Reporting adverse events and reactions

Blood Transfusion Procedure

Purpose of this procedure:

This procedure defines what constitutes an event or reaction that must be reported and how this is done.

The Procedure:

If a serious transfusion reaction or adverse event occurs, take steps to safeguard the patient. The transfusion laboratory, duty haematologist and the practitioner in charge of the clinical area must be informed.

Specific forms are available from each hospital transfusion laboratory to be completed in the event of a transfusion reaction.

The outcome of the transfusion including any adverse events/reaction must be recorded in the patient's healthcare record.

The event or reaction must be logged on Datix (select 'transfusion' category) by the clinical staff involved and be reported to the local transfusion team who will ensure that it is reported to the MHRA Serious Adverse Blood Reactions and Events (SABRE) scheme and / or to the national Serious Hazards of Transfusion (SHOT) reporting scheme. The SABRE & SHOT reporters will ensure that the information is anonymised. The staff involved in the incident will be offered support including relevant education or training as necessary.

The individual identifying the adverse event or reaction has the responsibility of ensuring it is entered on Datix. The local transfusion practitioner can provide advice.

Some clinical incidents may be identified by the laboratory e.g. failure to identify need for special transfusion requirements.

Events / reactions regarded as serious hazards include:

- incorrect blood component transfusion, including components which were intended for another patient or which did not meet appropriate requirements (e.g. irradiated or CMV-negative)
- inappropriate or unnecessary transfusion
- blood component handling and storage errors
- anti-D related incidents
- acute transfusion reactions (<24 hours) (ATR) - including febrile non-haemolytic transfusion reactions with temperature rise of >2°C above baseline and moderate or severe allergic reactions
- haemolytic transfusion reactions (HTR) (these might be acute or delayed)
- transfusion-related acute lung injury (TRALI)
- transfusion-associated circulatory overload (TACO)
- transfusion-associated dyspnoea (TAD)
- post-transfusion purpura (PTP)
- transfusion-associated graft versus host disease (TaGvHD)
- bacterial contamination of a blood component
- post-transfusion viral or other infection
- autologous transfusion incidents (e.g. associated with cell salvage)

Near-miss events

Near miss events should also be reported on Datix (choose ‘transfusion’ from drop-down menu). These are defined as any errors, which, if undetected, could have resulted in the issue, collection or administration of incorrect, inappropriate or unsuitable components, but were recognised before transfusion took place. They include:

- samples labelled with the wrong patient’s personal details, or wrong details given by telephone
- wrong component requested or special requirements incorrectly specified
- laboratory error in patient details or results

- laboratory error in issuing incorrect component
- wrong component collected from laboratory or satellite blood fridge
- incorrect transportation or ward storage
- error in identification of patient at the time of administration of the component

Associated materials/references:

NHS Lothian Blood Transfusion Procedure: Monitoring of patient during and following transfusion

NHS Lothian Blood Transfusion Guideline: Adverse reactions to blood components

NHS Lothian Adverse Event Management Policy and Procedure