Serious Transfusion Incident Report (STIR) Summary 2022-23

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

245 notifications received from 50 health services

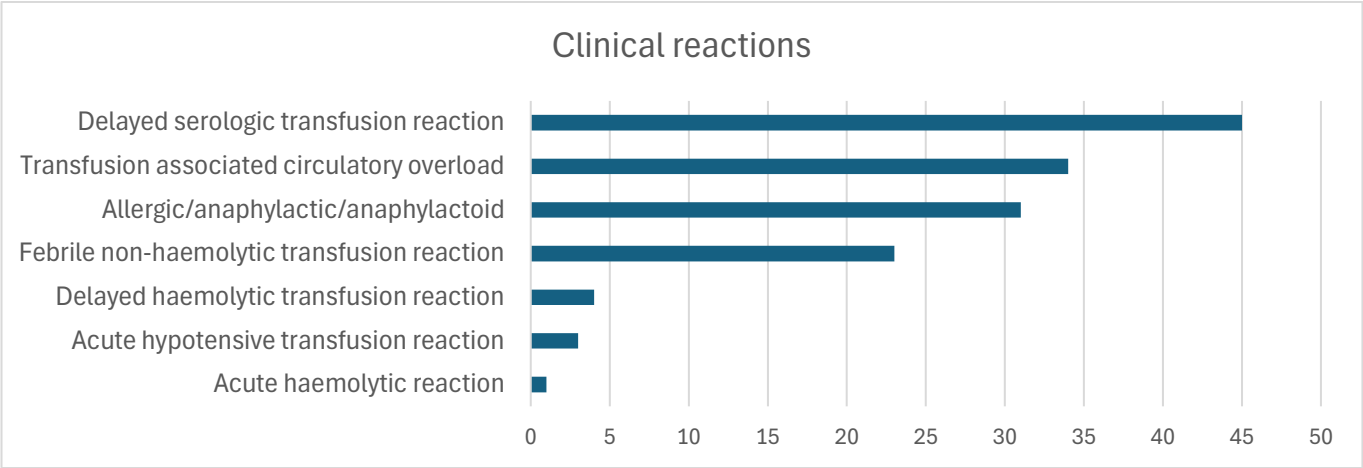
36 notifications withdrawn (17 by health services, 19 by expert review)

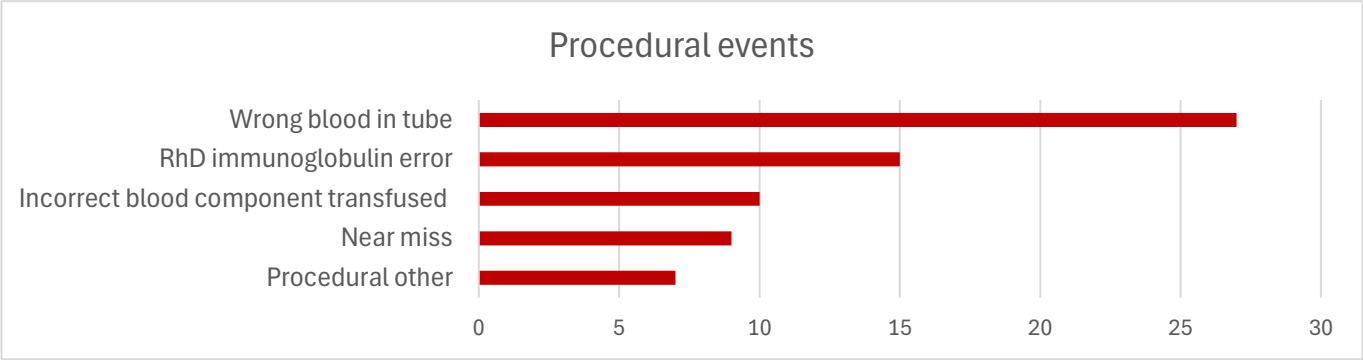
209 validated investigations – 141 clinical reactions, 68 procedural events

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

- Average age 55 years (range 0-97 years)
- 50 per cent male, 50 per cent female
- Red blood cells were most often associated with reports -130, Platelets -33, FFP -19, Cryoprecipitate -2 (multiple components may be involved in a report)

Types of validated reports





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Key messages

Area	Message
Clinical management of reactions	Treatment should be based on the symptoms and signs that occur at the time of the reaction. Diagnosis of type of reaction may require further investigations, blood tests and/or X-rays, to determine the actual or most likely cause of the reaction.
Clinical management - determining the need for transfusion	Only transfuse blood components where there is an indication of need. Do not use to treat a number (Hb, INR). Each transfusion should be an independent decision based on the patient's current clinical condition.
Clinical management – large-volume FMH and product/route selection	Health services providing maternity and obstetric care should have clear guidelines regarding the suitability of RhD Ig products and administration route for the different products. It should also be clear when to use the IV product, either due to patient factors, for example thrombocytopenia, or due to the dose required.
Patient / product identification and matching	The two-person (double) independent check is still not routinely performed or completely understood. Health services need to provide training on this topic to ensure the right product is given to the right patient.
Documentation - recording and sharing of transfusion information	STIR has repeatedly advocated for the development of a national antibody registry. While this is currently available in Western Australia, this is not a nation-wide system. Patients move between health services, and the information regarding known antibodies is not always available to each health service providing care. This puts patients at risk of receiving an incompatible blood component.
Documentation -transcription errors	Do not manually transcribe results from one system to another. STIR receives multiple reports of errors associated with this process each year. Incorrectly transcribing a blood group can lead to incorrect or missed blood components or products (such as RhD immunoglobulin). Health services should consider electronic transfer of results, or easy access to systems containing those results when clinical staff work in a separate system.

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 (VIC) <Bloodmatters@redcrossblood.org.au>

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