

Serious Transfusion Incident Report (STIR) Summary 2023-24

OFFICIAL

For the complete report and further information on the STIR program go to the Blood Matters website
<https://www.health.vic.gov.au/patient-care/blood-matters-program>



248 notifications received from 40 health services



48 notifications withdrawn (34 by health services, 14 by expert review)

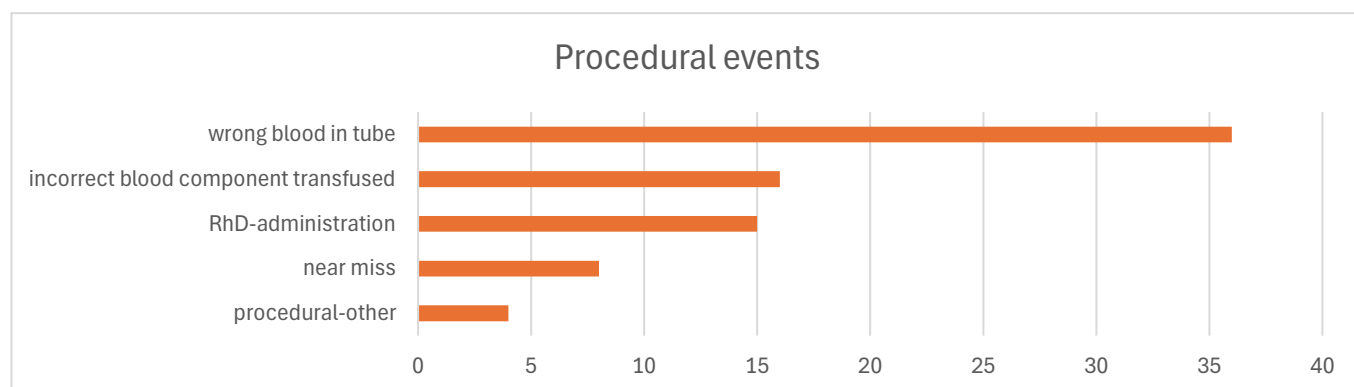
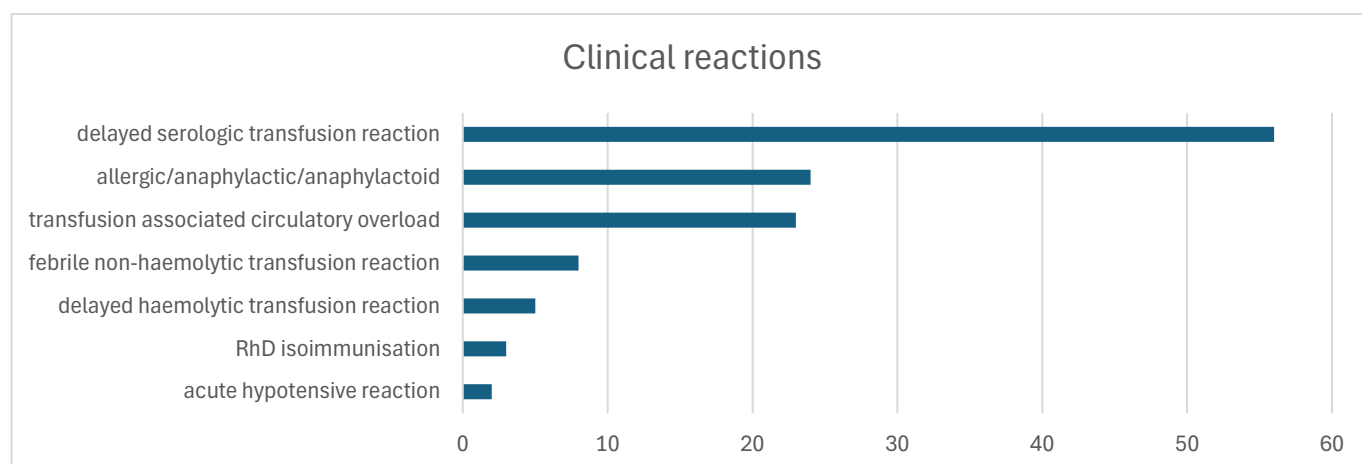


200 validated investigations – 121 clinical reactions, 79 procedural events

Characteristics for all validated reports (excluding RhD-related incidents)

- Average age 55 years (range 0-94 years)
- 41 per cent male, 59 per cent female
- Red blood cells were most often associated with reports -113, Platelets -13, FFP -11, Cryoprecipitate -1 (multiple components may be involved in a report)

Types of validated reports



Key messages

Area	Message
Patient identification	<p>The final pre-transfusion patient and product identity check is the last chance to identify errors that occurred earlier in the transfusion chain.</p> <p>Health services should:</p> <ul style="list-style-type: none"> ensure that their health service policy clearly documents these procedures as outlined in the ANZSBT guidelines. train all staff involved in transfusion practice how to undertake positive patient identification and the double-independent pretransfusion checking procedure.
Communication between clinicians, and clinicians and laboratory staff	<p>Communication must always be clear and where there is any confusion, this must be clarified before proceeding with any procedure.</p> <p>Communication to the laboratory is vital to ensure the correct product for the patient needs can be provided. Information on patient pregnancy, any special requirements or previous reactions must be communicated to ensure an appropriate blood component is supplied.</p> <p>Communication must be clear, timely and comprehensive. (Narayan, et al., 2024)</p>
Monitoring of patients for transfusion reactions	<p>Health services need policies for the monitoring of patients receiving blood components. This needs to include pre-transfusion assessment, as a baseline, and ongoing monitoring throughout the transfusion, and awareness of the possibility of a reaction occurring after the transfusion has ceased.</p> <p>Any change in patient condition during or shortly after a transfusion, consideration should be given to the transfusion as a possible cause.</p>
National antibody database	<p>As in previous years we recommend a national antibody database to reduce the risk of haemolytic reactions in patients and improve communication between laboratories.</p>
Investigation of incidents	<p>Not to assign blame, but to identify contributory factors that led to the event and investigate ways to minimise recurrence.</p> <p>From SHOT 2023 (Narayan, et al., 2024), Errors continue to be the source of most SHOT reports (83.1%). Errors must be investigated using human factors principles-based incident investigations and appropriate improvement measures implemented.</p>

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