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Reporting undesirable effects of transfusion (Haemovigilance)

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Haemovigilance reports

- Transfusion reactions (TR)
- Near miss incidents (NM pretransfusion errors discovered in time)
- Transfusion errors (IBPT - incorrect blood product transfused)
- Notifiable incidents in blood product manufacture
  - Safety risks for blood donors, donor reactions (SP)
  - Suspected quality defect (QS)
  - Detection of a transfusion-transmissible infection in a blood donor (QS)

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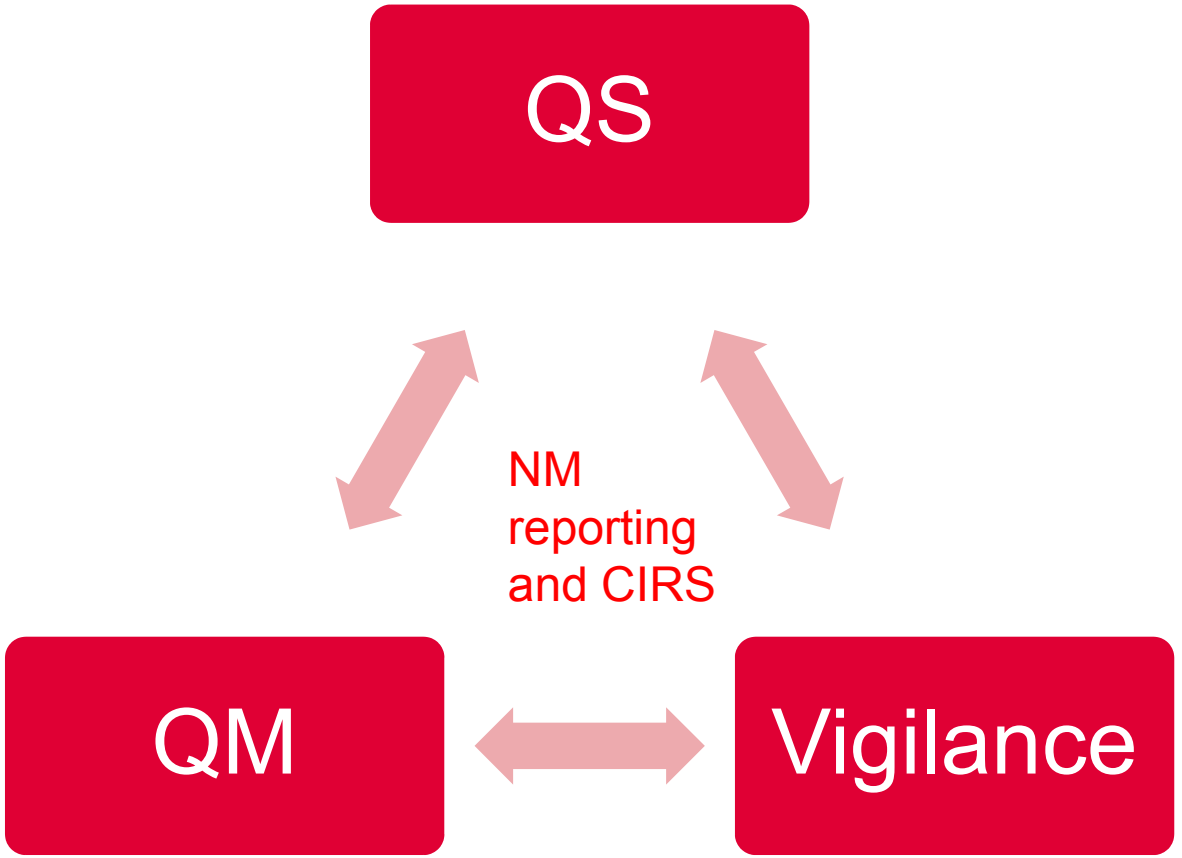
Vigilance ≠ QM



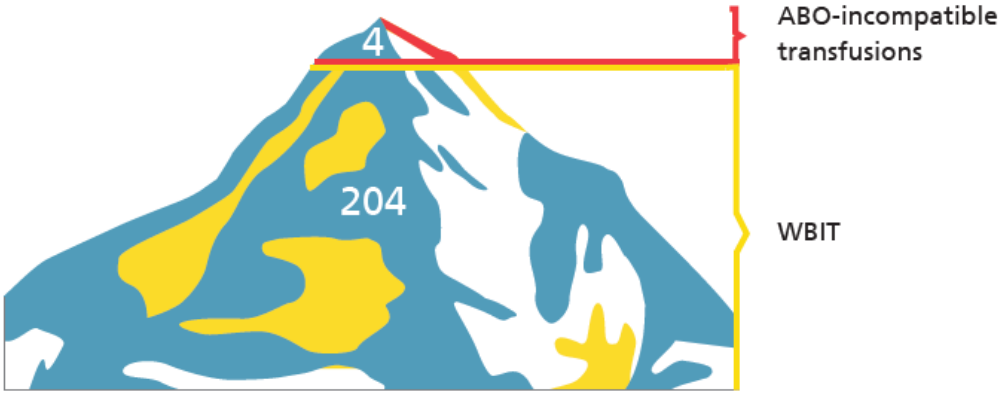
NM? Important?

- Signal
- Indicator

2017

IBCT versus NM

There were 204 WBIT cases compared to 4 ABO-incompatible transfusions. The risk of IBCT is prevented partly by correct patient identification.



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Sneak peek Data 2018

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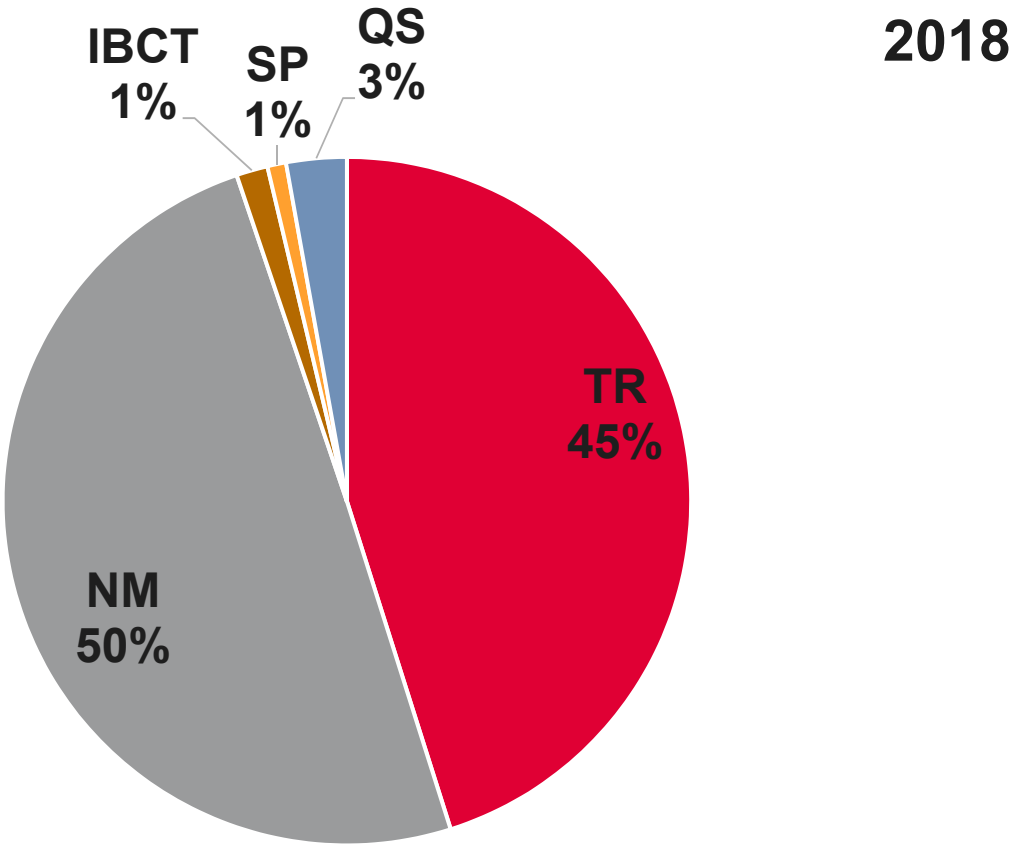
Reports 2018



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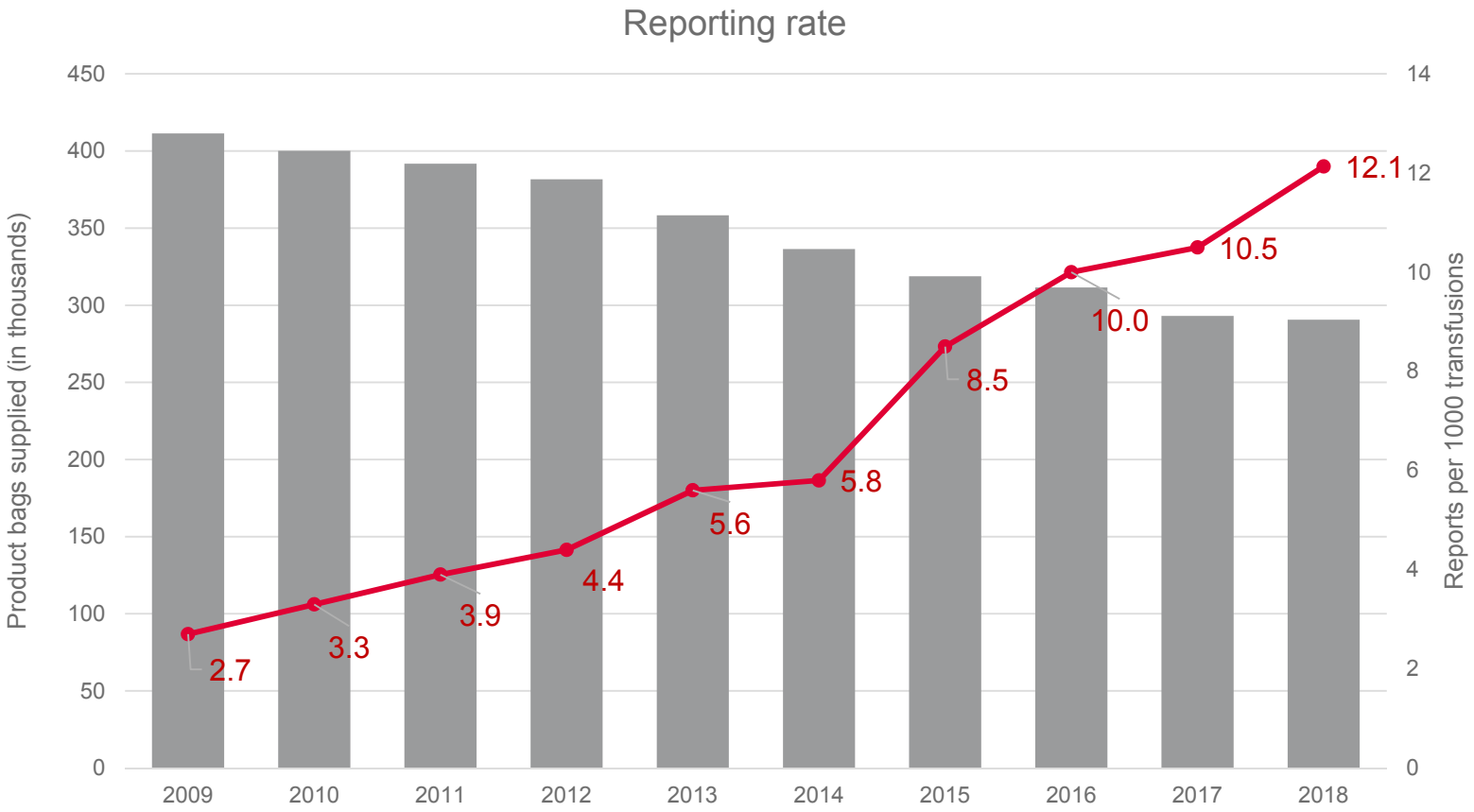
Reporting rate



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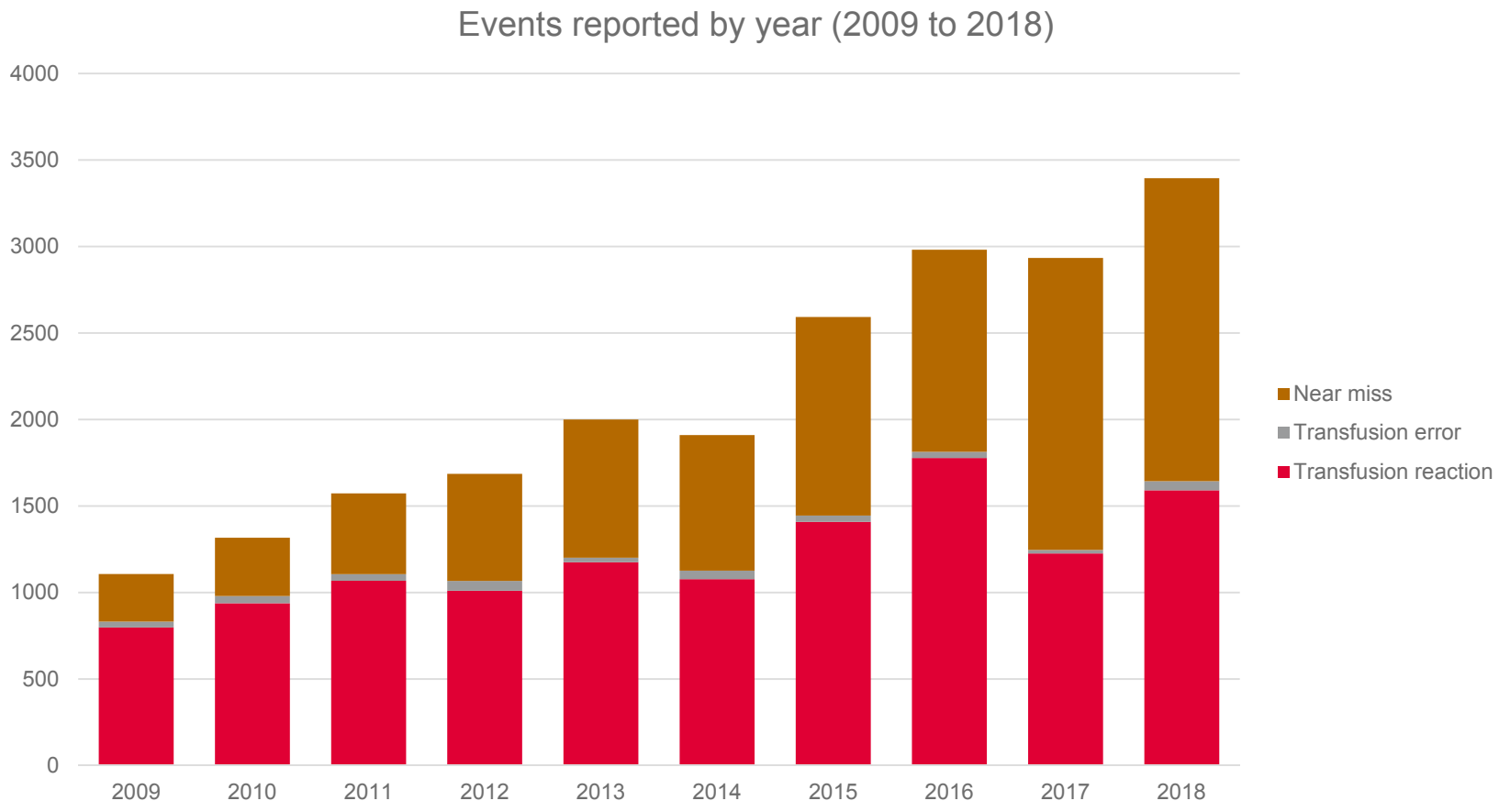
HV reports by year



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Transfusion reactions

- Aetiology
- Frequency
- Severity
- Preventability

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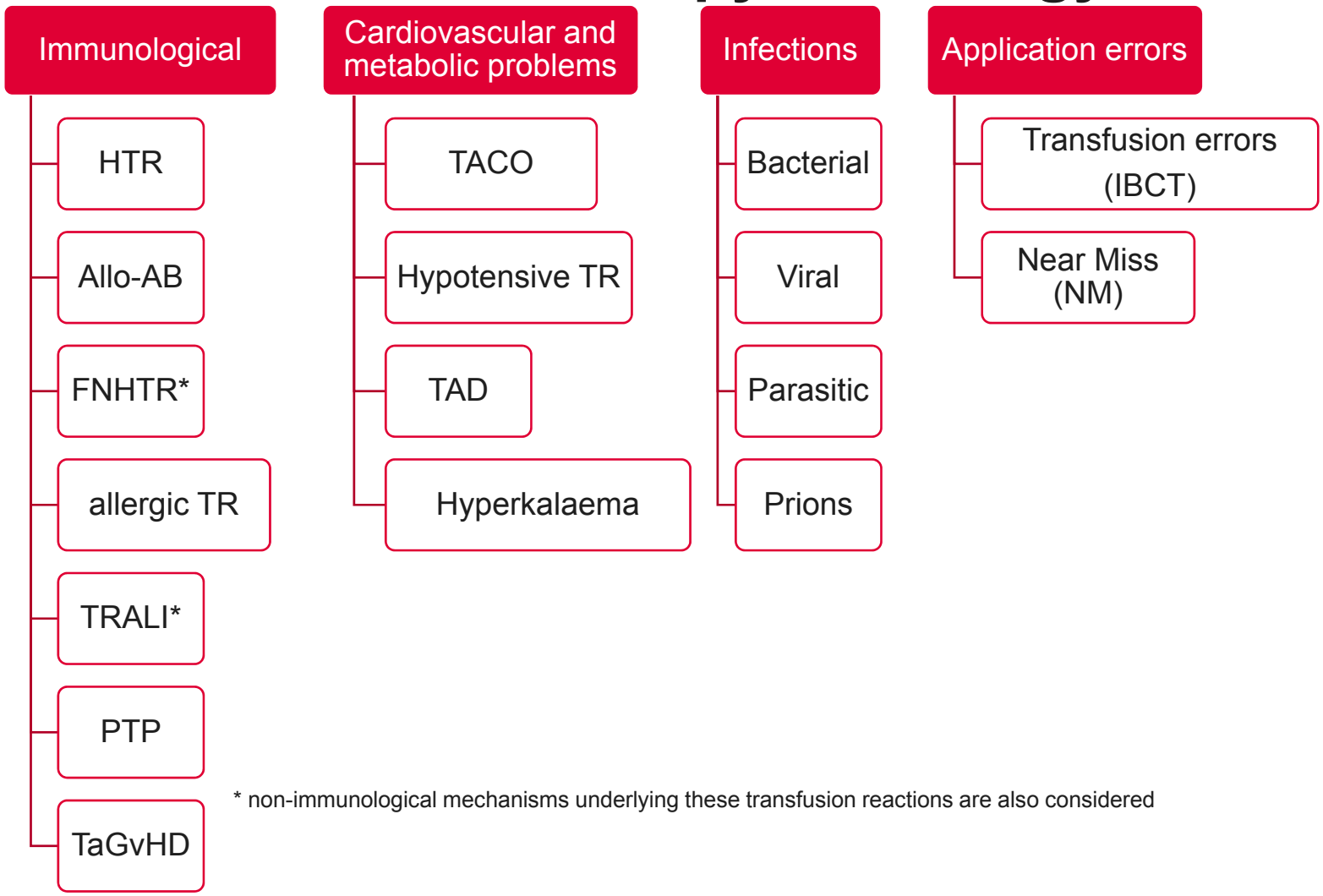
Risks of transfusion therapy : Aetiology



* non-immunological mechanisms underlying these transfusion reactions are also considered

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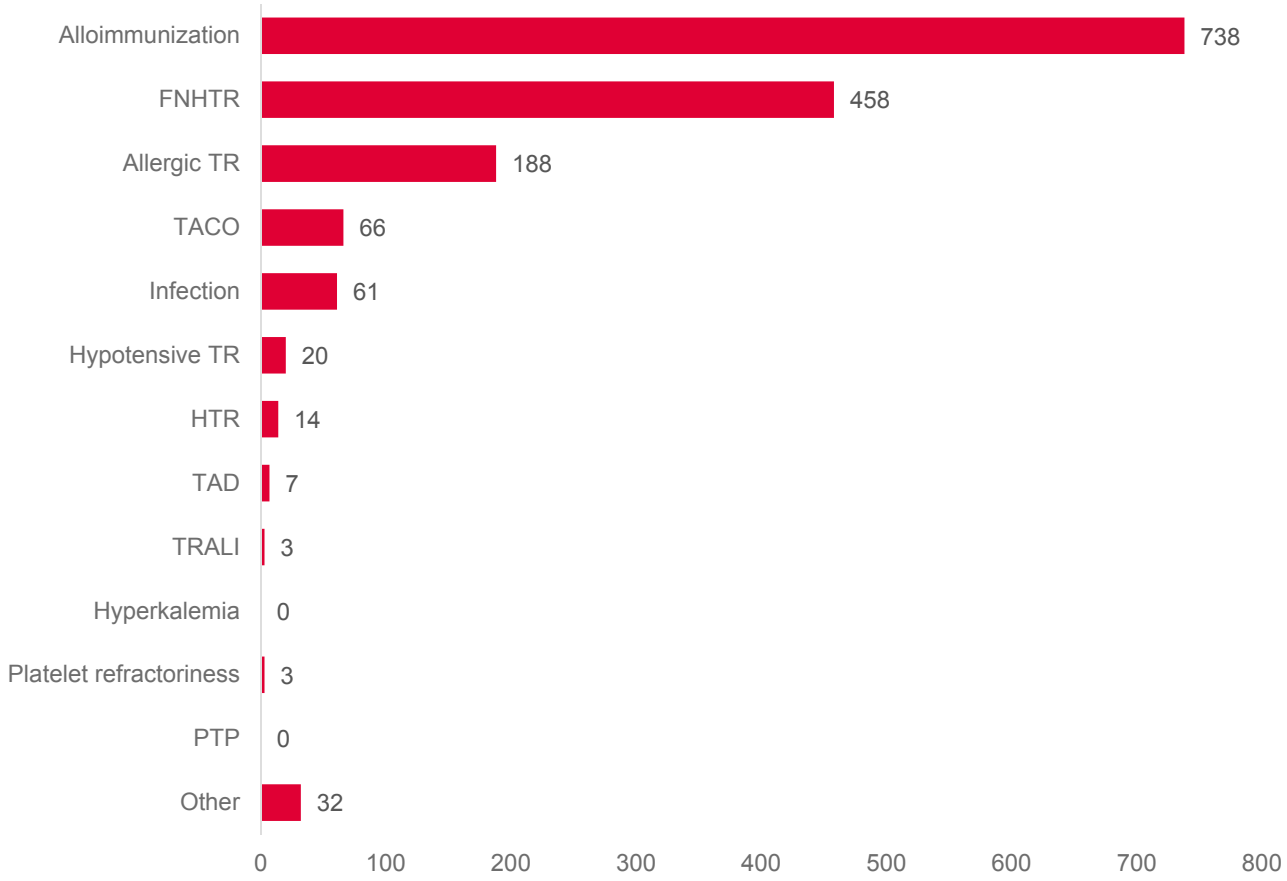
TR in 2018: Frequency



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TR: Severity

1 Non-severe	2 Severe	3 Life-threatening	4 Death
•Rash •Erythema •Temp. < 2°C	•Alloimmunization •Temp >2°C •HTR •Loss of consciousness •drop in BP •Positive blood cultures	•Deterioration of the condition in general	

The severity of TR is evaluated independently of its possible connection with the transfusion (Imputability)!

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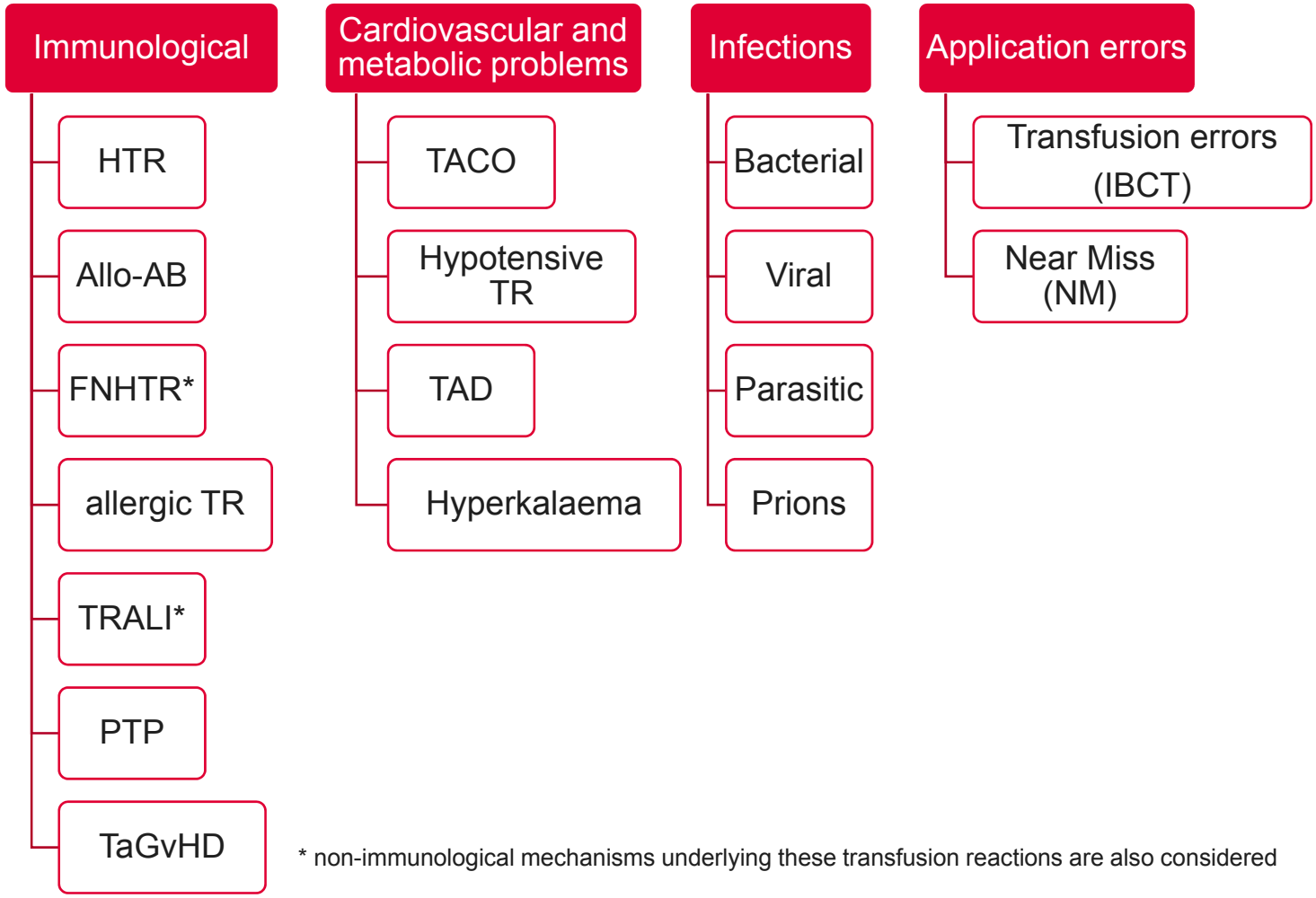
TR: Avoidable?



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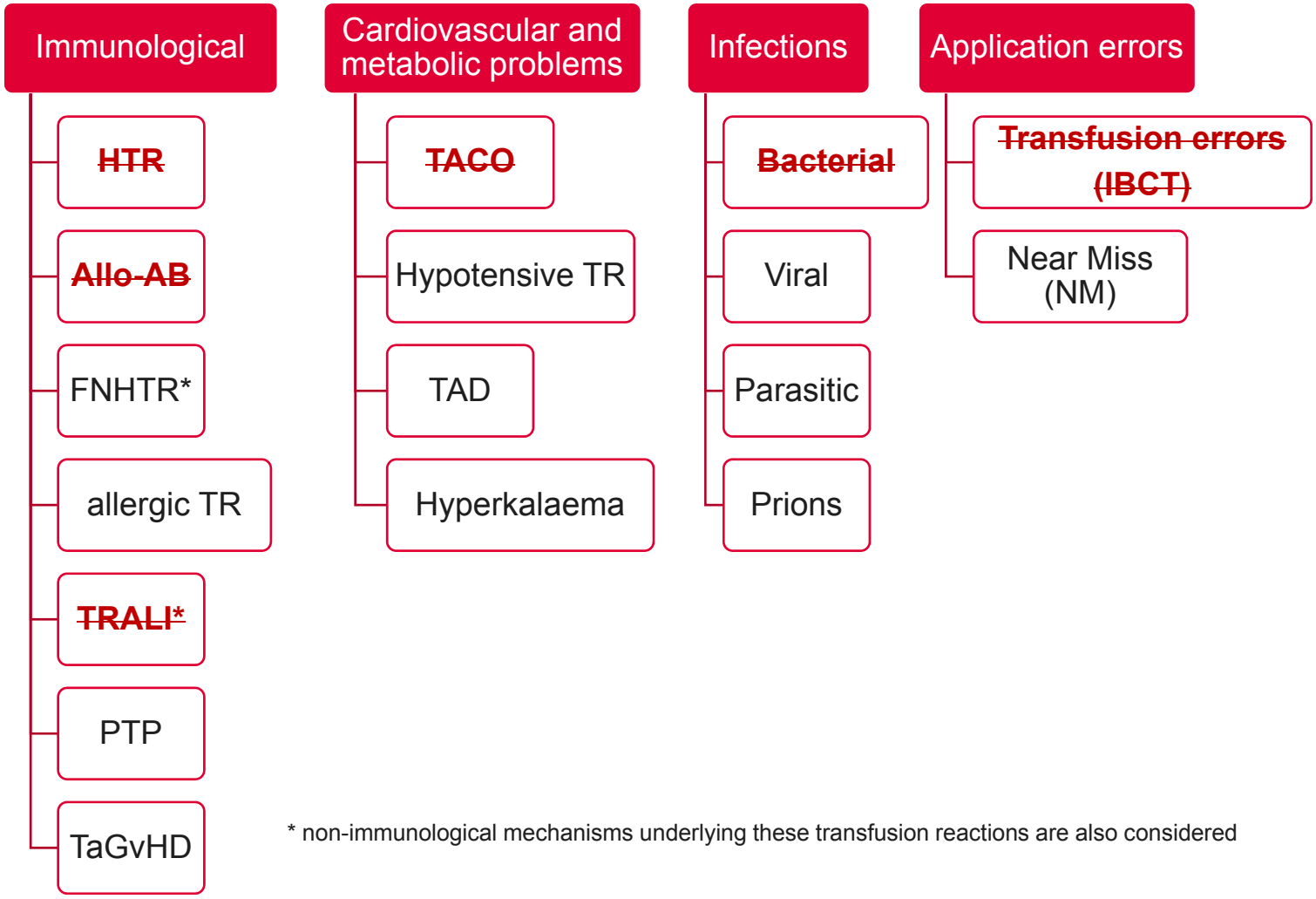
TR: Avoidable!



* non-immunological mechanisms underlying these transfusion reactions are also considered

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TR: Preventability

Pre-transfusion assessment is important to identify patients at risk and management should be adjusted accordingly

- Avoid unnecessary transfusion
- Avoid transfusing more than one unit at a time
- Patient identity and labelling
- AG negative products
- Premedication
- Transfuse over longer periods

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Isn`t it? Is it?

- Symptoms often do not allow direct diagnosis
- Do not jump to conclusions
  - FNHTR
  - TAD
  - Hypotensive TR
- Investigations necessary

You never get a second chance for a first classification!

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Summary

- Errors in the transfusion chain are common
- Transfusion errors can be prevented by attention throughout the transfusion chain and by safety mechanisms
- The basis for this is the quality assurance system, which clearly regulates the processes and interfaces
- Learning from mistakes is an important part of quality assurance (own mistakes as well as from the national haemovigilance data)

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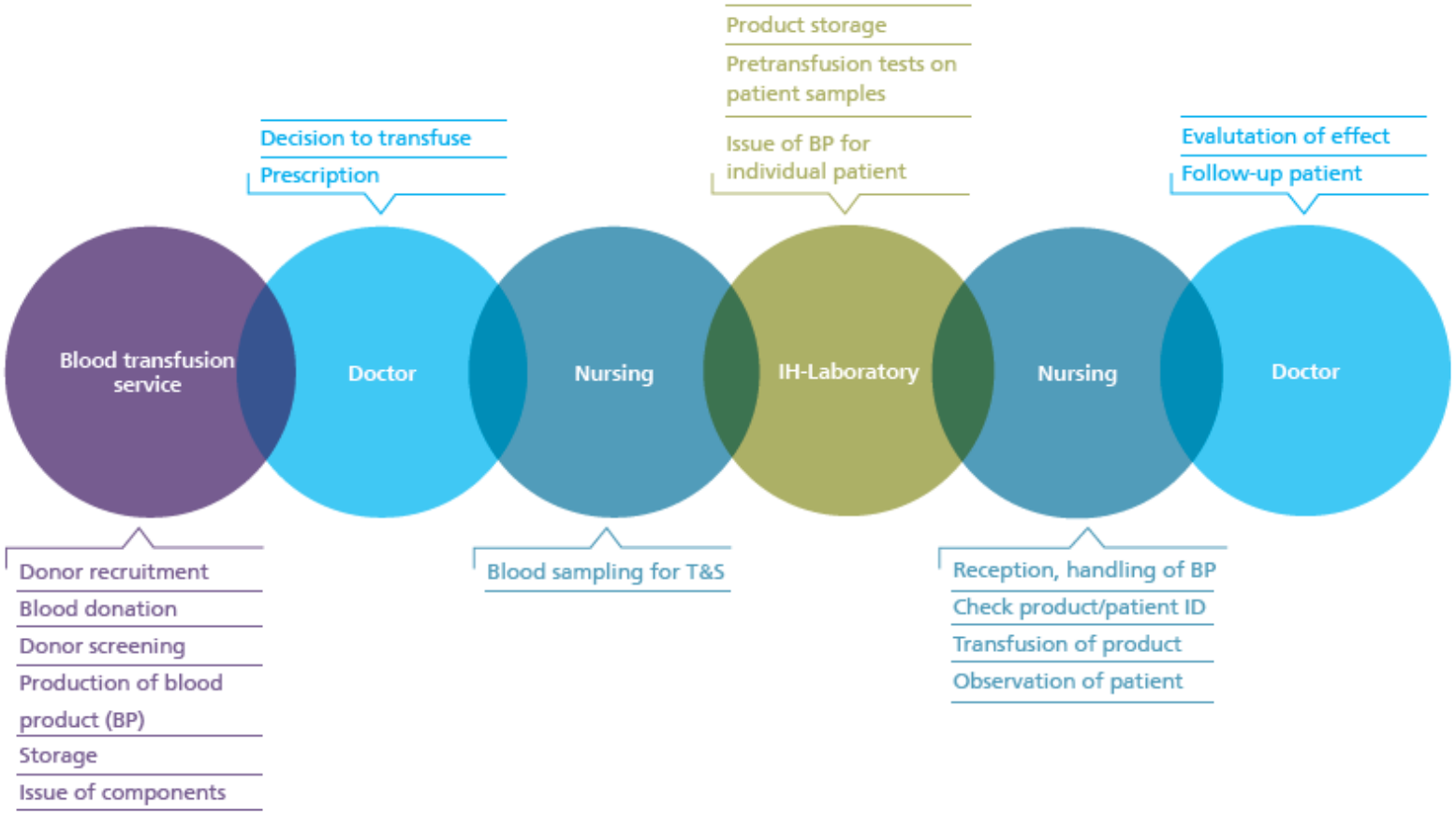
Transfusion chain



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Goal

Early detection of new risks and quality deficiencies through attention in the transfusion chain to increase transfusion safety!

thank you
danke
謝謝
ngiyabonga
شكراً جزيلاً
teşekkür ederim
gracias
merci
obrigado
dziękuję
bedankt
спасибо
Баярлалаа
рахмат
dank je
go raibh maith agat
mochchakkeram
sukriya
kop khun krap
terima kasih
grazie
arigatô
dakujem
takk
tapadh leat
мерси
감사합니다
ありがとう
ευχαριστώ
хвала
mauruuru
hvala
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taiku
mersi
barka
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tack
spas
kia ora
faafetai lava
vinaka
blagodaram
misaotra
matondo
paldies
grazzi
mahalo
kiitos
dankie
nanni
nandri
dhanyavad
köszönöm
bayarlalaa
gràcie
enkosi
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