

# BEDSIDE AUDIT OF BLOOD ADMINISTRATION FORM – PRODUCTS



<b>Demographics</b>	<b>Hospital Name:</b>	
<b>Record ID:</b> <small>(REDCap generates)</small>	<b>Patient Code:</b> <small>(Created by auditor, as per tracking log)</small>	<b>Transfusion Date:</b>
<b>Transfusion Priority:</b> <input type="checkbox"/> Routine <input type="checkbox"/> Urgent <input type="checkbox"/> Stat	<b>Transfusion Location:</b> <input type="checkbox"/> Chronic Care/Rehabilitation <input type="checkbox"/> Emergency <input type="checkbox"/> Intensive/Cardiac Care Unit <input type="checkbox"/> Medical/Surgical Ward <input type="checkbox"/> Neonatal/Pediatric <input type="checkbox"/> Obstetrical Unit <input type="checkbox"/> Operating Room <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> Post Anesthetic Care Unit <input type="checkbox"/> Other <i>(specify)</i> _____	
<b>Blood Product:</b> <input type="checkbox"/> Albumin <input type="checkbox"/> Fibrinogen Concentrate <input type="checkbox"/> Intravenous Immune Globulin <input type="checkbox"/> Prothrombin Complex Concentrate <input type="checkbox"/> Other <i>(specify)</i> _____		
<b>Pre-Transfusion Checks – Transfusionist</b> (References # 1)		
Was the authorized prescriber’s order documented?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did the order include: <ul style="list-style-type: none"> <li>• Product type</li> <li>• Volume/quantity/dose</li> <li>• Rate/duration of infusion or stated in facility specific standard operating procedure (as per manufacturer’s recommendations)</li> </ul>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was informed consent documented?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was the IV established and * patent prior to the product arriving at clinical area?	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A FOR PRODUCT
<b>Pre-Transfusion Checks – Transfusion Service (TS)</b> (References # 2)		
Were the * <b>Transfusion Medicine (TM) patient identifiers</b> on the order/pick-up slip verified to match those on the TS label/tag?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Time product issued from TS:	____:____ hrs.	
<b>Transfusion</b> (References # 3)		
Was the product type received from TS verified to match the authorized prescriber's order?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were all the checks done in the presence of the patient, at the bedside?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>Patient Identification Checks</b> (References # 4)		
Were the * <b>TM patient identifiers</b> verified to be identical on the following: <ul style="list-style-type: none"> <li>• Patient’s arm band</li> <li>• Authorized prescriber’s order</li> <li>• TS label/tag</li> </ul>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were the patient identification checks documented in the paper/electronic medical record (EMR)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>Product Checks</b> (References # 5b)		
Was the <b>lot number</b> verified as identical on: <ul style="list-style-type: none"> <li>• Manufacturer labelling</li> <li>• TS label/tag</li> </ul>	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A FOR PRODUCT
Was the <b>expiry</b> date on the blood product verified to be acceptable?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were date & time of entering/spiking product vial/bottle checked to determine <b>maximum timeframe</b> for completing the infusion?	<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A FOR PRODUCT
Were the product checks documented in the paper/electronic medical record (EMR)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

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<b>Procedure Checks</b> (References # 6)	
Was the patient advised of signs & symptoms to watch for and report during or following the infusion?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A FOR PATIENT
Was appropriate IV tubing used (as per the manufacturer e.g., vented tubing, standard IV tubing)?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A FOR PRODUCT
Was compatible IV fluid used (as per the manufacturer)?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A FOR PRODUCT
Was the infusion start time documented?	<input type="checkbox"/> YES, START TIME __:__:__ hrs <input type="checkbox"/> NO
Were vital signs checked within 30 minutes prior to infusion?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Was the infusion rate within manufacturer's recommendations?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A FOR PRODUCT
Were vital signs checked 15 minutes after start of the infusion?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A FOR PRODUCT
For vital signs checks, indicate if the vital sign parameter was assessed: <ul style="list-style-type: none"> <li>• Temperature</li> <li>• Blood Pressure</li> <li>• Pulse</li> <li>• Respiration</li> <li>• Oxygen Saturation</li> <li>• Other (<i>specify</i>)</li> </ul>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
Was the transfusionist aware of the steps to manage a transfusion reaction?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Post-Transfusion</b> (References # 7)	
Was the infusion end time documented?	<input type="checkbox"/> YES, END TIME __:__:__ hrs <input type="checkbox"/> NO <input type="checkbox"/> NOT ASSESSED <input type="checkbox"/> N/A FOR PRODUCT
Was the infusion completed within 4 hours from time of entering/spiking the product vial/bottle or as per the manufacturer's recommendations?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> N/A FOR PRODUCT
Were vital signs checked on completion of the infusion?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A FOR PRODUCT
Did the TS label/tag remain attached to the product until completion of the infusion?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does paper/electronic medical record (EMR) documentation provide the identity of the transfusionist?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the paper/electronic medical record (EMR) documentation include: <ul style="list-style-type: none"> <li>• Volume transfused</li> <li>• Vital signs</li> <li>• Patient assessments (if applicable)</li> </ul>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT ASSESSED
<b>Summary</b>	
<b>Name of Auditor:</b>	<b>REDCap Entered By:</b>
<b>Comments:</b>	
* <b>Patent:</b> correctly placed IV which permits IV solution to flow directly into the vein * <b>TM patient identifiers</b> include: 1.Patient surname and first name 2.Unique hospital identification number	