**Blood Bank/ Blood Transfusion Documentation Training**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_Unit\_\_\_\_\_\_\_**

**Trainer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Check each item below as it is covered)

**ORDERING/COLLECTING SAMPLES**

**NOTE: refer to Blood Bank Specimen Collection checklist for more detailed information**

* + Patient consent form MUST be signed PRIOR to ordering any blood products.
	+ Follow protocol for patient identification before collecting specimens.

When collecting samples for Carter Blood Care

* + Label all tubes AT THE BEDSIDE with patient label, time/date/initials
	+ Fill out the requisition COMPLETELY with patient label, date/time/initials, ordering facility written out i.e. Harris Southlake
	+ Make copy of requisition and leave in lab
	+ White copy goes to Carter with the samples, the yellow goes on the chart.

*\*\*\*incomplete documentation/labeling - samples will be rejected\*\*\**

* + Place Blood Bank orders in CPSI (found on first page of lab tests – answer questions with WHAT the physician has ordered i.e. T&C 2 units PRBC, and the reason for the transfusion i.e. post op anemia, active bleeding, etc.)

          **When units are delivered from Carter:**

* + Verify all patient information on the units, unit tags, and packing slip all match including patient name, acct#/MR#/DOB
	+ Sign, date and time the packing slip indicating you have verified the information
	+ Log units into the Blood Bank log book
	+ Place units immediately into Blood Bank refrigerator.
	+ If **Platelets** are delivered, store them at **ROOM TEMPERATURE in the box they were delivered in – DO NOT PUT INTO BB REFRIGERATOR**

          **Picking up units from lab for transfusion**

* + Bring the patient label to the lab

**NOTE:**  If no technologist in lab, 2 PEOPLE must come to the lab to check out the blood – an R.N. and another nurse or patient care tech from the floor to verify patient information.

**ONE PERSON ABSOLUTELY MAY NOT CHECK OUT BLOOD FROM THE LAB!!!!!**

* + Obtain unit from BB refrigerator for correct patient
	+ Verify all patient/unit information and complete “Issued to/Transfused” section of log book
	+ Electronic Transfusion Record will usually be started in the lab when a Medical Technologist is present. The electronic form may be started in the patient room, and all information shall be verified as it is in the lab.
	+ You may only check out 1 unit at a time EXCEPTION: patient has 2 IV lines, Dr. orders to give over short period of time in the OR or ER.
	+ Inspect the units for hemolysis, discolorations, and clots.

**Starting the transfusion**

* + Patient information AND unit information must be verified by 2 nurses and documented on the unit tag AND the transfusion record.
	+ Blood transfusion MUST be started within 30 minutes of issuance of blood from lab – document start and completion time on the unit tag and transfusion record.
	+ VS are taken and documented on the Blood Transfusion Record as follows:

Pre-transfusion, 15 minutes after START time, 30 min. after start, 1 hr and 2 hrs after start, at completion, and 1 hour after completion.

* + Blood unit may be returned to lab for future use if returned w/in 30 minutes of being checked out. The “Blood Returned to BB” must be completed in the log book as being returned to the lab, and the unit information should be “re-logged” into the log book in case the unit is checked out again.
	+ Unit must be transfused over 2-4 hours – not shorter, not longer!! (except platelets and FFP may be administered more quickly – blood may be transfused in short time period **only by** **physician order**)  DOCUMENT TIMES!

**Upon completion of transfusion**

* Complete unit tag – make copy, and place original white unit tag on chart
* Complete Transfusion Record and print a copy when completed.
* Lock the Transfusion Record
	+ Document completion time in log book in lab
	+ Give the charge RN the copies of the Transfusion Blood Record and unit tag along with the Transfusion Audit (found in FOD). Audit must be completed by charge RN or an RN not involved in the transfusion ASAP – preferably during the same shift so that any missing info/clerical errors can be corrected immediately.
* **Transfusion Reactions**

**If ANY adverse symptoms or abnormal physical signs are noted during transfusion, STOP the transfusion and keep IV line open with normal saline to keep vein open.**

* Reverify blood product is meant for this patient same as you did at bedside before starting transfusion
* Notify charge nurse, and determine whether or not to initiate “Transfusion Reaction Investigation Work-up”.
* Refer to policy “Transfusion Reactions” for specific instructions.

**Emergency Blood Transfusion**

* Collect specimens for a Type/Crossmatch ( will be used to crossmatch with the Oneg unit AND for additional Type specific units).
* Two pig tails from Oneg unit will be sent to Carter for crossmatch with the patient’s blood samples
* When getting units from the lab, the units must be checked out like any other unit – you must sign the Blood Bank logbook, and note in the comment area the name of the patient receiving that unit.
* Before administering Oneg blood, an Emergency Blood Administration Record must be completed and signed by physician (attached to O neg unit)
* Administer Blood as usual, being sure to complete the “Emergency / Uncrossmatched or High Risk Incompatible Blood” area on the Transfusion Record
* Carter should be notified that the Emergency Oneg units have been utilized – they will send replacement units.

For more detailed information, refer to Blood Bank policies which can be found on

on the intranet using the following path:

Resources/Policy and Policy Information Server( ‘PARIS’) folder/Policies and
Procedures/Laboratory 2012/Blood Bank

Blood Component Administration

Blood Transfusion Emergency

BB Receipt and Return of Blood Products

Storage of BB products

Blood Sample Collection

Blood Transfusion Emergency

Transfusion Reaction