The Newcastle upon Tyne Hospitals NHS Foundation Trust

Administration of Blood Components Procedure

Version No.:	9
Effective From:	17 April 2018
Expiry Date:	17 April 2021
Date Ratified:	19 March 2018
Ratified By:	Hospital Transfusion Committee

1 Introduction

The National Comparative Audits (NCA) of England and Wales have shown that patients continue to be placed at risk of avoidable complications of transfusion through misidentification and inadequate patient monitoring.

The Serious Hazards of Transfusion (SHOT) scheme has shown that 'incorrect blood component transfused' episodes are frequently reported. These incidents have been found to be primarily due to human error relating to misidentification of patients during the prescription and administration of the blood components. Errors of this type can lead to life-threatening transfusion reactions and other significant morbidity.

Guidelines for the Administration of Blood Components (BSH 2017) highlight Patient Identification, Documentation and Communication as 3 key principles which underpin every stage of safe blood administration.

2 Policy Scope

This policy is intended for all Trust staff who are involved in the administration of the following blood Components within the Trust: Red Blood cells (RBC), Platelet components (PLT), granulocytes (WBC, GRAN), Fresh Frozen Plasma (FFP), Octoplas (OCT), and Cryoprecipitate (CRYO) and batch products Beriplex (PCC), Albumin (HAS) and Anti-D.

This policy applies to all patients who require transfusion of blood Components/products either as an emergency or as a planned procedure within the Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH).

3 Aim of Policy

The aim of the policy is to provide guidance on the requirements and responsibilities of staff when administering blood and blood products.

4 Duties (Roles and responsibilities)

4.1 Chief Executive and Trust Board

The Chief Executive and Trust Board have responsibility for the safety and welfare of all Trust patients, visitors and staff. This includes overall responsibility for ensuring effective corporate governance within the organisation.

4.2 Hospital Transfusion Committee (HTC)

The Trust Hospital Transfusion Committee meets Quarterly and reports via the Chair of the Committee to the Trust Medical Director who reports to the Trust Board, this group is responsible for:

- Promoting safe and appropriate blood transfusion practice through local protocols based on national guidelines.
- Audit the practice of blood transfusion against the NHS Trust policy and national guidelines, focusing on critical points for patient safety and the appropriate use of blood.
- Lead multi-professional audit of the use of blood within the NHS Trust, focusing on specialities where demand is high, including medical as well as surgical specialities, and the use of platelets, plasma, and other blood components as well as red cells.
- Provide feedback on audit of transfusion practice and the use of blood to all NHS Trust staff involved in blood transfusion.
- Regularly review and take appropriate action regarding data on blood stock management, wastage and blood utilisation provided by the Blood Stocks Management Scheme (BSMS) and other sources.
- Develop and implement a strategy for the education and training for all clinical, laboratory and support staff involved in blood transfusion.
- Promote patient education and information on blood transfusion including the risks of transfusion, blood avoidance strategies and the need to be correctly identified at all stages in the transfusion process.
- Consult with local patient representative groups where appropriate.
- Modify and improve blood transfusion protocols and clinical practice based on new guidance and evidence.
- Be a focus for local contingency planning and management of blood shortages
- Contribute to the development of clinical governance.

4.3 Hospital Transfusion Team (HTT)

The Trust Hospital Transfusion Team meets monthly and reports to the Trust Hospital Transfusion Committee. This group is responsible for developing strategy for and monitoring compliance with policy including:

- Implement the HTC's objectives.
- Promote and provide advice and support to clinical teams on the safe and appropriate use of blood.
- Promote patient information and education on blood transfusion safety and use of alternatives.
- Actively promote the implementation of good transfusion practice.
- Be a source for training all NHS Trust staff involved in the process of blood transfusion.
- Produce an annual report including its achievements, action plan and resource requirements for consideration by senior management at board

level through the HTC and the Trust's clinical governance and risk management arrangements.

4.4 Consultant Lead in Blood Transfusion

The Consultant Lead in Blood Transfusion has responsibility for the clinical blood transfusion policies and procedures and will provide clinical direction to the Trust ensuring:

- Promotion of best practice through local protocols.
- Promote education and training.
- Participate in HTC, HTT and Regional Transfusion committees.

4.5 Transfusion Manager

The Transfusion Manager has responsibility for the scientific policies and procedures and maintenance of the Blood Transfusion Section. They report to Departmental Laboratory Management on the functioning and effectiveness of the blood transfusion section and works with the Consultant Lead. They are responsible for:

- Ensuring Transfusion complies with national standards and legislation.
- Promote best practice through local protocols.
- Provide scientific lead and direction.
- Carry out research and development in the field of Blood transfusion.
- Provide advice on the use of blood/blood products.
- Provide advice on the interpretation of scientific tests.
- Participate in HTC, HTT and Regional Transfusion committees.

4.6 Transfusion Practitioners

The Transfusion Practitioner works within the Blood Transfusion Team and are responsible for:

- Providing advice on the use of blood/blood products -Education, training and assessment of clinical and support staff.
- Implementation of evidence based practice and local and national guidelines
- Follow up of incidents and near misses.
- Reporting to SABRE.
- Conduct local and national audit.
- Act as a conduit between the blood transfusion laboratory and clinical areas.

4.7 Transfusion Section Leaders

Section Leaders will work within the Blood Transfusion Team and are responsible for ensuring that all the requirements of this policy are applied within their areas of responsibility. They must identify within their areas of responsibility, the need for processes described in this policy and ensure that they are performed as required. Under the guidance of the Transfusion Manager they will lead and delegate within the transfusion laboratory area. They are also responsible for training, audit, evaluation and the processes to

investigate nonconformities with the introduction of corrective actions within reasonable timescales.

4.8 Quality Manager (QM)

The QM is responsible for ensuring that processes conform to and operates within the Quality Management system of Blood Sciences. The Quality Manager is responsible for development and maintenance of the Quality Management system and is responsible for ensuring that the systems for audit, registration and for addressing adverse results and nonconformities are in operation.

4.9 All Staff

It is the responsibility of individual members of staff to ensure that they are conversant with the content of this policy and are appropriately trained and competent to act on the requirements to select and give appropriate products as part of their duties. Staff must comply with the conditions contained within this document and have a duty to indicate any non-conformity to this procedure to their line managers. Staff in training must be supervised by a competent member of staff.

4.10 Authorised Staff

A transfusion of blood or blood products must be checked by the following members of staff:

2 Qualified Nurses / Midwives / Operating Department Practitioners (ODP's)

Or

1 Qualified Nurse / Midwife / ODP and

1 Doctor

Or

2 Doctors

All staff involved in administration of Blood Components/products must undertake yearly mandatory training and have completed a one off practical competency assessment. For further information regarding training contact the Transfusion Practitioners.

5 Definitions

Blood Components	Defined as the components derived from blood such as red cells, platelets, FFP, Octaplas, cryoprecipitate and granulocytes.
Blood Products	Defined as batched products such as Human Albumin Solution, Prothrombin Complex Concentrate (Beriplex), Anti-D and Recombinant Factor VII (Novo 7).

6 Policy

6.1 Request for Group & Screen (G&S) and Crossmatch

The samples should be taken and labelled according to the Trust Sample Acceptance And Rejection Policy and patients identified in line with the Trust Patient Identification – Establishment and Confirmation Prior to Investigative Testing and Treatment.

6.2 Informed Patient Consent

The Supreme Court decision in Montgomery v Lanarkshire Health Board (2015) resulted in a significant change in legislation on patient consent, such that healthcare practitioners have a duty to provide patients with accurate, up-to-date information about proposed treatments.

Informed valid consent for blood transfusion should be obtained and documented in the patient's clinical record. As part of the consent process a standardised patient information leaflet should be given to the patient outlining the risks and benefits of transfusion.

Patients who have received a blood transfusion and who were not able to give valid consent prior to transfusion must be provided with the information retrospectively prior to discharge and made aware they have received a transfusion.

Where a patient refuses transfusion of all, or specific blood components, or an Advance Decision exists, this should be documented in the patient's clinical records and communicated to all relevant Healthcare Practitioners. In these situations, refer to the Trust Jehovah's Witness Policy and the Trust Advance Decision to refuse treatment policy for further guidance.

6.3 Authorisation of Blood Components

Blood components are excluded from the legal definition of medicinal products and therefore must be 'authorised' rather than 'prescribed'. Where possible, blood components should be authorised by the Healthcare professional making the decision to transfuse.

The decision to transfuse must be based on a thorough assessment of the patient and their individual needs, including an evaluation of age, weight,

symptoms, concomitant medical conditions, and should be documented in the patient's clinical record.

The authorisation documentation must contain:

- Patient core identifiers (surname, forename, date of birth, MRN)
- Date transfusion required
- Type of blood component to be administered – any additional specific requirements for the patient (e.g. Irradiated)
- Volume or number of units with exact number in mLs for paediatric transfusions
- Duration (or rate) that each unit (or volume in mL) is to be transfused
- Any special instructions e.g. concomitant drugs required such as a diuretic
- Signature of authoriser

6.4 Requesting Blood Components

Requests for red blood cells are communicated to the hospital transfusion laboratory either as a written request on the sample request form accompanying the patient's blood transfusion sample to the laboratory for testing or via a telephone request made to the laboratory on a valid sample.

All other blood component requests are made via a telephone request made to the laboratory on a valid sample.

All requests must include:

- Patient core identifiers (surname, forename, date of birth, MRN)
- Type of blood component and volume/number of units required
- A clear reason for the transfusion request being made
- Date the transfusion is required for and the urgency of the transfusion
- Location of the patient at the time of request and where the transfusion will take place if it will be elsewhere
- Any other relevant information e.g. any special requirements
- The name and contact details of the requestor

6.4.1 Request for Unknown Patients

When patients are admitted to ED and are unidentified the following identifiers will be accepted:

- Surname = the MRN assigned on admission to ED
- Forename = the patient's gender (Male, Female or Unknown)
- MRN = the MRN assigned on admission to ED
- Default Date of Birth = as assigned electronically on admission to ED

The request form and the sample tube must each be labelled with all the above and match exactly otherwise the laboratory will be forced to reject the sample.

6.4.2 Urgent Requests

If the request for components/products is urgent the blood transfusion laboratory must be contacted by the requesting ward to express this. Ward staff should then communicate the urgency to portering staff when making the request for collection of the blood components.

6.5 Pre-Collection of Blood Components

Ensure the blood component has been authorised for the patient by a medical practitioner or a nurse trained and competent in the authorisation of blood Components.

Ensure the patient has a Patient identification wristband attached and that the details on the band are correct for the patient.

In non-emergency situations the patient must have patent venous access or available line space and venous cannulation documentation is complete. Perform and document a full set of baseline observations (Temp, HR, BP, and Respiratory Rate) prior to the blood component being collected from the laboratory. **Note: Baseline observations can be performed up to 60 minutes prior to transfusion starting.**

Ensure there are sufficient, relevantly trained staff available to monitor the patient throughout the transfusion episode. Transfusions should be given with the same attention to patient observations regardless of the time of day/night. Where there is no clear clinical indication to transfuse overnight, deferral of transfusion to the following day should be considered.

6.6 Receipt of Blood Components from the Portering staff

Ensure the patient's name, MRN & date of birth on the porter's collection slip match the name, MRN and date of birth on the laboratory generated label attached to component.

If correct sign, date & time collection slip and hand slip back to porter.

Place blood component back into the transport box until ready to commence transfusion OR if the red cells are taken to an area with a satellite fridge they must be taken straight to the fridge and signed in according to the register for the satellite fridge until transfusion is ready to commence.

The transfusion must commence within 30minutes of component leaving the laboratory.

If for any reason transfusion is delayed and the blood components have already been received in the clinical area they **MUST** be returned immediately to the Laboratory to avoid the component being wasted.

6.7 Retrieving Blood Components from Satellite Fridge

Ensure the patient's name, MRN & date of birth on satellite fridge register match the name, MRN and date of birth on the laboratory generated label attached to component

Fully complete the satellite fridge register with details of the date/time unit is removed and your signature.

Take the blood component straight to the patient's bedside ready to be administered.

6.8 Pre-Administration Checks

Ensure the blood component has been authorised for the patient by a medical practitioner or a nurse trained and competent in the authorisation of blood components.

The final administration checks must **always** be conducted next to the patient by means of a two person 'double independent check' including the Healthcare Professional who is going to administer the component. Once the checks have been completed successfully the transfusion should be started immediately. If any interruptions occur during the checks, the process must be started over.

If for any reason transfusion is delayed and the blood components/products have already been received in the clinical area they **MUST** be returned immediately to the Laboratory to avoid the component/product being wasted.

6.8.1 Positive identification of the Patient

A patient identification band must be worn by all patients receiving a transfusion.

All spelling and number sequences on all transfusion documentation must match exactly the information on the patient's identification band.

- **Conscious Patient (must be undertaken at the bedside):**

Ask the patient to state their name and date of birth and check this matches the name and date of birth on the laboratory generated label attached to component and the patient's identification band.

Check MRN on the laboratory generated label attached to component matches MRN on the patient's identification band.

If any discrepancies are found the transfusion laboratory should be informed and the component must not be transfused until any discrepancies have been resolved.

- **Unconscious Patient (must be undertaken at the bedside):**

Check the name, date of birth and MRN on the laboratory generated label attached to component match the name, date of birth and MRN on patient identification band.
If possible ask a relative or carer to confirm name and date of birth if present at the patient's bedside.

If any discrepancies are found the transfusion laboratory should be informed and the component must not be transfused until any discrepancies have been resolved.

6.8.2 Blood Component Check (must be undertaken at the bedside):

The donation number, blood group and expiry date on the component pack label must match the laboratory generated label attached to component and the component blood group must be compatible with the patient blood group. Check that any additional clinical requirements have been met e.g. irradiated or CMV screened negative.

Inspect the blood component bag for any signs of leakage or damage. Inspect for unusual colour or clumping.

If any discrepancies are found the transfusion laboratory should be informed and the component must not be transfused until any discrepancies have been resolved.

If all checks are correct, sign, date and time both sides of the blood bag receipt.

6.8.3 Pre-Administration Checks for an Unknown Patient

In the event that emergency blood components, not labelled specifically for the patient are to be administered, pre-administration checks must still be performed to ensure the correct blood component (unit donation number, blood group and expiry date) is transfused to the correct patient.

Inspect the blood component bag for any signs of leakage or damage. Inspect for unusual colour or clumping.

If any discrepancies are found the transfusion laboratory should be informed and the component must not be transfused until any discrepancies have been resolved.

If all checks are correct, sign, date and time both sides of the blood bag receipt.

The brown label which accompanies the laboratory generated label attached to the unit must be completed with the patient's details as soon as they are known and returned to the transfusion laboratory so full traceability can be maintained.

The component donation number, date, start time and volumes of each blood component administered and the ID of the person administering the component should be recorded in the patient's clinical record.

6.9 Administration of Blood Components

Transfusions should only take place if there are sufficient appropriately trained staff available to administer, monitor and manage transfusion

reactions and where resuscitation facilities are readily available.

6.9.1 Technical Aspects of Administration

Blood components can be administered through peripheral IV cannulae or most central venous access devices (according to manufacturer's specifications). Where considered clinically necessary, blood components may be administered via the intraosseous route.

The size of the peripheral cannula depends on the size and integrity of the vein and the rate the blood component is to be transfused.

All blood components should be administered using a blood component administration set with an integral mesh filter (170 – 200 micron). The administration set should be changed at least every 12 hours. Red blood cells and plasma may be transfused using the same administration set. Platelets should not be transfused through an administration set that has been used for other blood components.

Either gravity or electronic infusion devices may be used for the administration of blood components in accordance with manufacturer's instructions. The volume delivered should be monitored regularly to ensure expected rate of flow is achieved.

Rapid infusion devices may be used when large volumes have to be infused, as in major haemorrhage.

Blood warmers should be used in the transfusion of red cells to patients with clinically significant cold agglutinins, in the management of major haemorrhage and in adults undergoing elective or emergency surgery. Each patient should be assessed individually and consideration should be given when transfusing to neonates, paediatrics, elderly patients and patients susceptible to cardiac dysfunction.

The pre administration checks should include a check of the device and the device settings.

Staff using the device should be deemed competent in line with the Trust Medical Device Management Policy.

Under no circumstances should drugs be directly added to a blood component bag or administered through an IV line containing blood components.

6.9.2 Rates of Transfusion

Red Blood Cells:

- Routine administration: 90 – 120 minutes per unit
- Rapid transfusion may be appropriate in major haemorrhage
- Patients less tolerant of increased blood volume should be transfused more slowly with careful monitoring throughout.

- The transfusion must be completed within 4 hours of removal from temperature-controlled storage
- A dose of 4mL/kg raises Hb by approx. 10g/L
- Paediatrics 5mL/kg/hr

Fresh Frozen Plasma / Octoplas:

- 20-30 minutes per unit
- Rapid transfusion may be appropriate when given to replace coagulation factors during major haemorrhage
- The transfusion must be completed within 4 hours of removal from temperature-controlled storage
- Paediatrics 10 - 20mL/kg/hr

Platelets:

- 30 – 60 minutes per adult therapeutic dose
- Platelets should not be transfused through a giving set already used for other blood components.
- Transfusion must be commenced as soon as possible once the component arrives in the clinical area.
- One Adult Therapeutic Dose typically raises the platelet count by 20-40x10^9/L
- Paediatrics 10 - 20mL/kg/hr

Cryoprecipitate:

- 30 – 60 minutes per pool
- The transfusion must be completed within 4 hours of removal from temperature-controlled storage
- Typical adult dose (two pools) will raise fibrinogen by approx. 1g/L in an average adult.
- Paediatrics 10 – 20mL/kg/hr

Once the transfusion has commenced the completed (date, time and signed) peel off pink label on the component pack label receipt portion should be peeled off and stuck in the patient's clinical notes.

The rest of the tear off 'receipt portion' should be removed and placed in the collection box on the ward to be collected by portering staff. This receipt **MUST** be returned to blood bank within 24 hours of administration of the blood component in order to comply with Blood Safety and Quality Regulations (BSQR SI 2005 No. 50 as amended).

6.10 Monitoring of a Patient during Transfusion

Observation and monitoring of the patient throughout a transfusion episode are essential to ensure any adverse reactions are quickly identified and managed. Transfusions should only take place if there are sufficient appropriately trained staff available to administer, monitor and manage transfusion reactions.

6.10.1 Observations

Pulse, blood pressure, temperature and respiratory rate should be undertaken and documented for every unit transfused. Minimum monitoring of the patient should include:

- **Pre-Transfusion** – No more than 60 minutes before the start of the transfusion
- **15 minutes** – Taken at 15 min after the start of each unit
- **Post-Transfusion** - At the end of the component transfusion, no more than 60 min after completion.
- **Visual Monitoring** - Regular visual monitoring of the patient throughout the transfusion episode.

Transfusion observations must be documented in the patient's clinical notes and must be clearly distinguished from other routine observations.

Deterioration of the patient's condition or development of symptoms suggesting a transfusion reaction should prompt more frequent observations and review, dictated by the clinical situation.

Additional observations (oxygen saturation, urine output and fluid balance) should be recorded if indicated by patient's condition. This is particularly important for any patients identified as at risk of TACO, being mindful that TACO can occur after only one unit of red blood cells in 'at risk' patients and at any age.

Patients should be informed about possible adverse effects of transfusion, and the importance of reporting immediately any potential symptoms of an adverse event e.g. **shivering, rashes, flushing, shortness of breath, pain at transfusion site or loin pain**. Special care should be taken in patients who are unable to communicate symptoms of a developing transfusion reaction (e.g. unconscious, confused or too young), and in patients for whom reactions may be more subtle (e.g. neonates) and more frequent observations may be required.

If the patient shows any signs or symptoms suggestive of a transfusion reaction take appropriate action as dictated by the clinical situation and Transfusion Reaction Flowchart which is available via the intranet (Clinical Directorates>Laboratory Medicine>Blood Sciences>Transfusion) or follow the link: Transfusion Reaction Investigation form

6.11 Post Administration

The date and time each unit completed should be recorded in the clinical notes.

Do not flush giving set with fluid either flush cannula or change giving set.

If there is any suspicion of a transfusion reaction the blood component bag should be returned to blood bank with a transfusion reaction investigation form following discussion with blood bank staff.

If the transfusion is uneventful the empty blood component bag and administration set should be discarded in line with the Trust clinical waste policy.

Bags can be disposed of immediately in the clinical waste

An indication of whether or not the transfusion achieved the desired effect and details of any reactions to the transfusion should be documented in the patient's clinical notes.

On discharge, details of any transfusion episodes should be included with the discharge summary for the attention of the patients GP.

7 Transfer of Blood Components between Hospital Trusts

It should only be on rare occasions that transfer of blood with a patient is undertaken. . It is essential for legal reasons (Blood Safety and Quality Regulations, 2005), that an accurate audit trail is maintained.

If blood products are to be transported with the patient, the local transfusion laboratory must be informed where the products are going. This will ensure that the products are supplied in a specialised, sealed and insulated blood product transport box.

On dispatch of the blood components, the local transfusion laboratory will immediately contact the transfusion laboratory of the receiving hospital and inform them of the dispatch.

The transferring team should leave the box seal intact and check the documentation on the outside of the container. Once opened, the contents will go out of temperature control and transfusion must be completed within four hours. When blood products are required either during the patient's journey or immediately on arrival to the receiving hospital, (before local crossmatch can be performed), these should be checked and given in accordance with local policy. It is also essential that any unused products are returned to the receiving hospital transfusion laboratory as soon as is reasonably practical to minimise any wastage. Further information can be found on the "Blood Transfer Advice for Staff" sheet that is issued with the transfer box.

8 Error Reporting

Any performance errors should be notified to the Transfusion Practitioners / Blood Transfusion Team and investigated, reported and corrective action taken; which may include Blood Sciences Non-Compliance Form, Datix and SABRE, the latter being dependent on severity.

All documentation which is part of the error reporting system should be maintained by the Blood Sciences document control system and retained for a minimum of 15 years.

9 Training

All staff must complete yearly mandatory online training Blood Transfusion - Administration

Following an individuals initial training, a one off practical competency assessment must be undertaken. This practical assessment need not be repeated if there is ongoing satisfactory performance but should be repeated if there is a period of greater than one year out of a workplace where transfusion routinely takes place (NBTC 2016a, 2016b).

A record of all training & competency assessment will be held by the Trust education department.

10 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

11 Monitoring Compliance

Standard / process / issue	***Monitoring and audit***			
	Method	***By***	***Committee***	***Frequency***
Compliance against policy	Audit of policy as identified in section 7.	Transfusion Practitioners	Hospital Transfusion Committee	Annually
Non-Compliance / Clinical Incidents / Complaints	Blood Sciences Non-compliance forms	Blood Transfusion Team Blood Sciences Quality Manager	Hospital Transfusion Committee	Weekly meeting Included in Annual Management Review
Mandatory Training / Mandatory Training	As part of policy audit	Transfusion Practitioners	Hospital Transfusion Committee	Annually
	Training Reports for Directorate Monitoring	Education Centre Administrators	TEG	Monthly

12 Consultation and review

The policy is based on BSH guidelines and has been reviewed by the Hospital Transfusion Team and the Hospital Transfusion Committee. Changes in guidelines, practice and legislation are considered during review and implemented accordingly.

13 Implementation (including raising awareness)

This policy will be communicated to all Trust staff who undertake this procedure. The policy will be available on the intranet and will be referred to in mandatory training sessions.

14 References

- BSH(2017)The Administration of Blood Components: a British Society for Haematology Guideline. Available at:Administration of Blood Components | British Society for Haematology
- Bolton Maggs, P.H.B(Ed), Poles, D. et al on behalf of the Serious Hazards of Transfusion (SHOT) Steering Group (2016). *The 2064 Annual SHOT Report.*
- National Patient Safety Agency (2006). *Right Patient, Right Blood*. Available at: http://www.nrls.npsa.nhs.uk/resources/collections/right-patient-right-blood
- National Blood Transfusion Committee (2016a) Indication Codes for Transfusion – An Audit Tool. http://www.transfusionguidelines.org.uk/uk-transfusion-committees/national-blood-transfusion-committee/responses- and-recommendations
- National Blood Transfusion Committee (2016b) Requirements for Training and Assessment in Blood Transfusion. http://www.transfusionguidelines.org.uk/document-library/documents/nbtc-requirements-for-training-and-assessment-final

15 Associated documentation

- Asepsis Policy
- Consent for Examination or Treatment Policy
- Mandatory Training Policy
- Medical Device Management Policy
- Patient Identification Policy
- Patient Identification – Establishment Prior to Investigative Testing and Treatment
- Waste Management Policy

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 16/03/2018

2. **Name of policy / strategy / service:**
Administration of Blood Components Procedure

3. **Name and designation of Author:**
Aimi Baird, Transfusion Practitioner

4. **Names & designations of those involved in the impact analysis screening process:**
Aimi Baird, Transfusion Practitioner

5.

Is this a:	Policy	√	Strategy		Service		
Is this:	New		Revised	√			
Who is affected	Employees	√	Service Users		Wider Community		

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*
To provide guidance in line with national guidelines on the requirements and responsibilities of all staff when administering blood components.

7. **Does this policy, strategy, or service have any equality implications?** **Yes** [ ] **No** [√]

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
Policy applies to all patients who consent to blood transfusion. The transfusion information leaflets are available in different languages from the NHSBT website (hyperlink in policy) and in large format from Transfusion Practitioners enabling all patients to have access to the information

8. **Summary of evidence related to protected characteristics**

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address *(by whom, completion date and review date)*	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? *(by whom, completion date and review date)*
Race / Ethnic origin (including gypsies and travellers)	Policy relates to all races and ethnic origin	No	No
Sex (male/ female)	None relevant to this policy	No	No
Religion and Belief	None relevant to this policy	No	No
Sexual orientation including lesbian, gay and bisexual people	None relevant to this policy	No	No
Age	None relevant to this policy	No	No
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	None relevant to this policy	No	No
Gender Re-assignment	None relevant to this policy	No	No
Marriage and Civil Partnership	None relevant to this policy	No	No
Maternity / Pregnancy	None relevant to this policy	No	No

9. **Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?**

No

10. **Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.**

Do you require further engagement? Yes [ ] No [√]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?

No policy is designed to ensure safe administration of blood components in all groups requiring transfusion

PART 2

Name:

Aimi Baird

Date of completion:

16/03/2018

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)