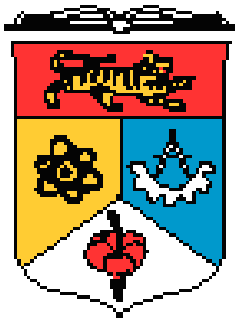

GUIDELINES ON BLOOD AND BLOOD COMPONENTS TRANSFUSION (Haemovigilance Program)

Universiti Kebangsaan Malaysia Medical Center

2nd Edition 2013

Reviewed December 2015

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2nd Edition

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Reviewed by Hospital Transfusion Committee

(December 2015)

1. Prof (K) Dr Jaafar Hj Mohd Zain
2. Prof Madya Dr Leong Chooi Fun
3. Prof Madya Dr Ani Amelia Zainuddin
4. Prof Madya Dr Goh Eng Hong
5. Dr Fadzlon Mohd Yatim
6. Dr Loh C-Khai
7. Dr Nor Rafeah Tumian
8. Dr Muhammad Maaya
9. Dr Ashraff Ariff
10. Dr Nurasyikin Yusof
11. Dr Suria Abdul Aziz
12. Dr Rabeya Yousuf
13. Pn Maryana Razali
14. En Mohd Herman Mobin

Guidelines on Haemovigilance Program in Blood Transfusion

(Adopted and modified from Transfusion Practice Guidelines for Clinical and Laboratory Personnel, National Blood Centre, Ministry of Health, Malaysia. 3rd Edition, March 2008)

Blood transfusion safety can be defined as a series of processes implemented to either remove or reduce allogeneic blood-transfusion-related immunologic or infectious risks. Haemovigilance is a system of surveillance and alarm, from blood collection to the follow-up of the recipients, gathering and analysing all untoward effects of blood transfusion in order to identify, correct their cause and take remedial measures to prevent recurrence.

National Blood Centre is the Haemovigilance Coordinating Centre for the Ministry of Health. The Blood Transfusion Unit in UKM Medical Center obtains the blood components from the National Blood Centre, and is mainly involved in providing blood components for the patients in UKM Medical Centre. The Blood Transfusion Unit of UKM Medical Centre shall participate and abide to the Haemovigilance Program implemented by the National Blood Centre, Ministry of Health at all times.

The Haemovigilance Program in UKM Medical Centre has the following objectives:

i. To collect and analyse all the adverse events (immunological and non-immunological) in transfusion.
ii. To collect and analyse “near miss” events in transfusion process.
iii. To use the information obtained to identify training needs, to evaluate transfusion practices and corrective measures to prevent the recurrence and to improve transfusion safety.

In order to ensure accurate data can be collected, evaluated and acted upon, the support from the Hospital Directors, the doctors and all other allied health personnel are needed.

Procedure for "Adverse Transfusion Reaction" data collection:

For any suspected cases of transfusion reaction, a "Report of Reaction to Blood or Plasma" Document No: PPUKM/JPMD/BB/B-06 (pin-01) (*appendix 1)* together with the investigation for transfusion reaction has to be sent to Blood Bank UKMMC soon after the incidence.

i. Upon receipt of the "Report of Reaction to Blood and Plasma" forms by the Blood Bank UKMMC, investigations for Transfusion Reaction will be performed in the laboratory and reported by the Haematologist in the Laboratory information system (LIS)

ii. The Blood Bank UKMMC shall collect the data at regular interval in the "Reporting format for Adverse Transfusion Event" form, and a copy of this form will be sent to National Blood Centre.

iii. The data shall be presented and reviewed regularly by the Hospital Transfusion Committee, UKM Medical Centre at least twice a year to identify any training needs, to discuss any procedural problem and provide recommendation for better safety in transfusion.

Note : At any one time, an Emergency Hospital Transfusion Committee Meeting may be called for any urgent arising matters.

Procedure for "Near Miss" data collection:

A "near miss" is an error or deviation from standard procedures or policies that is discovered before the start of the transfusion and that could have led to a wrongful transfusion or to a reaction in a recipient, e.g wrong sample, wrong label, wrong blood product issued, and clerical errors.

i. For **ALL** cases that fulfilled the criteria for "Near Miss" as defined above either in the ward or in the laboratory have to be reported to the Head of Unit, Blood Bank UKMMC.

ii. To report a "near miss", all the personnel who identified / noted the incident are required to fill in the "Report of Near Miss Event" form *(appendix 2)* and submit it to the Head of Unit, Blood Transfusion Unit, UKMMC *immediately.*

iii. For all reported cases of "near miss", a thorough investigation shall be carried out and reported.

iv. The data collected shall be presented and reviewed regularly by the Hospital Transfusion Committee at least twice a year to identify any procedural problems, and to provide recommendation for better safety in transfusion.

Note : For all the data collected for Blood Transfusion Unit, UKMMC, a copy of these data will be sent to the National Blood Centre regularly.