Guideline			
Title:	**AGENCY STAFF AND BLOOD TRANSFUSIONS (Addendum to 0219 Blood Transfusion Policy)**		
Ref No:	**2144 Version 1**		
Document Author:	**Transfusion Practitioner** **Associate Director of Nursing and Workforce**	**Date**	**23 February 2017**
Ratified by:	**Patient Blood Management Group**	**Date:**	**15 January 2017**
Review date:	**10 March 2021**		
Links to policies: **1697 – Transfusion Package – Competency Assessments** **0902 – Intra-Operative Cell Salvage** **0219 – Blood Transfusion Policy**			

Contents

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
To ensure all agency staff partaking in the transfusion process meet the National Standards for Transfusion Education, Training and Competence.

2 Introduction

To reduce the risk of 'Wrong Blood Events' and to meet MHRA traceability requirements ALL blood transfusions within TSDFT MUST be carried out on BloodHound (electronic transfusion system)

All staff involved in the transfusion process 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.

All staff participating in the transfusion process must be trained and have demonstrated competency in the parts of the process they are involved in.

The National Standards 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.

Training, testing and assessments that have been undertaken against National Standards (Appendix 1) and referenced are transferable between trusts.

TSDFT has decided that to avoid any confusion all training, knowledge and understanding assessments will be undertaken a minimum of every 2 years.

3 Roles and Responsibilities

All agency staff (Nurses and ODPs) partaking in the transfusion process at Torbay and South Devon NHS Foundation Trust.

4 Procedure

All agency staff

- Will provide evidence of compliance with transfusion education, competency and knowledge as detailed above
- If this cannot be provided the staff member must complete the following

4.1 Transfusion Education

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

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.

4.2 Transfusion 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 the 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)

4.3 Transfusion Knowledge Assessment

Knowledge and understanding assessment should be performed at least every 2 years

4.4 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.

4.5 BloodHound Training

All Agency staff who can demonstrate compliance with the requirements for transfusion education, competence and knowledge assessment as detailed above must then undergo hands-on training on the BloodHound system either with a member of the Transfusion Team or ward based Blood Champion prior to having their BloodHound account activated.

4.6 Activation of BloodHound Accounts

Evidence of compliance with the requirements for transfusion education, competence and knowledge assessment must be forwarded to the Hospital Transfusion Team htt.tsdft@nhs.net or by post to Hospital Transfusion Team c/o Department of Transfusion Medicine.

5 Operating Department Practitioners

In addition to the above all Agency Anaesthetic Practitioners must

- All agency staff are to complete the Learn Cell Salvage modules via http://www.learnbloodtransfusion.org.uk/ as detailed in section 4.1
- Attend face-to-face teaching in the correct use and set up of Intraoperative Cell Salvage
- Be assessed as competent by a designator assessor

Intraoperative cell salvage must not be performed by any agency staff member who does not fulfil these criteria
Please refer to policy 0902 Intra-Operative Cell Salvage

6 Equality and Diversity

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

7 Further Information

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

Amendment History

Issue	Status	Date	Reason for Change	Authorised
1	Ratified	10 March 2017	New	Patient Blood Management Group
1		2 February 2018	Review date extended from 2 years to 3 years	
1		19 February 2018	Review date extended from 2 years to 3 years	

Appendix 1 - NBTC National Standards for the Clinical Transfusion Process

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 e.g. platelets, FFP etc

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.

Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	☒	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☒
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process? no	☐
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity? no	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?				

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Details *(please state):*			

South Devon and Torbay Clinical Commissioning Group

Torbay and South Devon NHS
NHS Foundation Trust

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

Policy Title (and number)	**2144 AGENCY STAFF AND BLOOD TRANSFUSIONS**	**Version and Date**	*1 February 2017*
Policy Author	Transfusion Practitioner		

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 favorably 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-centered 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?)

To ensure all agency staff partaking in the transfusion process meet the National Standards for Transfusion Education, Training and Competence.

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	Transfusion Practitioner	**Signature**	
Validated by (line manager)	Transfusion Practitioner	**Signature**	