SHOT Serious Hazards of Transfusion

Safe Transfusion Practice: Transfusion Checklist

Transfusion Request **Ensure that:**	**Signature to confirm**
The reason for transfusion is documented in the patient record	
Details on the transfusion authorisation (prescription) sheet are completed and any specific requirements documented	
All fields on the transfusion request form are completed and the form is signed	
The identity details on the transfusion sample are completed correctly and samples labelled at the patient's bedside. These must be handwritten unless electronic systems are available that generate and print a label at the bedside from the patient ID band are available	
The patient has (and where appropriate family/carers have) received information, has agreed to the transfusion, and this is documented **Or** In cases where the patient is unconscious and/or unable to consent and the blood component is given in patient's best interest, ensure this is documented in the patient's notes, and information given retrospectively	
The laboratory is informed of the degree of urgency of the request	
Pre-Transfusion Checks **Ensure that**	
There is adequate and satisfactory venous access: establish or verify patency of peripheral or central venous access device	
A formal pre-transfusion risk assessment for transfusion-associated circulatory overload (TACO) is undertaken whenever possible (especially if older than 50 years or weighing less than 50kg), and appropriate preventative actions taken	
The blood component is ready to be collected	
Collection **Ensure that:**	
Documentation stating the patient identity details is correct and matches the details on the unit	
You have the correct component as per the prescription or authorisation	
The unit has the special requirements that are documented on the prescription or authorisation	
The patient blood group matches or is compatible with the group of the unit	
The unit is in date and is in good condition (i.e. no leaks/clots or discolouration)	
The unit is signed for by a person trained and competency assessed in blood collection	
The time the component was removed from temperature control (e.g. refrigerator) and received in the clinical area are both recorded	
Administration **Ensure that:**	
Pre-transfusion observations are taken and recorded within 60 before commencement	
Documentation for the transfusion record is complete and accurate	
The unit has the special requirements that are documented on the prescription or authorisation	
You have the correct component as per the prescription or authorisation	
The patient blood group matches or is compatible with the group of the unit	
The correct blood transfusion administration set is used, (and a fresh set if transfusing platelets)	
Pre-administration identification checks are performed at the bedside, including a check of the identity band against the unit compatibility label. Confirm identity verification with the patient where possible, using open ended questions	
A blood warmer or infusion device (if used) is set correctly and monitored	
Observations are carried out, as a minimum at 15 minutes	
Any adverse events/complications are reported to the responsible clinician and the transfusion laboratory, and are immediately acted upon and documented in the patient record and reported	
The finish time of the transfusion is documented	
The transfusion is completed within 4 hours of removal from temperature-controlled storage *(Note that once thawed, FFP should be transfused as soon as possible. If delay is unavoidable, FFP should be used within 4 hours if stored at 20–24 °C or within 24 hours if stored at 2–6 °C. Cryoprecipitate, once thawed has to be kept at room temp and used within 4 hours)*	

Temperature		Blood pressure	
Pulse		Respiration rate	

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Post Transfusion Ensure that:	Signature to confirm
Post-transfusion observations are taken and recorded	
The traceability documentation record is completed and correctly returned or scanned electronically as, as per local policy	
The component pack and other equipment is disposed of correctly	
The outcome of the transfusion is documented in the patient record	
A post-transfusion information sheet given to the patient (if a day-case or received the transfusion in an emergency)	

Temperature		Blood pressure	
Pulse		Respiration rate	

The A-E Decision Tree to facilitate decision making in transfusion

A
- **A**ssess patient
- **A**ny avoidable blood loss (frequent, unnecessary tests/interventions)

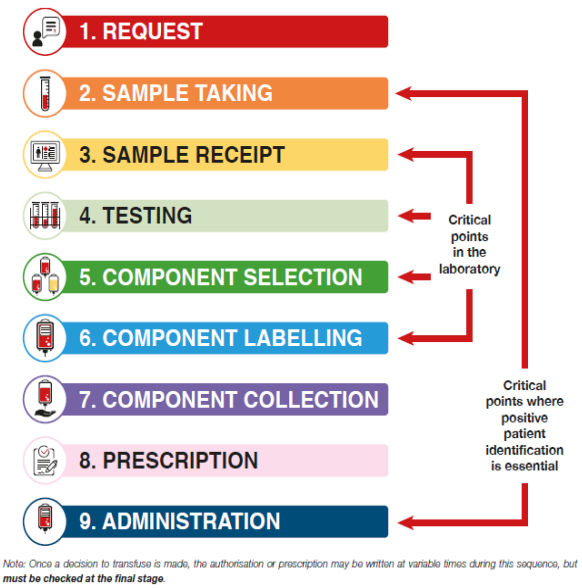
B
- **B**lood results (all) reviewed including trends - ensure results valid and reliable
- **B**est treatment option- is transfusion the best treatment option? If yes, what components needed, how many, what order and any specific requriements needed?

C
- **C**onsent/**C**ommunication (adequate patient information- both verbal and written) to patients and where appropriate families and carers
- **C**orrectable factors to be addressed like bleeding, haematinic deficiency

D
- **D**o not forget other measures (vitamin K, tranexamic acid, cell salvage, etc)
- **D**o not hesitate to question colleagues regarding decisions made and ask for rationale
- **D**o not forget to document in patient's notes and in discharge summaries

E
- **E**nsure timely communications to laboratory- need to be clear, concise and accurate
- **E**nsure all relevant transfusion checklists including TACO risk assessment and actions rising thereafter have been completed
- **E**vidence based decisions made weighing risks, benefits and options available
- **E**nsure patient receives adequate post-transfusion information if transfusion given as a day case

Transfusion process (nine steps)



Note: Once a decision to transfuse is made, the authorisation or prescription may be written at variable times during this sequence, but must be checked at the final stage.

This checklist has been updated in June 2020 and provides a structured process to ensure that the right component is transfused to the right patient at the right time for the right reason and will help ensure patients have received the right information about their transfusion in a timely manner where possible. There is a lack of unequivocal evidence to support either a one- or two-person checking procedure. There is no evidence from SHOT reports (Bolton-Maggs, 2015) to suggest that two-person checking is safer than one. If local policy requires a two-person checking procedure, each person should complete all the checks independently (double independent checking).The checklist will help improve transfusion safety and is a requirement following the CMO CAS alert sent out in November 2017: CEM/CMO/2017/005 and can be found at this link: https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=102663. We encourage users to utilise this document to help draft checklists locally.

The NHSBT Patient Blood Management team and SHOT have co-produced a 'Pre-transfusion blood sampling' animated video and another outlining critical steps for completing 'Pre-administration bedside checks of blood components'. These can be found here: https://www.shotuk.org/resources/current-