

A view across the whole transfusion safety chain:  
Where are the missing and weakest links?



Erica Wood  
Monash University, Australia

“A set of surveillance procedures covering the whole transfusion chain (from the collection of blood and its components to the follow-up of recipients), intended to collect and assess information on unexpected or undesirable effects resulting from the therapeutic use of labile blood products, and to prevent their occurrence or recurrence.”

What are some of our weakest links?



# Policy

- Strong support from many professional organisations, governments, WHO
- Not yet part of national health policy in many countries
- Policy → recognition, resources



# ANNUAL SHOT REPORT 2012

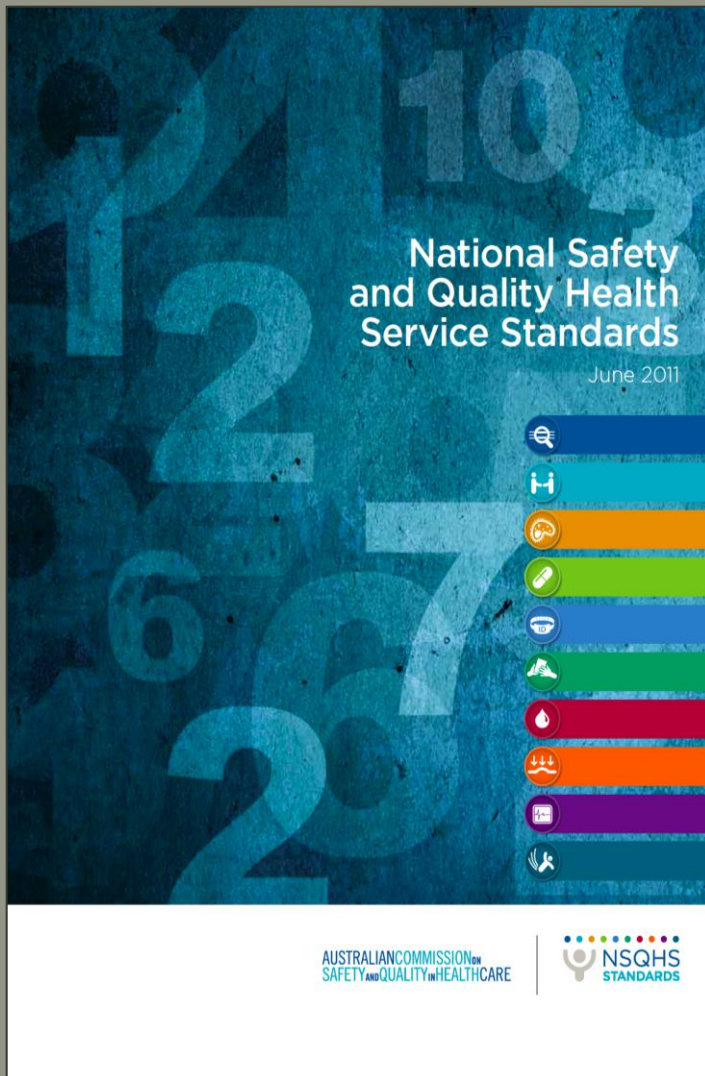
## Affiliated to the Royal College of Pathologists

The Steering Group includes members representing the following professional bodies:

British Blood Transfusion Society	Royal College of Nursing
British Society for Haematology	Royal College of Midwives
British Society of Gastroenterology	Royal College of Obstetricians and Gynaecologists
British Committee for Standards in Haematology	Royal College of Physicians
Faculty of Public Health	Royal College of Surgeons
Institute of Biomedical Science	Royal College of Paediatrics and Child Health
Public Health England (formerly the Health Protection Agency)	Intensive Care Society
NHS Confederation	Faculty of Intensive Care Medicine
Royal College of Anaesthetists	The College of Emergency Medicine
	Defence Medical Services
	UK Forum



# Clinical practice standards



## Blood and Blood Products Standard 7

### **The Blood and Blood Products Standard:**

Clinical leaders and senior managers of a health service organisation implement systems to ensure the safe, appropriate, efficient and effective use of blood and blood products. Clinicians and other members of the workforce use the blood and blood product safety systems.

### **The intention of this Standard is to:**

Ensure that the patients who receive blood and blood products do so appropriately and safely.

### **Context:**

It is expected that this Standard will be applied in conjunction with Standard 1, 'Governance for Safety and Quality in Health Service Organisations' and Standard 2, 'Partnering with Consumers'.

**AUSTRALIAN COMMISSION on  
SAFETY and QUALITY in HEALTH CARE**

To lead and coordinate the safety and quality  
agenda in Australia's health care system

[www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)

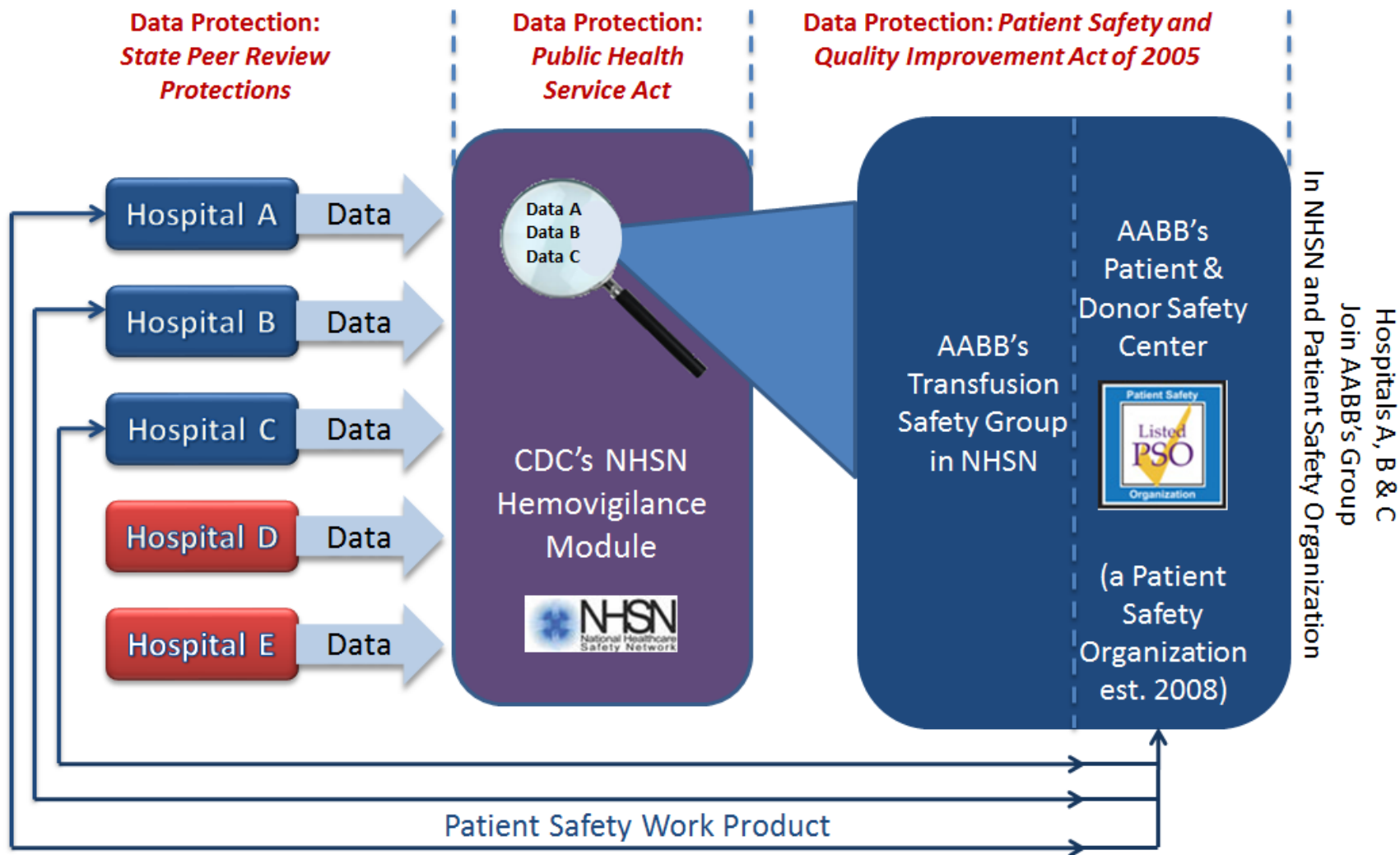
# Structures and systems

- Organisational structure
- Integration (biovigilance: MPHO)
- Type of system influence on data collected
- IT support
- Data management, analysis
- Status/protection/indemnity
- Reporting and feedback





# AABB's Patient and Donor Safety Center Data Protection Diagram



**Data Protection: HIPAA and the Patient Safety Act**

Note: Reports, benchmarking, analysis, etc. cannot be returned to participating facility without the HIPAA Business Agreement and AABB's Participation & Confidentiality Agreement in place.





## Haemovigilance Information

### What's New

**15 November 2013** Transfusion Information of transfusion-related AE/ARs and TTIs 2012 uploaded.

**9 May 2013** Transfusion Information of Transfusion-Related Acute Lung Injury uploaded.

**15 October 2012** Transfusion information of transfusion-related AE/ARs and TTIs 2011 uploaded.

**15 October 2012** Blood Services 2011 & 2012 (booklet about Japanese blood service) released.

### Haemovigilance Reports

[Haemovigilance Report 2008 \[PDF:5000kb\]](#) 

[Haemovigilance Report 2007 \[PDF : 2200kb\]](#) 

### Transfusion Information

[Non-Hemolytic Transfusion Reaction Cases 2012\(No.137\)](#)  
[\[PDF:1,074KB\]](#) 

[Transfusion Transmitted Infectious Cases 2012\(No.136\)](#)

# Scope

- Vein to vein: donors, products, patients
- Procedural: e.g. cell salvage
- Links to pharmacovigilance (e.g. fractionated plasma products, ESAs, PRT etc)



# Resources

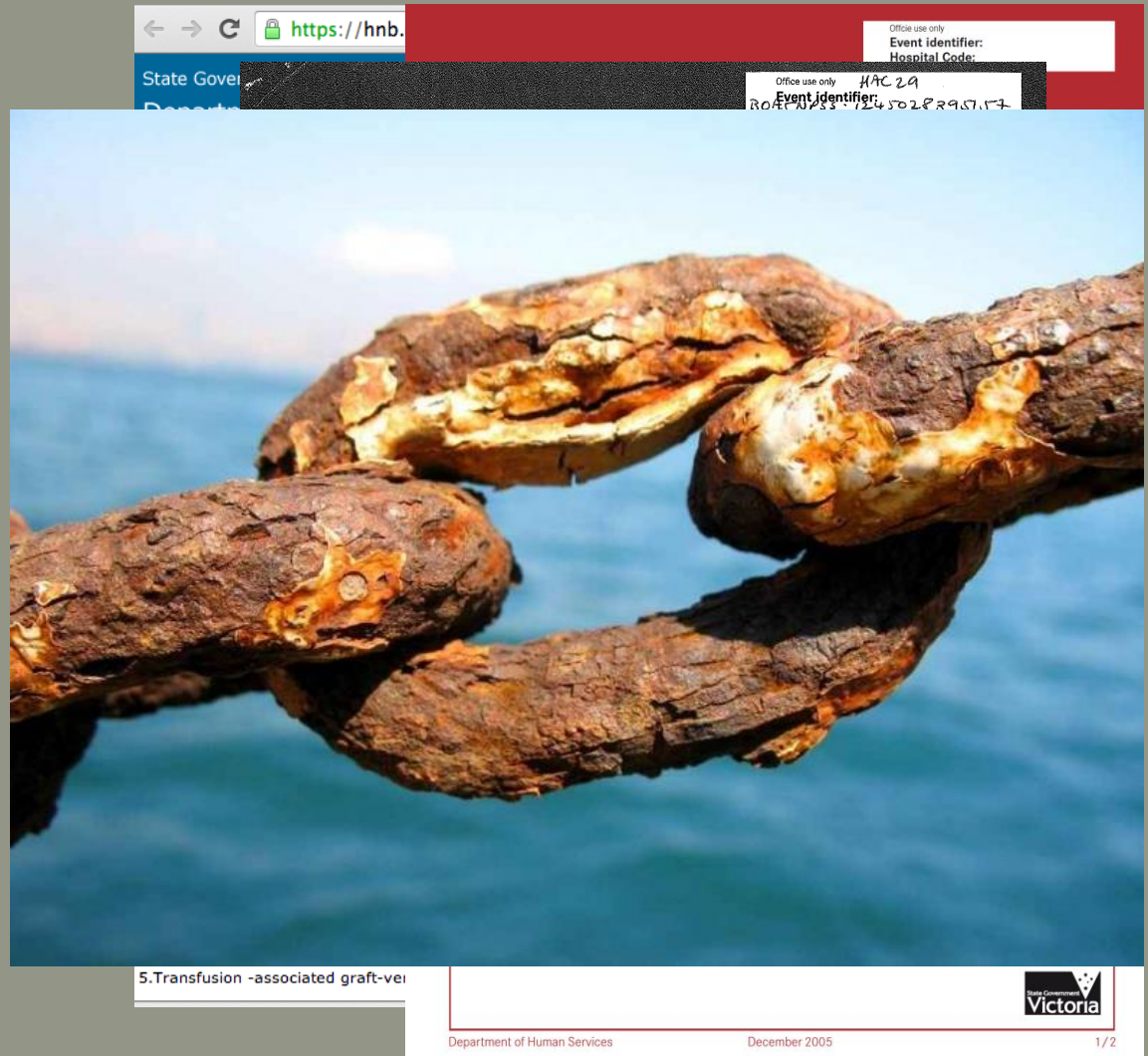
- Not secure in many settings
- “Home”
- Personnel
- Tools





# IT support

- HV programme
- BTS
- MoH
- Hospital



# People

- Professional mix
- Education and training
- Time
- Culture:
  - reporting, no blame
- Clinician engagement
- Management responsibility (MoH, hospital, BTS etc)



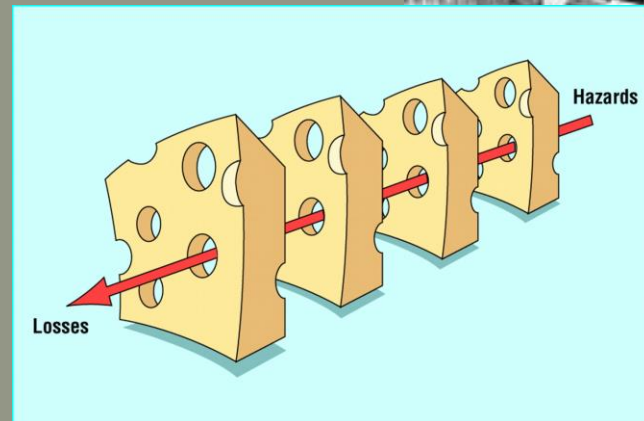
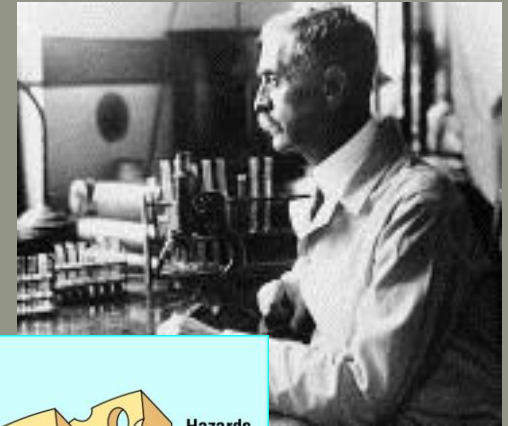
# Data

- Definitions
- Gaps, denominators
- Validation
- Analysis



# Research

- We know (many of) the problems
- Human factors
- Need more solutions:
  - Development
  - Testing
  - Implementation
  - Evaluation
- Implementation science: study of methods to promote integration of evidence/research findings into policy and practice



Reason,  
BMJ 2000



# Publication



ELSEVIER

Contents lists available at SciVerse ScienceDirect

## Transfusion and Apheresis Science

journal homepage: [www.elsevier.com/locate/tafs](http://www.elsevier.com/locate/tafs)

Online reporting system for transfusion-related events to enhance recipient haemovigilance in Japan

Chikako Odaka<sup>a</sup>, Hidefumi Kato<sup>b</sup>, Hiroko Otsubo<sup>a</sup>, Shinya Maiko Taneichi<sup>a</sup>, Kazu Okuma<sup>a</sup>, Kimitaka Sagawa<sup>c</sup>, Yasuhiko Fujii<sup>e</sup>, Yuji Yonemura<sup>f</sup>, Noriaki Iwao<sup>g</sup>, Asahiko Shun-ya Momose<sup>j</sup>, Junichi Kitazawa<sup>k</sup>, Hiroshi Mori<sup>l</sup>, Hitoshi Yasoshima<sup>o</sup>, Yasushi Ohkusa<sup>p</sup>, Kazunari Yamashita<sup>q</sup>

<sup>a</sup> Department of Safety Research on Blood and Biological Products, National Institute of Infectious Diseases, Tokyo, Japan

<sup>b</sup> Department of Transfusion Medicine, Aichi Medical University, Aichi, Japan

<sup>c</sup> Department of Laboratory Medicine, Kurume University, Fukuoka, Japan

<sup>d</sup> Department of Transfusion Service, Tokyo Jikei University, Tokyo, Japan

<sup>e</sup> Depa

<sup>f</sup> Depa

<sup>g</sup> Depa

<sup>h</sup> Depa

<sup>i</sup> Centr

<sup>j</sup> Blood

<sup>k</sup> Kuro

<sup>l</sup> Mina

<sup>m</sup> Shib

<sup>n</sup> Sanri

<sup>o</sup> Yao

<sup>p</sup> Infec



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Transfusion and Apheresis Science

Department of Health

health

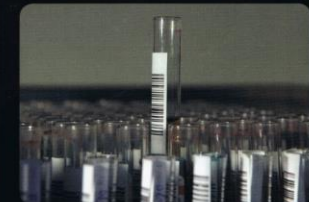
## Hemovigilance: is it making a difference to safety in the transfusion chain?

Johanna C. Wiersum-Osselton

## HEMOVIGILANCE

AN EFFECTIVE TOOL FOR IMPROVING TRANSFUSION SAFETY

EDITED BY RENÉ R.P. DE VRIES AND JEAN-CLAUDE FABER



WILEY-BLACKWELL

Eight years with haemovigilance in Norway: what have we learnt?

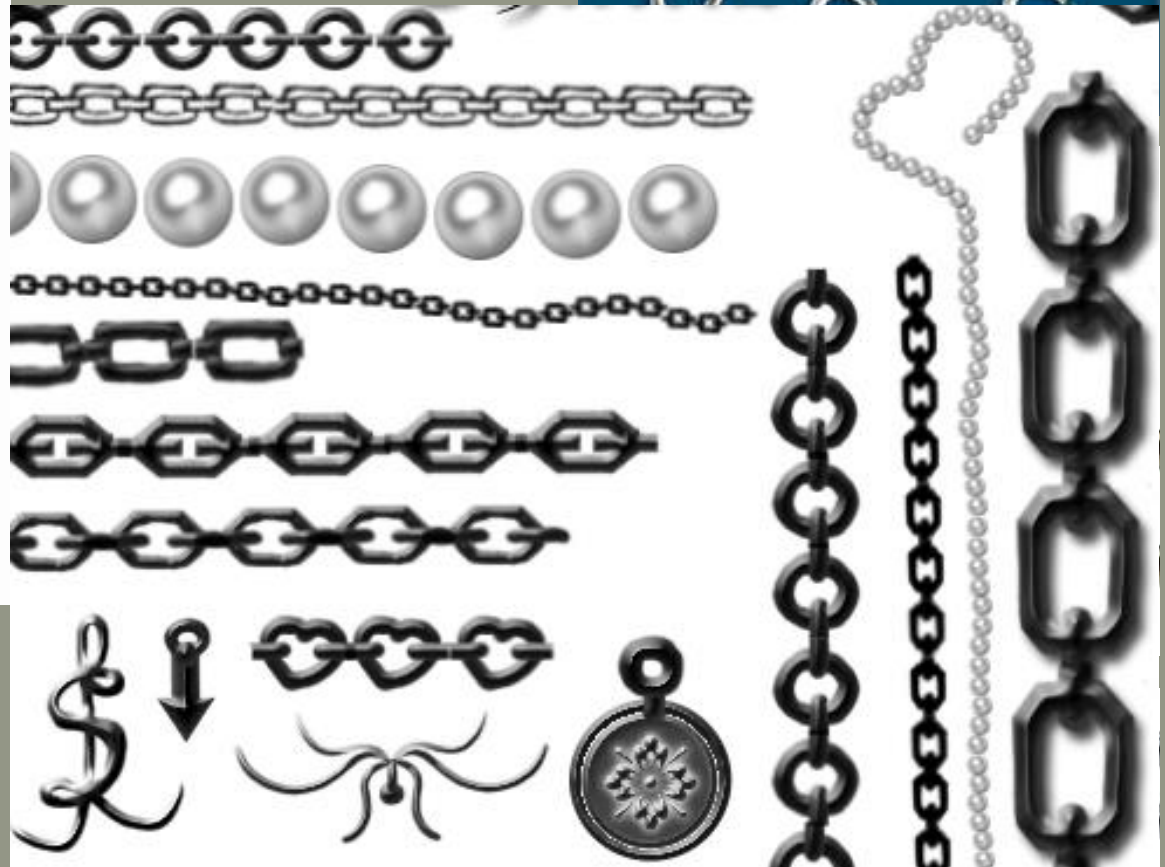
Christine Torsvik Steinsvåg<sup>a,b,\*</sup>, Aurora Espinosa<sup>a,c</sup>, Øystein Flesland<sup>a,d</sup>

<sup>a</sup> The Norwegian Knowledge Centre for the Health Services, Norway

<sup>b</sup> Department for Clinical Immunology and Transfusion Medicine, Sørlandet Hospital HF, Kristiansand, Norway

<sup>c</sup> Department for Immunology and Transfusion Medicine, St. Olav University Hospital, Trondheim, Norway

<sup>d</sup> Department for Clinical Immunology and Transfusion Medicine, Vestre Viken HF, Bærum, Norway



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