NURSING PROCEDURES

TITLE: BLOOD & BLOOD PRODUCTS - ALBUMIN ADMINISTRATION
A. Prior to Obtaining Albumin
B. Obtaining Albumin
C. Preparation and Verification of Albumin
D. Commencing Albumin
E. Transfusion Reaction (Actual or Suspected)
F. Following Administration of Albumin

CATEGORY: RN – General
         LPN – General
         RPN – General

PURPOSE

- Safe administration and documentation of Albumin.
- Report and management of adverse reactions.

NOTE: For NICU administration see unit specific procedure.

NURSING ALERT:

Indications:
- To restore and maintain circulating volumes.
- To replace volume loss due to shock from burns, trauma, surgery or infections.
- To treat hypoproteinemia.

Contraindications:
- Known hypersensitivity.
- Stabilized chronic anemia.
- Congestive heart failure.
- Albumin is to be infused within 4 hours of issue from transfusions department.
- A filter is not required to administer albumin.
- Use caution in clients with renal insufficiency.
A. Prior to Obtaining Albumin

EQUIPMENT

1. Documents (see APPENDICES for sample transfusion forms):
   - Informed consent Appendix #1, 1a
     - Consent for Administration of Blood/Blood Components and or Plasma Protein Products/Refusal/Withdrawal of Consent RQHR 1163 (12/15) (http://rhdintranet/Transfusions/public/Consent/ConsentInformation.htm)
   - Blood and Blood Products Administration Checklist – Appendix #2
   - Albumin Administration Checklist – Appendix #3
2. PPE
3. Equipment for starting intravenous access (IV), if not already in progress
4. Appropriate vented administration set: Pump #313406, Gravity #310813 – Appendix #4
5. Normal saline (N/S) IV Solution
6. IV Pump; if required

PROCEDURE

1. Verify Practitioner’s order.

2. Ensure Consent/Refusal for Administration of Blood/Blood Components and or Plasma Protein Products completed by practitioner.

   NURSING ALERT:
   - Informed consent must be obtained by Practitioner as per Health Canada Blood Regulations (refer to reverse side of consent form for products requiring consent).
   - If consent not completed, notify Practitioner to obtain one of the following:
     - Informed consent.
     - Practitioner’s order that states "Ok to proceed with transfusion without signed consent" or;
     - Order to hold transfusion until consent can be obtained.

3. Discuss previous reactions to albumin and document.

4. Don PPE.

5. Prime administration tubing set with N/S.

6. Ensure patent IV access.

   NOTE: If central venous access device (CVAD) present, refer to appropriate procedure for checking line patency (C.2, I.7, P.11, T.3):
   - http://rhdintranet/np/Public/Procedures/C.2.pdf
NOTE: Any size IV gauge is adequate for administration of Albumin. For pediatrics use 22-25g.

7. Obtain and document baseline vital signs (BP, HR, RR and Temp) within 30 minutes prior to initiation of Albumin.

NOTE: Notify practitioner of vital signs outside parameters prior to transfusion (i.e. increased temperature).

B. Obtaining Albumin

EQUIPMENT

1. Documents (see APPENDICES for sample transfusion forms):
   - Request for Transfusions Services Requisition – Appendix #5
   - RQHR Patient Transfusion Notification Form – (Must use form RQHR 425 (10/99 Supplied by lab with first transfusion during current admission) – Appendix #6

PROCEDURE

1. Complete the pink Request for Transfusion Service requisition including stamp with client’s addressograph, and required blood product.

2. Present completed requisition to staff in Transfusion Department.

   NOTE: Any RQHR employee certified to transport blood and blood products may obtain product from Transfusion Department. Certification entails yearly completion of Portering Blood and Blood Products E-quiz. Volunteers are not regarded as employees of the RQHR.

   A check is performed with lab personnel. Check Transfusion Record Tag client name, MRN#, date of birth and against Albumin for correct concentration, expiry date and lot number.

   Any discrepancies are to be resolved before leaving the lab.

   Albumin is available in 5% and 25%.

4. Sign transfusion record tag in lab upon receipt of blood product.

5. Obtain a Notification of Transfusion Form (RQHR form 425 (10/99)) from the laboratory if this is first transfusion client has received on current admission.

6. Place Notification of Transfusion Form with discharge instructions. Ensure client signs and receives canary copy prior to discharge.
C. Preparation and Verification of Albumin

EQUIPMENT

1. Documents (see APPENDICES for sample transfusion forms):
   - Document with client identification including name, date of birth, MRN i.e. stamped with addressograph
   - Transfusion Record Tag (two part tag that comes with blood product – pink on front, white on back) – Appendix #7
   - Albumin Label with patient identification (Sticker on Albumin Bottle) Appendix #8

2. Albumin

PROCEDURE

1. Inspect albumin. **Do not use** if turbid, cloudy, has particulate matter, vial cracked or damaged or previously entered.

   **NOTE: If a problem is noted, call Transfusions Department.**

2. Verify at bedside by two individuals the following:
   - Client Identification (Name, MRN#, Date of birth).
   - Verbal validation of client identification by client/family if possible.
   - Correct concentration of product.
   - Lot#.
   - Expiry date.

NURSING ALERT:

- All blood products must be CHECKED AT BEDSIDE BY TWO INDIVIDUALS from the following designations:
  - Registered nurse (RN)
  - Registered psychiatric nurse (RPN)
  - Licensed practical nurse (LPN)
  - Nurse practitioner (NP)
  - Medical doctor (MD)
  - Perfusionist
  - Nursing student – under supervision of instructor, RN/RPN/LPN

A grad nurse (GN), Advanced Care Paramedic, or competent trained adult (for home infusion) may check blood only if checking with RN/RPN/LPN (see policy #4.2.4 – Administration of Blood Products, in RQHR Policy Manual).

3. Sign Transfusion Record Tag (both individuals).

4. Detach top pink portion of Transfusion Record Tag and affix to Laboratory Reports Page (RQHR 312) or Blood Bank Report in transfusions section of client chart using adhesive tab. Client identification to remain with Albumin throughout entire transfusions process.
D. Commencing Albumin

EQUIPMENT

1. Documents (see APPENDICES for sample transfusion forms):
   - Albumin Administration Chart Appendix #3
2. PPE
3. Albumin 5% or 25%
4. Alcohol swabs
5. N/S syringe
6. Pre-primed vented administration set (Appendix #4)
7. IV pump if required

PROCEDURE

1. Don PPE.
2. Remove seal to expose stopper on vial and scrub with alcohol swab.
3. Spike Albumin bottle at a 90° angle through the center circle of the stopper with pre primed tubing.
4. Invert and hang bottle on IV pole.
5. Squeeze drip chamber to ½ full.
6. Open vent on drip chamber.

   NOTE: This allows air to enter the bottle and ensures flow of Albumin.

7. Scrub Micro Clave® adapter port of IV access for 15 seconds with alcohol swab.
8. Access IV adapter with N/S syringe and flush IV access with 5 mL N/S.
9. Remove flush syringe.
10. Attach vented administration tubing to IV access.

   NOTE: Infuse or drain 15 mL of normal saline prime to ensure Albumin has reached the client prior to commencing infusion.

11. Commence infusion.

   NOTE: Infusion may be run by gravity, or on a pump (primary or secondary).
   - If infusing via secondary setting of pump, must use piggyback mode.
   - Albumin is compatible with all IV solutions.
   - When infusing albumin 25%, due to its hyperosmotic nature, the rate of infusion should not normally exceed 1 to 2 mL/minute (60-120 mL/hour). Rate must be adjusted to individual requirements (check practitioner order).
• When infusion Albumin 5% the rate of infusion should not exceed 5 mL/minute (300 mL/hour).
• For pediatrics:
  o Rate is usually 1 to 3 mL/min (check Practitioners order).
  o A pump is always used.
• For infusion rates refer to Albumin Administration Chart – Appendix #3.

12. Obtain client’s vital signs (T, HR, BP, R, SpO2) and assess for signs of a transfusion reaction after 15 minutes and document.

NURSING ALERT:
• Severe transfusion reactions commonly occur within first 15 minutes of exposure to blood and blood products.
• Common transfusion reactions are due to:
  o Bacterial contamination.
  o Client allergy.
  o Physiological reactions, i.e. febrile.
• Transportation of a client should not occur during first 15 minutes of transfusion, except in emergency situation.
• An RN, RPN, NP, LPN, MF or Paramedic MUST accompany clients on all transportation while Albumin is infusing (i.e. tests/procedures, interfacility transfers etc.).

13. Obtain vital signs (T, HR, BP, R, SpO2) and document every hour, PRN and upon completion of transfusion.

NOTE: Albumin should be administered within 4 hours of issue from transfusions department.

If at 4 hours transfusion is not complete, discontinue infusion and see discard instructions as per Section F.

14. Document:
• Date and time infusion commenced.
• Lot number and product concentration.
• Infusion site.

E. Transfusion Reaction (Actual or Suspected)

EQUIPMENT

1. Documents as required (see APPENDICES for sample transfusion forms):
   • Saskatchewan Hospitals Transfusion Adverse Event Report Form Appendix #9, 9a
     http://rhdintranet/Transfusions/public/AdverseEvents/AdverseEventInformation.htm
2. N/S IV Solution
3. IV tubing Plumset # 313404 Gravity #313410
4. Oxygen tubing and Oxygen as required
5. Patient Identification
6. Plastic Blood Product Bag

NURSING ALERT:

- The following are common signs of a transfusion reaction:
  Early (first 1-2 hours):
  - Increased pulse
  - Hives or itching / allergic reaction
  - Temperature elevation >1°C
  - Hypo or hypertension
  - Chills
  - Dyspnea / hypoxemia
- Notify Practitioner if symptoms present.
- Complete Saskatchewan Hospitals Transfusion Adverse Event Report Form whenever a client experiences a reaction or suspected reaction.

PROCEDURE

1. STOP TRANSFUSION IMMEDIATELY if a transfusion reaction is suspected Albumin administration set intact until further instruction.

2. Keep IV open with N/S in a NEW PRIMARY LINE to ensure no further Albumin is administered.

3. Obtain vital signs (T, HR, BP, R, SpO2) and document.

NURSING ALERT:

- Implement Code Blue and resuscitation for severe reactions as client symptoms indicate.

4. Apply supplemental oxygen if required.

5. Re-check client identification and Albumin.

6. Notify Practitioner and Transfusion Department for further instruction.

7. Return residual Albumin and tubing in plastic bag (clamped and capped) to transfusion department if discontinued.

8. Complete Saskatchewan Hospitals Transfusion Adverse Event Report Form whenever client experiences a blood reaction or suspected reaction and document on health record.
F. Following Administration of Albumin

**EQUIPMENT**

1. Plastic Blood product bag – Appendix #11
2. Alcohol swabs
3. N/S syringe flush (5-20 mL)

**PROCEDURE**

1. Flush administration tubing with N/S to clear remaining Albumin (approximately 30 mL).
2. Discontinue the vented administration infusion set from client and discard.
4. Attach N/S flush to IV access.
5. Flush using 5 ml or see CVAD procedure for flushing post blood products.
6. Document:
   - Completion time of transfusion.
   - Volumes infused.
7. Retain empty Albumin bottle and client identification (can be sticker on bottle or Transfusions Record Tag) in designated area on ward for 12 hours post transfusion.
8. If no reaction occurs 12 hours post transfusion, discard glass bottle per unit protocol and shred white Transfusion Record Tag.
REFERENCES

Alberta Health Services (Sept 2013) Albumin (Human), 25%
http://www.albertahealthservices.ca/LabServices/wf-lab-clin-tm-albumin25.pdf

Albumin (Human), 25%/5% Solution, Summary Product Information, November 2014.


RQHR Procedure B.1 Blood Products Administration (2017)


Revised by: Anita MacPherson
Date: September 2014

Revised by: Anita MacPherson, CNE & Lisa Roland, CNE
Date: September 2017

Approved by:
Date: 4-Oct-17

Regina Qu’Appelle Health Region
Health Services
Nursing Procedure Committee

Approved: October 4, 2017
## CLIENT OR SUBSTITUTE DECISION MAKER

I, ________________________, give consent for administration of blood products to _________________________.

(Print name of client or decision maker)  (Print name of client)

I have been advised of the nature, consequences, benefits, and material risks associated with the administration of blood products and have been advised of any reasonable alternatives that may be available for my (or the client’s) condition. I have been informed of the consequences of refusing the administration of blood products. I have had the opportunity to seek clarification and have had my questions answered.

Signed: ___________________________________________  Date: ______________________________

(SIGNATURE OF CLIENT OR SUBSTITUTE DECISION MAKER)  (DD/MM/YYYY)

Telephone Permission Date: ____________________  Relationship to Client: ____________________________

Date: ____________________  Witness: ____________________  (Competent Adult)

## REFUSAL OF BLOOD OR BLOOD PRODUCTS

I do not consent to the administration of blood or blood products to myself or _______________________.

(SIGNATURE OF CLIENT)  (NAME OF CLIENT)

Signed: ___________________________________________  Date: ______________________________

(SIGNATURE OF CLIENT OR SUBSTITUTE DECISION MAKER)  (DD/MM/YYYY)

## PHYSICIAN / AUTHORIZED NURSE PRACTITIONER (NP)

The risks of administration of blood/blood components and/or plasma protein products (blood products) have been explained to the client or substitute decision maker. The nature, consequences, benefits, material risks, and the reasonable alternatives, including the consequence(s) of refusing the administration of blood products has been discussed with the client or substitute decision maker.

- INFORMATION PAMPHLET GIVEN TO CLIENT

This consent will remain valid per course of treatment up to 1 year or upon hospitalization discharge.

(PRINT NAME OF PHYSICIAN / AUTHORIZED NP)  (SIGNATURE OF PHYSICIAN / AUTHORIZED NP)

## PHYSICIAN

FOR USE IN **EMERGENCY SITUATIONS WHERE CAPACITY CANNOT BE DETERMINED AND INFORMED CONSENT CANNOT BE OBTAINED** (TRANSFUSION OF FULLY CROSSMATCHED DONOR RED BLOOD CELLS AND OTHER BLOOD PRODUCTS).

I certify that any delay in administering this transfusion will seriously endanger the health or life of the patient.

(SIGNATURE OF PHYSICIAN OR PHYSICIAN DESIGNATE)  (DD/MM/YYYY)

## USE OF UNCROSSMATCHED DONOR RED CELLS

I am aware the risk of transfusion of uncrossmatched donor red blood cells is greater than the risk of fully crossmatched donor red blood cells. It is my clinical judgment, the risk of awaiting fully crossmatched donor red blood cells is greater than the risk of administering uncrossmatched donor red blood cells.

Physician Signature: ___________________________  Date: ___________________________

(STARS EVENT Number: ______________________)

CALL RGH TRANSFUSIONS (306)766-4474 AND FAX FORM TO (306)766-4004 WHEN UNCROSSMATCHED RBCs required.
**Duration of Consent:**
For the purposes of transfusion medicine in Saskatchewan, the duration of consent is for either one admission or, if a client suffers from a chronic condition, for one course of treatment within 12 months, so long as the client’s condition or medical knowledge in general about the condition has not significantly changed. (Approved by the Senior Medical Officer Committee on May 11, 2011.)

**List of products for which the Blood Products Consent form is required:**
Some Products must have approval by Transfusion Physician on Call

<table>
<thead>
<tr>
<th>Require Blood Products Consent</th>
<th>Do not require Blood Products Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red Blood Cells, Leukocyte Reduced (LR), including washed and irradiated RBC</td>
<td></td>
</tr>
<tr>
<td>Platelets, including apheresis and buffy coat-derived platelets (Pooled Platelets LR)</td>
<td></td>
</tr>
<tr>
<td>Plasma components, including Apheresis Fresh Frozen Plasma, Frozen Plasma, Cryosupernatant Plasma, Cryoprecipitate, Solvent Detergent (S/D) Plasma</td>
<td></td>
</tr>
<tr>
<td>Albumin</td>
<td></td>
</tr>
<tr>
<td>Hyperimmune Globulins: Anti-D IG (WinRho SDF), Anti-VZIG, Anti-HBIG, IMIG, Anti-CMV IG, Hepatitis A Immune Globulin</td>
<td></td>
</tr>
<tr>
<td>Immune Globulins, including intravenous (IVIG) and subcutaneous formulations</td>
<td></td>
</tr>
<tr>
<td>C1-Esterase Inhibitor</td>
<td></td>
</tr>
<tr>
<td>Prothrombin Complex Concentrates (octaplex, Beriplex)</td>
<td></td>
</tr>
<tr>
<td>Factor Concentrates: Anti-Inhibitor Coagulant Complex (FEIBA NF)</td>
<td>Factor Concentrates: rFVIIa (NiaStase RT)</td>
</tr>
<tr>
<td>Antithrombin</td>
<td>rFVIII (Advate, Helixate FS, Kogenate FS, Xyntha)</td>
</tr>
<tr>
<td>FVII Special Access</td>
<td>rFIX (BeneFIX)</td>
</tr>
<tr>
<td>FVIII/vWF (Humate-P, wilate)</td>
<td></td>
</tr>
<tr>
<td>FIX</td>
<td></td>
</tr>
<tr>
<td>FXI Special Access</td>
<td></td>
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<tr>
<td>FXIII Special Access</td>
<td></td>
</tr>
<tr>
<td>Fibrinogen Special Access</td>
<td></td>
</tr>
<tr>
<td>Protein C Special Access</td>
<td></td>
</tr>
<tr>
<td>Fibrin Sealants: Tisseel</td>
<td></td>
</tr>
<tr>
<td>Evicel</td>
<td></td>
</tr>
<tr>
<td>Artiss</td>
<td></td>
</tr>
</tbody>
</table>

For new or other products not listed, please contact Transfusions Department at 306-766-4474.
**APPENDIX 2 - Checklist**

**BLOOD AND BLOOD PRODUCTS ADMINISTRATION CHECKLIST**

**Refer to Applicable Nursing Procedures (B.1, B.1.1, B.1.2, B.1.3, B.1.6)**

<table>
<thead>
<tr>
<th>No.</th>
<th>Step Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Practitioner Order Verified</td>
</tr>
<tr>
<td>2</td>
<td>Consent for Administration of Blood/Blood Products Signed</td>
</tr>
<tr>
<td></td>
<td>• Yes – Proceed to #3</td>
</tr>
<tr>
<td></td>
<td>• No – Was the Practitioner notified to obtain informed consent or have a Practitioner Order that states: “Ok to proceed with transfusion without signed consent”</td>
</tr>
<tr>
<td>3</td>
<td>Patient Education Completed</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• No – Record reason in notes</td>
</tr>
<tr>
<td>4</td>
<td>Patient Identity Confirmed (2 Client Identifiers)</td>
</tr>
<tr>
<td></td>
<td>• ID band</td>
</tr>
<tr>
<td></td>
<td>• Verbal confirmation</td>
</tr>
<tr>
<td>5</td>
<td>Crossmatch Results (Required for PRBC, Cryoprecipitate, Plasma, Platelets)</td>
</tr>
<tr>
<td></td>
<td>• On chart</td>
</tr>
<tr>
<td></td>
<td>• Using uncrossmatched blood (practitioner’s signature required)</td>
</tr>
<tr>
<td>6</td>
<td>IV in place, IV Fluid</td>
</tr>
<tr>
<td></td>
<td>• 0.9% Sodium Chloride</td>
</tr>
<tr>
<td>7</td>
<td>Baseline Vital Signs (T, P, R, B, SpO$_2$)</td>
</tr>
<tr>
<td></td>
<td>• Recorded within 30 minutes prior to initiation</td>
</tr>
<tr>
<td>8</td>
<td>Premeds</td>
</tr>
<tr>
<td></td>
<td>• Ordered</td>
</tr>
<tr>
<td></td>
<td>• Administered</td>
</tr>
<tr>
<td></td>
<td>• N/A</td>
</tr>
<tr>
<td>9</td>
<td>Visual Inspection/Expiry Acceptable (If not acceptable, return to Transfusions Department)</td>
</tr>
<tr>
<td>10</td>
<td>Verbal Validation (Blood Unit Label, Blood Bank Report, Transfusion Record Tag &amp; Patient Armband) - Done at bedside by 2 appropriate designates) Note: It is not necessary to have Donor Unit # on Blood Bank Report</td>
</tr>
<tr>
<td></td>
<td>• Name and Date of Birth</td>
</tr>
<tr>
<td></td>
<td>• MRN/HIN and/or Transfusion Services Identification Number (TSIN)</td>
</tr>
<tr>
<td></td>
<td>• Client ABO and Rh (required for cellular products)</td>
</tr>
<tr>
<td></td>
<td>• Unit ABO and Rh (required for cellular products)</td>
</tr>
<tr>
<td></td>
<td>• Unit # (verify Transfusion Record Tag and Blood Unit Label)</td>
</tr>
<tr>
<td></td>
<td>• 2 signatures on tag</td>
</tr>
<tr>
<td>11</td>
<td>Final Verification</td>
</tr>
<tr>
<td></td>
<td>• Crossmatch tag verified with armband</td>
</tr>
<tr>
<td>12</td>
<td>Documentation</td>
</tr>
<tr>
<td></td>
<td>• Transfusion initiated within 30 minutes of issue</td>
</tr>
<tr>
<td></td>
<td>• Vital Signs (T, P, R, BP SpO$_2$)</td>
</tr>
<tr>
<td></td>
<td>• 15 minutes</td>
</tr>
<tr>
<td></td>
<td>• Every hour and PRN</td>
</tr>
<tr>
<td></td>
<td>• Upon completion</td>
</tr>
<tr>
<td></td>
<td>• Infused within 4 hours of issue</td>
</tr>
<tr>
<td></td>
<td>• Pink copy of transfusion record tag affixed on chart</td>
</tr>
<tr>
<td>13</td>
<td>Transfusion Reaction (Algorithm Appendix 4a)</td>
</tr>
<tr>
<td></td>
<td>• Adverse Reaction Noted – See Below</td>
</tr>
<tr>
<td></td>
<td>• No Adverse Reaction</td>
</tr>
<tr>
<td></td>
<td>• Transfusion stopped immediately</td>
</tr>
<tr>
<td></td>
<td>• IV patency maintained with compatible fluid</td>
</tr>
<tr>
<td></td>
<td>• Practitioner notified</td>
</tr>
<tr>
<td></td>
<td>• Vital signs taken every 15 minutes</td>
</tr>
<tr>
<td></td>
<td>• Client identification And blood product re-checked</td>
</tr>
<tr>
<td></td>
<td>• Transfusion Service/Lab notified</td>
</tr>
<tr>
<td></td>
<td>• SK Transfusion Adverse Event Report form completed</td>
</tr>
<tr>
<td>14</td>
<td>Following Transfusion</td>
</tr>
<tr>
<td></td>
<td>• Retain empty blood bag and white Transfusion Record Tag in designated area on ward for 12 hours post transfusion.</td>
</tr>
<tr>
<td></td>
<td>• Remove white Transfusion Record Tag from blood bag after 12 hours and send to Transfusions Department</td>
</tr>
<tr>
<td></td>
<td>• Discard empty blood bag after 12 hours into appropriate container</td>
</tr>
<tr>
<td>15</td>
<td>Notification of Blood and Blood Products (RQHIR #425)</td>
</tr>
<tr>
<td></td>
<td>• On chart with discharge planning</td>
</tr>
<tr>
<td>Blood Component</td>
<td>Uses</td>
</tr>
<tr>
<td>-----------------</td>
<td>------</td>
</tr>
<tr>
<td>Albumin (5% and 25%)</td>
<td>Restore and maintain circulating volumes. Replace volumes due to shock from burns, trauma, surgery or infection. To treat hypoproteinemia.</td>
</tr>
</tbody>
</table>

Route is via IV using gravity or Pump
Transfusions of all blood products must start within 30 minutes of issue.
Infusion rates should be prescribed by MRP. If no rate prescribed please follow the above guidelines for infusion times Compatible with all IV solutions.
NOT Venting Tubing

Vented Tubing
# Health Services

## Appendix 5 Request for Transfusion Services Requisition

### Regina Qu'Appelle Health Region

**REQUEST FOR TRANSFUSION SERVICES**

Transfusions samples must be labelled with:
- ✓ Full name (First and Last)
- ✓ Date of Birth
- ✓ MRN (Use HSN only if MRN unknown)

**Ordered by:**

**Priority:**
- [ ] STAT
- [ ] URGENT
- [ ] ROUTINE

**Diagnosis:**

**Date & Time Required:**

**Reason for Request:**
- [ ] Surgery
- [ ] Transfusion
- [ ] On Hand

**Typenex:**

Place red sticker here

**Collected by:**

**Date and Time:**

**Patient History:**

- Previous Transfusions:
  - [ ] Yes Date __________
  - [ ] No
- Previous Pregnancies:
  - [ ] Yes
  - [ ] No
- Currently pregnant [ ]

**BLOOD GROUP & Rh:**

**ABO/OTHER SCREEN:**

**OTHER:**

**LAB USE ONLY**

**File Search Results:**

**Initials:**

**Testing Required**

<table>
<thead>
<tr>
<th>Blood Product Required</th>
<th>Reason for Product</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Surgery</td>
</tr>
<tr>
<td></td>
<td>Anemia / Bleeding</td>
</tr>
<tr>
<td></td>
<td>Correction of Coagulopathy</td>
</tr>
<tr>
<td></td>
<td>Low Platelet Count</td>
</tr>
</tbody>
</table>

**Blood Product Required # Units**

- [ ] Packed Cells ______
- [ ] Ped Packed Cells (ml) ______
- [ ] Platelets (Adult Dose) ______
- [ ] Ped Platelets (ml) ______
- [ ] Plasma ______
- [ ] Cryoprecipitate ______

**Reason for Product**

<table>
<thead>
<tr>
<th>Plasma Protein Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVIG g</td>
</tr>
<tr>
<td>IVIG PPO 561 sent (Required prior to 1st dose)</td>
</tr>
<tr>
<td>Coagulation Products Factor ______ Dose ______</td>
</tr>
<tr>
<td>Prothrombin Complex (PCC) ______ ml</td>
</tr>
<tr>
<td>PCC PPO 489 sent (Required prior to issue)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other (Please State):</th>
</tr>
</thead>
<tbody>
<tr>
<td>25% Albumin # vials</td>
</tr>
<tr>
<td>5% Albumin # vials</td>
</tr>
<tr>
<td>WinRho (300 µg)</td>
</tr>
<tr>
<td>Cl Esterase Inhibitor Dose ______ IU</td>
</tr>
</tbody>
</table>

ROHR 1274 (09/15)
Notification of Administration of Blood and/or Blood Products

Name: ________________________________

MRN: ________________________________

During your stay in the Regina Qu’Appelle Health Region you were given a human blood product.

If you have any questions regarding this product please contact your physician.

Discharge/Transfer

(Signature of person or substitute decision maker) ____________________________ (Date mm/dd/yyyy)

(Health Care Professional providing discharge or transfer documentation) __________________________

White - Health Records    Canary - Patient
TRANSFUSION RECORD TAG

[Image of a transfusion record tag]

Appendix 7
Pink Transfusion Tag
Patient Identification Sticker (Attached to Albumin Bottle)
HEALTH SERVICES

Appendix 9
Adverse Events Form

Saskatchewan Transfusion
Adverse Event Report Form

Reporting Facility Name: ____________________________

Phone Number: ____________________________ Fax Number: ____________________________

Diagnosis: ____________________________

Indication for Transfusion: ____________________________

Category (choose one): [ ] Hematology/BMT [ ] Oncology [ ] Medical [ ] Surgical [ ] Obstetrics/Gynecology/Perinatal [ ] Trauma [ ] Neonatal/Peds

1. Patient and Blood Component/Package Identifier Verification (Clinical check)

IF NO, contact TMS/Lab IMMEDIATELY. Another patient may be at risk.

Date/Time TMS/Lab notified: ____________________________ Person contacted: ____________________________

2. Clinical History (Check all that apply)

   [ ] Pre-existing fever (> 38.9°C before transfusion)
   [ ] History or pre-transfusion evidence of hypervolemia
   [ ] Immune-compromised (specify):

   [ ] Transfused under GENERAL anesthesia
   [ ] Transfused under REGIONAL anesthesia
   [ ] Transfusion pre-medications (specify):

   Patient currently prescribed: [ ] ACE inhibitor [ ] Diuretic [ ] Antibiotics (specify):

   History of transfusion: [ ] No [ ] Unknown [ ] Yes (within 3 months) [ ] Yes (> 3 months)

   History of pregnancies/miscarriages: [ ] No [ ] Unknown [ ] Yes (within 3 months) [ ] Yes (> 3 months)

3. Location, Date and Time of Transfusion Reaction

   Choose one: [ ] ICU [ ] ER [ ] Medical Ward [ ] Surgical Ward [ ] OR/Post Anesthesia Care [ ] OB/Gyn [ ] Outpatient [ ] Chronic Care [ ] Lab (Serologic)

   Date (dd/mm/yyyy): ____________ Time Transfusion Started: ____________ Time Reaction Occurred: ____________ Time Transfusion Stopped: ____________ Time Transfusion Repeated: ____________ Time Transfusion Completed: ____________

4. Vitals & Clinical Signs and Symptoms


   Clinical Signs and Symptoms (Check all that apply; attach medication record, nursing notes, physician notes, and transfusion administration record, if available)

   [ ] Urticaria (wheal)
   [ ] Pruritus (itching)
   [ ] Headache
   [ ] Fever (oral T ≥ 38°C AND 21°C rise above baseline temp)
   [ ] Chills (sensation of cold)
   [ ] Rigors (involuntary shaking)
   [ ] Flushing
   [ ] Skin rash other than urticaria
   [ ] Restlessness/anxiety
   [ ] Nausea/vomiting

   Other relevant clinical information:

   [ ] Joint/muscle pain
   [ ] Back pain
   [ ] Chest pain
   [ ] Head pain at IV site
   [ ] Dizziness
   [ ] Jaundice
   [ ] Red or brown urine
   [ ] Oliguria
   [ ] Diffuse hemorrhage
   [ ] Facial or tongue swelling
   [ ] Dyspnea (shortness of breath)
   [ ] Wheezing
   [ ] Hypoxemia: SpO2 _____% or PaO2 _____ mm Hg on _____ L/min
   [ ] Room air
   [ ] Supplementary O2 _____ L/min
   [ ] Hypertension
   [ ] Hypotension (SBP drop by > 30mmHg)
   [ ] Tachycardia (HR rise by > 40bpm)
   [ ] Shock

5. Blood Component/Product(s) and Equipment Information (Attach sheet with additional information if needed)

   Blood Component/Product Type
   Product ABO/Rh
   Unit Number or Lot Number
   Expiry Date (dd/mm/yyyy)
   Volume Transfused (mL)
   Transfusion Rate (mL/min)

   Filters or Equipment Used
   [ ] Standard blood filter
   [ ] Other blood filter
   [ ] IV pump
   [ ] Blood warmer
   [ ] Rapid infusion device
   [ ] Re-infusion device
   [ ] Cell saver

6. Measures Taken and Notifications

6a. Transfusion Reaction Treatment Measures Taken (Check all that apply)

   [ ] None
   [ ] Analgesics
   [ ] Vasopressors
   [ ] Antibiotics
   [ ] Antihistamines
   [ ] Steroids
   [ ] Mechanical Ventilation
   [ ] ICU
   [ ] Chest X-ray
   [ ] Patient Blood Culture Ordered
   [ ] Other Measures Taken

6b. Notifications

   [ ] Physician Name: ____________________________ Date/Time: ____________________________ TMS/Lab Name: ____________________________ Date/Time: ____________________________

   Reported By: ____________________________

   Signature: ____________________________ Name (print): ____________________________ Designation: ____________________________ Facility: ____________________________ Date/Time: ____________________________

Appendix # 9 • Saskatchewan Transfusion Resource Manual • Version January 11, 2017

Approved: October 4, 2017

Revised: September 2014

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Appendix 9a
Adverse Events Form Reverse Side

Saskatchewan Transfusion Adverse Event Report Form

Patient Demographics
Patient Legal Last Name: ____________________________
Patient Legal First Name: ____________________________
HSNMRN: ____________________________
Date of Birth (dd/mm/yyyy): ____________________________
Gender: ☐ Male ☐ Female ☐ Unknown

TO BE COMPLETED BY THE TRANSFUSION SERVICE/LABORATORY

7a. History of Previous Transfusion Reactions
☐ None ☐ Unknown ☐ Yes (within 3 months) ☐ Yes (> 3 months)

Type of previous reaction:

7b. Relevant Lab Results (attach all reports with the results of completed investigations, where applicable)

<table>
<thead>
<tr>
<th>Level 1 Investigation</th>
<th>Pre-transfusion Result</th>
<th>Post-transfusion Result</th>
<th>Level 2 Investigation</th>
<th>Pre-transfusion Result</th>
<th>Post-transfusion Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab Cerclage Check</td>
<td>☐ pass ☐ fail</td>
<td>☐ pass ☐ fail</td>
<td>DAT</td>
<td>☐ negative ☐ positive</td>
<td>☐ negative ☐ positive</td>
</tr>
<tr>
<td>Visual Hemolysis Check</td>
<td>☐ negative ☐ positive</td>
<td>☐ negative ☐ positive</td>
<td>ABO/Rh</td>
<td>☐ patient</td>
<td>☐ RBC unit</td>
</tr>
<tr>
<td>DAT</td>
<td>☐ negative ☐ positive</td>
<td>Ab Screen (negative ☐ positive)</td>
<td>IAT Crossmatch (negative ☐ positive)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BLOOD CULTURE RESULTS: (attach all microbiology reports)

☐ patient ☐ positive ☐ negative
☐ product ☐ positive ☐ negative

7c. Notifications / Reports (check and provide details for all that apply)

Facility Risk Management ☐ No ☐ Yes ☐ Contact Person: ____________________________Date Reported: ____________________________

CBS or Product Manufacturer ☐ No ☐ Yes ☐ Contact Person: ____________________________Date Reported: ____________________________

Health Canada ☐ No ☐ Yes ☐ Contact Person: ____________________________Date Reported: ____________________________

TO BE COMPLETED BY SK TRANSFUSION MEDICINE CONSULTANT OR DESIGNATE

8. Review of Investigation & Conclusion (based on 2007 PHAC definitions)

☐ No transfusion reaction ☐ FNH ☐ Minor allergic ☐ Severe allergic/anaphylactic/anaphylactoid ☐ Anaphylactic shock

☐ Incompatible transfusion ☐ Intentional ☐ Unintentional ☐ ABO System Anti- ☐ Other System Anti-

☐ Acute hemolytic reaction ☐ Delayed hemolytic reaction

Causes: ____________________________

☐ Delayed serological transfusion reaction

Specify new alloantibody(ies) within 26 days of transfusion: Anti- ____________________________

☐ TACO ☐ Diuretics effective ☐ TAD ☐ PTP ☐ TA-GVHD ☐ Hypotensive reaction

☐ Blood borne infection: ☐ Bacterial ☐ Viral ☐ Other (specify): ____________________________

Recipient Specified organism: ____________________________

☐ Donor/product infected: ☐ Yes ☐ No If yes, specify organism: ____________________________

☐ TRALI ☐ Possible TRALI ☐ Risk factors:

☐ CBS TRALI criteria met (1+2+3+4):

1. Hypoxemia (FiO2 < 96% or Pao2 < 65 mm Hg or Pao2/FiO2 < 300) 2. Transfusion within 6 hours of TRALI

3. New chest X-Ray findings of bilateral infiltrates 4. No evidence of circulatory overload ☐ Diuretics ineffective

Ventilation Duration: ____________________________

☐ IVIG headache ☐ Aseptic meningitis (IVIG related) ☐ Unknown ☐ Other (specify): ____________________________

Implication Cause of Transfusion Reaction (if applicable):

☐ Incident (Error/Accident) ☐ Patient identification ☐ Product related ☐ Equipment related ☐ Other (specify): ____________________________

9. Relationship, Severity and Outcome of Adverse Reaction

a. Relationship of reaction to transfusion ☐ Definite ☐ Probable ☐ Possible ☐ Doubtful ☐ Ruled out ☐ Not determined

b. Severity (Grade) ☐ 1 (non-severe) ☐ 2 (severe) ☐ 3 (life-threatening) ☐ 4 (death) ☐ Not determined
c. Outcome ☐ Minor or no sequelae ☐ Major or long-term sequelae ☐ Death ☐ Not determined
d. Status of investigation ☐ In progress ☐ Concluded ☐ Cannot be concluded → Reason (specify): ____________________________

10. Comments and Recommendations

11. Conclusion Sign Off

SK TM Consultant Signature: ____________________________ Name (print): ____________________________ Date: ____________________________

For cases reported to Health Canada:

Local TM Medical Director/Pathologist Signature: ____________________________ Name (print): ____________________________ Date: ____________________________

Fax SK Adverse Event Report Form to SHR 306-655-0987 or RQHR 306-766-4382

SK TTISS Number: ____________________________ CNP/HS Number: ____________________________

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