Nursing Standards of Practice

Bridging Towards
Northwell System
Policies and Practice

September's "Hot Topics"

- **<u>Blood Component Administration</u> (Northwell Policy # SLS.702)**
  - Transfusion Administration Record (form 1178) *See example*
  - *Quick Look* Phelps Vital Signs & Northwell Flow Rates
  - Phelps Hospital Guidelines (Attachment B)
  - *Do's and Don't*
    - **Do**
      - Write the **Date/Time and Signature** (**RN Signature** with Start/End time)
      - Write **RN Signature** as review of VS that were taken by the MST/NT
      - Use black ink
    - **Don't**
      - Leave signatures area blank (Start time and End time)
      - Use an *down* ARROW for each Date ↓

- **<u>Enhanced Supervision</u>** ES (problem details)
  - Nurse Action-No prescriber order
  - **Tele-Sitter Monitoring** documentation (Other Planned Interval of ES Monitoring)
  - The problem details automatically adds the ES Note, ES Intervention, and ES Outcome

- **<u>Quick Reference for Venous Access Devices</u> (VAD) Peripheral and Central Catheters**
  - Use Alcohol Impregnated Caps (**Curos** caps and tips) on all needleless connector sites/tubing and tips. Caps/tips disinfect in 1 minute upon contact.
  - **Scrub-the-Hub, with friction, using Alcohol or CHG swab (preferred) 5 seconds scrub time, 5 seconds dry time** if injection port does not have a cap or if soiled.

sample

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TRANSFUSION ADMINISTRATION RECORD

Pre-transfusion:
- ✓ Consent signed prior to blood component administration
- ✓ Patient and blood component verified

Sign: JMendoza RN (Transfusionist RN)

Sign: (Verifying RN)

Pre-medication administered:
- ☐ Benadryl 25mg po/IV
- ☐ Acetaminophen 650mg po/pr

☐ Blood Warmer used, per provider order

Product Administered/Unit # W2004 19 157006 ____

Complete vital signs must be taken and documented within intervals **after** the transfusion is initiated/started.

DATE	TIME	VS (minutes)	T	P	R	SpO_2	BP	COMMENT Signature for VS	RN SIGNATURE
9/16/19	0600	Pre	99	69	20	98	133/62	JMendoza RN	
9/16/19	0615	START	Time when the blood enters the patient's vein						JMendoza RN
9/16/19	0630	10-15	98.6	68	18	98	133/57		JMendoza RN
9/16/19	0700	45	99.1	67	18	98	135/56	Judith Vasquez MST	JMendoza RN
9/16/19	0815	120	99.5	68	18	97	142/63	Judith Vasquez MST	JMendoza RN
		180							
9/16/19	0830	END	Time when blood lead clamp is closed and the saline bag clamp is opened Start and End time must be **within 4 hours**						JMendoza RN
Post Transfusion Vital Signs: Within 30 minutes of END time									
9/16/19	0900	Post	99	74	18	97	134/49	Judith Vasquez MST	JMendoza RN

	Transfusion Safety	Immediate Management of Suspected Transfusion Reaction	
Safety	**Record** ▪ Use **three identifiers** and if patient is able to participate, have patient state Full Name, Date of Birth and verify Medical Record Number with wristband. ▪ The blood component label matches the blood component ordered (ex. Irradiated) ▪ Blood component will be **started within 30 minutes** of the time it was dispensed from blood bank. ▪ Blood component is completed within **4 hours (START time to END time).** ▪ Ensure all documents are labeled with the correct patient ID.	**Recognize** ▪ Fever (rise of 1°C or 2°F) ▪ Chills ▪ Local erythema/Hives ▪ Flushing ▪ Restlessness ▪ Dyspnea/stridor/ wheeze ▪ Pain (IV site, chest or back) ▪ Hypotension ▪ Shock **Delayed Reaction** ▪ Elevated liver enzymes ▪ Jaundice ▪ Hematuria / dark urine ▪ Bleeding (DIC)	**React** **Stop the transfusion immediately** Remove tubing and blood unit from patient. Then, ▪ Keep IV line open with **new** normal saline bag and **tubing**. ▪ Provide emergency patient care. Consider RRT. ▪ Repeat VS and assess patient condition. **Report** ▪ Call blood bank immediately **(x3915)** to report possible transfusion reaction. ▪ Notify physician of possible transfusion reaction, patient condition, and that workup has been initiated. ▪ Follow procedure for transfusion reaction investigation as detailed on the **Possible Transfusion Reaction Form** (#1092NEPs). ▪ Return bottom page of Blood Bank Record and any blood product with tubing to blood bank. ▪ Document reaction in a NOTE using Meditech or patient Medical Record.

Northwell Health SLS.702 Blood Component Administration Policy System Approval 06/21/18. Phelps Hospital Implementation 08/27/2019

Instructions: Upon completion of the transfusion, place the Transfusion Administration Record and the Blood Bank Record in the Laboratory section of the patient's Medical Record.

Form #1178 Rev.08/2019

Phelps Vital Signs

A. Patient Monitoring

Vital signs will be recorded on the Phelps Hospital **Transfusion Administration Monitoring** form (NEPS # 1178). See policy pages 10-11.

1. Pre Transfusion (baseline)
   - Within 30 minutes before the start of the transfusion
2. After Start of Transfusion
   - **START** time is defined as the time when the blood enters the patient's vein.
   - Within the first 10-15 minutes after the start of the transfusion
   - Within 45 minutes after the start of the transfusion.
   - Within 120 minutes after the start of the transfusion.
   - Within 180 minutes after the start of the transfusion.
3. End of the Transfusion
   - **END** time of transfusion is defined as time when the blood lead **clamp is closed** and the saline bag clamp is opened.
4. Post Transfusion
   - Within 30 minutes of completion of the transfusion.

Northwell Recommended Flow Rates

Time Limits and Flow Rates for Transfusion

- PRBCs transfusion will be completed in **4 hours or less from the time the unit is spiked**.
- The blood administration tubing should be **primed and the transfusion started immediately after spiking the unit** to prevent delays and possible bacterial contamination.
- It is recommended that all routine adult non-emergent transfusions be started at lower limit of **60 ml/hr,** and under the close observation of clinical personnel. If no evidence of a reaction is noted within the first 15 minutes, flow can be increased to the prescribed rate or transfusion time period according to the provider's order.
- Pediatric volumes being small in nature the rate is started at the ordered volume to be infused

Recommended Flow Rates

Adult

BLOOD COMPONENT	RATE	LOWER LIMIT	UPPER LIMIT
Red Blood Cells	100 mls/hour	60 mls/hour	125 mls/hour
Plasma (FFP)	600 mls/hour	100 mls/hour	900 mls/hour
Platelets	600 mls/hour	50 mls/hour	900 mls/hour
Cryoprecipitate	600 mls/hour	100 mls/hour	900 mls/hour

Neonatal and Pediatric

Suggested Transfusion Rate for Neonatal and Pediatrics- ALL blood products are ordered per kilogram

BLOOD COMPONENT	RATE
Red Blood Cells	can be administered over 2-4 hrs
Plasma (FFP)	can be administered over 1 hour
Platelets	can be administered over 1-2 hrs
Cryoprecipitate	as rapidly as tolerable
Granulocyte	can be administered over 1 hour

Phelps Hospital / Northwell Health

Administration of Blood Components Verification, Vital Signs, and Monitoring Guidelines

In addition to the Northwell *SLS.701 Blood Component Administration Policy:*

A. Blood Component Verification

Blood Verification will be performed at the patient bedside or procedure area using the Blood Verification Script Procedure. See policy pages 8-9.

B. Patient Monitoring (Vital Signs)

Vital signs will be recorded on the Phelps Hospital **Transfusion Administration Monitoring** form (NEPS # 1178). See policy pages 10-11.

Pre Transfusion Vital Signs (baseline)

- Within 30 minutes before the start of the transfusion
  - The patient's vital signs (temperature, pulse, respirations, and blood pressure) should be recorded before transfusion as a baseline for subsequent comparison.
  - In patients with unstable vital signs, the baseline vitals should be obtained immediately prior to the transfusion but, prior to spiking the bag.
  - If patient is febrile consult with prescriber.

After Start of Transfusion Vital Signs

- **START** time is defined as the time when the blood enters the patient's vein.
- Within the first 10-15 minutes after the start of the transfusion
  - The person administering the blood component should either remain with, or be in a position to visually observe the patient (e.g. Intensive care units only) and the patient's monitors for the first 15 minutes of the transfusion, since most transfusion reactions become evident during this time period.
  - Vital signs should be between 10-15 minutes after initiation of the transfusion just prior to increasing the transfusion rate. These vital signs will be compared to the pre-vital signs.
- Within 45 minutes after the start of the transfusion.
- Within 120 minutes after the start of the transfusion.
- Within 180 minutes after the start of the transfusion.

End of the Transfusion Vital Signs

- **END** time of Transfusion is defined as time when the blood lead **clamp is closed** and the saline bag clamp is opened.
- **Post**: Within 30 minutes of completion of the transfusion
  - The patient's vital signs (temperature, pulse, respirations, and blood pressure) should be recorded, and compared with the previous values.

Additional vital signs can be taken at the discretion of the prescriber, clinical area and assessment of patient, dependent on:

- ***Unstable clinical condition;***
- ***Level of consciousness;***
- ***Inability to communicate adverse effects, for example if patient is a neonate or small child.***

C. When transfusion is complete, close clamp to blood bag & open clamp to saline bag. Allow approximately 25-50 mL of normal saline to infuse before discontinuing transfusion set.

Enhanced Supervision with/without Telesitter Monitoring (Problem)

Current Documentation (8/29/2019)

2	ENHANCEDSUP	Enhanced Supervision	A
3			

	Long Term Outcome	Target	Sts
1	Remains free from harm to self/others		A
2	Enhanced Supervision not required		A
3			

	Short Term Outcome	Target	Sts
1			
2			
3			

	Intervention	Sts
1	ES Enhanced Supervision Note	A
2	ES Monitoring performed	A

1. At the beginning of your shift (0800/2000)

ENHANCED SUPERVISION NOTE

Date Enhanced Supervision Started:	Aug 29, 2019
Time Enhanced Supervision started:	0930
ONGOING DOCUMENTATION	
Reason(s) for ES:	☑ Fall Risk ☑ Maintain tubes/lines ☑ Not following instruction ☐ Agitation ☐ Aggression ☐ Elopement Risk ☑ Confusion ☑ Impulsivity ☐ Wandering
Other reason(s) for ES:	
The patient now...	◉ Shows need for ES ○ No longer needs ES **If no longer needs ES, document date/time STOPPED below.
Planned Interval of ES checks:	☑ Continuous ☐ Every 15 minutes ☐ While awake ☑ RN Rounding Q2H ☐ Every 30 minutes ☐ While sleeping ☐ When fam/SO not present ☐ Every hour
Other Planned Interval of ES checks:	Telesitter Monitoring
Description of Patient Behavior:	
ES Explanation & Education given to:	○ Patient ◉ Family/Signif Other ○ Legal guardian ○ Family/SO not available ○ Other **Explain that there is a need to provide Enhanced Supervision to help assure safety.

2. At the END of your Shift (1800/0600)

	Intervention	Text/ Ord	Status	Src	Frequency
	ES Monitoring performed	🗨	A	CP	Q0600.1800
	TeleSitter Monitor	View ES Monitoring performed			
	ES Enhanced Sup	Text			

Patient was observed at planned intervals throughout the shift.