

Consent for Transfusion: Discussion Checklist

WQN1389

Patient's Name: Date of Birth:
 ID No: Ward: Site:
 Today's Date: Your Name: Position:

When discussing consent for transfusion with patients or those with parental responsibility, the following points should be offered for discussion (*and then consent form 1 (adults) or consent form 2 (children) must be signed*)

- Is the transfusion absolutely necessary & why
- Can any anaemia be corrected with iron/B12/folic acid/Erythropoietin
- Are there any alternatives to transfusion available for this patient
- How the benefits of the transfusion in question outweigh the risks
- Explain the risks of transfusion pertinent to this patient (*e.g. risk of TAGvHD*)
- Have you informed the patient that once transfused, they will not be able to donate blood
- Have you stopped anti coagulants (*aspirin, warfarin etc*) pre operatively where appropriate
- Have you commenced anti fibrinolytics *e.g.* Tranexamic acid where appropriate

All patients or those with parental responsibility must be offered the following information on the risks of transfusion before they make their decision as to whether or not to accept the transfusion:

- Risk of receiving the incorrect blood component (*usually due to a failure of the patient ID check at the bedside*): 1 in 12,000 transfusions
- Risk of contracting HIV: 1 in 6.5 million donations
- Risk of contracting hepatitis B: 1 in 1.3 million donations
- Risk of contracting hepatitis C: 1 in 28 million donations
- Risk of contracting HTLV (*Human T-Lymphotropic Virus*): 1 in 18 million
- Risk of contracting syphilis is extremely low
- Risk of contracting vCJD is extremely low (*4 out of 177 cases of vCJD in UK have shown to be transfusion transmitted*)
- Risk of TAGvHD (*transfusion associated graft versus host disease*) is extremely low and only a risk to those susceptible *e.g.* immunosuppressed patient's or those receiving or who have received certain drugs/treatments. For more detailed information as to who is at risk, see:

Leeds Health Pathways: Policy for written informed consent for transfusion

There have only been 14 cases of TAGvHD reported since 1996

- Risk of allergic reaction ranging from urticaria to life threatening anaphylaxis
- Risk of Transfusion Associated Circulatory Overload (*TACO*): any patient with cardiac or renal problems or in receipt of large volumes of blood components and intravenous fluids
- Risk of contracting a transfusion transmitted infection (*TTI*): 1 in 500,000 donations (*mainly from platelets*)
- Risk of Transfusion Related Acute Lung Injury (*TRALI*), mainly from plasma rich components such as Fresh Frozen Plasma (*FFP*) and/or platelets
- Does the patient fully understand all of the above

continued overleaf

However the risks of transfusion should be counterbalanced with the fact that all blood transfused in the U.K. is collected from unpaid volunteers who are carefully selected to ensure they are in good health. And to put the risks ratios into context, there are approximately 3 million donations made each year.

Also, following donation, each unit of blood is rigorously tested for: hepatitis B, hepatitis C, HIV, human T-cell lymphotropic virus (*HTLV*) and syphilis. As a result of these measures, the risk of being infected by these organisms through receiving a blood transfusion is now extremely small and the benefits of the transfusion may well exceed the risks.

The alternatives to transfusion must also be discussed where appropriate, during the consent process, such as:

- Intra-operative cell salvage
- Post-operative cell salvage – the system must be a closed circuit (*may not be acceptable for some Jehovah's Witnesses*)
- Acute normovolaemic haemodilution (*may not be acceptable for some Jehovah's Witnesses*)
- Anaesthetic techniques such as induced hypotension or hypothermia
- Surgical techniques such as argon beam diathermy
- Radiology guided arterial occlusion (*pre or post operative*)
- Anti fibrinolytics such as Tranexamic Acid
- Clotting promoters such as Desmopressin
- Prothrombin Concentrate Complex (*e.g. Octaplex*) instead of FFP to reverse warfarin
- Local haemostatics such as Fibrin glue and sealants (*Tisseal*)
- Volume expanders such as crystalloids or some colloids
- Pharmaceutical options pre or post operatively such as Erythropoietin (*EPO*), Ferrous Sulphate, B12 and/or Folic Acid. **NB:** IV Iron should be considered in those patients with hypochromasia and/or those resistant to oral Iron
- Limit the number of blood samples taken for investigation

NB: Pre-operative autologous blood donation (*PAD*) is not available in the U.K.

More information about the uses and/or appropriate doses of these can be obtained from the Clinical Haematologist or Transfusion Medicine Consultant, Duty Pharmacist or the Hospital Transfusion Team.

- Have you offered the patient/those with parental responsibility a Patient Information Leaflet on transfusion
- Have you documented the consent discussion in the patient's case notes
- Have you documented the patient's decision in their case notes
- Has consent form 1 or 2 been signed appropriately if the patient/those with parental responsibility agrees to transfusion
- If the patient has refused transfusion has this discussion/refusal been fully documented within their case notes
- Have you documented the reason for transfusion within the patient's case notes
- Have you sent a correctly completed transfusion request form (*including the need for irradiated blood components, if appropriate*)
- Has the transfusion prescription chart been fully & correctly completed indicating the patient's consent (*& need for irradiated blood components if appropriate*)

FILE THE COMPLETED CHECKLIST IN THE PATIENT'S CASE NOTES AS EVIDENCE OF DISCUSSION