Attach patient label here

NHS
Cornwall Partnership
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Community blood prescription sheet

Date required:		**Hospital site:**	
GP name:		**GP telephone:**	
Allergies:			

TACO checklist	Patient risk assessment (adapted from SHOT)	Response
Heart 	Does the patient have any of the following? Diagnosis of heart failure, congestive cardiac failure, severe aortic stenosis, or moderate to severe left ventricular dysfunction?	☐ Yes ☐ No
	Is the patient on a regular diuretic?	☐ Yes ☐ No
	Does the patient have severe anaemia?	☐ Yes ☐ No
Lungs 	Is the patient known to have pulmonary oedema?	☐ Yes ☐ No
	Does the patient have respiratory symptoms of undiagnosed cause?	☐ Yes ☐ No
Fluids 	Is the fluid balance clinically significantly positive?	☐ Yes ☐ No
	Is patient receiving intravenous fluids (or received them in previous 24 hours)?	☐ Yes ☐ No
	Is there any peripheral oedema?	☐ Yes ☐ No
	Does the patient have hypoalbuminaemia?	☐ Yes ☐ No
	Does the patient have significant renal impairment?	☐ Yes ☐ No

Date	Prescription	Dose	Frequency	Route	Additional directions and comments	Prescribers name and signature	Signature of administrator

Patient risk assessment	Completed by
Has this been identified as an increased risk of TACO? ☐ Yes ☐ No	
If yes, what management has been put in place?	

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Blood transfusion assessment and care plan

Patient name		**Date of birth:**	
Signature of admin:		**CR number:**	

Action, intervention and care instruction	Unit 1	Unit 2
Start time		
Completion time		
Identify reason for transfusion in notes and Rio		
Identify that consent has been obtained, alternatives, risks and explained to the patient, pre-transfusion leaflet given to patient		
Check equipment and cannula is in-situ and patency. Complete cannula care plan.		
Identify blood expiry time and use by date and dereservation date.		
Baselines pre-observations undertaken and documented on National Early Warning Score 2 chart.		
Check that unit was correctly prescribed or requested.		
Take the transfer box to the patient (remains with patient for duration)		
Positive patient ID: Ask patient to verbally confirm name and date of birth. Make sure what they state matches their wristband, blood traceability tag and prescription. Also check NHS number from the wristband matches the prescription and blood traceability tag.		
Positive patient ID: Check that product name form the prescription matches the product name on the traceability tag. Check that all of the information form traceability tag matches the information on the blood bag. Check if special blood requirements stated on the prescription are stated on the blood bag.		
Identify that the blood products are safe to administrate and no evidence of tampering, clots, faults or leaks.		
Sign traceability and consent on the back of the traceability tag		
Unit sticker and donation number to be placed on prescription chart.		
Commence transfusion and sign, time and date the unit started by on the back of the traceability tag.		
Observations after 15 minutes, and on clinical assessment. Advise and observe the patient of possible reactions and to summon help.		
If any signs of transfusion reaction, . Only disconnect on medical advice.		
On completion of blood transfusion take down, flush cannula, complete cannula care plan.		
Complete observations and assessment. Patient to be observed for 30 minutes post transfusion.		
Sign, time and date unit taken completed box or on back of traceability tag. Ensure documented in patients notes and Rio.		
Dispose of completed blood bag in the clinical waste except for blood products supplied by Derriford which require empty unit returned.		
Offer the patient a post transfusion leaflet.		
Arrange collection of any unused blood products, or if there was any transfusion reaction to the laboratory.		
• Royal Cornwall Hospitals NHS Trust: Before disposal of the bag, dis-attach the traceability tag form the bag and make sure appropriate information is documented on back of the tag. Completed tag to be sent back to • Derriford: Return used blood bag and traceability tag.		

NEWS2 observation chart: ACS inpatient

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NAME:	DoB:	NHS No:

YEAR		DATE																			
		TIME																			
A+B Respirations Breaths/min		≥25									3										
		21-24									2										
		12-20																			
		9-11									1										
		≤8									3										
A+B SpO2 Scale 1 Oxygen saturation (%)		≥96																			
		94-95									1										
		92-93									2										
		≤91									3										
SpO2 Scale 2† Oxygen saturation (%) Use Scale 2 if target range is 88-92%, eg in hypercapnic respiratory failure. †ONLY use scale 2 under direction of a qualified clinician.		≥97 on O2									3										
		95-96 on O2									2										
		93-94 on O2									1										
		≥93 on air																			
		88-92																			
		86-87									1										
		84-85									2										
		≤83%									3										
Air or oxygen?		A=Air																			
		O_2 L/min									2										
C Blood Pressure Score uses systolic BP only Accept systolic BP of ..... mmHg for this patient Signed: Date:		≥220									3										
		201-219																			
		181-200																			
		161-180																			
		141-160																			
		121-140																			
		111-120																			
		101-110									1										
		91-100									2										
		81-90									3										
		71-80									3										
		≤70									3										
C Pulse Accept HR of ..... bpm as normal for this patient Signed: Date:		≥131									3										
		121-130									2										
		111-120									2										
		101-110									1										
		91-100									1										
		81-90																			
		71-80																			
		61-70																			
		51-60																			
		41-50									1										
		≤40									3										
D Consciousness Score for NEW onset confusion (not chronic)		Alert																			
		Confusion									3										
		VPU									3										
E Temperature °C		≥39.1°									2										
		38.1-39°									1										
		37.1-38°																			
		36.1-37°																			
		35.1-36°									1										
		≤35°									3										
NEWS TOTAL																					
URINE OUTPUT Y/N																					
BLOOD SUGAR																					
ESCALATION OF CARE Y/N																					
Obs performed by																					
RN Signature																					

St 3 mins BP: /

St-BP: /

L-BP: /

Time:

Date:

CHA4002 / A-020-2

Escalation of patient

Concern about a patient should lead to escalation, regardless of the score.

NEWS 2 score and clinical risk	Action	Monitoring
0. Low	Routine observations.	12 hourly.
1 to 4 or a score of 3 in a single parameter Low to medium	• Is this normal and within recorded acceptable parameters for this patient? • If not normal for the patient, undertake ABCDE assessment, increase monitoring and alert the nurse in charge. Consider medial consultation and/or escalation. • RN overseeing care needs to countersign NEWS2 score.	Minimum 4 to 6 hourly*
5 to 6 or medium	• Alert the RN in charge, ABCDE assessment and screen for sepsis using the sepsis screening tool. RN to seek urgent medical consultation and countersign chart. • If assessment not possible within 1 hour, consider 111 or 999.	30 minutes then 1 hourly*
7 or more. High.	• Gain immediate help and alert the RN in charge. • Continuous ABCDE assessment and screen for sepsis using the sepsis screening tool. RN to countersign NEWS2 score. • Call 999 for immediate medical help (consider TEP form and ceilings of care).	15 minutes*

* Minimum monitoring unless more/less frequent monitoring is considered appropriate by senior staff.

Management of transfusion reactions

- Transfusion reactions can occur very soon after the start of transfusion, during the transfusion or several hours later. Some are life-threatening, others are minor.
- Signs and symptoms may include, fever, breathlessness, hypotension, itching, stridor, facial swelling or a feeling of doom.
- Be particularly alert for transfusion-associated circulatory overload (increased risk with age and underlying diseases).

Immediate actions

- Inform medical staff immediately.
- Stop the transfusion but maintain venous access.
- Assess and maintain airway, breathing and circulation.
- Treat the symptoms.
- Confirm patient identification and compatibility of product.

Depending on the type and severity of the reaction, it may be appropriate to continue the transfusion (slow rate if required). Guidance will be available from your local transfusion team. The patient will require close monitoring for further deterioration.

Investigations in severe reactions

- Full blood count.
- Coagulation screen (including fibrinogen).
- Urea and electrolytes.
- Repeat group and screen and DAT.

Report all moderate or severe reactions to laboratory and complete incident report.

- Return blood component and giving set to laboratory.
- Complete transfusion reaction form and report to issuing acute Trust.

Additional actions

- Monitor patient observations: Check temperature, pulse and respiration, blood pressure, urine output and oxygen saturation.
- Review and monitor fluid balance.
- Retain component bag and administration set.
- Inform transfusion practitioner and/or transfusion laboratory.
- Document in patient notes.
- Report as an incident.
- Escalate to senior clinical teams as needed and get additional help promptly.

Others (to consider depending on symptoms and reaction type): Liver function tests (including bilirupin), LDH, haemoglobin, blood cultures for patient, urine test for presence of haemoglobin, blood glucose, blood gases and chest x-ray.

Send blood bag and giving set sealed back to transfusion laboratory for further investigation.

RCHT transfusion lab: 01872 252 500
RCHT transfusion practitioner: Ext 3093. Bleep 3046.
UHP transfusion lab: ext 5211.
UHP emergency blood bank hotline: ext 52828
NHDHT transfusion lab: 01271 322 327. Bleep 045.
Bleep on-call haematology consultant through switchboard if life-threatening or severe.