

the child, such as packed RBCs in anemia or platelets for bleeding disorders. Regardless of the blood component administered, the nurse must be aware of the possible transfusion reactions. [Table 24-3](#) summarizes the major complications of transfusions, the signs and symptoms typically associated with each, and nursing responsibilities. General guidelines that apply to all transfusions include:

- Take vital signs, including blood pressure, *before* administering blood to establish baseline data for pretransfusion and posttransfusion comparison; 15 minutes after initiation; hourly while blood is infusing; and on completion of transfusion.
- Check the identification of the recipient along with his/her blood type and group against the donor, regardless of the blood product being used.
- Administer the first 50 ml of blood or initial 20% of the volume (whichever is smaller) *slowly* and stay with the child.
- Administer with normal saline on a piggyback setup or have normal saline available.
- Administer blood through an appropriate filter to eliminate particles in the blood and prevent the precipitation of formed elements; gently shake the container frequently.
- Use blood within 30 minutes of its arrival from the blood bank; if it is not used, return it to the blood bank—do not store it in the regular unit refrigerator.
- Infuse a unit of blood (or the specified amount) within 4 hours. If the infusion will exceed this time, the blood should be divided into appropriately sized quantities by the blood bank and the unused portion refrigerated under controlled conditions.
- If a reaction of any type is suspected, stop the transfusion, take vital signs, maintain a patent IV line with normal saline and new tubing, notify the practitioner, and do not restart the transfusion until the child's condition has been medically evaluated.

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**TABLE 24-3**  
**Nursing Care of the Child Receiving Blood Transfusions**

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Complication	Signs and Symptoms	Precautions and Nursing Responsibilities