TRANSFUSION RELATED NOTIFICATIONS IN IIMs

INFORMATION FOR CLINICIANS & HEALTH PROFESSIONALS

Background

All transfusion related incidents and near miss events should be notified through IIMs for investigation, management and analysis at local facilities. See PD2018_042 Blood Management for detailed information. The NSW Clinical Excellence Commission, via the Blood Watch Program is responsible for:

- Collating and reporting haemovigilance activities in NSW for the National Haemovigilance Program, as per the Australian haemovigilance minimum dataset.
- Undertaking analysis of state-wide events

The following guidance and templates are provided, to assist those with responsibility for investigation and review of transfusion related incidents, within the current NSW IIMs platform. The templates are provided as guidance only, their use is not mandatory; however they represent the minimum information that would facilitate thorough investigation of such events. PD2018_042 Blood Management provides detailed advice for the clinical management of transfusion related adverse events.

First steps

To assist staff with responsibility for the transfusion specific investigation and review of transfusion related incidents, contact your facility IIMs administrator to negotiate (where appropriate), the following:

- Automated email notifications for ***Blood and blood product*** incidents
- ***Blood and blood product*** view permission in the management tab, to enable a group view of all blood and blood product incidents without the need to scroll through all incidents
- Establish an IIMS report that meets the needs of the facility Blood Management Committee (or equivalent)

Transfusion related documentation in IIMs

The templates are provided to minimise data entry and prompt the investigating staff member to gather and document required information to facilitate:

- local management and follow up of the incident
- state-wide analysis

The text can be copied into the ***Incident Management view***, and *completed* / *deleted* / *modified* as required. Please document any further information (beyond that in the original notification) that assists in understanding the incident.

Information entered into the ***Notes*** or ***3rd Party*** sections cannot be captured in the NSW haemovigilance data analysis or submitted to the National Haemovigilance Program as per NSW PD2018_042 Blood Management.

Reaction type

The four most common reaction types have been included. The choice of template will be determined by the suspected reaction type.

NB: 'Modifications' refers to special characteristics: e.g. irradiated, CMV negative, etc.

Febrile Non Haemolytic Transfusion Reaction (FNHTR) or clinical deterioration incidents

Results of incident review:

HAEMOVIGILANCE REVIEW
Blood product details:
Transfusion reaction to *PRODUCT TYPE* unit No:
Concomitant product(s):
Modifications:

Vital signs:
Baseline: T= HR= RR= BP= SpO_2 =
Peak/trough: T= HR= RR= BP= SpO_2 =
Further relevant information

Post transfusion tests:
Pre and post transfusion samples compatible with red cell unit number
Patient blood cultures:
Pack cultures:
Suspected FNHTR OR …..
Imputability:

Clinical Outcome:

TACO events

Results of incident review:

HAEMOVIGILANCE REVIEW
Blood product details:
Transfusion reaction to *PRODUCT TYPE* unit No:
Concomitant product:
Modifications:

Vital signs:
Observations within normal parameters **or**
Baseline: T= HR= RR= BP= SpO_2 =
Peak/trough: T= HR= RR= BP= SpO_2 =

Post transfusion tests:
Biochemistry within patient parameters pre-transfusion
Fluid balance status
Medications administered and response
Suspected TACO
Imputability:

Clinical Outcome

Allergic Reactions

Results of incident review:

HAEMOVIGILANCE REVIEW
Blood product details:
Transfusion reaction to *PRODUCT TYPE* unit No:
Concomitant product(s):
Modifications:

Vital signs:
Observations within normal parameters **or**
Baseline: T= HR= RR= BP= SpO_2 =
Peak/trough: T= HR= RR= BP= SpO_2 =

Mucocutaneous signs and symptoms:
morbilliform rash with itching / urticarial / localised angioedema
oedema of lips, tongue and uvula / periorbital pruritus
erythema and oedema / conjunctival oedema

Further relevant information if applicable
Post transfusion tests:
Suspected ALLERGIC reaction
Imputability:

Clinical Outcome:

TRALI (suspected) events

Results of incident review:

HAEMOVIGILANCE REVIEW
Blood product details:
Transfusion reaction to *PRODUCT TYPE* unit No:
Concomitant product(s):
Modifications:

Vital signs:
Observations within normal parameters **or**
Baseline: T= HR= RR= BP= SpO_2 =
Peak/trough: T= HR= RR= BP= SpO_2 =
Further relevant information if applicable

Post transfusion tests:
Referred to Blood Service
Suspected TRALI event (unless confirmed by the Blood Service. Otherwise need to update with the Blood Service Report)

Imputability:

Clinical Outcome:

Note: the following clinical information assists in determination of a TRALI event:
Fluid balance status;
Response to medications (diuretics / steroids);
CXR

Imputability[1]

Imputability refers to the likelihood of the adverse event being attributed to the transfusion, which requires specific expertise. For LHDs with capacity to determine an imputability rating, please see further details in the table below.

Value	Meaning
0	*Excluded* When there is conclusive evidence beyond reasonable doubt for attributing the reaction to causes other than blood or blood components.
1	*Unlikely* When the evidence is clearly in favour of attributing the adverse reaction to causes other than the transfusion.
2	*Possible* When the evidence is indeterminate for attributing the adverse reaction either to the transfusion
3	*Probable (likely)* When the evidence is clearly in favour of attributing the adverse reaction to the transfusion
4	*Definite (certain)* When there is conclusive evidence beyond reasonable doubt for attributing the adverse reaction to the transfusion
9	*Not Assessable* When there are insufficient data for assessment

1. Australian Haemovigilance Minimum Data Set (Version 1) published by the National Blood Authority.

About the Blood Watch Program

The CEC's Blood Watch program aims to provide leadership and support in quality care, clinical safety and supply security of blood and blood products to achieve world class transfusion medicine practice in NSW

For further information, please visit http://www.cec.health.nsw.gov.au