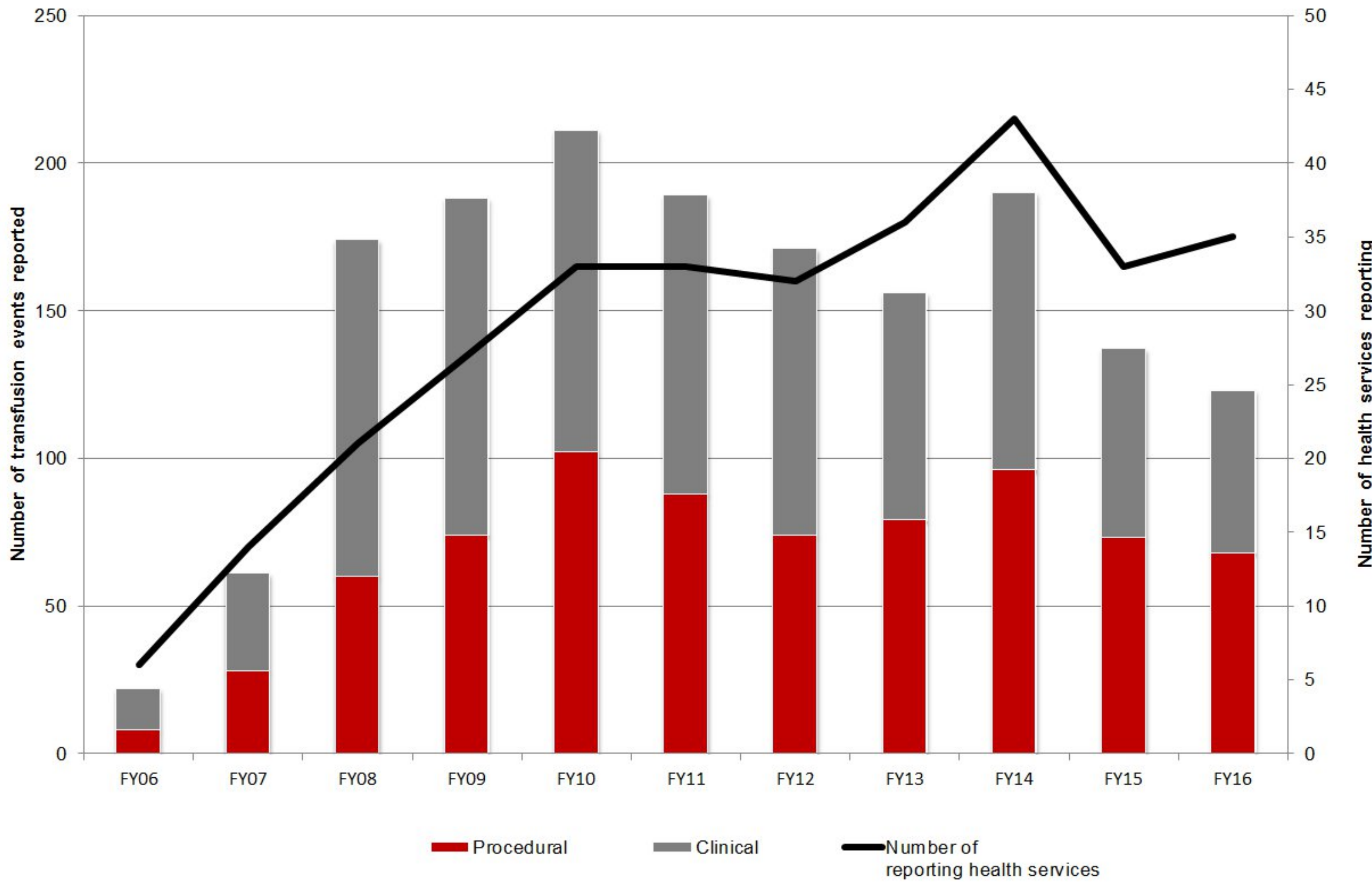


# STIR SUMMARY REPORT 2015-16

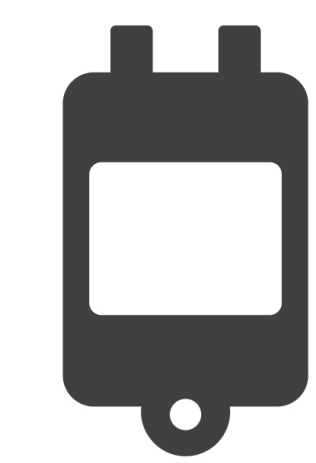
## Number of validated clinical and procedural reports and health services reporting to STIR by financial year



**153** notifications



**14** withdrawn or excluded



**122** validated events

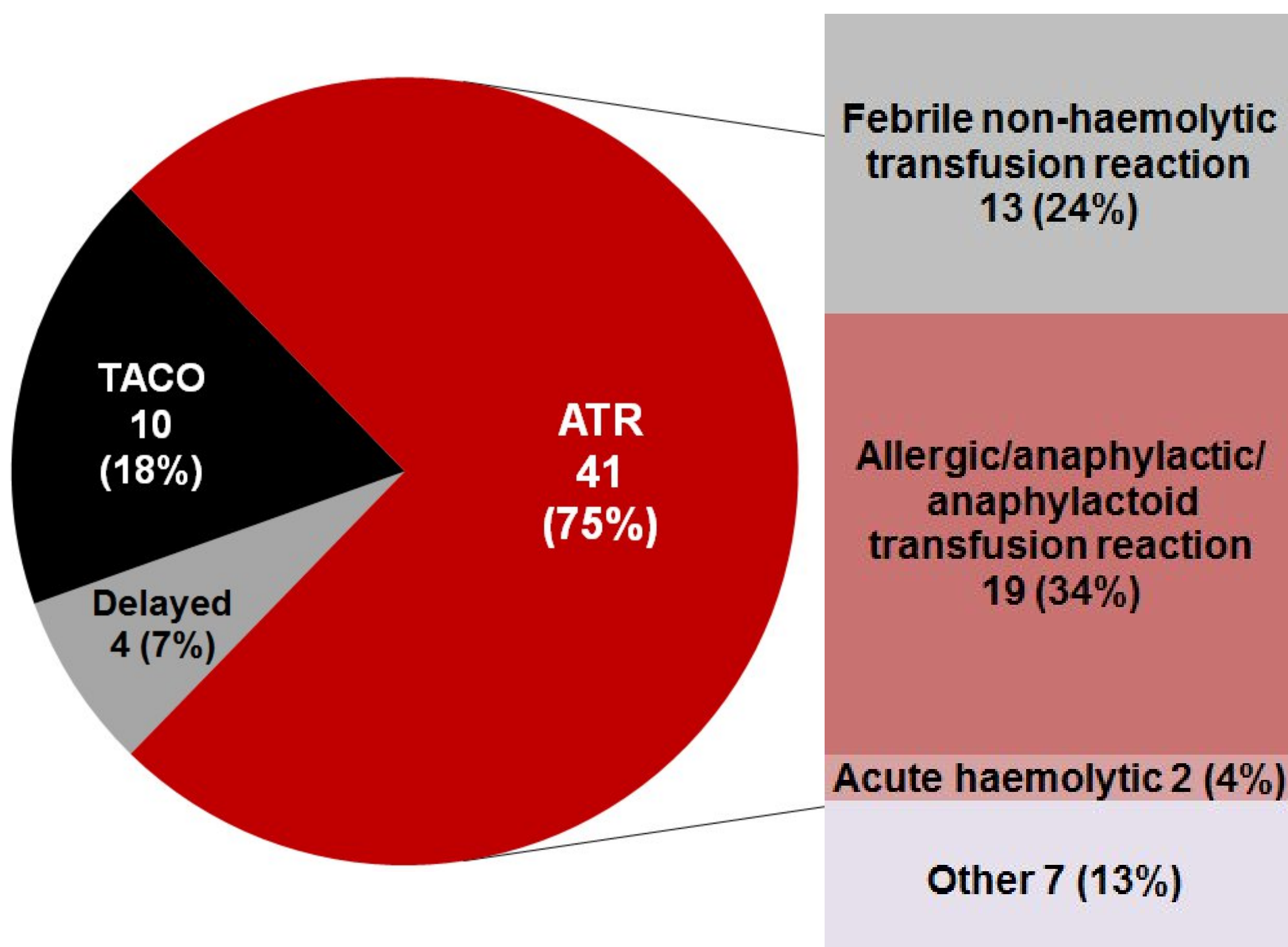


**44%** events were associated with red cells

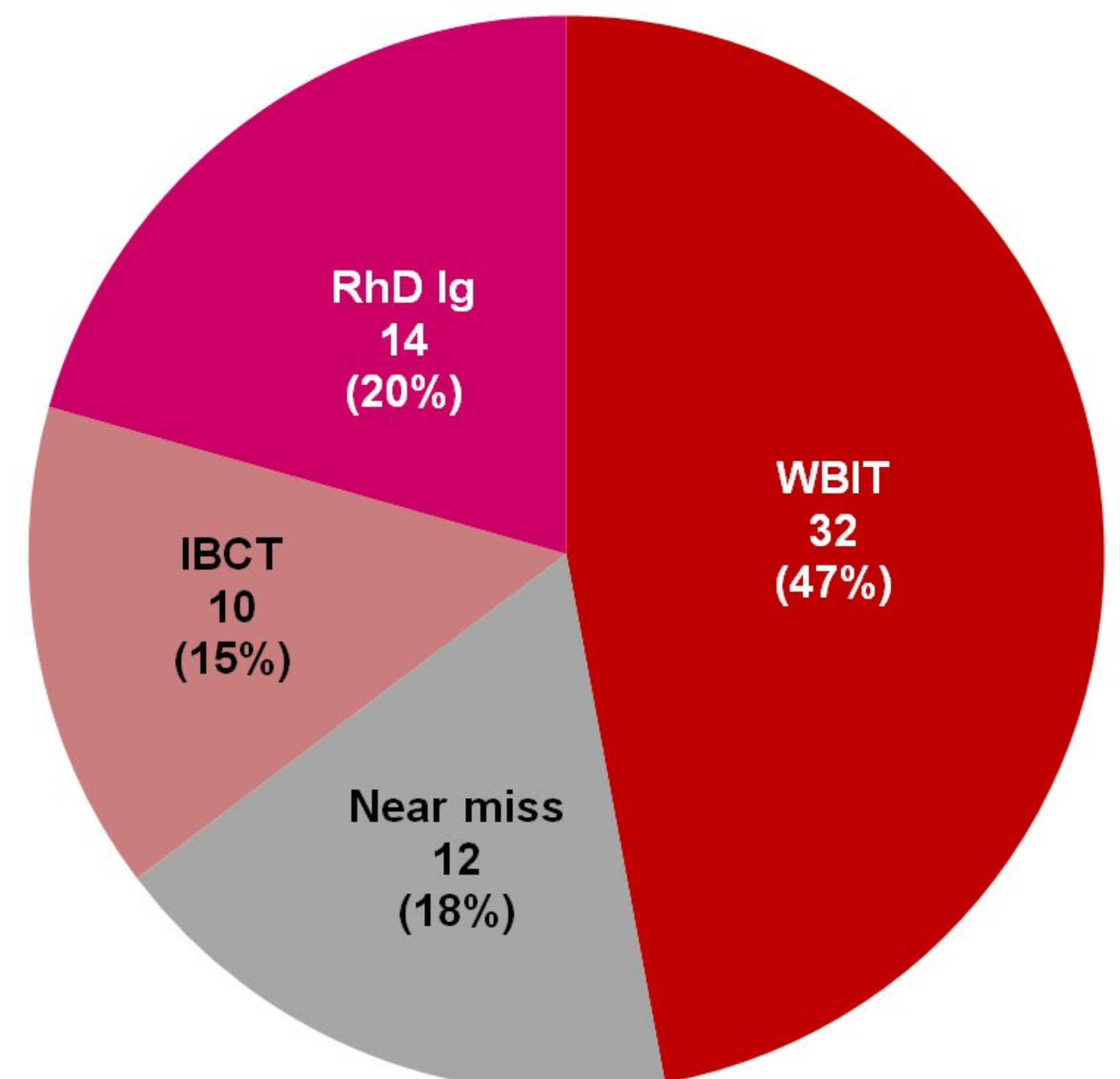
**1:4711** frequency of events to red cells\*

\*VIC data only

## CLINICAL REACTIONS FY 2016

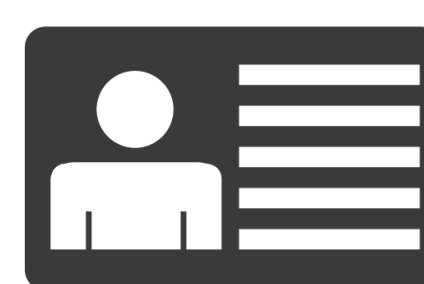


## PROCEDURAL EVENTS FY 2016



Two new categories of clinical reaction will be included in future reports; delayed serologic and transfusion associated dyspnoea.

See the reporting guide on the Blood Matters website for more information.



Patient identification is important in all steps in the transfusion chain.

Procedural errors in almost all categories demonstrate how lack of, or incorrect patient identification contribute to these incidents.

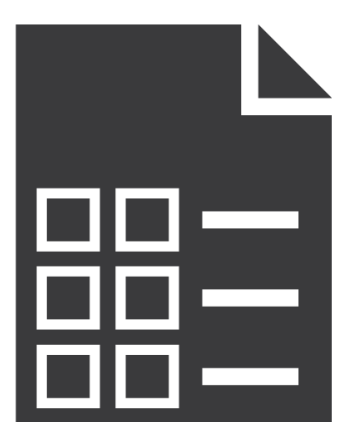


# STIR SUMMARY REPORT 2015-16

## KEY MESSAGES AND RECOMMENDATIONS

More information on the Serious Transfusion Incident Reporting system (STIR) go to: [j.mp/bloodmattersSTIR](http://j.mp/bloodmattersSTIR)

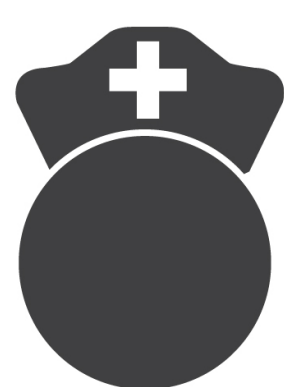
## CLINICAL RECOMMENDATIONS



1. Health services should have a process in place for investigating all reactions to blood and blood products.

This should include appropriate testing, as required, such as tryptase and IgA levels in severe allergic reactions, chest x-ray in reactions associated with breathlessness, such as TACO or TRALI, and bacterial cultures in febrile reactions.

De-identified results of such testing should be made available with STIR investigation forms as appropriate to assist with validation.

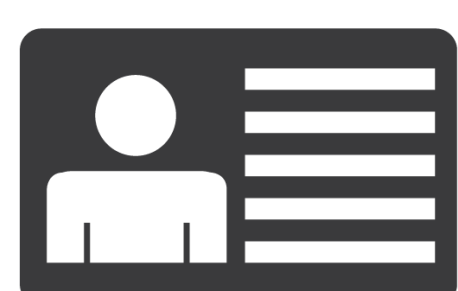


2. Education of staff should include the pillars of patient blood management, including appropriateness of transfusion. Blood components should only be used where the benefit to the patient outweighs the risk.



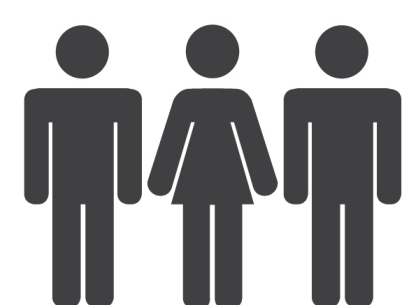
3. Unless required to treat life-threatening bleeding, a slow infusion rate should be used for all blood products to minimise the risk of reactions such as TACO and allergic reactions.

## PROCEDURAL RECOMMENDATIONS



1. Correct patient identification should be completed at all steps of the transfusion process. Procedural errors demonstrate how poor patient identification contributes to these incidents.

Correct patient identification includes the confirmation of full name, date of birth and hospital number, or an alternative recognised system for identifying patients where patient identity has not yet been established.



2. Staff involved in the prescription and/or administration of RhD immunoglobulin should be educated in order to understand test results and appropriate indications for use of RhD immunoglobulin.



3. Laboratory services need to have alerts within the laboratory information system to alert staff when an inappropriate blood product due to ABO or RhD incompatibility is being issued. This should be in place for both ABO and RhD discrepancies to avoid inappropriate crossing of blood groups. Non-essential alerts should be minimised.

Australian governments fund the Australian Red Cross Blood Service to provide blood, blood products and services to the Australian community.