1. AIM: To assess and improve compliance to documentation during blood transfusion.

2. BACKGROUND:

SAFE BLOOD ADMINISTRATION GUIDELINES *(BCSH: British Committee For Standards In Haematology) states that documentation in clinical records should entail:

- Pre-transfusion documentation:
  - Reason(clinical and laboratory data).
  - Summary of information(leaflet) and consent.
- Post-transfusion documentation:
  - If transfusion achieved desired outcome (improvement in symptoms, haemoglobin increment).

Advisory Committee on Safety of Blood Tissues and Organs(SaBTO) also emphasizes on

- Valid consent to be obtained and documented
- Use of standardised source of information/leaflets

3. METHODOLOGY:

A prospective audit was carried out on 50 clinical records of patients receiving blood transfusion in orthopaedic wards over a period of three months. Data was collected from blood transfusion form(FIGURE 1) and medical notes.

Variables measured

- Pre-transfusion haemoglobin/reason for transfusion
- Post-transfusion haemoglobin/improvement
- Consent
- Leaflet

Results were distributed through department meeting and outcome following changes made was measured through re-audit cycle.

4. CHANGES MADE:

- Education of junior doctors regarding the importance of documentation of blood transfusion.
- Dissemination of results at department meeting, hospital transfusion committee and wards to inculcate a multidisciplinary approach.
- Introduction and reinforcement of consent stickers(FIGURE 2) to prompt changes in practice

5. RESULTS:

- Marked improvement in documentation across all variables measured was observed in the re-audit cycle especially in leaflet provision and documentation of pre-transfusion haemoglobin. (CHART 1).
- The practice in documentation of indication and consent was significantly better in the QA hospital compared to national comparative audit (CHART 2).
- Significant improvement in provision of leaflets to patients.

6. LESSONS LEARNT:

- To start with small samples and identify stakeholders early.
- Recognising that improvement in practice is a slow and steady process requiring repeated cycles.

7. NEXT STEPS:

- Continue to reinforce consent stickers and provision of patient leaflets.
- Promote engagement of multidisciplinary team to improve the practice.
- Extending practice to outpatient department to target poor compliance in consent and leaflet provision.

1. SaBTO recommendations on consent for blood transfusion  2. NCA 2014 Audit of Patient Information and Consent for Blood Transfusion

Patient information can also be found at NHS Choices at: http://www.nhs.uk