9.1 ESSENTIAL DOCUMENTATION

A permanent record of the transfusion of all blood and blood components must be kept in the patient’s medical records in a form that allows easy and accurate review when required e.g.

- The investigation of a transfusion-related adverse event.
- Performance of quality improvement audits and blood utilisation review.
- To aid in the management of legal risk.

These records must include the following:

- The clinician’s prescription (see 1.1)
- The reason for transfusion and notes on whether or not transfusion achieved the desired effect.
- The peel-off compatibility label from the blood product. This should be affixed to Form MR735 Blood Transfusion Record (KEMH)
- The relevant sections on MR735 should be completed for every unit transfused. This information should include the following:
  - The date and time each unit was commenced and completed.
  - The identity of the persons responsible for the performing the pre-transfusion checks.
- Nursing observations recorded during the transfusion – at start of infusion, 15 minutes later, then hourly and at completion of transfusion.
- Any adverse effects and their management.

In addition there should be a record of 'Informed Consent'. *(See Section 1.2 Informed Consent for Transfusion)* Informed Consent means that a dialogue has occurred between the doctor and the patient. The significant risks, benefits and alternatives to transfusion including the patient’s right to refuse should have been discussed.

A range of patient information leaflets are available to aid this process.

These may be viewed on the Intranet under the Pathology page of the WNHS intranet


OR under Consumer Information – Brochures and Publications (hospital specific leaflets only)

To order stocks of any of these leaflets for your area contact the Blood Bank or email the Transfusion Coordinator.