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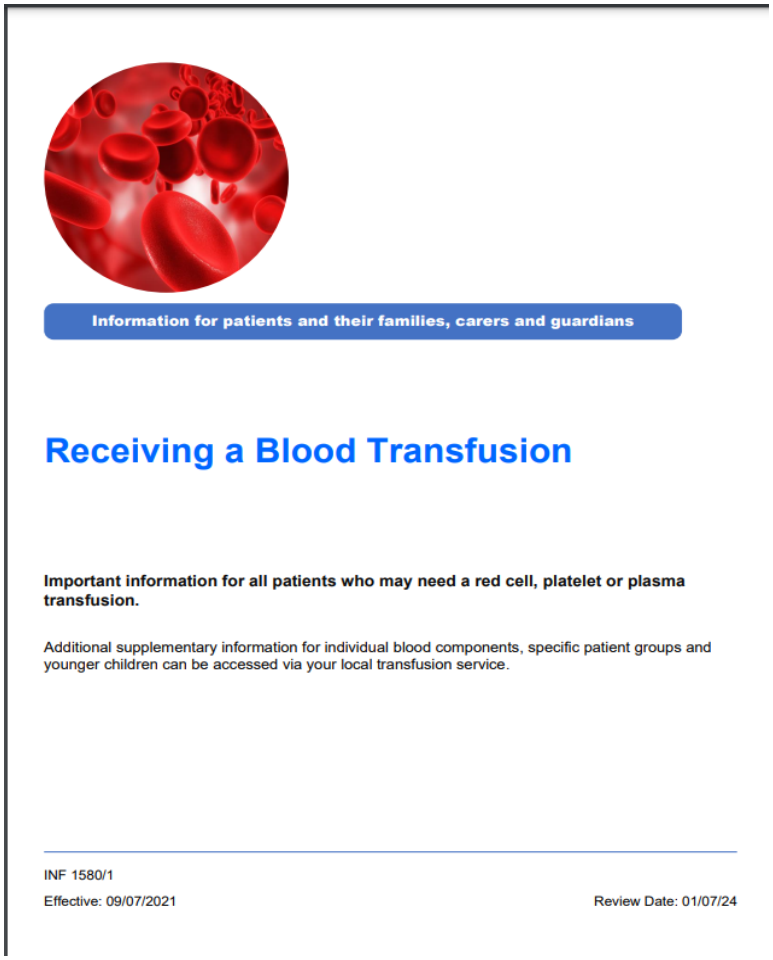
Consent and Blood Transfusion

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Transfusion Practitioner 2025

By the end of this session

- Understand legal and practical aspects of capacity
- Understand rationale and requirement for consent to transfusion
- Be aware of information resources available to patients and healthcare staff
- Understand benefits, risks and alternatives to transfusion



Information for patients and their families, carers and guardians

Receiving a Blood Transfusion

Important information for all patients who may need a red cell, platelet or plasma transfusion.

Additional supplementary information for individual blood components, specific patient groups and younger children can be accessed via your local transfusion service.

INF 1580/1

Effective: 09/07/2021

Review Date: 01/07/24

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What is consent?

- It is a general legal and ethical principle that valid consent should be obtained from a patient (parent/ guardian) before they are treated
- General Medical Council 2008: Consent guidance: patients and doctors making decisions together
- Involving the patient in the consent process respects the right of the patient to be included in decisions about their treatment

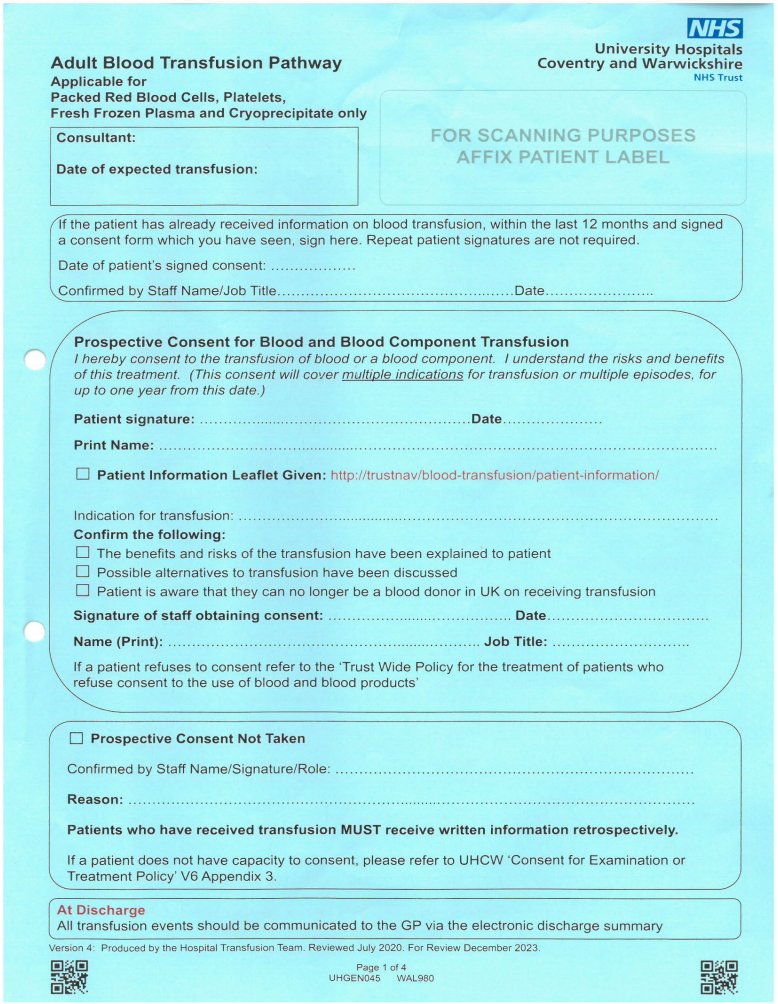
Consent and blood transfusion

- October 2011 SaBTO published guidelines on Patient Consent for Transfusion, this was revised in 2020:
- 'Valid consent' for blood transfusion should be obtained and **documented in the patient's clinical record** by the healthcare professional.
- Modified form of consent for long term multi-transfused patients.
- Standardised information resource for clinicians indicating the key issues to be discussed with patient
- Patients who have received a blood transfusion and who were not able to give valid consent prior to the transfusion should be provided with information retrospectively.

What is ‘Valid Consent’

- For the consent process to be valid, the patient must be competent (have capacity) and have received sufficient information to make an informed decision
- Written information should be given, NHSBT provide a standardised source of information for patients who may receive a blood transfusion in the UK
- The discussion on consent should be clearly documented in the patient’s case notes

Adult Transfusion Pathway



NHS
University Hospitals
Coventry and Warwickshire
NHS Trust

Adult Blood Transfusion Pathway
Applicable for
Packed Red Blood Cells, Platelets,
Fresh Frozen Plasma and Cryoprecipitate only

Consultant:

Date of expected transfusion:

FOR SCANNING PURPOSES
AFFIX PATIENT LABEL

If the patient has already received information on blood transfusion, within the last 12 months and signed a consent form which you have seen, sign here. Repeat patient signatures are not required.

Date of patient's signed consent: .....

Confirmed by Staff Name/Job Title.....Date.....

Prospective Consent for Blood and Blood Component Transfusion

I hereby consent to the transfusion of blood or a blood component. I understand the risks and benefits of this treatment. (This consent will cover multiple indications for transfusion or multiple episodes, for up to one year from this date.)

Patient signature: .....**Date**.....

Print Name: .....

☐ **Patient Information Leaflet Given:** http://trustnav/blood-transfusion/patient-information/

Indication for transfusion: .....

Confirm the following:

☐ The benefits and risks of the transfusion have been explained to patient
☐ Possible alternatives to transfusion have been discussed
☐ Patient is aware that they can no longer be a blood donor in UK on receiving transfusion

Signature of staff obtaining consent: ..... **Date**.....

Name (Print): ..... **Job Title:** .....

If a patient refuses to consent refer to the 'Trust Wide Policy for the treatment of patients who refuse consent to the use of blood and blood products'

☐ **Prospective Consent Not Taken**

Confirmed by Staff Name/Signature/Role: .....

Reason: .....

Patients who have received transfusion MUST receive written information retrospectively.

If a patient does not have capacity to consent, please refer to UHCW 'Consent for Examination or Treatment Policy' V6 Appendix 3.

At Discharge
All transfusion events should be communicated to the GP via the electronic discharge summary

Version 4: Produced by the Hospital Transfusion Team. Reviewed July 2020. For Review December 2023.

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UHGEN045 WAL980

Sections for Transfusion dependant patients and when prospective consent cannot be taken. Communicate any Transfusion episodes to the GP at discharge

Why?

- Patients are not always given information on the risks, benefits, and alternatives to transfusion, or the right to refuse transfuse
- Patients are not always made aware that they have received a transfusion
- Patients who are unaware that they have received a transfusion may go on to donate blood when they should not
- There is inconsistent practice across the UK. In 2014 a

NCA of notes reviewed showed only 43% of consent was documented.

Recommended framework adapted from NICE Transfusion Guidelines 2015

- the reason for the transfusion
- the benefits of the transfusion
- the risks of transfusion – both short- and long-term risks (and including any additional risks pertinent to long term multi-transfused patients)
- any transfusion needs specific to them
- any alternatives that are available, and how they might reduce their need for a transfusion

- the possible consequences of refusing a blood transfusion
- the transfusion process
- that they are no longer eligible to donate blood (with the exception of individuals who have received Convalescent Plasma from donating Convalescent Plasma to treat individuals with SARS-CoV-2
- that they are encouraged to ask questions

Who?

- All patient's requiring a blood transfusion or who are cross matched in expectation of a transfusion.
- The consent discussion should be initiated by a doctor or nurse authoriser, however all practitioners involved in the transfusion process should have the knowledge to answer patients' questions and explain their treatment

When?

- In a timely manner - sufficiently in advance of the proposed treatment (if possible) e.g. at the surgical outpatient department, and allowing time to consider alternatives to transfusion (if appropriate)
- Before commencing treatment that may require ongoing transfusion support e.g. stem cell transplant, cardiac surgery etc
- Before taking the blood sample for pre-transfusion testing (group and save/cross match)

When?

- If the patient cannot communicate e.g., they are unconscious, it is essential that you explain the proposed treatment to the patient's relative or carer – keep them informed
- However, consent issues should not delay necessary transfusion in an emergency situation
- Consent is an ongoing conversation with the patient and more than one discussion may be required. Patient information needs can change over time e.g. risks of long-term transfusion therapy may need to be explained once it is clear a patient will require this

Information - Risks

- Virus/Prion Risk of Infection with each unit of blood transfused
- HIV 1:6.5 million
- Hepatitis B 1:1.3 million
- Hepatitis C 1:28 million
- vCJD unknown risk (4/170 cases have been transfusion related)

Transfusion Reactions

Usually mild

- Allergic reactions – itching, hives (1:300)
- Febrile non-haemolytic (1:100)

Potentially Severe

- Haemolytic (1:25,000)
- Severe allergic and anaphylactic
- Transfusion-acquired acute lung injury
- Septic shock

Other Risks

- Hypocalcaemia or Hypercalcaemia
- Iron overload
- Antibody formation
- Fluid overload, TACO remains the most common cause of death and co-morbidity world wide
- Hypothermia
- Immune suppression – 40% risk of infection

Delayed Complications

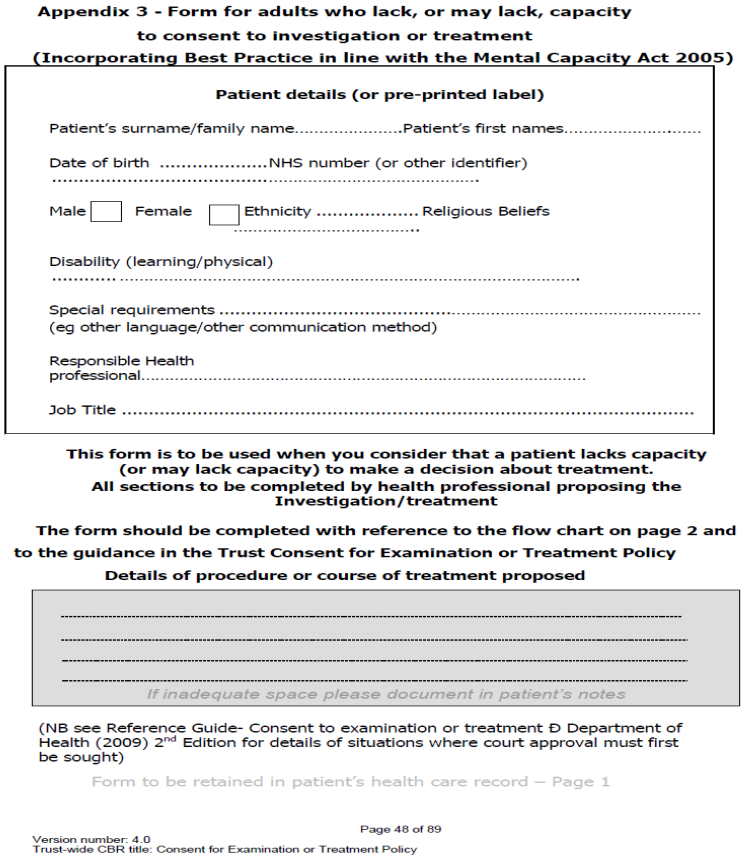
- Delayed Haemolytic Transfusion Reactions (DHTR) are the most frequent
  - Seen in patients who have developed red cell antibodies from a previous transfusion or pregnancy
  - Over time these antibodies may fall to low levels and are not detected by laboratory testing
  - Red cell transfusion can boost these antibodies and cause red cell destruction
  - Some patients may require further transfusion
- Transfusion Associated Graft versus Host Disease
- Post transfusion purpura

What happens if a patient has not got capacity

- Lack of competence can be temporary, partial or fluctuating
- There are many causes:
  - Psychiatric
  - Learning disabilities
  - Dementia
  - Loss of consciousness
  - Refer to your ‘Consent for Examination to Treatment Policy’ Appendix 3
  - Complete ‘Form for Adults who are unable to consent to Treatment or investigation’
  - Minor interventions can be documented in the medical notes

Action to take if a patient does not have capacity

- You may need to seek cooperation with the following;
- Interpreters
- Learning Disability Teams
- Use of sign language
- If using another person to aide consent document who they are and their role in the medical notes



Appendix 3 - Form for adults who lack, or may lack, capacity to consent to investigation or treatment
(Incorporating Best Practice in line with the Mental Capacity Act 2005)

Patient details (or pre-printed label)

Patient's surname/family name.....Patient's first names.....

Date of birth .....NHS number (or other identifier)
.....

Male ☐ Female ☐ Ethnicity ..... Religious Beliefs
.....

Disability (learning/physical)
.....

Special requirements .....
(eg other language/other communication method)

Responsible Health professional.....

Job Title .....

This form is to be used when you consider that a patient lacks capacity (or may lack capacity) to make a decision about treatment.
All sections to be completed by health professional proposing the Investigation/treatment

The form should be completed with reference to the flow chart on page 2 and to the guidance in the Trust Consent for Examination or Treatment Policy

Details of procedure or course of treatment proposed

.....
.....
.....
.....

If inadequate space please document in patient's notes

(NB see Reference Guide- Consent to examination or treatment Ð Department of Health (2009) 2nd Edition for details of situations where court approval must first be sought)

Form to be retained in patient's health care record – Page 1

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Version number: 4.0
Trust-wide CBR title: Consent for Examination or Treatment Policy

University Hospitals Coventry and Warwickshire NHS Trust

Mental Capacity Act 2005

- A person must be assumed to have capacity unless it is established that he lacks capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests

Capacity

- The functional test for decision making is as follows:-
  - Does the patient comprehend the information given?
  - Did the patient retain the information?
  - Did the patient use and weigh up the information to arrive at a choice?
- Fail one of above criteria – they are unable to make a decision

Retrospective information

- To ensure patients are aware of the treatment they have received and informed of any associated potential risks relating to transfusion
- To ensure patients who have received a transfusion know they are no longer eligible to donate blood (this is due to concerns over the potential transmission of vCJD via blood transfusion)

Which patients?

- Patients treated in an emergency setting, where it was not possible to obtain valid consent pre-transfusion due to the patient's clinical condition
- Patients who were told pre-operatively that they *might* require a transfusion need to be informed whether they did or did not receive a transfusion
- Patients who consented pre-procedure to receiving a blood transfusion and received information, only need confirmation that they did or did not receive a transfusion
- Patients who received no information pre-transfusion should be provided with this information, both verbally and in writing, and given the opportunity to ask any questions

When?

- Retrospective information can be given to patients at any stage of their hospital treatment. All patients must be informed before their discharge from hospital. It should be part of the patient discharge procedure
- Information about transfusion should also be included in the discharge letter to the patient's GP, with advice that patient is no longer able to donate blood
- GP Discharge letter.
- Compliance monitored by audit

Refusal

- **Elective Treatment**
- If an adult patient informs you of a refusal to have blood components or products, or they produce any documentation which may alert you that they are a Jehovah's Witness / orthodox Rastafarian, then a discussion **MUST** take place between the patient and the consultant in charge of the surgical/ medical management
- Some patients may accept certain components/ products or interventions like cell salvage – this should be clarified with the patient

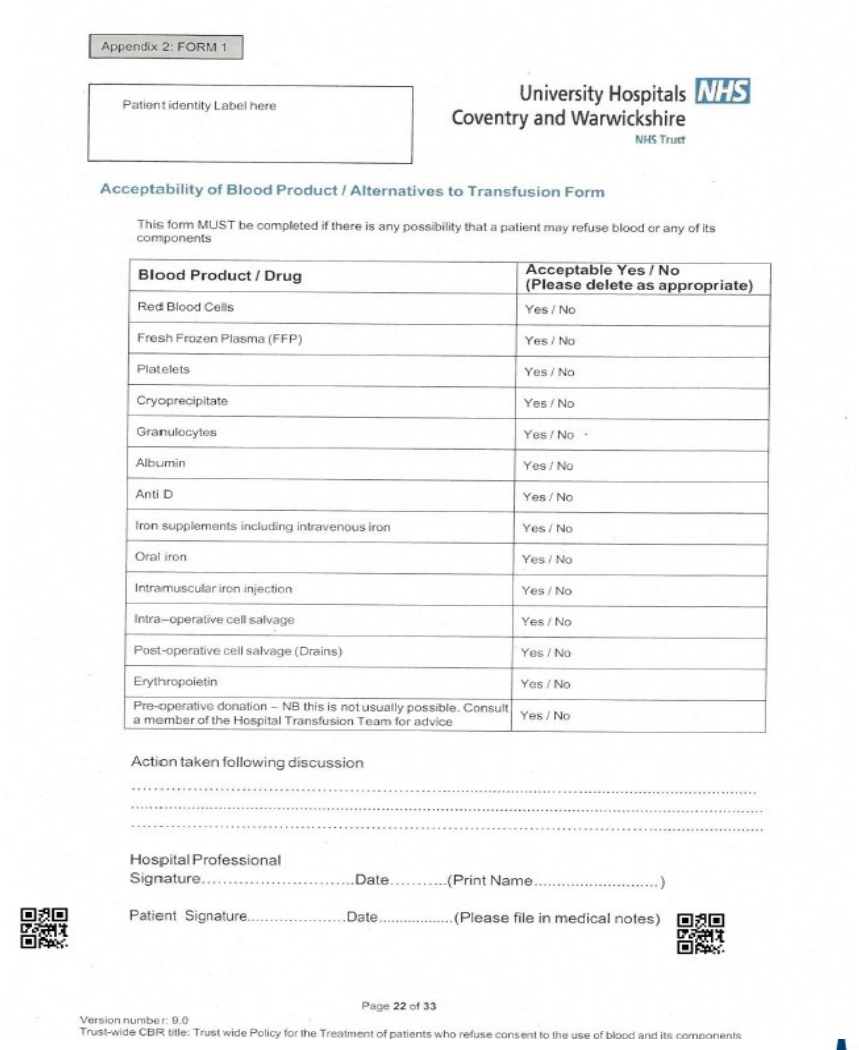
Refusal

- The patient **MUST** be asked whether, if a massive haemorrhage should occur, they will accept a blood component transfusion
- If the patient **ABSOLUTELY** refuses blood/component transfusions, the consultant in charge **MUST** inform the patient they may be at increased risk of death or complications as a result of blood loss
- Discuss the benefits and risks of carrying out the procedure with the patient

Refusal

- Patient and consultant must be allowed to have thinking time prior to surgery to assess perceived benefits and risks of the planned surgery
- If the clinician or the patient is unwilling to proceed, consider referral for treatment at an alternative centre
- Refer to the Refusal of Consent for Transfusion Policy on the e library.

Acceptability of Blood



Appendix 2: FORM 1

Patient identity Label here

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Acceptability of Blood Product / Alternatives to Transfusion Form

This form MUST be completed if there is any possibility that a patient may refuse blood or any of its components

Blood Product / Drug	Acceptable Yes / No (Please delete as appropriate)
Red Blood Cells	Yes / No
Fresh Frozen Plasma (FFP)	Yes / No
Platelets	Yes / No
Cryoprecipitate	Yes / No
Granulocytes	Yes / No
Albumin	Yes / No
Anti D	Yes / No
Iron supplements including intravenous iron	Yes / No
Oral iron	Yes / No
Intramuscular iron injection	Yes / No
Intra–operative cell salvage	Yes / No
Post-operative cell salvage (Drains)	Yes / No
Erythropoietin	Yes / No
Pre-operative donation – NB this is not usually possible. Consult a member of the Hospital Transfusion Team for advice	Yes / No

Action taken following discussion

.....

.....

.....

Hospital Professional Signature.....Date.....(Print Name.....)

Patient Signature.....Date.....(Please file in medical notes)

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Version number: 9.0
Trust-wide CBR title: Trust wide Policy for the Treatment of patients who refuse consent to the use of blood and its components

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Children

- The Family Law Reform Act 1969 entitles people aged 16-17 years to consent to their own medical treatment
- As with adults, consent must be valid (i.e. given voluntarily after appropriate advice)
- A competent consent to treatment cannot be overruled by a parent, but refusal may be overruled
- The refusal of consent by a child (whether ‘Gillick competent’ or not) can be overridden by the consent of a parent or the court

Children

- If, during the course of elective treatment, a life-threatening emergency arises, treat the child on the basis of what is immediately necessary and in the best interests of the child notwithstanding the views of parents.
- Parents **MUST** be informed of all intended actions by clinicians whilst their child is receiving emergency and elective care, and given the opportunity to present their views on blood and components

Alternatives to Blood Transfusion

- **Pre-operative assessment**:

  Goal is to optimise the patient

  (male > 130gL; female > 120gL)
- **Intra-operative management**:

  Surgical & anaesthetic techniques to reduce blood loss
- **Post-operative management**:

  Minimise blood loss and control transfusion

Pre-Operative Assessment

- Manage haemoglobin level - correct anaemia using iron, B12 and/or folate
- Some patients may benefit from EPO

  e.g. renal failure, anaemia of chronic disease such as rheumatoid arthritis
- Manage haemostasis – detect haemostatic defects/coagulopathies, stop anticoagulants (e.g. warfarin) & antiplatelet agents (e.g. aspirin, Clopidogrel) where clinically appropriate
- Consider intra-operative cell salvage and arrange, if appropriate

Intra-Operative Management

- Manage haemoglobin level – use haematocrit or blood loss to guide red cell replacement
- Manage haemostasis – keep the patient warm, use haemostatic testing to guide blood component replacement e.g. coagulation screen, thromboelastogram, local haemostatic agents such as fibrin glues and systemic anti-fibrinolytic drugs (e.g. tranexamic acid)
- Intra-operative cell salvage, if appropriate e.g. cardiac; orthopaedic; vascular; obstetrics

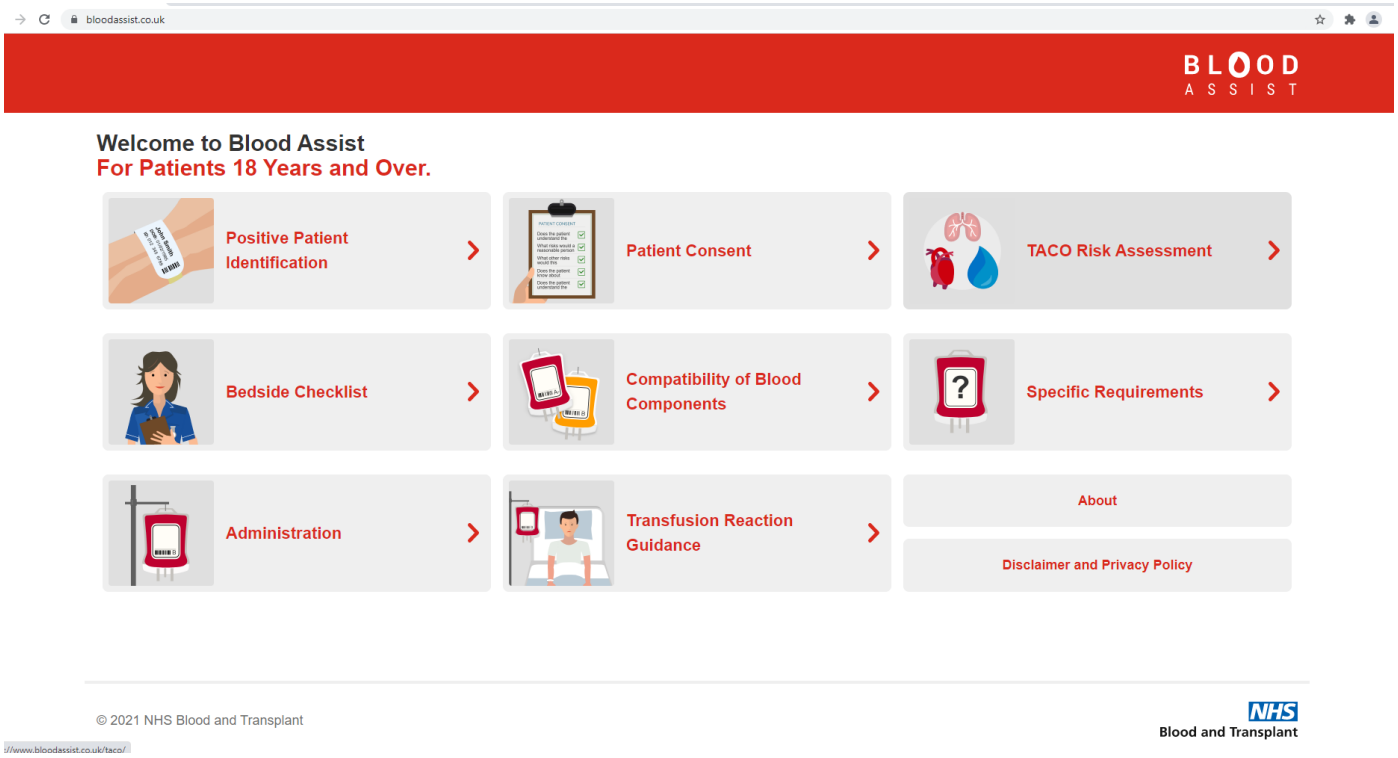
Post-Operative Management

- Manage haemoglobin level - strict protocols for checking haemoglobin levels and transfusion triggers, minimise blood taken for laboratory testing
- Protocol to guide re-exploration at specified level of blood loss
- Post-operative cell salvage and re-infusion (mainly orthopaedic surgery)

Post-Operative Hb Triggers

- Maintain Hb above 70 in fit patients
- Maintain Hb above 80 in older patients
- Maintain Hb above 90 in patients with Cardiac disease respiratory disease
- Transfuse enough blood to get above trigger and no more

Resources



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Questions?