SOP Template: Post-transfusion Patient Assessment and Completion Documentation

This SOP details **post-transfusion patient assessment and completion documentation**, including monitoring patient vital signs, identifying and managing transfusion reactions, documenting transfusion details accurately, ensuring patient safety, and completing all required records promptly. It aims to provide a standardized approach for healthcare professionals to evaluate patient responses after transfusion and maintain comprehensive documentation for quality and compliance.

1. Purpose

To ensure safe, standardized assessment of patients following transfusion and prompt, accurate documentation in accordance with institutional and regulatory requirements.

2. Scope

This SOP applies to all healthcare professionals involved in post-transfusion care and documentation.

3. Responsibilities

- Nurses: Monitor, assess, and document patient status post-transfusion.
- Physicians: Respond to and manage any post-transfusion reactions.
- · All staff: Ensure timely, accurate record-keeping.

4. Procedure

4.1 Immediate Post-transfusion Assessment

- Check and record patient's vital signs immediately at completion of transfusion (temperature, pulse, respiratory rate, blood pressure, oxygen saturation).
- Observe for signs of transfusion reaction (fever, chills, rash, dyspnea, pain, hypotension, anxiety, nausea).
- Ask patient about any new symptoms experienced during/after transfusion.
- Document findings promptly.

4.2 Ongoing Monitoring

- Continue monitoring vital signs as per institutional policy (e.g., 15, 30, 60 minutes post-transfusion and as indicated).
- · Document all assessments.
- Report and manage any abnormal findings or adverse reactions according to reaction protocol.

4.3 Documentation of Transfusion Details

- · Record date and time transfusion was completed.
- Document the blood product(s) transfused (type, volume, unit numbers).
- Note any difficulties or deviations from standard procedure.
- Complete any transfusion records or checklists as per policy.
- Report and log all suspected or confirmed transfusion reactions.

4.4 Final Patient Safety Checks

- Ensure proper disposal of used transfusion equipment.
- Confirm patient comfort and stability before leaving bedside.
- Educate patient/family on signs and symptoms to report following discharge.

5. Documentation Requirements

Documentation	Required Elements	Who Completes?
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Transfusion Record/Form	Patient demographics, product details, start/end times, vital signs, signatures	Nurse
Progress Notes	Patient reaction, assessment findings, management steps	Nurse/Physician
Incident/Adverse Event Report	Details of reaction, interventions, outcome	Responsible Clinician

6. References

- Institutional transfusion policy
 National Blood Transfusion Guidelines
 Regulatory standards (e.g., AABB, JC, local health authority)