

## Mosby's Nursing Video Skills

### Procedure Guideline for Initiating a Transfusion

1. Verify the health care provider's orders.
2. Gather the necessary equipment and supplies.
3. Introduce yourself to the patient and family, if present.
4. Provide for the patient's privacy.
5. Prepare for the transfusion, as shown in the Video Skill "Preparing for a Transfusion." Once you and one other qualified clinician have completed the process for verifying the correct blood product and correct patient, and both nurses have signed the form to verify that the information matches the blood bag, you are ready to initiate the transfusion.
6. Administration of blood transfusion:
  - A. Check the blood product for leaks and contamination. Prepare the blood for administration by gently agitating the blood unit bag, turning it back and forth and upside down.
  - B. Perform hand hygiene. Apply clean gloves.
  - C. Open the Y-tubing blood administration set for a single unit of blood. Use a multi-set administration set if multiple units are to be transfused.
  - D. Set all clamp(s) to the "off" position.
  - E. Spike the bag of 0.9% normal saline with one of the Y-tubing spikes. Hang the bag on the IV pole, and prime the tubing. Open the upper clamp on the normal saline side of the tubing, and squeeze the drip chamber until fluid covers the filter and fills one-third to one-half of the drip chamber.
  - F. Maintain the clamp on the blood product side of the Y-tubing in the "off" position. Open the common tubing clamp to finish priming the tubing to the distal end of the tubing connector. Close the tubing clamp when the tubing is filled with saline. All three tubing clamps should be closed. The protective sterile cap should be replaced on the tubing connector.
  - G. Prepare the blood component for administration.
    - (1) Remove the protective covering from the access port.
    - (2) Spike the blood component unit with the other Y connection.
    - (3) Open the clamp above the filter to the blood unit, and prime the tubing by letting blood flow into the drip chamber. Gently squeeze the filter chamber until the fluid level is above the filter. Tap the filter chamber to ensure that residual air has been removed.
  - H. Clean the IV port and attach the primed tubing to the patient's venous access device. Keep the connecting end of the IV tubing sterile. Open the common tubing clamp, and regulate the blood infusion to allow only 2 mL/min (20 gtt/min if you are using macrodrip set that administers 10 gtt/mL) to infuse during the first 15 minutes.
  - I. Remain with the patient during the first 15 minutes of the transfusion. Monitor the patient's vital signs at 5 minutes and 15 minutes after initiating the infusion, and every 30 minutes until 1 hour after the transfusion, or according to your agency's policy.

- J. If no transfusion reaction occurs after 15 minutes, adjust the rate of the transfusion according to the health care provider's orders. If the patient is stable, assessment of vital signs may be delegated to nursing assistive personnel (NAP).
  - K. After the blood has infused, clear the IV line with 0.9% normal saline, and discard the blood bag and administration set according to your agency's policy. When consecutive units have been ordered, maintain the patency of the IV with 0.9% normal saline infusing at a keep-vein-open (KVO) rate. Send someone to retrieve the subsequent unit for administration from the blood bank.
7. Appropriately dispose of all supplies. Remove your gloves, and perform hand hygiene.
  8. Leave the patient's room tidy.
  9. Help the patient into a comfortable position, and place toiletries and personal items within reach.
  10. Place the call light within easy reach, and make sure the patient knows how to use it to summon assistance.
  11. To ensure the patient's safety, raise the appropriate number of side rails and lower the bed to the lowest position.
  12. Document the amount of blood given, and any adverse reactions noted.
  13. As part of your follow up care, assess the patient's lab values and continue to monitor the patient's vital signs to determine how the patient is responding to the blood component. For more information, refer to the Video Skill "Monitoring for Adverse Reactions to a Transfusion."