Appendix 3: Examples of methods to document consent to transfusion from hospitals in the UK*

Documentation of consent for transfusion

1. All Wales Transfusion Record. Paper prescription and observation record for transfusion, and a pre-administration checklist including consent for transfusion and assessment for the risk of transfusion-associated circulatory overload (TACO).
2. Scottish National Blood Transfusion Service. Paper prescription and observation record for transfusion, and a pre-administration checklist including consent for transfusion and assessment for the risk of transfusion-associated circulatory overload (TACO). A flowchart for the management of transfusion reactions is also included.
3. Northern Ireland. Electronic record and checklist for consent for transfusion.
4. Oxford University Hospitals, England. Electronic process for consent for transfusion.
5. Frimley Park Hospitals, England. Electronic process for prescription for transfusion including consent for transfusion.
6. Hampshire Hospitals, England. Paper record and checklist for consent for transfusion including a section for patients unable to provide consent.
7. Hampshire Hospitals, England. Paper prescription and observation record for transfusion, and a pre-administration checklist including consent for transfusion.

Documentation of parental consent for transfusion in children

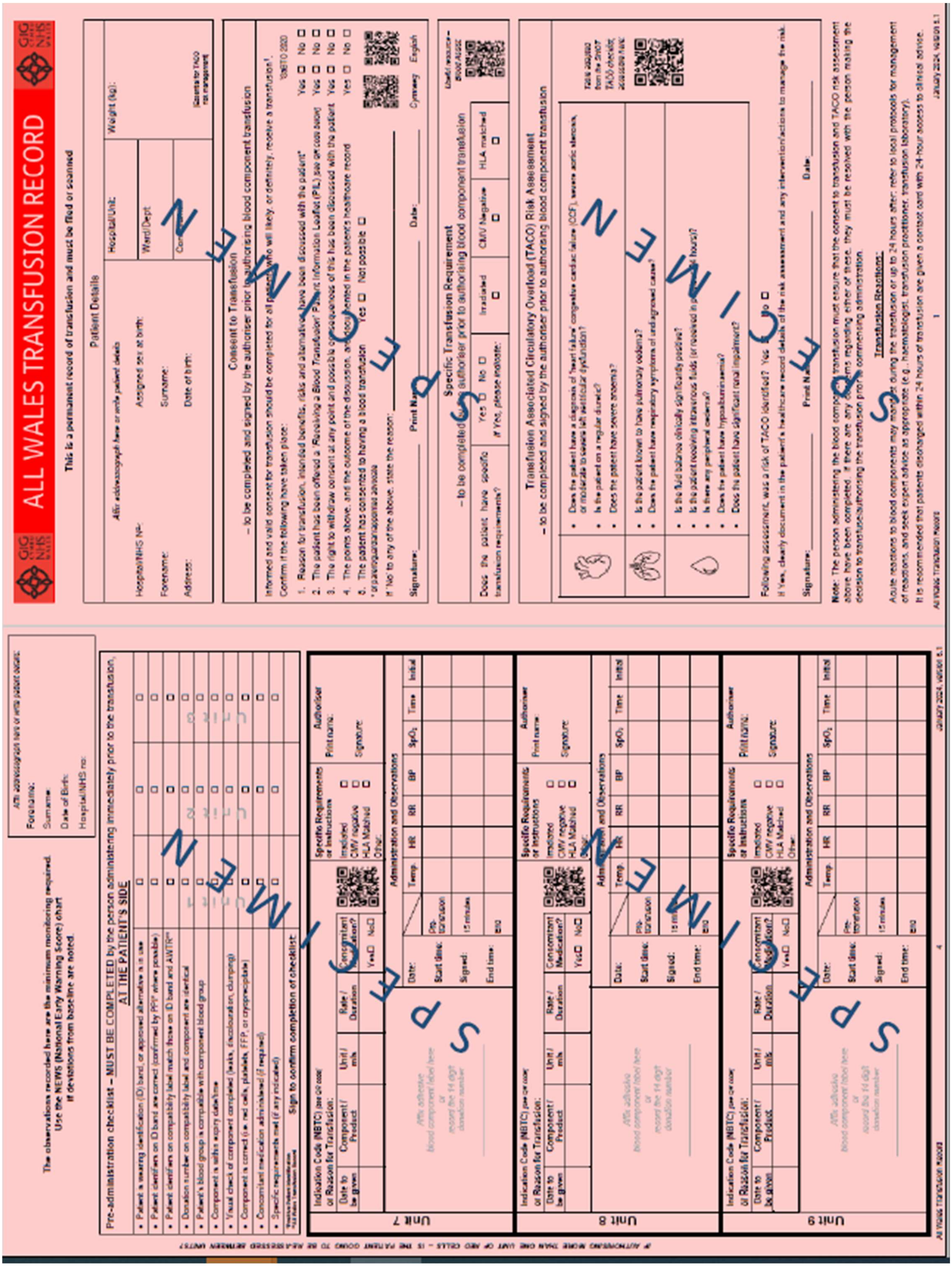
8. Alder Hey Hospital, England. Electronic record and checklist for consent for transfusion.

Documentation of refusal of consent for transfusion

9. Great Ormond Street Hospital, England. Paper record for refusal of consent to transfusion for Jehovah's Witness patients under the age of 18.
10. Northern Ireland. Electronic record for documentation of Advance Directive and explicit consent or refusal to different blood products.

*Please note that updated versions for these examples might be available now or in the future.

Document 1: All Wales Transfusion Record. Paper prescription and observation record for transfusion, and a pre-administration checklist including consent for transfusion and assessment for the risk of transfusion-associated circulatory overload (TACO)



ALL WALES TRANSFUSION RECORD

GIG CYMRU NHS WALES

This is a permanent record of transfusion and must be filed or scanned

Patient Details

Affix addressograph here or write patient details

Hospital/NHS Nº:	Assigned sex at birth:	Hospital/Unit:	Weight (kg):
Forename:	Surname:	Ward/Dept:	
Address:	Date of birth:	Consultant:	(Essential for TACO risk management)

Consent to Transfusion

– to be completed and signed by the authoriser prior to authorising blood component transfusion

Informed and valid consent for transfusion should be completed for all patients who will likely, or definitely, receive a transfusion¹.

Confirm if the following have taken place: ¹SaBTO 2020

1. Reason for transfusion, intended benefits, risks and alternatives have been discussed with the patient* Yes ☐ No ☐
2. The patient has been offered a '*Receiving a Blood Transfusion*' Patient Information Leaflet (PIL) (see QR code below) Yes ☐ No ☐
3. The right to withdraw consent at any point and possible consequences of this has been discussed with the patient Yes ☐ No ☐
4. The points above, and the outcome of the discussion, are documented in the patient's healthcare record Yes ☐ No ☐
5. The patient has consented to having a blood transfusion Yes ☐ Not possible ☐

* or parent/guardian/appointed advocate

If 'No' to any of the above, state the reason: ____________

Cymraeg English

Signature: ____________ Print Name: ____________ Date: ____________

Specific Transfusion Requirement

– to be completed by the authoriser prior to authorising blood component transfusion

Useful resource – Blood Assist

Does the patient have specific transfusion requirements?	Yes ☐ No ☐ If Yes, please indicate:	Irradiated ☐	CMV Negative ☐	HLA matched ☐

Transfusion Associated Circulatory Overload (TACO) Risk Assessment

– to be completed and signed by the authoriser prior to authorising blood component transfusion

- Does the patient have a diagnosis of 'heart failure' congestive cardiac failure (CCF), severe aortic stenosis, or moderate to severe left ventricular dysfunction?
- Is the patient on a regular diuretic?
- Does the patient have severe anaemia?

- Is the patient known to have pulmonary oedema?
- Does the patient have respiratory symptoms of undiagnosed cause?

- Is the fluid balance clinically significantly positive?
- Is the patient receiving intravenous fluids (or received in previous 24 hours)?
- Is there any peripheral oedema?
- Does the patient have hypoalbuminaemia?
- Does the patient have significant renal impairment?

Table adapted from the SHOT TACO checklist, accessible here:

Following assessment, was a risk of TACO identified? Yes ☐ No ☐

If Yes, clearly document in the patient's healthcare record details of the risk assessment and any intervention/actions to manage the risk.

Signature: ____________ Print Name: ____________ Date: ____________

Note: The person administering the blood components transfusion must ensure that the consent to transfusion and TACO risk assessment above have been completed. If there are any concerns regarding either of these, they must be resolved with the person making the decision to transfuse/authorising the transfusion prior to commencing administration.

Transfusion Reactions:

Acute reactions to blood components may manifest during the transfusion or up to 24 hours after: refer to local protocols for management of reactions, and seek expert advice as appropriate (e.g., haematologist, transfusion practitioner, transfusion laboratory).

It is recommended that patients discharged within 24 hours of transfusion are given a contact card with 24-hour access to clinical advice.

All Wales Transfusion Record 1 January 2024, version 5.1

The observations recorded here are the minimum monitoring required. Use the NEWS (National Early Warning Score) chart if deviations from baseline are noted.

Affix addressograph here or write patient details:
Forename:
Surname:
Date of Birth:
Hospital/NHS no:

IF AUTHORISING MORE THAN ONE UNIT OF RED CELLS – IS THE PATIENT GOING TO BE RE-ASSESSED BETWEEN UNITS?

Pre-administration checklist – **MUST BE COMPLETED** by the person administering immediately prior to the transfusion, **AT THE PATIENT'S SIDE**	Unit 1	Unit 2	Unit 3
Patient is wearing identification (ID) band, or approved alternative is in use	☐	☐	☐
Patient identifiers on ID band are correct (confirmed by PPI* where possible)	☐	☐	☐
Patient identifiers on compatibility label match those on ID band and AWTR**	☐	☐	☐
Donation number on compatibility label and component are identical	☐	☐	☐
Patient's blood group is compatible with component blood group	☐	☐	☐
Component is within expiry date/time	☐	☐	☐
Visual check of component completed (leaks, discolouration, clumping)	☐	☐	☐
Component is correct (i.e. red cells, platelets, FFP, or cryoprecipitate)	☐	☐	☐
Concomitant medication administered (if required)	☐	☐	☐
Specific requirements met (if any indicated)	☐	☐	☐
Sign to confirm completion of checklist:			

*Positive Patient Identification
**All Wales Transfusion Record

Unit 7

Indication Code (NBTC) (see QR code) or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?	Specific Requirements or Instructions	Authoriser
				Yes☐ No☐	Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:	Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

		Temp.	HR	RR	BP	SpO₂	Time	Initial
Date:								
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

Unit 8

Indication Code (NBTC) (see QR code) or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?	Specific Requirements or Instructions	Authoriser
				Yes☐ No☐	Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:	Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

		Temp.	HR	RR	BP	SpO₂	Time	Initial
Date:								
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

Unit 9

Indication Code (NBTC) (see QR code) or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?	Specific Requirements or Instructions	Authoriser
				Yes☐ No☐	Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:	Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

		Temp.	HR	RR	BP	SpO₂	Time	Initial
Date:								
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

All Wales Transfusion Record 4 January 2024, version 5.1

SPECIMEN

The observations recorded here are the minimum monitoring required. Use the NEWS (National Early Warning Score) chart if deviations from baseline are noted.

Affix addressograph here or write patient details:
Forename:
Surname:
Date of Birth:
Hospital/NHS no:

Pre-administration checklist – MUST BE COMPLETED by the person administering immediately prior to the transfusion, AT THE PATIENT'S SIDE

• Patient is wearing identification (ID) band, or approved alternative is in use	☐	☐	☐
• Patient identifiers on ID band are correct (confirmed by PPI* where possible)	☐	☐	☐
• Patient identifiers on compatibility label match those on ID band and AWTR**	☐	☐	☐
• Donation number on compatibility label and component are identical	☐	☐	☐
• Patient's blood group is compatible with component blood group	☐	☐	☐
• Component is within expiry date/time	☐	☐	☐
• Visual check of component completed (leaks, discolouration, clumping)	☐	☐	☐
• Component is correct (i.e. red cells, platelets, FFP, or cryoprecipitate)	☐	☐	☐
• Concomitant medication administered (if required)	☐	☐	☐
• Specific requirements met (if any indicated)	☐	☐	☐
*Positive Patient Identification **All Wales Transfusion Record	**Sign to confirm completion of checklist:**		

IF AUTHORISING MORE THAN ONE UNIT OF RED CELLS – IS THE PATIENT GOING TO BE RE-ASSESSED BETWEEN UNITS?

Unit 1

Indication Code (NBTC) (see QR code) or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?	Specific Requirements or Instructions	Authoriser
				Yes☐ No☐	Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:	Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number:

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

Unit 2

Indication Code (NBTC) (see QR code) or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?	Specific Requirements or Instructions	Authoriser
				Yes☐ No☐	Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:	Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

Unit 3

Indication Code (NBTC) (see QR code) or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?	Specific Requirements or Instructions	Authoriser
				Yes☐ No☐	Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:	Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

SPECIMEN

The observations recorded here are the minimum monitoring required. Use the NEWS (National Early Warning Score) chart if deviations from baseline are noted.

Affix addressograph here or write patient details:
Forename:
Surname:
Date of Birth:
Hospital/NHS no:

Pre-administration checklist – MUST BE COMPLETED by the person administering immediately prior to the transfusion, AT THE PATIENT'S SIDE

• Patient is wearing identification (ID) band, or approved alternative is in use	☐	☐	☐
• Patient identifiers on ID band are correct (confirmed by PPI* where possible)	☐	☐	☐
• Patient identifiers on compatibility label match those on ID band and AWTR**	☐	☐	☐
• Donation number on compatibility label and component are identical	☐	☐	☐
• Patient's blood group is compatible with component blood group	☐	☐	☐
• Component is within expiry date/time	☐	☐	☐
• Visual check of component completed (leaks, discolouration, clumping)	☐	☐	☐
• Component is correct (i.e. red cells, platelets, FFP, or cryoprecipitate)	☐	☐	☐
• Concomitant medication administered (if required)	☐	☐	☐
• Specific requirements met (if any indicated)	☐	☐	☐
*Positive Patient Identification **All Wales Transfusion Record	**Sign to confirm completion of checklist:**		

IF AUTHORISING MORE THAN ONE UNIT OF RED CELLS – IS THE PATIENT GOING TO BE RE-ASSESSED BETWEEN UNITS?

Unit 4

Indication Code (NBTC) (see QR code) or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?	Specific Requirements or Instructions	Authoriser
				Yes☐ No☐	Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:	Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

Unit 5

Indication Code (NBTC) (see QR code) or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?	Specific Requirements or Instructions	Authoriser
				Yes☐ No☐	Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:	Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

Unit 6

Indication Code (NBTC) (see QR code) or Reason for Transfusion:

Date to be given	Component / Product	Unit / mls	Rate / Duration	Concomitant Medication?	Specific Requirements or Instructions	Authoriser
				Yes☐ No☐	Irradiated ☐ CMV negative ☐ HLA Matched ☐ Other:	Print name: Signature:

Affix adhesive blood component label here or record the 14 digit donation number

Administration and Observations

Date:		Temp.	HR	RR	BP	SpO_2	Time	Initial
Start time:	Pre-transfusion							
Signed:	15 minutes							
End time:	End							

SPECIMEN

Document 2: Scottish National Blood Transfusion Service. Paper prescription and observation record for transfusion, and a pre-administration checklist including consent for transfusion and assessment for the risk of transfusion-associated circulatory overload (TACO). A flowchart for the management of transfusion reactions is also included.

Transfusion Record

This is a permanent record of transfusion and must be filed or scanned into the nursing notes section of the patient's health records

NHS National Services Scotland

Patient Details

Hospital/Unit:	**Affix label here or write patient details**	
Ward/Dept:	Forename:	Surname:
Consultant:	Gender:	Date of birth:
Patient's weight (kg):	CHI number:	

Section to be completed prior to prescribing/authorising blood components

If this patient is on a regular transfusion programme or has previously consented e.g. pre-operatively, is there evidence of consent for transfusion and previous discussion recorded in the patient's health record?

Yes ☐ Proceed to prescriber/authoriser signature No ☐ Complete checklist below

- Risks and benefits, alternatives and option to refuse discussed? Yes ☐ No ☐
- Patient offered a 'Receiving a Transfusion' patient information leaflet? Yes ☐ No ☐
- Reason for transfusion discussed with patient and documented in health records? Yes ☐ No ☐
- Has the patient experienced a previous transfusion reaction? Yes ☐ No ☐
- Does the patient consent to have a blood transfusion? Yes ☐ No ☐
- Is an advance directive (refusal of blood transfusion) document in place? Yes ☐ No ☐

If it is not possible to discuss with the patient, please give reason/details below:

It is the responsibility of the authoriser of blood components to ensure that any specific transfusion requirements are met (e.g. irradiated, CMV negative components, or use of a blood warmer).

Consider the risk of Transfusion Associated Circulatory Overload (TACO)

1. Consider if the patient has any of the following risks for TACO and tick as many as apply:

☐ Congestive cardiac failure, severe aortic stenosis, moderate to severe LV dysfunction?	☐ Positive fluid balance?
☐ Taking a regular diuretic?	☐ Receiving supplementary fluids either currently or in the last 24 hours?
☐ Pulmonary oedema?	☐ Peripheral oedema?
☐ Respiratory symptoms of unknown cause?	☐ Hypoalbuminaemia?
☐ Severe anaemia?	☐ Renal impairment?
☐ Other risk, please specify:	

If no, sign below and proceed.

If yes:

2. Does the benefit of the transfusion outweigh the risks? Yes ☐ No ☐

3. Can the transfusion be safely deferred? Yes ☐ No ☐

If proceeding with transfusion consider the patient's body weight before authorising the blood component, especially for low body weight adult patients, and consider prophylactic diuretic if medically indicated.

When authorising red cells authorisers should consider transfusion of a single unit for non bleeding patients and clinically reassess after each unit

I confirm that the patient has consented to transfusion and I have undertaken a TACO risk assessment

Signature:_____ **Print Name:**_____ **Designation:**_____ **Date:**_____

NHS National Services Scotland

Blood component authorisation to be completed by medical staff or *designated* non-medical authoriser of blood components

Please note that red cell transfusion is usually not appropriate for the treatment of chronic iron deficiency anaemia, B12 or folate deficiency. Medications relating to blood transfusion such as diuretics or antipyretics must be in the patient's drug prescription chart.
For blood component dosing guidance consult local transfusion policy.

Affix label or write patient details:

Forename:

Surname:

Date of Birth:

CHI:

The checklist for *each unit* must be completed and signed by member of staff administering the blood component

UNIT 3	Bedside verbal ID check ☐	Patent cannula ☐	Baseline obs (no more than 60 mins prior to start) ☐	Ensure patient's ID details (on ID band) match the tag exactly ☐	Component matches prescription ☐	Inspect bag (expiry, condition) ☐	Once checks complete, print name _____	Completed blue tag sent to lab ☐	Date & time transfusion completed _____
	Blood component	Unit or mls	Specific requirements/ Instructions (please tick)		*Complete & attach pink portion of compatibility label or complete:*				
			Irradiated ☐ CMV negative ☐ Blood warmer ☐ Other medication ☐						
	Reason for transfusion:	Acute blood loss ☐	Low platelet count ☐	Other:					
		Anaemia ☐	Abnormal coagulation ☐						
	Date	Duration	Authoriser's signature						
UNIT 4	Bedside verbal ID check ☐	Patent cannula ☐	Baseline obs (no more than 60 mins prior to start) ☐	Ensure patient's ID details (on ID band) match the tag exactly ☐	Component matches prescription ☐	Inspect bag (expiry, condition) ☐	Once checks complete, print name _____	Completed blue tag sent to lab ☐	Date & time transfusion completed _____
	Blood component	Unit or mls	Specific requirements/ Instructions (please tick)		*Complete & attach pink portion of compatibility label or complete:*				
			Irradiated ☐ CMV negative ☐ Blood warmer ☐ Other medication ☐						
	Reason for transfusion:	Acute blood loss ☐	Low platelet count ☐	Other:					
		Anaemia ☐	Abnormal coagulation ☐						
	Date	Duration	Authoriser's signature						

When authorising red cells authorisers should consider transfusion of a single unit for non bleeding patients and clinically reassess after each unit.

Management of transfusion reactions:

Adverse reactions to blood components may manifest during the transfusion or up to 24 hours after the transfusion is completed.
It is recommended that patients, such as day cases, discharged within 24 hours of transfusion be issued with a contact card giving 24-hour access to clinical advice.

1. Refer to flow chart & contact medical staff (See page 4)
2. **Medical staff** contact Haematologist and Hospital Transfusion Laboratory for support (if appropriate)
3. **Medical/Nursing/Midwifery staff** complete local **adverse incident report and transfusion reaction form** to enable internal and external reporting of incident.(if applicable)

Resources

British Society for Haematology (BSH) Guidelines
http://www.b-s-h.org.uk/guidelines
Norfolk (ed) (2013) Handbook of Transfusion Medicine (5th ed)
http://www.transfusionguidelines.org.uk

Serious Hazards of Transfusion (SHOT) Annual Report
http://www.shotuk.org

Learnbloodtransfusion (LBT) Education Programme
http://www.learnbloodtransfusion.org.uk

Blood component authorisation to be completed by medical staff or *designated* non-medical authoriser of blood components
Please note that red cell transfusion is usually not appropriate for the treatment of chronic iron deficiency anaemia, B12 or folate deficiency. Medications relating to blood transfusion such as diuretics or antipyretics must be in the patient's drug prescription chart.
For blood component dosing guidance consult local transfusion policy.

Affix label or write patient details:

Forename:

Surname:

Date of Birth:

CHI:

The checklist for *each unit* must be completed and signed by member of staff administering the blood component

UNIT 1

Bedside verbal ID check	Patent cannula	Baseline obs (no more than 60 mins prior to start)	Ensure patient's ID details (on ID band) match the tag exactly	Component matches prescription	Inspect bag (expiry, condition)	Once checks complete, print name	Completed blue tag sent to lab	Date & time transfusion completed
☐	☐	☐	☐	☐	☐	_____	☐	_____

Blood component	Unit or mls	Specific requirements/ Instructions (please tick)	*Complete & attach pink portion of compatibility label or complete:*
		Irradiated ☐ CMV negative ☐ Blood warmer ☐ Other medication ☐	

Reason for transfusion: Acute blood loss ☐ Low platelet count ☐ Other:
Anaemia ☐ Abnormal coagulation ☐

Date	Duration	Authoriser's signature

UNIT 2

Bedside verbal ID check	Patent cannula	Baseline obs (no more than 60 mins prior to start)	Ensure patient's ID details (on ID band) match the tag exactly	Component matches prescription	Inspect bag (expiry, condition)	Once checks complete, print name	Completed blue tag sent to lab	Date & time transfusion completed
☐	☐	☐	☐	☐	☐	_____	☐	_____

Blood component	Unit or mls	Specific requirements/ Instructions (please tick)	*Complete & attach pink portion of compatibility label or complete:*
		Irradiated ☐ CMV negative ☐ Blood warmer ☐ Other medication ☐	

Reason for transfusion: Acute blood loss ☐ Low platelet count ☐ Other:
Anaemia ☐ Abnormal coagulation ☐

Date	Duration	Authoriser's signature

When authorising red cells authorisers should consider transfusion of a single unit for non bleeding patients and clinically reassess after each unit

General Guidance on Transfusion Observations

Record on a **National Early Warning System (NEWS)** chart (or local equivalent) and highlight as 'transfusion observations'
The **minimum*** transfusion observations for each unit are temperature, blood pressure, respiratory rate & pulse at:

- **Baseline** no more than **60 minutes prior** to the start of the unit
- **15 minutes after** the start
- **Hourly thereafter** until the unit is completed *
- At **the end** of each unit, within 60 minutes of completion of transfusion

NB All blood component transfusions must be completed within 4 hours of removal from controlled storage.

***In patients of all ages who are incapacitated it is more difficult to detect signs of early transfusion reactions therefore more frequent observations may be required. This includes those who are ventilated, confused, sedated or unconscious**

Clinical flowchart for the Management of Acute Transfusion Reactions: (based on B-S-H Blood Transfusion Taskforce Guideline on the investigation and management of Acute Transfusion Reactions (May 2012)

PATIENT EXHIBITING POSSIBLE FEATURES OF AN ACUTE TRANSFUSION REACTION, WHICH MAY INCLUDE: Fever, chills, rigors, tachycardia, hyper- or hypotension, collapse, flushing, urticarial, pain (bone, muscle, chest, abdominal), respiratory distress, nausea, general malaise

STOP THE TRANSFUSION: undertake rapid clinical assessment, check patient ID/blood compatibility label, visually assess unit

Evidence of:

Life-threatening **A**irway and/or **B**reathing and/or **C**irculatory problems and/or wrong blood given and/or evidence of contaminated unit

Yes

Call for urgent medical help

SEVERE/LIFE-THREATENING

- Initiate resuscitation-ABC
- Is haemorrhage likely to be causing hypotension? If not –
- Maintain venous access
- Monitor patient: e.g. TPR, BP discontinue transfusion (do not discard implicated unit/s), urinary output, oxygen saturations

- If likely anaphylaxis/severe allergyfollow anaphylaxis pathway
- If bacterial contamination likely start antibiotic treatment
- Use BP, Pulse, urine output (catheterise if necessary) to guide intravenous physiological crystalloids administration
- Inform hospital transfusion laboratory
- Return unit (with administration set attached minus all sharps) to transfusion laboratory
- If bacterial contamination suspected return to transfusion laboratory who will contact blood service to discuss recall of associated components
- Perform appropriate investigations

- Review at Hospital Transfusion Committee (HTC)
- Report to SHOT/MHRA as appropriate Lab staff/TP)

No

Inform medical staff

MODERATE

- Temperature ≥ 39°C or rise ≥2°C and/or
- Other symptoms/signs apart from pruritus/rash only

- Consider bacterial contamination if the temperature rises as above and review patient's underlying condition and transfusion history
- Monitor patient more frequently e.g. TPR, BP, oxygen saturations, urinary output

- Not consistent with condition or history
- Discontinue (do not discard implicated unit/s)
- Perform appropriate investigations

- If consistent with underlying condition or transfusion history consider continuation of transfusion at a slower rate and appropriate

MILD

- Isolated temperature ≥38°C and rise of 1-2°C and/or
- Pruritus/rash only

- Recommence transfusion
- Consider symptomatic treatment
- Monitor patient more frequently as for moderate reactions
- If symptoms/signs worsen, manage as moderate/severe reaction

Continue Transfusion

Transfusion – related event

Transfusion – unrelated

Document in notes that no HTT/HTC review/SHOT report necessary

Document 3: Northern Ireland. Electronic record and checklist for consent for transfusion

Northern Ireland Transfusion Record for Blood Components

(Red Blood Cells, Platelets, Fresh Frozen Plasma (FFP), Cryoprecipitate, Octaplas)

Applicable to all patients

Patient Identification Details	
Name: HCN or Hosp no. Sex: Date Of Birth: MRN:	Hospital: Clinical area: Consultant: Date: Body weight (kg):

Patient Information concerning Consent for Transfusion of Blood Component(s)

(Taken from Consent for Blood Transfusion - Guidance for Healthcare Practitioners in the UK (transfusionguidelines.org))

Reason for Blood Transfusion

Reason for Blood Transfusion discussed with patient:

○ Yes ○ No

BENEFITS

○ Yes ○ No

Red cells: Relieve symptoms of anaemia; Prevent complications of anaemia (tissue ischaemia, organ damage); Earlier mobilisation/quicker recovery after illness or surgery

Platelets/plasma: Stop or prevent bleeding

RISKS and actual or potential consequences

○ Yes ○ No

- Wrong blood/wrong patient
- Febrile non-haemolytic reaction
- Allergic reaction
- Pulmonary complications:
  - Transfusion-Associated Circulatory Overload (TACO)
  - Transfusion-Related Acute Lung Injury (TRALI)
- Haemolytic Transfusion Reaction - acute or delayed
- Transfusion Transmitted Infection - bacterial, viral, other
- Antibody formation
- Iron overload
- Other complications

ALTERNATIVES as relevant/appropriate to the clinical situation

○ Yes ○ No

Red cells: Iron therapy (oral/IV); Other haematinic replacement (B_{12}, folate); Erythropoietin; Cell salvage (surgery)

Plasma: Factor concentrates if applicable

Platelets: Tranexamic acid

INFORMED PATIENT/PARENT/GUARDIAN

○ Patient ○ Parent ○ Guardian

Written information given

○ Yes ○ No

Give the patient written information, with sufficient time to read and consider and an opportunity to ask questions (if written information is not available then provide verbal information). There may be particular considerations to take into account for specific patient groups, such as paediatrics, multi-transfused, etc.

CONSENT (or REFUSAL)

○ **Consent Obtained** ○ **Refused** ○ **Retrospective Information given**

Document your discussion and the outcome in the patient's care records. If the patient is refusing the proposed treatment (transfusion), try to explore why this is; contact a transfusion expert if required. Make sure the patient understands the possible consequences of not having a transfusion, and ensure any Advanced Directive is applicable and valid.

Informed Patient can no longer donate blood

○ **Yes** ○ **No**

- The patient can no longer donate blood

STAFF NAME	SIGNATURE	GMC / NMC NUMBER	DATE
	Provider GMCNMC Fill in required fields first		

Retrospective information following transfusion

Patient's condition which prevented consent before transfusion:

RetroReason

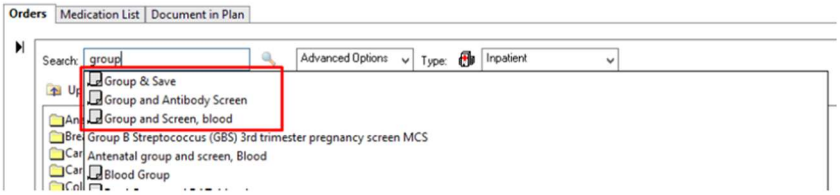
I have informed the Patient / Guardian of the risks and benefits following transfusion and that the Patient is no longer eligible to donate blood.

Document 4: Oxford University Hospitals, England. Electronic process for consent for transfusion

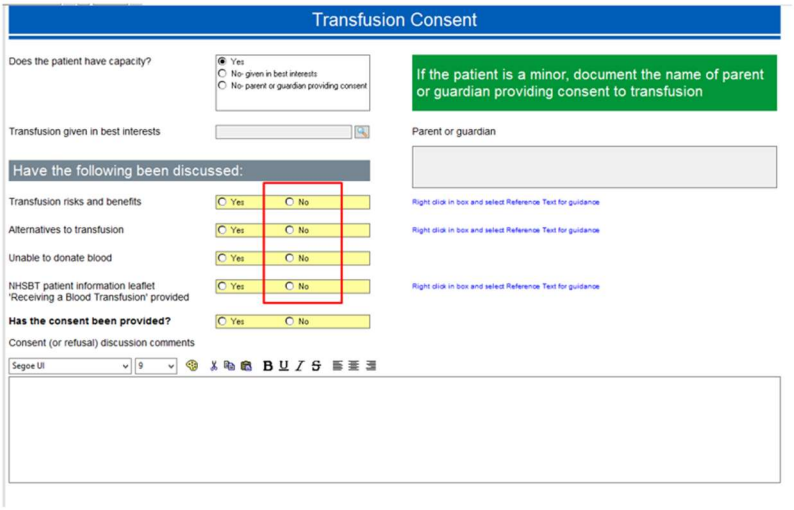
OUHFT electronic transfusion consent

STEP 1: Request blood group and antibody screen (G&S) on the EPR system

(samples will not be processed unless labels printed out from blood track Tx system)

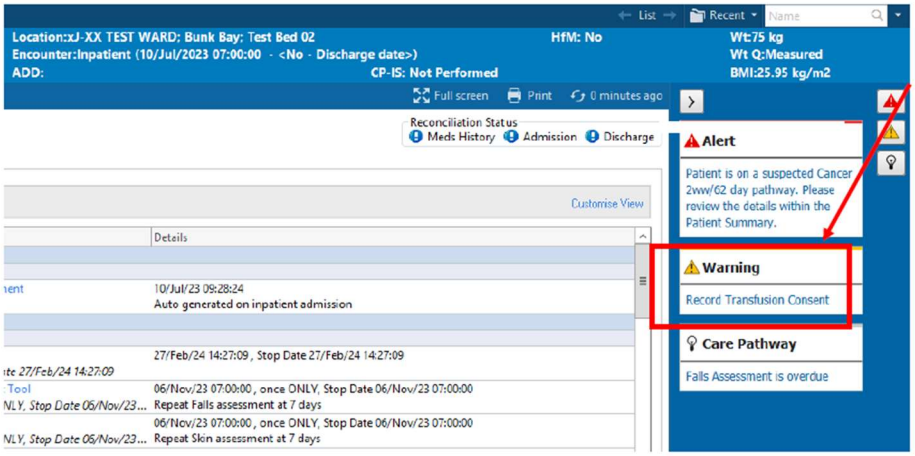


Step 2: Take Transfusion Consent



- 5 mandatory fields in yellow need to be completed (if capacity)
- When fields complete, G&S request can be finalised
- Outcome of the consent form recorded on EPR as electronic note
- If consent has not been completed (all boxes remain ticked 'No'), an alert will be generated to remind healthcare professionals to complete transfusion consent

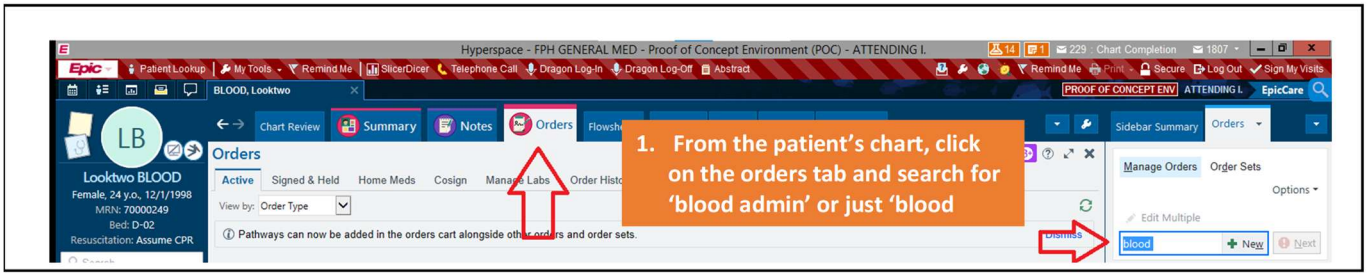
Step 3 (if necessary): SmartZone Alert

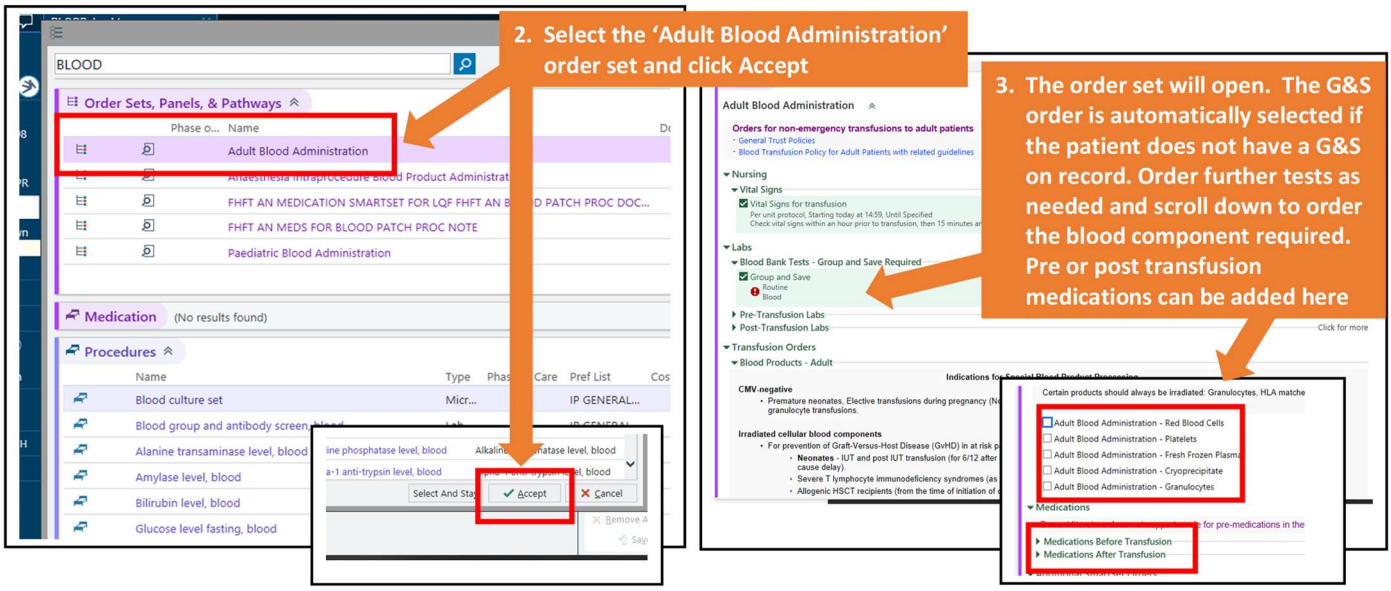


- SmartZone alert generated if consent not obtained when the G&S sample is taken
- Provides the opportunity to complete at later stage

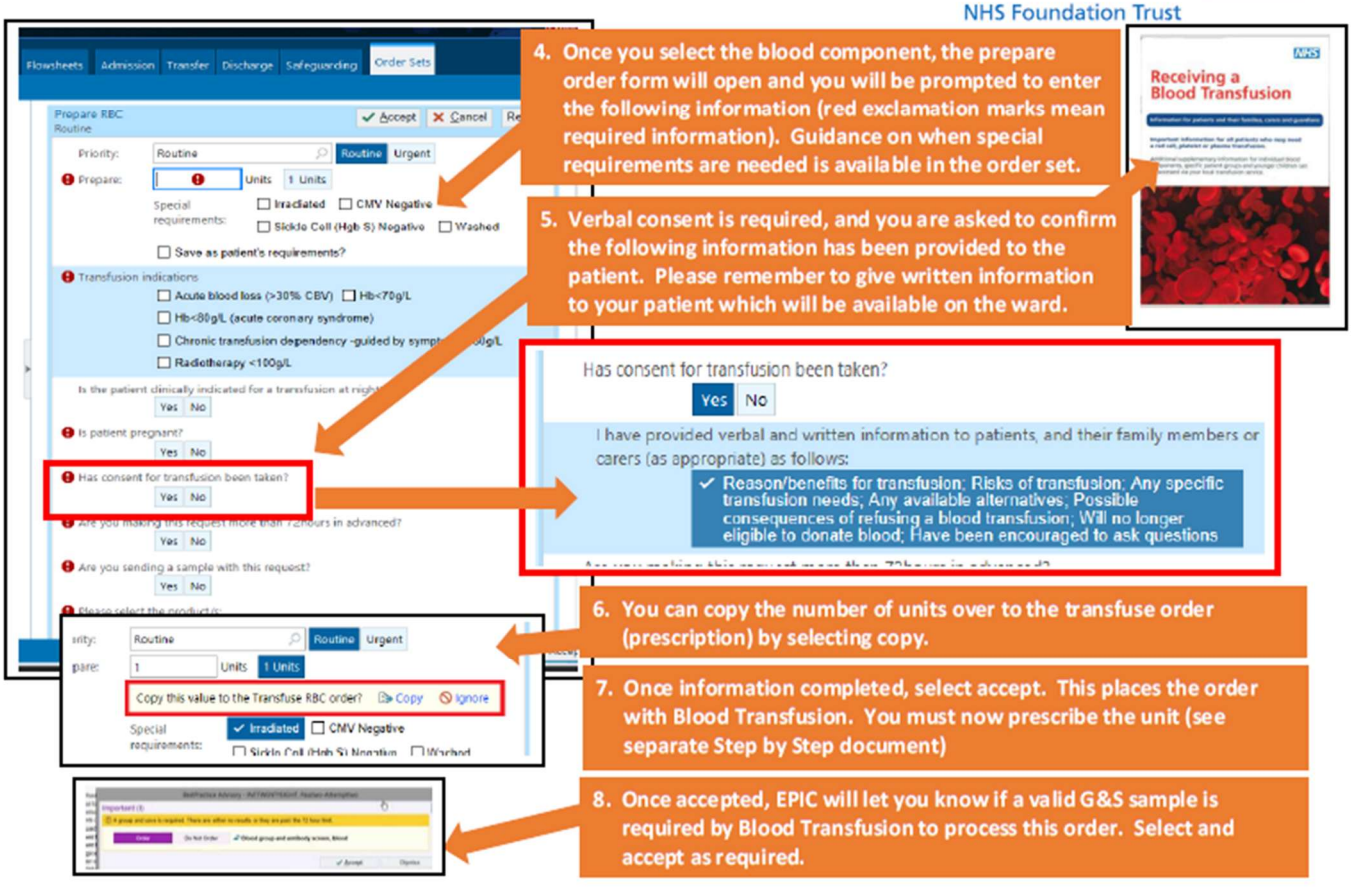
Document 5: Frimley Park Hospitals, England. Electronic process for prescription for transfusion including consent for transfusion

STEP BY STEP Ordering Blood Components (RBC, FFP, Plts, Cryo) from Transfusion





Frimley Health NHS
NHS Foundation Trust



Document 6: Hampshire Hospitals, England. Paper record and checklist for consent for transfusion including a section for patients unable to provide consent

Informed Consent for Blood Transfusion

Affix patient sticker here

Patient name:
Date of birth:
NHS number:
Hospital number:

The clinical team involved in your care feel that it is, or may become, necessary for you / your child or person for whom you are legally responsible, to have a blood transfusion.

Receiving a blood transfusion, although generally safe, has potential risks associated with it. Your doctor/ specialist nurse will explain the risks to you and provide you with access to written information, please see overleaf.

In some clinical situations, an alternative treatment to receiving a blood transfusion may be appropriate. Your doctor/ specialist nurse will explain/discuss if an alternative treatment is appropriate.

Statement of healthcare professional:

☐ I confirm that I have explained the reason for blood transfusion including benefits, potential risks, side effects and any suitable alternative options to the patient/parent/legally responsible person, as detailed below:

Reason for blood transfusion: .....

Benefits of blood transfusion: .....

Potential risks of blood transfusion:

☐ Risk of error and wrong blood given

Staff should carry out multiple careful identifications checks to make sure the right blood is given to the right patient. These stringent procedures are in place to minimise this risk

☐ Transfusion-associated circulatory overload

Patients at risk should be monitored closely; this includes children, elderly, low body weight, hypertension, and cardiac /respiratory / renal impairment

☐ Adverse immune response

Some people may experience a slight fever, chills, feel flushed or develop a rash, which is usually due to a mild immune reaction or allergy. A severe haemolytic or non-haemolytic reaction is very rare.

- Transfusion-transmitted infection

Very rare as all donated blood is screened for HIV, hepatitis (B, C and E), HTLV and syphilis – the risk of these tests failing is <1 in 1million. The risk of bacterial contamination is <1 in 1million, and there is an extremely small risk of vCJD.

- Patient has been informed that they will no longer be eligible to donate blood

Other relevant information .....

Document 7: Hampshire Hospitals, England. Paper prescription and observation record for transfusion, and a pre-administration checklist including consent for transfusion.

Obs	Baseline Time.....	15 min Time.....	End Time.....	Please ensure the start time of the unit is documented and name printed. **This is a legal requirement.** **Unit 1** **Affix sticky portion from traceability tag here.**
BP				
Pulse				
Temp				
RR				
Sats				
Signs of a Transfusion Reaction? *e.g. SOB, drop in sats, fever, rash*				Yes ☐ No ☐ Severity:

Obs	Baseline Time.....	15 min Time.....	End Time.....	Please ensure the start time of the unit is documented and name printed. **This is a legal requirement.** **Unit 2** **Affix sticky portion from traceability tag here.**
BP				
Pulse				
Temp				
RR				
Sats				
Signs of a Transfusion Reaction? *e.g. SOB, drop in sats, fever, rash*				Yes ☐ No ☐ Severity:

Obs	Baseline Time.....	15 min Time.....	End Time.....	Please ensure the start time of the unit is documented and name printed. **This is a legal requirement.** **Unit 3** **Affix sticky portion from traceability tag here.**
BP				
Pulse				
Temp				
RR				
Sats				
Signs of a Transfusion Reaction? *e.g. SOB, drop in sats, fever, rash*				Yes ☐ No ☐ Severity:

Obs	Baseline Time.....	15 min Time.....	End Time.....	Please ensure the start time of the unit is documented and name printed. **This is a legal requirement.** **Unit 4** **Affix sticky portion from traceability tag here.**
BP				
Pulse				
Temp				
RR				
Sats				
Signs of a Transfusion Reaction? *e.g. SOB, drop in sats, fever, rash*				Yes ☐ No ☐ Severity:

Severity of Transfusion Reaction		
Mild <39°C (or <2°C rise) with or without rash / pruritis	Moderate Temp ≥38°C and rise ≥2°C with signs and symptoms other than rash / pruritis	Severe Evidence of life-threatening problems Airway / Breathing / Circulation and / or wrong blood given and / or evidence of contaminated unit

Transfusion Reactions: Know what to do! Immediate Action… (see Transfusion reaction SOP for further information)

Temporarily stop the transfusion but maintain venous access
Perform a set of observations.
Check again the identification of the patient, the unit compatibility tag and the unit itself are all matching
Perform a visual inspection of the unit.
Inform medical staff (for a severe reaction – manage as per local guidelines for critically unwell patient e.g. 2222 call).
Do not stop Transfusion if symptoms are most likely due to **Major Haemorrhage** – seek further advice from on call Haematologist.

For *moderate or severe transfusion reactions* call the laboratory and an acute transfusion reaction epurple form must be completed by the clinical team caring for the patient. Search 'Acute Transfusion Reaction'.

Hampshire Hospitals NHS
NHS Foundation Trust

Prescription, Observation and Patient Record for Administration/Authorisation of Blood and Blood Products

Please affix addressograph / print all information	**Risk of Transfusion Associated Circulatory Overload (TACO)?**	If patient is at risk of TACO, please consider mitigatir
No / MRN.....	**Risks:**	Single unit transfusion and review
ame.....	Age >50 [] CCF, severe AS, LVF []	Review rate and volume transfused (weight based p
name.....	On a regular diuretic [] Peripheral oedema []	Consider diuretic cover unless contraindicated
.....	Hypoalbuminaemia [] Significant renal impairment []	Assess for signs of fluid overload e.g. drop in oxygen
	On concomitant fluids [] Pulmonary oedema []	Strict fluid balance monitoring
	Clinically significant positive fluid balance []	Reassess symptoms/Hb after each unit

Administration/authorisation of blood and blood products

(Red cells 2-3 hours, Platelets and FFP 30 minutes, Cryoprecipitate 30 minutes)

cial Requirements: **CMV negative*** **Yes** ☐ **No** ☐
Irradiated* **Yes** ☐ **No** ☐
(*)For further advice / policies etc on transfusion see transfusion page on intranet or Blood Assist App ⟶ Scan QR code for A

Date	Blood product	Pre transfusion: Hb (for RBC) Plt count (for Plt)	Indication Code (*) or target Hb	Volume (unit/ pool)	Rate	At risk of TACO (Y/N)	Diuretic required (Y/N)	Prescriber (name/ signature/bleep)	Start date / time	Transfu (print

The Final Bedside Check.

Each unit must be checked at the bedside using the second independent checking procedure.	Unit 1 **Initial against each check**		Unit 2 **Initial against each check**		Unit 3 **Initial against each check**		Unit 4 **Initial against each ch**	
	1st checker	2nd Checker	1st checker	2nd Checker	1st checker	2nd Checker	1st checker	2nd Che
Check unit integrity and expiry date								
Informed consent documented		2nd checker		2nd checker		2nd checker		2nd che
Leaflet provided		not		not		not		not
Confirm positive patient with ID band accuracy		required		required		required		requi
Confirm positive patient ID with prescription chart		when using		when using		when using		when u
Confirm positive patient ID with unit tag		electronic		electronic		electronic		electro
Confirm donation number on unit matches unit tag		Blood		Blood		Blood		Bloo
Confirm blood group on unit and tag are compatible		Track		Track		Track		Trac
Any special requirements identified are met		system		system		system		syste
Transfusion administration training in date?								
Signature of 1st staff member checking product								
Signature of 2nd staff member checking product								
Correct giving set selected								
Pump (if used) rate set correctly								

Document 8: Alder Hey Hospital, England. Electronic record and checklist for consent for transfusion

BLOOD TRANSFUSION

Patient Name:		**Date of Birth:**
NHS Number:	**Hospital Number:**	**Gender:**
Responsible Health Professional:		

Your doctor feels that it is, or it may become, necessary for your child to receive a blood product transfusion. You will be asked to read and sign this consent form to indicate that you understand the reason for the transfusion, the type of product likely to be given, the possible risks associated with it and any alternatives have been discussed.

Blood components that we may offer your child during their inpatient stay depending on their clinical course are red cells, platelets, fresh frozen plasma (Octaplas), cryoprecipitate, and very rarely granulocytes.

Valid for:
Consent to transfusion of all products - valid for extended treatment programmes.

I confirm that I have explained the reason for the transfusion and the type of products likely to be given. I confirm I have provided time for patients/parents/carers to ask questions.

Healthcare professional name

Grade/Role

Healthcare Professional Signature

Have you viewed the information video?
No

Have you received an information leaflet?
Yes - Prior to this consent

Have your queries been answered?
Yes

I confirm that I understand the information provided and hereby give consent to receive any blood product transfusions necessary for the agreed period.

I hereby give consent for:
Child

Patient Parent or Carer Name

Patient Parent or Carer Signature

Document 9: Great Ormond Street Hospital, England. Paper record for refusal of consent to transfusion for Jehovah's Witness patients under the age of 18

Great Ormond Street Hospital for Children NHS Foundation Trust

Name Hospital no DOB Please affix label

Additional Consent Form pages for GOSH Jehovah's Witness patients under the age of 18 years old

Notes:

[1] These two pages are only to be used for GOSH patients under 18 years old.

[2] These two pages must be used in addition to the GOSH procedure Consent Forms for (i) under 16 year old patients and (ii) 16/17 year old patients; these should be affixed firmly to the completed Consent Form.

[3] These additional two pages are optional. However, any other form from the Jehovah's Witness Liaison Committee should not be used as a substitute to these additional two pages.

Specific procedure(s) to which this form applies:

Your views

GOSH acknowledges your wish that no blood products or blood components be given to the patient for this procedure, except those stated **below**.

List of acceptable blood products and blood components:

Emergencies

All GOSH staff will endeavour to avoid use of blood and blood components if this is at all possible without causing risk of death or serious harm to the patient. All possible alternatives to blood, including cell salvage (where possible) and the use of the products or components identified as acceptable to you **above** will be considered first. However, if no alternative is possible in a situation that could lead to death or serious harm and if blood products and blood components are immediately necessary to try to prevent that, then blood products and blood components will be used prior to surgery, during surgery, in the post-operative period or in an acute medical situation (This will be considered a medical emergency and, in line with the legal position, consent will not be sought for that).

Non-emergencies

In relation to situations that do not amount to a medical emergency, and where an application is made for a Court Order, I/we understand that in all cases of which GOSH is aware, the Court in England & Wales has overridden the refusal of blood and blood components where the patient is under 18 years old and provision of blood or blood components is considered by the treating team to be in the patient's best interests. I/we understand that this is the case even where the patient themselves expresses a clear commitment to the Jehovah's Witness faith and refuses to accept blood products or blood components for themselves. GOSH is a

hospital that is bound by the law of England & Wales.

In recognition of the current legal position in England & Wales, I/we accept the reality that the treating team at GOSH will give blood products and blood components in the following specific circumstances, even when it is not an emergency:

- Where the patient is under 18 years old; **AND**
- Where the provision of blood products or blood components is considered to be in the patient's best interests – and a member of the clinical team has documented in the medical records the reasons why it is their professional opinion that giving blood products or blood components is in the patient's best interests; **AND**
- Where in the view of clinical team there is no other clinically appropriate alternative to administering blood or blood components.

Whatever course the treating surgeon and/or the clinical paediatric team follow they will always act in the patient's best interests, having regard to your known wishes.

These pages will be explained to you/the patient. If you have any further questions please ask – we are here to help you.

I/we understand that I/we have the right to change our mind at any time, including after you have signed these pages.

Signatures

Signature of Consultant (to confirm **ALL THREE** bullet points above apply to this patient)

Signature of Consultant	Date
Name of Consultant (PRINT)	

Job title	
Contact details of Consultant	

Signature of the under 18 year old patient OR person with Parental Responsibility belonging to the Jehovah's Witness faith

NB: The person signing these additional pages must be the same person who signs the GOSH procedure Consent Form

Signature	Date

Statement of interpreter (where appropriate)

I have interpreted the information above to the person(s) giving consent to the best of my ability and in a way in which I believe they can understand.

Name/ID number of interpreter (PRINT)	Date
Signature of interpreter (if present)	
Signature of health professional (if interpreter not present)	

Document 10: Northern Ireland. Electronic record for documentation of Advance Directive and explicit consent or refusal to different blood products

Patient Interview Prior to Completion Of Advance Directive

It is important to document the information discussed and any additional actions required in the Patient's notes. Patients, including Jehovah's Witnesses often have some knowledge about donated blood components, blood derived products and recombinant coagulation factors, such as recombinant Factor Vila. They may already have made their own personal decisions about which of these treatments they would accept or refuse and whether Or not they would accept cell salvage or cardiopulmonary bypass. However. it is important to clarify the following with the Patient before the Advance Directive is completed:

- Which blood components and products would normally be included in the treatment of major bleeding?
- Treatment options, acceptable to the Patient. which would be available to treat bleeding
- State which treatment options would not be suitable or not available
- Allow time for the Patient opportunity to discuss the treatment options listed in the Advance Directive with family and Witness Liaison Committee, as appropriate

Contact your Blood Bank about availability Of coagulation factor concentrates, such as Fibrinogen Concentrate and Factor Xlll concentrate.

Completion of Advance Directive

(See "Legal and Ethical Aspects" in Appendix 1 for additional information)

The following Directive should be completed by the Patient, under the supervision Of, and witnessed by a Senior Clinician, i,e, Consultant, Associate Specialist or Staff Grade, The Clinician should verify the following (using open-ended questions, where appropriate):

Patient

Full name :

Date Of birth:

Health and Care or Hospital number

Home address:

Advance Directive for the Consent or Refusal of Blood Components, Blood Products and Transfusion alternatives

For completion by the patient who has reached an informed decision,

I

Bom on

H&C (or Hospital) no:

Address:

Am Of sound mind and I voluntarily make this Healthcare Advance Directive

It will remain in force for this episode of care or until specifically revoked by me, concerning the following medical treatments:

Blood Components	
Red blood cells from a donor	○ I will accept ○ I will not accept
Red blood cells pre-donated by me and stored	○ I will accept ○ I will not accept
Platelets from a donor	○ I will accept ○ I will not accept
Granulocytes	○ I will accept ○ I will not accept
Fresh Frozen Plasma	○ I will accept ○ I will not accept
Cryoprecipitate	○ I will accept ○ I will not accept
Blood Products derived from Human Plasma	
4.5% Albumin	○ I will accept ○ I will not accept
20% Albumin	○ I will accept ○ I will not accept
Solvent-detergent treated pooled plasma (Octaplas)	○ I will accept ○ I will not accept
Prothrombin complex concentrate	○ I will accept ○ I will not accept
Fibrinogen concentrate	○ I will accept ○ I will not accept
Factor XIII concentrate	○ I will accept ○ I will not accept
Immunoglobulin, including Anti-D for Rhesus negative women)	○ I will accept ○ I will not accept
Human derived fibrin sealant	○ I will accept ○ I will not accept
Recombinant Products	
Recombinant coagulation factors, e.g. Factor VIIa	○ I will accept ○ I will not accept
Recombinant erythropoietin	○ I will accept ○ I will not accept
Intravenous Fluids	
Starch based plasma expander	○ I will accept ○ I will not accept
Gelatin (bovine) based plasma expander	○ I will accept ○ I will not accept
Red Cell Salvage	
I have been informed that intra-operative red cell salvage is available / is not available (*select as appropriate*)	○ Available ○ Not available
My red cells processed in a cell saver	○ I will accept ○ I will not accept
My blood from saline washed swabs, processed by cell saver	○ I will accept ○ I will not accept
Additional Techniques	
Cardiopulmonary bypass	○ I will accept ○ I will not accept
Haemodialysis	○ I will accept ○ I will not accept
Other Pharmaceutical Preparations	
Bovine derived fibrin sealant	○ I will accept ○ I will not accept
Anti-fibrinolytic drugs, e.g. Tranexamic acid	○ I will accept ○ I will not accept

Other treatments / therapies (Please specify) Type here	○ I will accept ○ I will not accept

Additional Blood Tests, if indicated

Blood Group and Screen for Atypical Antibodies (Required for transfusion of donated blood derived coagulation factors, e.g. cryoprecipitate)	○ I consent ○ I decline consent

Patient:

I . Confirm that I have recorded which blood components, blood products and alternatives I will accept or not accept as part of my medical or surgical treatment.

Intended procedure:

I confirm that Has informed me that the anticipated blood loss during or after this procedure is *(tick as appropriate)*:

- ○ Less than 500 ml
- ○ 500 – 900 ml (estimated decrease in Haemoglobin of 10 – 20 g/L)
- ○ 1,000 – 2,000 ml (estimated decrease in Haemoglobin of 30 – 40 g/L)
- ○ Greater than 2,000 ml (estimated decrease in Haemoglobin of more than 40 g/L)

I understand that there is a risk to my life if major blood loss occurs.

Patient

Fill in required fields first

Healthcare Professional:

I confirm that the Patient's Name, Date of Birth, H&C or Hospital Number and Home Address are correct and that the treatment options above have been discussed with the Patient.

Completed by (Print Full Name) :

Provider

Fill in required fields first

Grade: **GMC / GDC Number:**

Clinical Speciality: **Workplace:**