



TOOLKIT 21 · BLOOD TRANSFUSION · TOOL 1 OF 4

Transfusion — Bedside Two-Person Check

The wrong blood into the wrong patient is always a checking failure. Two people, at the bedside, with the patient, every unit

Two people. Independently. At the bedside. With the patient. Never in the treatment room; never from memory; never "I already checked it". If anything does not match: stop, do not connect, call the laboratory.

Check	Against	✓ 1	✓ 2
Patient states full name and date of birth (or wristband + second staff member who knows the patient, if unable)	Wristband · prescription · compatibility form	☐	☐
Wristband unique number	Compatibility form · unit label	☐	☐
Blood group and Rh on the unit	Compatibility form · patient's record group	☐	☐
Unit number	Compatibility form	☐	☐
Expiry date and time	Today's date and time	☐	☐
Component and volume prescribed; special requirements (irradiated, CMV-negative, leucodepleted)	Prescription	☐	☐
Unit inspected: no leaks, clots, discolouration, haemolysis	Visual	☐	☐
Consent recorded; patient told what to report (chills, itching, pain, breathlessness)	Record	☐	☐
Baseline observations taken (temp, pulse, BP, RR)	Chart	☐	☐
Checked by 1 (name, signature) _____ 2 _____ Date/time started _____ Unit no. _____ Completed _____			

Observations during transfusion

When	Record	Act if
Before starting	Temp, pulse, BP, RR	—
15 minutes after starting	Temp, pulse, BP, RR — the reaction window	Temp rise ≥ 1 °C, rigors, itch, pain, breathlessness, BP drop → stop, keep line open with saline, Tool 2
Hourly	Temp, pulse, BP, RR	As above
At completion	Temp, pulse, BP, RR; volume given; time	Record on the traceability log (Tool 3)

Adapted from WHO Clinical Transfusion Practice guidelines. Each unit started within 30 minutes of leaving the fridge and completed within 4 hours.

ASF standards: Hospital Standard 4 — transfusion safety (means of verification: two signatures per unit; audit); Universal Floor — identification