Transfusion or pregnancy may stimulate the production of unexpected antibodies against red cell antigens either through a primary or secondary immune response. It is important to note that all cellular blood components contain residual red blood cells and may elicit an immune response.
The timing of samples selected for crossmatching or antibody screening must take account of this.

If the patient has been transfused within 0-90 days or is pregnant the sample is valid for 72 hours

Patient Identification

All patients having a blood sample taken must be positively identified
The patient (or parent/carer if the patient is unable to respond) should be asked to state their full name (first and last name) and date of birth
It must be ensured that these details are the same as on the request form and wristband where available

All inpatients must wear an identification band

Sample Labelling Requirements

All samples should be labelled with

- Patient's full name (last name and first name)
- Patient's date of birth
- NHS or Hospital Number
- Signature of the phlebotomist
- Date and time sample taken

The request form should contain date and time the sample was taken and such details of the sample taker that will permit traceability.

Any sample not meeting these criteria will be rejected by the laboratory
No alteration of details on the request form or sample will be allowed

Delivery of samples to the Transfusion Laboratory

- **Routine samples**
  - Routine samples should be sent via the pneumatic air tube system to either Pathology Specimen Reception or the Blood Transfusion Laboratory; or delivered by hand to the same
- **Urgent or emergency samples**
  - It is recommended that all urgent or emergency samples are hand delivered to the Transfusion Laboratory on Level 5

Group check sample

All patients requiring blood transfusion must have two separate blood groups performed; this is to prevent incompatible transfusions arising as a result of Wrong Blood in Tube (WBIT) incidents.
Please note

- These samples must be taken at two different times
- Samples should ideally be taken by two different persons
- A historical record will suffice as one sample

If the blood group has not been confirmed through receipt of this second or 'Group Check' sample Group O blood only will be issued.
Dependent on blood stock levels male patients may be issued with O Rh (D) positive units in order to preserve O Rh (D) negative units for females of childbearing age

Wrong Blood in Tube

To ensure consistency following receipt of a sample deemed to be a WBIT a standard re-education and re-training program will be followed. This program is detailed in Appendix 5

9 BloodHound

All transfusions across TSDFT should be carried out using BloodHound, this electronic system is designed to increase patient safety by performing additional computer checks of patient identity to ensure that 'wrong blood' events do not occur. This process is dependent on bar-code technology. In addition to the safety features the system also achieves compliance with blood traceability requirements as specified in the Blood Safety and Quality Regulations, which are regulated by the MHRA

10 Blood and Blood Component Collection

Various reports from the Serious Hazards of Transfusion (SHOT) organisation have identified that the collection of the incorrect unit of blood from the hospital blood bank is a major factor in incidents where patients have been given the 'wrong blood'. Therefore, specific training is required for this procedure. Only staff members who have undertaken the necessary training and have been deemed competent to the standards originally set out in NPSA SPN 14 may collect blood components – please refer to Section 4 above for details.

10.1 Pre Collection

Before collecting the blood component, the following should be ensured by clinical staff

- The patient is wearing a wristband
- The reason for the transfusion has been documented in the patient's notes.
- Wherever possible the reason for the transfusion has been explained to the patient and consent obtained and documented in the patient's notes
- The blood component has been prescribed on an appropriate prescription chart
- The is appropriate and patent venous access
- There are suitably trained and competent staff members available for the duration of the transfusion
- The patient's baseline observations have been completed

Unless rapid transfusion of large quantities is needed, only ONE unit of blood should be collected for each patient at a time

10.2 Collection of Blood and Blood Components

10.2.1 Torbay Hospital – refer to BloodHound User Guide – Acute Trust
10.2.2 Community Hospitals – refer to BloodHound User Guide – Community Hospitals

Patient Identification required for the collection of blood components
The staff member removing the blood component from the storage location should carry documentation containing the patient's core identifiers (surname, forename, date of birth and hospital number).

Recording of the Procedure
If the blood or blood component collection is not recorded electronically, the person collecting must record their name, the date and the time of collection on the relevant paperwork.

10.3 Receipt in the Clinical Area

Every time a blood component is delivered to the clinical area, an appropriately trained and competent member of staff should check that the correct blood has been delivered

10.4 Return of Blood and Blood Components

All unused components should be returned to the blood fridge or Blood Transfusion laboratory (as appropriate) as soon as possible.

11 Administration of Blood and Blood Components

Only staff members who have undertaken the necessary training and have been deemed competent to the standards originally set out in NPSA SPN 14 may administer blood components – please refer to Section 4 above for details.

11.1 Identification and Checking

Recommended identification and checking procedures MUST be applied to ALL blood (red cells) and blood components (platelets, fresh frozen plasma, cryoprecipitate). Before administration to patients, blood must be checked to ensure that it has been compatibility tested and issued for the patient who is about to receive it. **This is a critical point and failure could result in death or serious harm (Department of Health "Never Events 2012/2013").** Failure to carry out the procedure as prescribed is therefore regarded as a most serious incident.

11.2 Bedside Checking and Administration

11.2.1 Torbay Hospital – refer to BloodHound User Guide – Acute Trust
11.2.2 Community Hospitals – refer to BloodHound User Guide – Community Hospitals

Transfusion should only take place if the patient identification details on the blood component and the patient identification band match. If they do not, the Transfusion Laboratory should be informed and the component MUST NOT be transfused until there has been an investigation and any discrepancies resolved. A repeat pre-transfusion blood sample may be required.

If the practitioner is unsure that the component issued is correct, for example an unexplained difference in blood groups in the donor and recipient or whether any special requirements have been met, they should check with the Blood Transfusion Laboratory before starting the transfusion

11.3 Recording of the Identification and Checking Procedure

Although BloodHound records the details of the staff member administering the transfusion and the second checker (where appropriate) the unique component donation number and the date, start and stop times and volume of all blood components administered and the name of the person administering the component should be recorded in the patient's notes. In practice this ideally should be recorded on the Blood Component Transfusion Record.

11.4 Checking in the Emergency Situation

Various SHOT reports have identified these situations as being a source of a relatively large number of transfusion errors. It is recognised that these situations can be very stressful; however, safety must not be compromised for expediency.
In emergency situations where un-crossmatched 'O Rh (D) negative' blood has to be given, there may be no (or minimal) patients details to check. However, as many of the above checks as practicable must be performed.
Please note: Emergency O negative units that have not been issued to a specific patient will not be recognised by BloodHound, therefore following administration of emergency 'O negative' blood, the accompanying paperwork must be accurately completed and returned to the Blood Transfusion Laboratory as soon as possible, in order that an effective audit trail may be maintained.

The Blood Transfusion Laboratory must be informed as soon as the emergency units are removed from the blood fridge.

Appendix 2 – Pre-Administration Checklist
Appendix 3 - Equipment

11.5 Administering the Transfusion

Red cells and fresh frozen plasma must be administered via a dedicated Blood Administration Set with an integral 170 – 200 micron filter.
Platelets should be given through a Platelet Administration set; in an emergency, they can be given through a standard Blood Administration set, but this **MUST BE A FRESH SET.**
Cryoprecipitate may also be administered via Platelet Administration set; it is particularly useful for this as it has a relatively small priming volume.
It is not necessary to prime a giving set before blood or blood components are run through, but if you wish to do so then **ONLY SODIUM CHLORIDE 0.9%** should be used.

- Blood must not be run through a giving set that has contained a dextrose solution.
- A giving set that has been used for blood should be replaced before any other substance, including Sodium Chloride, is infused.
- Drugs or other substances must not be added to a bag of blood or blood component, nor should drugs or other substances be injected directly into the line.
- Substances to be infused simultaneously with blood must run through a separate giving set so as to meet the blood transfusion just before entering the body. The compatibility of such substances with blood/blood components must be checked before simultaneous administration takes place.
- If Group O blood has been transfused unmatched in an emergency before a patient's ABO Group is known and is then to be followed by matched blood of a different ABO group, then a new administration set must be used for the latter.
- If a patient is issued with blood of different blood groups a fresh giving set must be used when the blood group changes.
- During a prolonged transfusion, the blood administration set must be changed at least every 12 hours; however, it is good practice to change the set after every 2-3 units, or if the integral filter appears to contain excessive debris.

11.6 Recording of the Checking and Administration Procedure

Although BloodHound records the details of the staff member administering the transfusion and the second checker (where appropriate) the unique component donation number and the date, start and stop times and volume of all blood components administered and the name of the person administering the component should be recorded in the patient's notes. In practice this ideally should be recorded on the Blood Component Transfusion Record.

12 Traceability

To ensure compliance with BSQR (SI2005 No.50 as amended) requirements for traceability, positive evidence of the transfusion of each component must be fully documented. This is achieved either through the use of BloodHound for the entire transfusion procedure, or by 'final fating' of the red tags by either the laboratory or the clinical area.

If for any reason BloodHound has not been used for the transfusion process it is imperative that all traceability information is recorded on the transfusion tag and this information entered onto the BloodHound web application and the tag returned to the Blood Transfusion Laboratory – these tags should arrive in the laboratory within 48 hours of the time the transfusion was completed.

13 Clinical Observations during Transfusion

Observation and monitoring of the patient during a transfusion is essential if adverse reactions to the transfusion are to be quickly identified and managed.
Transfusion must only taker place where there are enough staff available monitor the patient and when the patient can be readily observed.
All staff members carrying out observations during the transfusion must be current on Transfusion Education requirements and have been assessed as competent to the standards originally set out in NPSA SPN 14.
Many serious reactions are apparent within 30 minutes of starting the transfusion of a blood component unit, and close observation during this period is essential.
In critically ill medical patients, the respiratory rate is an early and important indicator of deterioration. Dyspnoea and tachypnoea may both be features of a serious transfusion reactions, and while routine monitoring of respiratory rate is unnecessary during a transfusion, a baseline measurement before the transfusion starts is recommended
Observations should be undertaken and recorded for every unit transfused

Please refer to Appendix 4 –Clinical Observations during Transfusion

14 End of the Transfusion

14.1 Used blood bags

If a transfusion has been uneventful, and the final observations following completion of the transfusion have been made (and reported to the registered nurse responsible for the care of the particular patient), then empty blood packs may be discarded into clinical waste.

For example: If a patient is receiving a three-unit transfusion, then the empty blood bags from units 1 & 2 should be retained until unit 3 is finished. Providing there has been no indication of a severe transfusion reaction, and the final observations upon completion of the transfusion have been made and are satisfactory, all three empty bags may then be disposed of via clinical waste. If a severe reaction is suspected, then the bags must be retained and advice sought from a Haematologist.

14.2 Transfusion Tags

Once the transfusion has completed all returnable tags from the bags which have not been fully processed through BloodHound must be returned to the blood transfusion laboratory – these tags should arrive in the laboratory within 48 hours of the time the transfusion was completed.

15 Transfusion Reactions and Untoward Events

Any adverse event or reaction before, during or following transfusions of blood and blood components must also be reported using the Trust's Clinical Incident Reporting Procedure. In turn, a member of the Hospital Transfusion Team will investigate the incident and report as appropriate (via the Serious Adverse Blood Reactions and Events – SABRE – reporting system) to the Medicines and Healthcare products Regulatory Agency (MHRA) and / or the Serious Hazards of Transfusion (SHOT) organisation.

The SHOT report (2008) emphasised that on occasion, transfusion reactions can occur many hours after the transfusion is completed and recommends that patients are observed during the subsequent 24 hours. For transfusions administered as day cases, the patients should be counselled about the possibility of late adverse reactions and issued with a copy of the post transfusion advice leaflet

All Serious Adverse Blood Reactions and Events must be reported to SABRE, other incidents may require reporting to SHOT. For a full list of all reportable incidents please refer to policy 1582 Reporting of Transfusion Incidents

16. Blood Administration Errors

In the unfortunate event of a blood transfusion error:

- Each practitioner must make an immediate, open and honest disclosure to the ward manager / senior nurse / midwife to ensure patient safety
- The incident should be reported immediately to the Hospital Transfusion laboratory (Ext. 55241 / Bleep 219 out-of-hours). The laboratory will inform the Transfusion Practitioner of the incident.
- The ward manager / senior nurse / midwife must report the incident to a senior member of the clinical team dealing with the patient, who will determine the clinical management of the situation.
- A Trust incident report must be generated using the Trust's incident reporting system, ensuring that cause group 'Blood Transfusion Incidents' is selected
- The senior nurse/midwife should inform the consultant/senior medical staff prior to discussing the incident with the patient and carers.
- The ward/department/unit manager has overall responsibility for ensuring that, where identified, action is taken with the individual practitioner to address any deficits in knowledge or competence
- A risk assessment should be undertaken by a senior member of the team to decide whether individuals involved in transfusion incidents are allowed to continue to be involved in the transfusion process pending full investigation.

Please refer to Section 4.6 above

All errors and incidents require thorough and careful investigation, which takes full account of the circumstances and context of the event and the position of the practitioner(s) involved.
It is recognised that people learn from mistakes and events of this kind, which require sensitive management and a comprehensive assessment of all the circumstances before a professional / managerial decision is taken. However, these errors must be monitored in order for the Trust to detect trends and identify training and policy issues.

17 Acute Transfusion Reactions

General information

Major reactions are rare but potentially lethal
Pyrexial and mild allergic reactions are more common and occur in about 2% of transfusions

Transfusion Reaction Flowchart

17.1 Febrile Reactions

These reactions are relatively common in patients who have been pregnant or previously transfused. The patient has fever or rigors, usually starting some 30 – 60 minutes after commencement of the transfusion. Fever may be up to 1.5 ^{o}C above baseline (any higher than this merits further investigation – seek advice from a Consultant Haematologist); in some cases facial flushing may occur; other observations are stable and the patient is otherwise relatively well.

17.2 Mild Allergic Reactions

These usually consist of an urticaria and / or itch within minutes of starting the transfusion – particularly common with relatively plasma rich components such as platelets or FFP.

17.3 Major Transfusion Reactions

These may occur very quickly after commencing the transfusion – perhaps after only 5 – 10mls has been given. Depending upon the exact type of reaction, a number of symptoms and signs (in any combination) may be displayed, i.e.

- Flushing
- Urticaria
- Vomiting
- Diarrhoea
- Fever
- Itching
- Headache
- Pinkish tinge in the urine (may indicate haemoglobin is present)
- Pain at or near the transfusion site
- Severe backache
- Collapse
- Circulatory failure

Major reactions include haemolytic transfusion reactions (almost always caused by ABO incompatibility, which in turn is almost always due to administrative error); acute hypersensitivity (anaphylactoid) reactions; septic shock; and transfusion related acute lung injury (TRALI). Further information can be found in the Handbook of Transfusion Medicine, via www.transfusionguidelines.org.uk or by contacting the Transfusion Practitioner (TP) on 01803 654283 / Bleep 435

18 Delayed Transfusion Reactions

These are relatively rare and include delayed haemolytic transfusion reaction, post transfusion purpura, transfusion-associated graft-versus-host disease (TAGvHD), fluid overload and iron overload.

Further details can be found in the Handbook of Transfusion Medicine via www.transfusionguidelines.org.uk ; the Transfusion Practitioner (TP) on 01803 654283 / Bleep 435 can also provide more information about the recognition of these reactions.

The management of cases of suspected delayed transfusion reaction must be discussed with a Consultant Haematologist at the earliest opportunity.

19 Further Information

Further information about blood transfusion can be found at:

www.transfusionguidelines.org.uk

www.bcshguidelines.com

Information about transfusion incidents can be found at:

www.shotuk.org

Further information, links to other transfusion policies and additional guidance can be found on Torbay and South Devon NHS Foundation Trust Intranet site (ICON). To access the Clinical Blood Transfusion web pages please follow the link below.
https://icon.torbayandsouthdevon.nhs.uk/areas/transfusion/Pages/default.aspx

20 Equality and Diversity

This document complies with the Torbay and South Devon NHS Foundation Trust Equality and Diversity statement.

21 References

Health Service Circular 2007 / 001 (Better Blood Transfusion: Appropriate Use of Blood)
British Committee for Standards in Haematology – Guideline on the Administration of Blood Components
NICE Guideline NG24 – Blood Transfusion
NBTC National Standards for the Clinical Transfusion Process

22 Appendices

Appendix 1 - NBTC National Standards for the Clinical Transfusion Process

Appendix 2 - Pre-Administration checks

Appendix 3 – Equipment

Appendix 4 – Clinical Observation during Transfusion

Appendix 5 – Action to be taken following confirmed WBIT

Appendix 6 – Prescribers Checklist

Appendix 1

NBTC National Standards for the Clinical Transfusion Process

Overview
These standards define the requirements for knowledge and practical assessments for healthcare workers involved in the transfusion process.

Key learning outcomes common to all tasks

All staff involved in the transfusion process must:

1. Have as a minimum a basic knowledge of the transfusion process and the principle of selection or matching of blood components for transfusion to avoid serious or fatal reactions.
2. Understand the critical steps in the process and that an error, deviation or omission during the process may lead to a serious or fatal reaction.
3. Understand the importance of unique patient identifiers and know the minimum information required and documentation needed at each stage of the transfusion process to safely proceed
4. Be able to explain the actions to take if inadequate information, discrepancies or mistakes are identified at any stage of the process.
5. Know that tasks **must not** be undertaken unless satisfactory assessment has been achieved in that task.

Performance Criteria:

Blood Component Standard 1: Blood transfusion- sampling

Blood Component Standard 2: Blood transfusion- pre collection checks and collection of blood components:

Blood Component Standard 3: Blood transfusion - administration of blood components

Blood Component Standard 1: Blood transfusion- sampling

Action	Rationale
Collect/Complete the sample request form (or electronic equivalent) and take this to the patient's side. Ensure all fields are completed.	To be able to positively identify the correct person to be bled. It is important to communicate as much relevant information to the laboratory e.g. the need for irradiated, CMV negative or HEV blood components.
Ask the patient to state their first name, last name and their date of birth. Cross check this information with the sample request form. Where the patient is unable to identify themselves follow local policy on patient identification.	The use of open questions must be used unless the patient is unable to identify themselves as this reduces the risk of misidentification of the patient. This is known as positive patient identification.
Confirm that the patient has received information about transfusion and consents to blood being taken for anticipated transfusion. Written information and discussion of risks and benefits can be given at this point. The discussion should be recorded in the patient's notes.	SaBTO recommends that consent should be achieved at all stages of the transfusion process. The consent process should include a discussion of the risks, benefits and possible alternatives to the transfusion and the patient should give consent for the transfusion to be given.
Check the patient details on the request form (first name, last name, date of birth and unique patient identification number) with the patient's wristband. The correct spelling of the patient's name should be verified. In emergency situations the patient's core identifiers may be unknown. At least one unique identifier, usually an identification number and gender must be used. Once full identification is obtained another sample, ID band, request form, other related documentation must be created for the patient.	In order to maintain consistency of ID throughout the process, at least 4 identifiers are required to positively identify a patient – this should be first name, last name, date of birth and unique patient identification number. In emergency situations, the unique patient identification number and gender must be used until full identification is obtained.
Take the sample. Complete the sample tube label **after** the sample has been taken. This task must be done at the patient's **side**, from the patient's ID, by the sample taker. Details to be completed should include: 1. Patient's first name, last name 2. Patient's date of birth 3. Patient's unique identification number 4. Date and time of draw 5. Signature/identity of sample taker	Pre labelling samples increases the risk of the tubes being used for another patient resulting in the wrong blood in the tube. Labelling away from the patient increases the risk of mislabelling the sample with the wrong patient's details. Printed labels are not permitted on the sample tube unless it has been generated 'on demand' by a handheld device at the patient's side. Errors may occur if printed labels from within the patient's notes or labels printed remotely from the patient are used as they may be incorrect (labels for the wrong patient).
Complete the request form with the date and time of sampling. The request form must clearly identify the staff member that has taken the sample.	To provide a full audit trail of the process.

Blood Component Standard 2: Blood transfusion- pre collection checks and collection of blood components:

Action	Rationale
Pre-collection checks	
Check that the component has been authorised (or prescribed), that any special requirements have been noted, the reason for transfusion documented, and that the patient consents to the transfusion wherever possible. Written information and discussion of risks and benefits can be given at this point. The discussion should be recorded in the patient's notes.	To ensure that the appropriate specification of blood component is issued/collected from the storage area and that the component can be used. The consent process should include a discussion of the risks, benefits and possible alternatives to the transfusion and the patient should give verbal consent for the transfusion to be given.
Check that the patient is available in the clinical area and there is patent venous access. Check that the component is ready for collection.	To avoid any delays in commencing the transfusion.
Check that the patient has appropriate ID	To avoid delay or errors in positively identifying the patient.
Check and document the patient's baseline observations, to include temperature, pulse, respiratory rate and blood pressure.	To ensure the swift recognition of a transfusion reaction when deviations from baseline are observed.
Collection of component	
Select the appropriate collection documentation containing the patient's first name, last name, date of birth and unique patient identification number. The documentation should also define which component should be collected. Check that the patient details on this documentation match the patient's appropriate ID.	To ensure the correct blood component is collected for the correct patient. Four identifiers are required for positive patient identification, and must be provided in written or electronic format by the clinical area.
Locate, remove and document the removal of the correct blood component for the patient from the storage area according to local policy (electronic or manual methods).	Following agreed procedures will ensure that the correct component is collected for the correct patient, that the components are used in the correct order, and that a full audit trail is maintained.
Check that the patient details (first name, last name, date of birth and unique patient identification number) on the issued label attached to the component pack match the patient details on the collection paperwork. Check that the unique component pack donation number matches that on the laboratory produced label. Check expiry date on the component. Check the blood group and product type.	To ensure the correct blood component is collected for the correct patient. This will prevent serious error and avoid unnecessary waste.
Transport the component to the clinical area as quickly as possible using the appropriate transportation method. Ensure the component is handed to the appropriate member of the clinical team and receipted into the clinical area according to your local policy. The component must not be left unattended at any time.	To ensure the component is stored correctly whilst in transit, that the component is readily identifiable on arrival in the clinical area, that there is no delay and that there is a full audit trail. This is to maintain the cold chain process

Blood Component Standard 3: Blood transfusion- administration of blood components:
NB: ALL THE ACTIONS BELOW MUST BE PERFORMED AT THE PATIENT'S SIDE

Action	Rationale
Check that the reason for the transfusion is documented, has been explained to the patient and the patient has given their consent. Written information and discussion of risks and benefits can be given at this point if not already undertaken. The discussion should be recorded in the patient's notes.	To ensure that the transfusion is appropriate, documented and the patient has given their informed consent. The discussion concerning consent including the risks, benefits and possible alternatives should have already been undertaken by the authoriser (or prescriber) who made the decision to transfuse.
Confirm the patient details on the prescription chart with the patient and the patient's appropriate ID*. Check that the appropriate component has been authorised (or prescribed), including any special requirements, the rate and volume of the infusion and whether any medications are required to be administered. Check that the prescription has been signed. Check that any special requirements documented on the prescription chart match those on the blood component.	To ensure the component has been authorised (or prescribed) for the correct patient To ensure that the correct specification of component has been collected and the infusion instruction is clear.
Check that the patient's baseline observations, to include temperature, pulse, respiratory rate and blood pressure have been recorded and are still valid (performed within one hour of starting the administration process).	To ensure a full set of baseline observations have been documented, to allow identification of a transfusion reaction.
Conduct a visual inspection of the component for any leaks and discolouration and check its expiry date.	To check that the component is in date, that there are no signs of infection (such as discolouration or flocculation) or risk of
	Bacterial ingress, and that the component is suitable to be administered. Administration of a bacterially contaminated component may be fatal
Check the blood group of the patient matches that of the component and its associated label. If the blood group is different the suitability of the component must be checked. Check that the unique component pack donation number matches that on the issued label. Check expiry date on the component. Check the product type.	Incompatible blood components can be fatal. An ABO incompatible blood transfusion is classed as a Department of Health 'Never Event'. Transfusion should not be commenced if the unit has exceeded its expiry date or will do so during the time period of administration. The product type should be checked to ensure that the correct product is being given eg platelets, FFP etc

Appendix 2

Pre-Administration checks

Patient

Ask the patient to state their full name (first and last name) and date of birth. For patients unable to identify themselves, verification should be obtained from a parent or carer.

These details must match exactly those on the patient's identification band.

In circumstances where the patient cannot state their details and no parent/carer is available, the patient's identification band will be the only means of positive patient identification

All details on the patient's identification band must match exactly the details on the prescription chart and the laboratory label attached to the blood bag

Blood Component

Check the expiry date of the component – unless a specific expiry time is shown the component expires at midnight of the date shown

The unique component donation number and the blood group on the blood component pack label must be the same as on the laboratory produced label attached to the blood component

Check the blood component pack to ensure that any clinical special requirements have been met

Inspect the blood component pack for any signs of leakage or damaged packaging

Inspect the blood component pack for unusual colour, turbidity or clumping of the contents

If any defect is suspected contact the Blood Transfusion Laboratory for advice before starting the transfusion.

Appendix 3

Equipment

Infusion pumps

To ensure greater efficacy and control of the blood transfusions in non-emergency situations, it is good practice to administer the blood transfusion via an infusion pump; this process has the added advantage in that the practitioner can lock the infusion pump to reduce the risk of unauthorised tampering of the blood transfusion.

Blood and blood products should only be administered through volumetric pumps that have been certified by the manufacturer and the Medical Device Support Services Department to be safe for such use. The Graseby 500 and Baxter Colleague are thus certified.

Graseby 500 volumetric pump - use the correct Graseby 500 blood administration set (Ref: 21-0346-25).

Baxter Colleague volumetric pump - use the correct Baxter Colleague blood administration set (Ref: VMC9609).

Infusion pumps should not be used unsupervised unless an appropriate level of training has been undertaken and staff members have been deemed competent in their clinical use and application.

Blood warmers

The warming of red cells and FFP is not recommended unless clinically indicated (platelets are administered at room temperature). Indications for using a blood warmer are:

- For transfusion rates above 50ml/Kg/hour in adults
- For transfusion rates above 15ml/Kg/hour in infants
- If the patient has cold agglutinins
- For exchange transfusion of infants (although this is controversial – seek advice from a Haematologist).

Blood warmers must be specifically designed for the purpose, with a visible thermometer and audible temperature range warning.

External compression devices

These should be equipped with a pressure gauge and must exert uniform pressure against all parts of the blood pack. Pressure must not exceed 300mm Hg.

Cannula

There is no minimum or maximum size of cannula for transfusion. The size of the cannula selected depends upon the size of the vein and the required speed of the transfusion.

Changing the giving set

A new giving set should be at least every 12 hours to prevent bacterial growth (or after 2 - 3 units whichever is the sooner). Some sets may be issued with different instructions; if the usage life of a giving set is shorter, always follow the manufacturer's instructions.

On completion of the Transfusion

Washing through the remainder of the blood in the line with saline (which holds approx. 15 - 20mls) **is unnecessary**.

Drugs

Trust guidelines state that 'drugs must not be added to blood under any circumstances'. This can cause damage to the cells or may cause the blood / blood component to clot. Additionally, if the patient has a reaction, it will be difficult to tell if the drug or the blood / blood component is the cause

Blood and blood component administration ('giving') sets

Listed are Blood and Blood Components which are administered via giving sets, alongside the specific requirement of the type of set to be used.
Note: All blood components (excluding granulocytes) in the UK are leucocyte depleted within 48 hours of collection, to minimise the theoretical risk of transmission of vCJD. Therefore the use of additional 'in line' filters is not necessary for blood / blood components supplied by the National Blood Service.

Component	Filter size	Comment
Packed Red Cells Whole Blood Autologous red cells	170 – 200 micron filter is required (blood giving set)	• Electronic infusion pumps should be used providing staff have been trained in their use
Platelets	170 – 200 micron filter is required (blood or platelet giving set)	• Gravity fed • Platelet concentrates should not be transfused through giving sets which have already been used for blood.
Fresh Frozen Plasma (FFP)	170 – 200 micron filter is required (blood giving set)	• Do not refreeze. Use within 4 hours of thaw time if maintained at 22°C± 2°C, or 24 hours if stored at 4°C in Transfusion Dept.(extended storage will result in a decline in labile coagulation factors).
Granulocytes	170 – 200 micron filter is required (blood giving set)	• Gravity fed • The whole dose should be transfused over 1-2 hours. No supplemental filter should be used.
Cryoprecipitate	170 – 200 micron filter is required (blood or platelet giving set)	• Gravity fed • (A platelet set has a much smaller priming volume and is suitable for cryoprecipitate)
Human Albumin Solution (HAS)	Any intravenous (I/V) fluid giving set	• A 15 micron filter is recommended but not mandatory
I/V Immunoglobulin	15 micron filter vented giving set (A Codan set is supplied by the manufacturer of Vigam)	
Stem cells	Any intravenous (I/V) fluid giving set	• There is currently discussion on whether or not filters remove some stem cells. • Current advice is to administer through a normal I/V fluid giving set; there is no benefit in washing out stem cell or granulocyte packs. • Many centres have however successfully used blood-giving sets for this procedure.

Appendix 4

Clinical Observations during Transfusion

Observations should be undertaken and recorded for every unit transfused.

- A baseline recording of the patient's blood pressure, temperature, respiratory rate and pulse should be recorded on the transfusion record chart. These should be taken and recorded no more than 60 minutes before the start of the component transfusion.
- The patient must be easily observable, and must be encouraged to report any new symptoms that develop after the transfusion has started.
- Patients should have a call buzzer to hand if they are able to use it, and be asked to summon assistance immediately if any new symptoms appear.
- Patients unable to report symptoms – e.g. unconscious patients or young children – must be monitored closely, with particular attention paid to the clinical observations, urine output and colour, and signs of agitation / restlessness.
- Record the start time of the unit.
- Temperature, pulse, respirations and blood pressure should be measured and recorded 15 minutes after the start of each unit of blood or blood component. A severe transfusion reaction, although rare, is most likely to occur during this first 15 minutes, and thus the patient should be observed particularly closely. If these measurements have altered significantly from the baseline values, then respiratory rate should also be taken.
- Further observations should be taken at 30 minutes from commencement.
- Subsequent observations during the transfusion of each unit are at the discretion of each clinical area but must be taken if the patient becomes unwell or shows signs of a transfusion reaction. It is necessary to have frequent contact with the patient throughout the transfusion. This is particularly important for patients who may be in side rooms.
- For patients who are unconscious or unable to communicate effectively, clinical observations must continue to be taken, recorded and monitored at frequent intervals as determined by the senior nurse on duty.
- When the administration is commenced record the relevant information on the fluid administration/fluid balance chart. The volume of blood packs can vary considerably; volume in mls is always given on the blood pack label.
- Throughout the transfusion the patient should be observed for any signs or symptoms of incompatibility or adverse reaction.
- Take and record a set of observations at the end of the transfusion episode, these should be recorded no more than 60 minutes after the end of the component transfusion.

Record the stop time of the transfusion.

Appendix 5

Actions to be taken following confirmed WBIT

1. Completion of mandatory Transfusion education package – this can either be by attending a face-to-face session with the Transfusion Practitioner (can be booked through the Horizon Centre) or by completing the e-learning package available Trust's learning management system.

   If e-learning package is undertaken the following modules MUST be completed.

   - Safe Transfusion Practice
   - Safe Sampling

2. Assessment via observational assessment to ensure best practice guidelines are followed both in correct identification of patients prior to transfusion sampling and in the correct labelling of samples.

3. A reflective piece of work, forwarded to HTT (htt.tsdft@nhs.net) with both an analysis of how the error occurred and the potential significance of such an error.

   Until the above conditions are satisfied the laboratory reserves the right to refuse to accept any samples taken by the instigator of the WBIT

Appendix 6

Prescriber's Checklist

Establish that transfusion is necessary

Ensure patient understands the reason for transfusion, the benefit of transfusion and any associated risks.

Issue Patient information Leaflet

Complete the 'Sample Request' form and arrange for blood samples to be taken in a timely manner – ensure all relevant information is given.

Complete the 'Blood Prescription'

- Consider single unit transfusion
- 4ml/kg for 10g/l rise in Hb
- Transfusion duration – maximum 3 ½ hours

Complete the 'Sample Request' form and arrange for blood samples to be taken in a timely manner.

Protocols & Guidelines – Document Control

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative. On receipt of a new version, please destroy all previous versions.

Ref: 0219	Title: Blood Transfusion Policy

Date of Issue:	15 December 2017	Next Review Date:	15 December 2020
Version:	11		
Author:	Transfusion Practitioner		
Index:	Laboratory Medicine		
Classification:	Guideline		
Applicability:	All patients		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief.		
Evidence based:	No		
References:	British Committee for Standards in Haematology (1999 – 2004); The Handbook of Transfusion Medicine (2007); South Devon Healthcare Trust 'Transfusion Medicine Handbook'		
Produced following audit:	No		
Audited:	No		
Approval Route:	See ratification	Date Approved:	18 October 2016
Approved By:	Patient Blood Management Group		
Links or overlaps with other policies:			
All TSDFT Trust strategies, policies and procedure documents.			

PUBLICATION HISTORY

Issue	Date	Status	Authorised
1	1 February 2000	New	Director of Nursing Medical Director
1	1 August 2001	Date Change	Director of Nursing Medical Director
2	1 October 2002	Amended	Director of Nursing Medical Director
2	13 October 2004	Date Change	Director of Nursing Medical Director
3	27 January 2006	Revised	Director of Nursing Medical Director
4	9 November 2006	Revised	Director of Nursing Medical Director
4	3 April 2008	Date Change	Medical Director Director of Nursing and Quality Consultant Haematologist and Head of Department Medicines Governance Group
5	17 April 2008	Revised	Consultant Haematologist Clinical Director of Pharmacy
6	30 April 2009	Revised	Transfusion Practitioner
6	19 November 2009	Document Information	

		Added	
7	10 February 2011	Revised	Consultant Haematologist, Transfusion Practitioner Clinical Director of Pharmacy
8	10 October 2013	Revised	Consultant Haematologist, Transfusion Practitioner Clinical Director of Pharmacy
8	25 September 2015	Date change	Consultant Haematologist, Transfusion Practitioner Clinical Director of Pharmacy
9	24 November 2016	Revised	Patient Blood Management Group
10	3 November 2017	Point 5.1 Linked to new document 2218 Patients including Jehovah Witnesses refusing Blood and Blood Products	Transfusion Practitioner
11	15 December 2017	Minor amendment to Appendix 5	Transfusion Practitioner
11	26 January 2018	Review Date Extended – 2 Years to 3 Years	

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Torbay and South Devon NHS
NHS Foundation Trust

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)		**Version and Date**	
Policy Author			

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

Patients/ Service Users ☐	Staff ☐	Other, please state… ☐

Could the policy treat people from protected groups less favorably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☐	Gender Reassignment	Yes ☐ No☐	Sexual Orientation	Yes ☐ No☐
Race	Yes ☐ No☐	Disability	Yes ☐ No☐	Religion/Belief (non)	Yes ☐ No☐
Gender	Yes ☐ No☐	Pregnancy/Maternity	Yes ☐ No☐	Marriage/ Civil Partnership	Yes ☐ No☐

Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐
Please provide details for each protected group where you have indicated 'Yes'.	

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☐ No☐ NA ☐
Are the services outlined in the policy fully accessible[6]?	Yes ☐ No☐ NA ☐
Does the policy encourage individualised and person-centred care?	Yes ☐ No☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐ NA ☐

EXTERNAL FACTORS

Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☐

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Who was consulted when drafting this policy?

Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups) ☐
Staff ☐	General Public ☐	Other, please state… ☐

What were the recommendations/suggestions?

Does this document require a service redesign or substantial amendments to an existing process? ***PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below***	Yes ☐ No☐

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:
For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
This form should be published with the policy and a signed copy sent to your relevant organisation.

Clinical and Non-Clinical Policies - General Data Protection Regulation (GDPR)

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) in mind and therefore provides the reader with assurance of effective information governance practice.

GDPR intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy.

Furthermore, GDPR requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data. The most effective way of being open is through data mapping. Data mapping for GDPR was initially undertaken in November 2017 and must be completed on a triannual (every 3 years) basis to maintain compliance. This policy supports the data mapping requirement of the GDPR.

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdft@nhs.net,
- See TSDFT's Data Protection & Access Policy,
- Visit our GDPR page on ICON.