Blood Transfusion Policy

<table>
<thead>
<tr>
<th>CATEGORY:</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLASSIFICATION:</td>
<td>Clinical</td>
</tr>
<tr>
<td>PURPOSE</td>
<td>The policy describes the framework and principles required to deliver best transfusion practice.</td>
</tr>
<tr>
<td>Controlled Document Number:</td>
<td>014</td>
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<tr>
<td>Version Number:</td>
<td>6.1</td>
</tr>
<tr>
<td>Controlled Document Sponsor:</td>
<td>Executive Medical Director</td>
</tr>
<tr>
<td>Controlled Document Lead:</td>
<td>Chairperson of the Hospital Transfusion Committee</td>
</tr>
<tr>
<td>Approved By:</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>On:</td>
<td>December 2014</td>
</tr>
<tr>
<td>Review Date:</td>
<td>March 2018 (review date extended)</td>
</tr>
<tr>
<td>Distribution:</td>
<td>All staff involved in the transfusion process.</td>
</tr>
<tr>
<td></td>
<td>Essential Reading for: All staff involved in the transfusion process.</td>
</tr>
<tr>
<td></td>
<td>Information for: All staff</td>
</tr>
</tbody>
</table>
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1. **Policy Statement**

1.1 The purpose of this policy and its associated documents is to ensure that all aspects of the transfusion process from blood sampling to the administration of blood is safely delivered within the Trust. This will be achieved by ensuring that:

1.1.1 A holistic approach to the management of a patient at risk of transfusion is adhered to by minimising the need for donor blood without detriment to the clinical outcome;

1.1.2 risks associated with blood transfusion are minimised by reducing unnecessary use of blood components together with the use of correct procedures throughout the transfusion process;

1.1.3 patients are appropriately identified at all relevant stages of the blood transfusion process;

1.1.4 appropriate consent is obtained; and

1.1.5 all current and relevant legislation, regarding blood transfusion, is adhered to.

2. **Scope**

The policy applies to all members of staff including students, locums and agency staff and staff employed on honorary contracts who are involved in the transfusion process in the Trust, on or off the premises.

3. **Framework**

3.1 This section describes the broad framework for the Blood Transfusion Policy. Detailed instructions are provided in the following associated procedural documents:

3.1.1 Blood Transfusion: Procedure 1 Prescribing and Requesting Blood.


3.1.3 Blood Transfusion: Procedure 3 Collection of Blood and Blood Components from blood bank fridges and incubators.

3.1.4 Blood Transfusion: Procedure 4 Blood administration and transfusion reactions.
3.1.5 Blood Transfusion: Procedure 5 Massive Haemorrhage Protocol and Urgent Transfusion.

3.1.6 Blood Transfusion: Procedure 7 Refusal of Blood and Blood Components including the care of Jehovah’s Witnesses.


3.2 The Chair of the Hospital Transfusion Committee shall approve all procedural documents associated with this policy, and any amendments to such documents, and is responsible for ensuring that such documents are compliant with this policy.

3.3 All patients that are identified as potentially needing a blood transfusion will be assessed by medical staff or nurses working to expanded practice protocol to authorise blood components. If appropriate, alternatives will be considered as set out in Procedure 7.

3.4 Appendix B provides details of the transfusion process and who is responsible at each stage of it (see section 3.5 - 3.12 below).

3.5 Informing Patients (see Procedure 1 for full details)

3.5.1 All patients or their representative (if the patient is unconscious, semi conscious or lacks capacity) must be informed where possible that the patient may require a transfusion of blood or blood components in accordance with Procedure 1.

3.6 Consent and Refusal (see Procedure 7 for full details)

3.6.1 Before any blood or blood component is administered appropriate consent should be obtained from the patient in accordance with Procedure 7 and the Procedure for Consent to the Examination or Treatment.

3.6.2 In an emergency situation if a patient refuses to have a blood transfusion the Legal Services Team must be contacted during office hours or the duty Executive for out of hours.

3.6.3 Where the patient refuses to consent to treatment Procedure 7 must be adhered to.
3.7 Prescribing and Requesting Blood Components (see Procedure 1 for full details)

3.7.1 The prescribing clinician must prescribe blood in accordance with Procedure 1.

3.7.2 When requesting blood or blood components the appropriate forms and all relevant information must be supplied as set out in Procedure 1.

3.8 Sample Labelling and Quality (see Procedure 2 for full details)

3.8.1 Only staff trained in phlebotomy and authorised to take samples for transfusion purposes can do so and must adhere to the process in Procedure 2.

3.8.2 Whenever a sample is being obtained a positive identification of the patient must be obtained by the staff member carrying out the task in accordance with Procedure 2.

3.9 Blood Bank Cross-match procedure /Issue of Blood Components (see Procedure 1)

3.9.1 The Blood Bank will not accept samples if insufficient patient details are supplied, there is a discrepancy between patient details on the form and on the sample and if tubes are labelled with a patient identification label.

3.9.2 The Blood Bank is open 24 hours and will provide blood or blood component for when it has been requested providing that 24 hour notice has been provided by the requestor. For emergency requests see 3.12.

3.9.3 Where there are any special requirements or instructions for the ward regarding the administration of blood or blood component the Blood Bank must provide details of this on the Transfusion Record.

3.10 Collection of Blood and Blood Components (see Procedure 3 for full details)

3.10.1 All blood components must be stored and issued in accordance with figure 1 in Procedure 3.
3.10.2 Blood is available for use for 24-48 hours after it has been required for a patient.

3.10.3 Blood and blood components that have not been transfused must be returned to the Blood Bank in accordance with Procedure 3.

3.10.4 If the wrong blood has been collected it must be returned to the blood bank immediately and an incident must be reported in accordance with the Trusts Incident Reporting Policy. Incidents must also be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) through Serious Adverse Blood Reactions and Events (SABRE).

3.11 Blood Administration (see Procedure 4 for full details)

3.11.1 The Pre-Transfusion process must be followed by relevant staff as set out in Procedure 4.

3.11.2 The transfusion must be commenced within 30 minutes of removal from the fridge and be complete within 4 hours of removal from the fridge.

3.11.3 Used blood bags and transfusion equipment must be safely disposed of in accordance with Procedure 4.

3.11.4 Where the patient experiences minor, severe or serious reactions to the administration of blood or blood components, procedure 4 must be adhered to.

3.11.5 In cases of serious reactions the transfusion must be stopped and must be reported in accordance with the Trust's Incident Reporting Policy. This will then be reviewed by the Hospital Transfusion Team and reported to Serious Hazards of Transfusion (SHOT) or Serious Adverse Blood Reactions or Events (SABRE).

3.12 Massive Transfusion for Trauma or Massive Haemorrhage (see Procedure 5 for full details)

3.12.1 Massive Transfusion is defined in Procedure 5.

3.12.2 In the case of a massive transfusion for trauma or massive haemorrhage the patient must be treated as described in Procedure 5.
3.12.3 Where a patient is being transferred from one hospital to another the receiving Blood Bank must ensure the blood is safe for use before it is administered by the receiving hospital.

3.13 Training (see Trust Training Catalogue for full details)

All those members of staff who are involved in the transfusion process must be appropriately trained as set out in the associated Training Catalogue (Training Needs Analysis).

3.14 Emergency Blood Management (see Procedure 8 for full details)

3.14.1 The Emergency Blood Management Group (EBMG) responds to the national integrated plan for blood shortages. The national plan is structured to provide a framework of actions for the NHS Blood and Transplant (NHSBT) Service and all hospitals in three phases:
   a) Green: ‘normal’ circumstances where supply meets demand
   b) Amber: Reduced availability of blood for a short or prolonged period
   c) Red: Severe prolonged shortage.

3.14.2 The Trust will initiate the plan in accordance with Procedure 8

3.15 Procurement

Clinical Laboratory Services on behalf of the Trust is responsible for the procurement of blood, blood components and named blood products. Such materials will only be procured from organisations that fully comply with the United Kingdom Safety and Quality Regulations 2005 (BSQR 2005).

3.15.1 The provision of blood and associated services between the Trust, its suppliers and users will be subject to a written contract.

3.15.2 Users as Contract Acceptors must also be compliant with BSQR 2005.

4. Duties

A detailed description of duties and responsibilities of individuals involved in each step of the process can be found in each specific linked procedure.
4.1 **Assistant Directors, Divisional Directors, Group Managers, Clinical Service Leads, Associate Directors of Nursing and Matrons**

Assistant Directors, Divisional Directors, Group Managers, Clinical Service Leads, Associate Directors of Nursing and Matrons are responsible for:

4.1.1 Incorporating the Blood Transfusion Policy and the associated procedures into their working practice; and

4.1.2 Ensuring that staff implement the policy and the associated procedures.

4.2 **Hospital Transfusion Committee (HTC)**

The HTC must ensure that there is a framework that enables the Trust to comply with current legislation and guidance. The framework is set out in this policy and the HTC has the authority to modify and improve existing Blood Transfusion procedures and introduce appropriate changes in practice.

4.3 **Hospital Transfusion Team (HTT)**

The HTT is responsible for implementing the Better Blood Transfusion programme in accordance with Health Service circulars 1998/224, 2002/009 and 2007/001, Patient Blood Management 2014, NHS England, Blood Safety and Quality Regulations 2005 and National Patient Safety Agency circulars involving blood transfusion. This is achieved through policy, review of services, education and audit. The HTT has representation from the laboratories and works closely with the Clinical Laboratory Services.

4.4 **Emergency Blood Management Group (EBMG)**

The EBMG is a sub group of the HTC. It is the responsibility of this group to action and monitor the contingency plan for blood shortages in accordance with Procedure 8.

4.5 **All those members of staff who are involved in the transfusion process in the Trust**

The specific duties of all those involved in the transfusion process are detailed in the associated procedural documents but where appropriate within their roles they are responsible for:
4.5.1 Maintaining competence and demonstrating evidence of this at their annual appraisal;

4.5.2 Adhering to Procedures 1-8;

4.5.3 Prescribing appropriately having considered the alternatives to transfusion of a blood component and document the reason for the transfusion and the desired clinical outcome;

4.5.4 Ensuring that the patient receives all relevant information and consents to transfusion and that this is documented;

4.5.5 Ensuring that the patient is correctly identified throughout the transfusion process;

4.5.6 Ensuring that samples are correctly labelled and are not contaminated;

4.5.7 Transporting and delivering blood components, between specified areas under correct storage conditions within a specified timeframe; and

4.5.8 Responsible for the investigation and clinical management of any reaction a patient may have to a transfusion

4.6 Laboratory Staff

Laboratory Staff are responsible for:

4.6.1 Maintaining competence in procedures, demonstrating evidence of this and required training and assessment at their annual appraisal;

4.6.2 Responding to requests for blood and blood components in a accordance with Procedure 1;

4.6.3 Alerting clinical staff to any problems;

4.6.4 Highlighting the records of patients needing special requirements on the Blood Bank electronic database; and

4.6.5 Providing the most appropriate component.
5. Implementation and Monitoring

5.1 Implementation

5.1.1 This policy will be available on the Trust’s Intranet Site. The policy will also be disseminated through the management structure within the Trust.

5.1.2 Implementation of the document is supported through training, linked procedures and the indication for transfusion on the front of each transfusion request form.

5.2 Monitoring

Appendix A provides full details on how the policy will be monitored by the Trust.

6. Associated Policy and Procedural Documentation

Blood Transfusion: Procedure 1 Prescribing and Requesting Blood and Blood Components (Procedure 1)

Blood Transfusion: Procedure 2 Patient Identification, sample labelling and sample quality (Procedure 2)

Blood Transfusion: Procedure 3 Collection of Blood and Blood Components from blood bank fridges and incubators (Procedure 3)

Blood Transfusion: Procedure 4 Blood administration and transfusion reactions (Procedure 4)

Blood Transfusion: Procedure 5 Massive Haemorrhage Protocol and Urgent Transfusion (Procedure 5)

Blood Transfusion: Procedure 7 Refusal of Blood and Blood Components including the care of Jehovah’s Witnesses (Procedure 7)

Blood Transfusion: Procedure 8 Emergency Blood Management Plan (Procedure 8)

Expanded Practice Protocol to Enable Haematology Outreach Nurse Specialists (Kay Kendall Leukaemia Fund) to Authorise Blood Component Transfusion

Procedure for Consent to Examination or Treatment
Training Catalogue (Training Needs Analysis)

7. References

Guidelines, directives and legislation contained in these references are incorporated into the document;


National Blood Transfusion Committee. NHS England


### Appendix A

#### Monitoring Matrix

<table>
<thead>
<tr>
<th>MONITORING OF IMPLEMENTATION</th>
<th>MONITORING LEAD</th>
<th>REPORTED TO PERSON/GROUP</th>
<th>MONITORING PROCESS</th>
<th>MONITORING FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>The decision to transfuse is made following consideration of the potential risks and benefits of, and the alternatives to, transfusion.</td>
<td>HTP supported by Clinical Audit Department</td>
<td>HTC</td>
<td>As part of a national audit of patient’s notes</td>
<td>Every 3 years</td>
</tr>
<tr>
<td>That all patients have been informed appropriately and verbal consent has been obtained</td>
<td>HTP</td>
<td>HTC</td>
<td>Audit of patient notes</td>
<td>Every 3 years</td>
</tr>
<tr>
<td>The prescribing and requesting of blood and blood components is done appropriately</td>
<td>HTP</td>
<td>HTC</td>
<td>Audit of patient notes</td>
<td>Every 3 years</td>
</tr>
<tr>
<td>For urgent transfusion, blood is available within the clinical area within 30mins.</td>
<td>Clinical Staff supported by HTT</td>
<td>HTC</td>
<td>Review of all activations of the Massive Haemorrhage Protocol</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Emergency blood management arrangements are established</td>
<td>Chair of EBMG</td>
<td>EBMG</td>
<td>Review following activation or as directed</td>
<td>Annual</td>
</tr>
<tr>
<td>The correct blood has been administered appropriately</td>
<td>HTP</td>
<td>HTC</td>
<td>All incidents reported via The online incident reporting (datix) will be reviewed and will form part of a report to the HTC</td>
<td>Quarterly</td>
</tr>
<tr>
<td>The correct blood has been administered appropriately</td>
<td>HTP</td>
<td>HTC</td>
<td>An audit of the patient’s records who have received a blood transfusion shall be carried out to ensure that the process in procedure 4 has been followed.</td>
<td>Every 2 years</td>
</tr>
</tbody>
</table>
Patients in need of a Massive Transfusion for Trauma or Massive Haemorrhage have received the correct treatment.

<table>
<thead>
<tr>
<th>Blood Bank Manager</th>
<th>HTC</th>
<th>Each case will be reviewed and any inaccuracies will be reported at the HTC</th>
<th>Quarterly</th>
</tr>
</thead>
</table>

Blood Transfusion Policy

Issue Date: 22.12.2017

Controlled Document Number: 014

Version: 6.1
Appendix B

Flow Chart of the Transfusion Process showing roles and responsibilities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Staff involve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient assessment / decision to transfuse / consideration of appropriate alternatives</td>
<td>Medical Staff/ Specialist Nurses working to algorithm</td>
</tr>
<tr>
<td>Provision of patient information and documentation of verbal consent</td>
<td>Medical Staff</td>
</tr>
<tr>
<td></td>
<td>Registered Nurses/Perfusionists</td>
</tr>
<tr>
<td>Documentation in patient’s case notes of baseline clinical and laboratory data and desired outcome of treatment Completion of request form by medical staff</td>
<td>Medical Staff</td>
</tr>
<tr>
<td>Blood sample taking (phlebotomy)</td>
<td>All staff trained in phlebotomy and authorised to take X-match samples</td>
</tr>
<tr>
<td>Blood Bank X-match procedure / Issue of blood components</td>
<td>Blood Bank Bio-Medical Scientists</td>
</tr>
<tr>
<td>Collection and transportation of blood / blood components from the hospital</td>
<td>All staff authorised to collect blood / blood components</td>
</tr>
<tr>
<td>Administration of blood / blood components</td>
<td>Medical Staff</td>
</tr>
<tr>
<td></td>
<td>Registered Nurses/Perfusionists</td>
</tr>
<tr>
<td></td>
<td>Authorised Operating Department Practitioners</td>
</tr>
<tr>
<td>Patient observation and monitoring</td>
<td>Medical Staff</td>
</tr>
<tr>
<td></td>
<td>Registered Nurses/ Perfusionists Operating Department Practitioners</td>
</tr>
<tr>
<td>Reporting of any adverse incidents</td>
<td></td>
</tr>
</tbody>
</table>