GREENVILLE HOSPITAL SYSTEM NURSING STAFF POLICY & PROCEDURE

TRANSFUSION RECORD, GUIDELINES FOR COMPLETING

GENERAL INSTRUCTIONS:

The Transfusion Record will be issued by the Blood Bank with each unit of blood product to be transfused. The upper right hand side of the form down to and including the date and technician identification will be filled in by the Blood Bank. The remainder of the form is to be completed by the RN/physician(s) transfusing the blood.

A sticker label from the bottom right hand side of the Transfusion Record will be printed in the Blood Bank, removed from the Transfusion Record and affixed to the unit of blood product. This sticker can be discarded with the blood unit.

PERSONNEL:

- Only Registered Nurses and physicians can administer blood products.
- Licensed Practical Nurses and physicians may check blood information and patient identification with the Registered Nurse.

SUPPORTIVE DATA:

- Transfusion Record (see Appendix A)
- GHS Nursing Staff Policy and Procedure Manual:
  - BloodPro 3 Administration of Cryoprecipitate
  - BloodPro 4 Administration of Fresh Frozen Plasma
  - BloodPro 5 Administration of Platelets: IV Drip Method and IV Push Method
  - BloodPro 6 Administration of Whole Blood and Packed Red Blood Cells

GUIDELINES FOR COMPLETING THE TRANSFUSION RECORD:

1. The date and time the blood/blood product was obtained from the Blood Bank or approved blood storage refrigerator and the name of the person obtaining the unit are recorded in the appropriate spaces.

2. The Registered Nurse should check the patient’s chart to verify a signed Consent for Blood Transfusion is on the chart and an order has been written to transfuse the blood product. The RN should check the appropriate box for each.

3. The RN with another RN, an LPN or an MD must take the unit of blood/blood product and Transfusion Record to the patient’s bedside and check the appropriate information as outlined in the appropriate nursing policy and procedure:

   BloodPro 3 Administration of Cryoprecipitate
   BloodPro 4 Administration of Fresh Frozen Plasma
When all appropriate information has been verified, the RN should check the box for each of the information sources checked. The RN or physician starting the transfusion should sign on the top line as Transfusionist and the other RN, LPN or physician signs as the Witness.

4. For outpatient transfusions, the nurse completes the Outpatient Transfusion section, entering the patient's lab values if appropriate, pre-medications given, IV site, needle type and gauge, and the amount of normal saline hung with the transfusion.

5. If the blood is warmed or a bedside leuko-filter is used, check the appropriate box(es) in the Special Preparation section.

6. Enter the date and time the transfusion was started.

7. If the transfusion is being infused during surgery, the box for “Transfused During Surgery” should be checked and the transfusionist can skip to number 11, below.

8. If the transfusion is given being given in an emergency, the box for “Transfused in an Emergency” should be checked and the transfusionist can skip to number 11, below.

9. If the transfusion is being given by Apheresis during an exchange, the box for “Transfused in an Emergency” should be checked and the transfusionist will write “See Apheresis form” above the box. No further documentation is required on this form.

10. For all other infusions, the vital signs taken before the transfusion was begun are to be recorded in the Vital Signs block at the top of the form labeled “Begin”, including the patient's mental status, time and name of the person who checked the vital signs.

11. Vital signs and patient’s mental status should be assessed again at 20 minutes and at the end of the transfusion and recorded in the appropriate boxes.

12. If a transfusion reaction is suspected at any time during the transfusion, STOP the transfusion and complete the “Suspected Transfusion Reaction” box. Each step must be checked off after it is performed. See BloodPro 7 (Transfusion Reaction, Blood and Blood Products) for complete information on handling suspected blood transfusion reactions. If no transfusion reaction is suspected during the transfusion, the “No” box must be checked upon completion of the transfusion.

13. At the end of the transfusion, the time completed and amount infused are to be entered in the spaces provided at the bottom left hand side of the form.

14. The nurse or physician completing the transfusion should sign on the “Transfusion Completed By” line.

15. For outpatient transfusions, the nurse enters the “IV Site Disposition” on the space provided and signs the line for “Post transfusion instructions reviewed and given by” when she/he completes the patient teaching.

16. The person sending the Emergency Release form or electronic message to the Blood Bank signs on the line, “Electronic message or Emergency Release to BB by”.
17. The form is placed under the LAB tab in the patient’s medical record. The person placing the Transfusion Record in the chart signs on the last line: “Transfusion Record placed on chart by”.

REFERENCES:


2. GHS Laboratory Reference Handbook – Blood Bank section

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