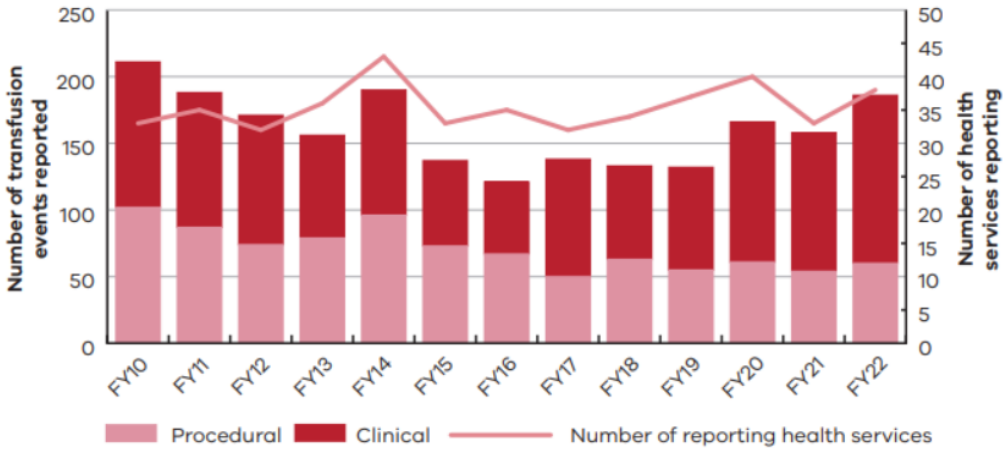
Summary Serious Transfusion Incident Report 2021-22

Number of validated clinical and procedural reports and health services reporting each financial year, FY2011–FY2022



216 notifications from health services

16 withdrawn by the health service

200 investigation forms returned and reviewed

14 excluded by expert review

Total validated reports are 186, 126 clinical and 60 procedural.

STIR is a voluntary haemovigilance reporting system that is used in four jurisdictions in Australia.

The annual report contains information on the number and types of reactions and events that occur, with case studies and key recommendations for improving transfusion and patient care.

For the complete report and further information on the STIR program go to the Blood Matters website [Blood Matters program | health.vic.gov.au]

Abbreviations:

ATR — acute transfusion reaction

DHTR — delayed haemolytic transfusion reaction

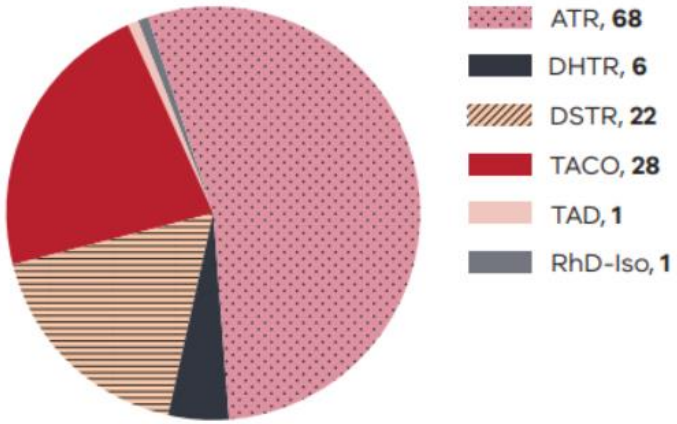
DSTR — delayed serological transfusion reaction

TACO — transfusion associated circulatory overload

TAD — transfusion associated dyspnoea

RhD Iso — RhD isoimmunisation

Validated clinical reactions FY22



Types of acute transfusion reaction (ATR)

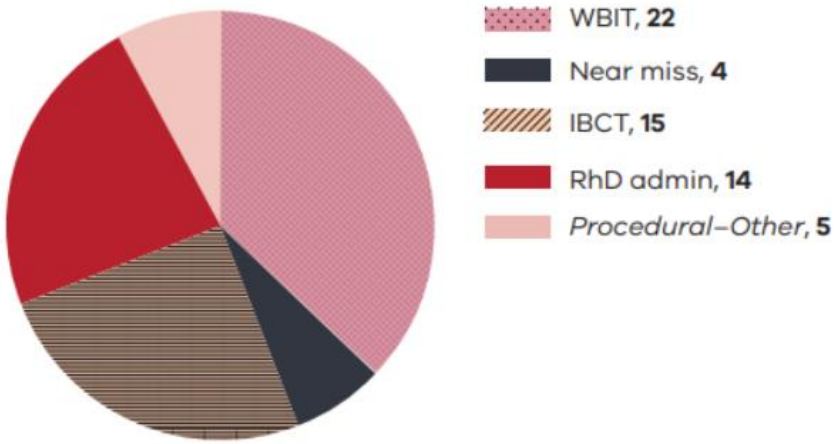
Reaction	Number (68)
Allergic/anaphylactic/anaphylactoid	33
Febrile non-haemolytic transfusion reaction (FNHTR)	31
Acute haemolytic (AHTR)	2
Hypotensive	1
Other	1

Key messages – clinical

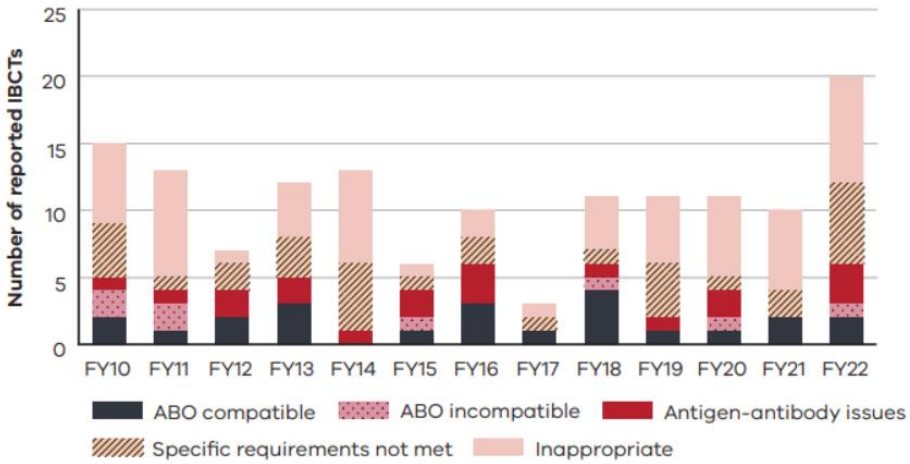
Area	Recommendation
Pre-transfusion patient assessment	Assessing patients for risk factors for things such as TACO or previous confirmed reactions to blood components prior to transfusion is necessary to reduce the risk of further reactions. If required, slowing the transfusion rate, closer monitoring or administering premedication should be considered.
Communication	All communication needs to be clear and concise. This includes at handovers, between the laboratory and clinical areas, and with the patient. Transcription of results into medical records should not occur routinely. When looking for blood group results go to the primary source, or documentation direct from the pathology service. When checking results, take the time to read them and be sure you have understood them. We have had several errors occur due to misreading of results.
Appropriate management of anaemia	Consideration of patient blood management strategies to reduce the need for transfusion improves patient safety by decreasing the number of times a patient may need to be transfused.

For the full key messages go to the annual report at Blood Matters program \| health.vic.gov.au

Validated procedural reports FY22



Reported IBCT* categories: FY10 – FY22



Abbreviations: WBIT – wrong blood in tube IBCT – incorrect blood component transfused

Key messages – procedural

Area	Recommendation
Patient identification	Patient identification (ID) remains an area in need of improvement, as per WBIT reports. Patient ID must be a part of all education as a key safety aspect of any procedure.
Blood administration	Two-person independent checking at the patient side is a must for health services. This process allows for each staff member to check each item required in the checking process and be certain the product they have is intended for this patient and is the correct product. Situations where one staff member checks some items and the other staff member other items has led to missed information and ABO incompatible transfusion in the past.
Fit for purpose information technology (IT) systems	Both clinical and laboratory systems rely more and more on IT systems to support work and safety. IT alerts should be relevant, understandable to the user, not easily overridden and have associated actions. These should be regularly reviewed and updated where appropriate. (SHOT 2022)
Patient safety culture	Fostering a strong and effective safety culture that is ‘just and learning’ is vital to ensure a reduction in transfusion incidents and errors, thus directly improving patient safety. (SHOT 2022)

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Available at Blood Matters Serious Transfusion Incident Reporting <https://www.health.vic.gov.au/patient-care/serious-transfusion-incident-reporting-system>