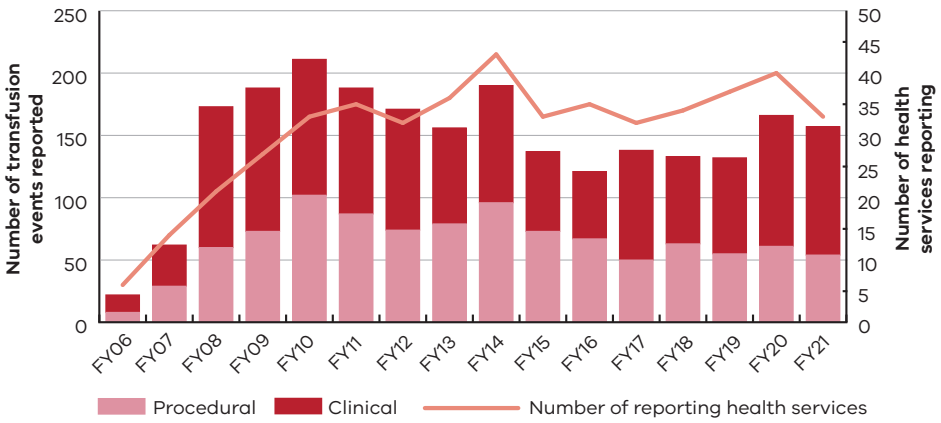
Summary STIR report 2020–21

Number of validated clinical and procedural reports and health services reporting each financial year, FY2006 to FY2021

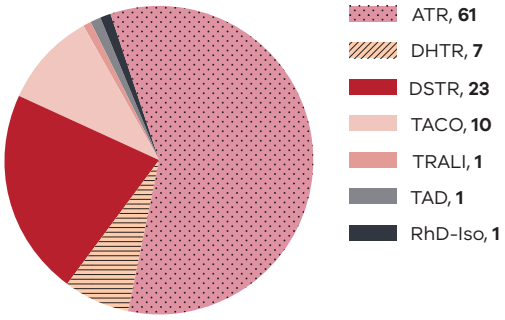


180 notifications from health services
9 withdrawn

171 investigations returned
14 excluded by expert review

Validated clinical reactions 2021–2022

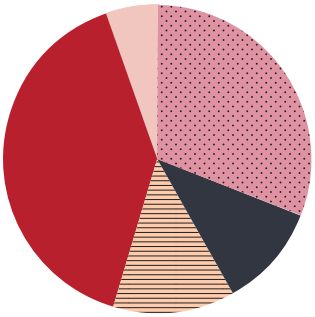
Some reactions can be minimised by pre-transfusion assessment of the patient for risk factors and close monitoring of the patient during the transfusion, e.g. TACO



Breakdown of ATR clinical reports

Reaction	Number
Febrile non-haemolytic transfusion reaction	25
Allergic/anaphylactic/anaphylactoid	31
Acute haemolytic	1
Hypotensive	1
Other	2

Validated procedural events 2021–2022



WBIT, **17**
Near miss, **6**
IBCT, **7**
RhD admin, **22**
Procedural–Other, **3**

Correct patient identification is essential to several steps in the transfusion process. Incorrect or inadequate patient identification can lead to serious incidents.

Key messages

Area	Recommendation
Patient identification	Correct patient identification is essential to several steps in the transfusion process. Incorrect or inadequate patient identification can lead to serious incidents. All staff need to understand what positive patient identification is and how it is to be performed: that is, asking the patient to state their name and date of birth where possible to compare to ID band and any documentation.
Clinical	Always suspect a transfusion reaction in the initial investigation of patient deterioration in the setting of current or recent transfusion. Treatment of life-threatening signs and symptoms is the priority in this situation and investigations occur once the patient has been stabilised (case study 1). Investigation of the reaction should include both clinical and laboratory components to eliminate possible reaction types. Clinical signs and symptoms alone may not help to eliminate all possible reaction types (case study 2). Health services should use checklists to assist in assessment of patient risk of TACO or to step clinical staff through the bedside check.
Governance	As seen in STIR reports delayed serologic transfusion reactions occur regularly. Pathology providers may not share information on antibody history when a patient moves between health services. This puts the patient at risk of a reaction if a known antibody can no longer be recognised on testing. We recommend a national database to record patient red cell alloantibodies, which would assist laboratories to share information on patient antibody history. Health services should ensure policies and procedures to prevent TA-GVHD are reviewed and up to date, and that these procedures decrease the risk of an at-risk patient receiving a non-irradiated product. Health services should ensure policies and procedures for RhD immunoglobulin administration are in line with recently updated guidelines, and that staff are aware of the guidelines and any changes in procedures (<https://www.blood.gov.au/sites/default/files/Guideline for the prophylactic use of Rh D immunoglobulin in pregnancy care.pdf>). Consider using electronic systems to identify patients and label specimens. These systems must have simple processes that cannot easily be overridden, in order to ensure safety mechanisms work (case study 12). See *ANZSBT guidelines* <https://anzsbt.org.au/guidelines-standards/anzsbt-guidelines/> for further information on developing electronic medical records for transfusion.

continued...

Key messages continued

Area	Recommendation
Blood administration	Processes for collecting blood from blood fridges must be robust to ensure the correct product is collected each time. Identifiers must be taken to the fridge and checked at the time of collection, with the staff member documenting removal from storage (case study 8). Positive patient identification is essential in several steps in the transfusion process. It is important staff are aware of the importance of correctly performing this task. They should involve the patient in the process, wherever possible, by asking them to state their name and date of birth. This is an opportunity to pick up errors in patient identification earlier in the process, for example errors in details on the wristband (case study 9).

The full STIR report is available on the Blood Matters website Serious Transfusion Incident Reporting system (health.vic.gov.au)

To receive this document in another format, phone 03 9694 0102, using the National Relay Service 13 36 77 if required, or email Blood Matters <bloodmattters@redcrossblood.org.au>.

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