Section 4: Competency Requirements

Blood Administration Return Demonstration

Facilitator states - The physician informs you that your patient requires 1 unit of red blood cells to be administered now.

Key Point	✓If competent

<u>Physician Order</u>
Facilitator states:
• What is your first step? *Confirm order*
  ○ Confirm presence of physician order documented on patient chart.
• Does it contain all the required information? *Yes/no?*
  ○ State physician order requirements- date, time, required blood product, quantity of product to be transfused, volume/duration of transfused product, pre and post medications (if applicable).
• Check to see if patient has a valid Type and Screen result on patient chart. If not, obtain a physician order to collect a Type and Screen on patient.
  ○ If all the order information is present, what should you check on the patient chart? *Consent and an in-date Type and Screen is required.*
Have participant show you in the chart the in-date type and screen and the form that would be used to collect a type and screen if there wasn't one.	

<u>Informed Consent</u> Facilitator states: How do we know that informed consent has been given? • Confirm that informed consent has taken place with patient and this conversation has been documented on health record by physician. Show participant the two separate types of consent: ○ Consent for treatment ○ Surgical consent that includes transfusion Ask nurse: What would happen if the person had a total knee replacement but the transfusion was required because the patient developed an unrelated GI bleed, is the surgical consent for blood still good? Answer: No. Stress the importance of discussing consent with the patient as patient may not realize that they have given consent for transfusion by signing the surgery	

consent. If they were unaware a discussion between physician and patient would be necessary. • Nurse proceeds to bedside and informs patient that a transfusion will occur soon. Ask patient if they have any concerns related to this procedure. Confirm with patient that they agree to proceed with transfusion. Show participant pamphlet they can use.	
Documentation Required for Transfusions Facilitator states: What forms for documentation of transfusion are required. When is this documentation initiated and what is documented? • Record of Transfusion is completed and returned to Blood Bank at earliest opportunity after infusion has started. • Cumulative Blood Product Record is completed as per hospital standards. • Patient Notification Card is completed by nurse and given to patient. • Integrated progress note may be required for additional documentation.	
Obtain Blood from Blood Bank Facilitator states: Before we request the red blood cell unit what else besides consent and an in-date type and screen do we have to ensure we have and what do we need to do? *Have them check patency of IV and set up the equipment.* • Nurse starts IV and/or checks patency of existing IV. Nurse establishes and primes blood administration set. Ensure that an additional IV set, (tubing and 500 cc NS bag) is in close proximity to patient's bedside in the event of a transfusion reaction. Facilitator states: How do we get the red blood cells from the lab? *Have them look over the request for release form*. Instruct: o The steps for completing the form. o Sending the form to the Blood Bank. o Procedure for making the Blood Bank aware • Nurse completes Request for Release of Red Cells form, faxes it to Blood Bank, and calls the Blood Bank or delegates this task to ward clerk to complete. Facilitator states: You have now received the unit of red blood cells from the trained designated transporter. Facilitator states: What is the maximum length of time that blood can be out of the refrigerator if it will not be infused? EMPHASIZE: Blood can be infused for total of 4 hours. If it is determined that this will not be possible, the blood must be returned to the Blood Bank within 60 minutes. Facilitator states: What would you do with the unit if the IV has gone interstitial and blood cannot be initiated prior to this timeline?	

- Nurse identifies:
  - The maximum length of time that blood can be out of the refrigerator if it will not be transfused prior to initiation on patient.
  - What to do if blood cannot be initiated prior to timeline. *Blood is returned to Blood Bank ASAP!*

Pre Transfusion Checks

Facilitator states: Before transfusion what are we inspecting the blood bag for*? Blood is visibly observed for discoloration, sediment, and expiry date.*

Facilitator states: What 2-nurse pre-transfusion checks are required? Perform these checks with another participant as outlined at the beginning of the session.

- Blood is checked for accuracy with the physician's order and with the patient's Transfusion Medicine Results Report.
- Verbally confirm accuracy of patient's personal health information by performing a 2-nurse check.
  - Confirm there are two patient identifiers.
  - Compare blood tag information with information on chart records.
- Compare information on blood bag with information on blood tag and Record of Transfusion.

Person 1 Reads aloud from the Blood or product tag and Record of Transfusion:	Person 2 Compares and verifies the information on:
• Product type • Donor ABO/Rh, as applicable • Donor unit # or Lot #, as applicable • Compatibility status • Crossmatch expiry date, unit expiry date • Modifiers, if applicable. Example(s): CMV negative or irradiated	• Blood bag

Facilitator states: What do you do with the tag now that you have confirmed the information? *The tag must be left in place for the duration of the transfusion. On transfusion completion it is removed and placed in confidential waste.*

Ensure participant completes the following:

- Ensure all equipment is ready for transfusion to begin.
- Educates patient on expectations, and signs and symptoms of transfusion reaction to report to nurse. Provide the information pamphlet for their resource.
- Nurse confirms baseline vital signs are charted on the Cumulative Blood Product Record appropriate to begin treatment and starts treatment

Facilitator: At this point set up should be done and now participants will switch.	
Initiation of Transfusion Facilitator: Ask the nurse what the starting rate of transfusion will be? *Initial infusion rate must not exceed 50 ml/hr.* Identify the correct rate programmed into the infusion pump. Initiate the blood transfusion. • Nurse starts transfusion, states initial rate, and when rate would increase. Nurse must have continuous 1-1 patient monitoring during the first 15 min of transfusion Facilitator: Ask how often do you do transfusion checks including vital signs? Facilitator: Ask what are the signs and symptoms of transfusion reaction. Facilitator Scenario: After 15 minutes you perform a routine vital sign check on the patient. You note the temperature rose one (1) degree above baseline and a rash has formed. What will you do? • Nurse can state signs and symptoms of a transfusion reaction. • Nurse can state the immediate interventional step if a patient is experiencing an acute transfusion reaction. Nurse demonstrates how he/she will report an adverse event (if it occurs) and identify documentation of same.	
Patient Education • Informs patient of signs and symptoms of a delayed transfusion reaction. An educational pamphlet is provided to patient upon leaving the hospital if the patient is an outpatient. • Nurse advises and encourages outpatient to remain on the unit for 1 hour post-transfusion for observation of a potential adverse reaction. • Patient Notification Card is provided to patient at discharge indicating administration of blood, blood components, and/or blood products during their hospitalization.	

Name: _____ Unit: _____