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If you have not visited our website recently, we encourage you to do so. It was re-launched in early 2012 to provide easier access to many e-tools and resources available for healthcare professionals working in the field of transfusion medicine.

In this issue of the ORBCoN report, you will find articles focusing on the blood administration process and the importance of accurate patient identification, which we hope you will find of interest.

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**What's New at ORBCoN?**

*Wendy Owens, Regional Coordinator ORBCoN Northern and Eastern Ontario*

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**Heading Home After a Transfusion**

*Ana Lima TTISS Ontario Educational Subgroup Chair, Julie Di Tomasso, TTISS Ontario Coordinator*

Currently under development by the Ontario Transfusion Transmitted Injury Surveillance System Educational Subgroup is an instruction sheet to be given to patients when they are discharged home following a transfusion. Typically this would occur in an outpatient clinic setting but would also apply to patients transfused and then discharged shortly after from other areas of the hospital such as the Emergency department.

Although still under revision, the current draft includes a brief introduction about the small risk of having a transfusion reaction; a description of mild and serious symptoms and how to proceed if the patient experiences these symptoms; and finally contact information for reporting the transfusion reaction.

We propose to have two versions of this information sheet, one that will allow users to add their hospital logo and contact information only, and a second version that allows more edits to the document in addition to the ones listed above. This will allow hospitals to adapt the sheet to meet their individual hospital
Heading Home After A Transfusion continued

needs. Both versions will be available on the Transfusion Ontario website with a tracking mechanism to assess the request rates for each document. The expected implementation date is still pending although the group anticipates a final version will be available in early 2012. Standards (CSA Z902-10, 11.4.14 and CSTM Version 3, 5.8.3.11) dictate that patients be given instructions concerning possible adverse events when direct observation or monitoring will not be available after the transfusion. The creation of ‘Heading Home After A Transfusion’ will assist hospitals to comply with these Standards.

A Community Hospital’s Experience with the ORBCoN Bedside Audit of Blood Transfusion Practice

Allison Collins, Theo Hutchinson, Gail Murray, Peterborough Regional Health Centre (PRHC)

One of the hazards of blood transfusion is the risk of receiving a blood component intended for another recipient. In 2010, ORBCoN developed an audit tool for auditing bedside transfusion practice in Ontario hospitals. One of us (AC) served on the Working Group which developed the audit tool, and our hospital participated in the pilot audits done in October, 2010.

In 2009, our Transfusion Committee and nursing staff had revised and updated PRHC’s nursing procedure for blood transfusion, so the timing of this project was ideal. The PRHC Transfusion Committee agreed that participation in the audit would be beneficial to our staff and patients.

Our Chief Nursing Officer shared our enthusiasm for the project. We kept her informed about the timing of the audits, performed in early 2011, so that our nursing staff would not feel ‘blind-sided’. We asked the Chair of our Ethics Committee for his opinion. He perceived the audit as a quality improvement exercise as opposed to a research project, so Ethics Committee approval was not required at PRHC.

During the audit period, our nursing and transfusion medicine laboratory staff performed 16 audits on several nursing units (excepting the OR and ICU). Our audits revealed that, as in other Ontario hospitals, there was room for improvement in our bedside patient ID checks, review of physician orders and patient consent forms, and specification of product infusion rates. When ORBCoN released the audit results, we prepared a slideshow presentation and delivered it to our Nursing Professional Practice Committee in June 2011, where it was well received. Both provincial and PRHC data were presented.

The audit helped to raise awareness of the importance of patient armbands, including those on outpatients, when transfusing blood. We look forward to repeating the audit in 2012, after pursuing more nursing and physician education initiatives.
Wristband Audit at Cornwall Community Hospital

Judy Kyte, Patient Safety Coordinator, Cornwall Community Hospital and Dr. Elianna Saidenberg, Hematologist, The Ottawa Hospital

When the Transfusion Committee at Cornwall Community Hospital (CCH) recognized that a current transfusion practice, initially put into place to protect patient safety, actually posed significant risk, we undertook to make some changes. The task: to discontinue use of a separate blood ID band and ensure only the patient ID wristband is used for identifying patients needing transfusion therapy. The blood bracelet had a long history at CCH and there was significant resistance to its discontinuation. We had to prove to naysayers that this change would indeed be a safe one. One concerned party indicated that compliance with wristband use was suboptimal and therefore not an appropriate method of identifying patients. An audit was therefore designed to determine the hospital’s compliance with accurate ID wristbands.

During the summer of 2011, a total of 180 patients were audited in the Emergency Department, CCU, Day Surgery, PACU as well as all in-patient units. Some high risk, high turn-over areas were audited on more than one day. Patients were considered correctly identified if they were wearing their ID band on their arm or ankle and if the information was legible and correct.

Our results showed that 88% of patients reviewed were correctly identified. The results were presented to the Transfusion Committee, Nursing Leadership and Nursing Advisory Committee. Gaps have been identified and individual departments will develop plans to improve their compliance. Follow up audits will be done to ensure that the improvements made are sustained.

A small bump in the road presented itself when it was discovered that the blood bracelet system also included stickers that were used as compatibility labels on the components. New stickers were found and purchased and we are thrilled to report that as of November 2011 the blood bracelet system is a historical artifact at the Cornwall Community Hospital. It is our first major undertaking to improve transfusion safety, but it won’t be our last!

CASE STUDY: “Point of Care” Blood Banking

Setting: Ms. Smith*, an 85 year old female from the local nursing home is found to have decreased levels of consciousness and is brought into the emergency room of Hospital A. Her Hgb measures 70g/L which is decreased from 110g/L when last checked 3 weeks ago. Her ECG shows signs of cardiac ischemia. At the same time the Ontario Provincial Police (OPP) reports to the ER that a nearby motor vehicle accident has occurred and that more information will follow. (*name has been changed)

Background information: Hospital A is a small rural hospital with 6 beds, an ER, limited point of care testing, is not accredited by Ontario Laboratory Accreditation, and is affiliated with a nearby long term care facility. It maintains an emergency stock of 2 units of O RhD Neg RBCs and stores crossmatched RBCs for patients that have been supplied by hospital B. Hospital B is a community hospital supporting Hospital A’s transfusion needs. They receive specimens for compatibility testing and prepare and ship crossmatched RBCs as well as provide the emergency stock of 2 units of O RhD Neg RBCs.

Description of event: The ER physician deems a transfusion is necessary for Ms. Smith but is reluctant to use the group O trauma stock due to the recent OPP report. There are 2 units of group A RhD Neg RBCs available in the ER fridge, crossmatched for a young woman who gave birth two nights previously.
CASE STUDY: “Point of Care” Blood Banking continued

Ms. Smith’s chart result, faxed from the nursing home indicates that she is group A RhD Pos, antibody screen negative. The ER physician orders the two units of group A RhD Neg RBCs be transfused to Ms. Smith. During the first unit Ms. Smith’s temperature increases from 36.5 to 39.6°C accompanied by rigors and hypotension. The transfusion is stopped and the medical director from the blood bank at Hospital B is consulted. Ms. Smith is then transferred to Hospital B for further investigation. Upon arrival, she has low grade DIC and acute renal failure. Laboratory findings reveal that Ms. Smith is actually group O RhD Pos with a previously detected anti-Jka still reacting in her plasma. The DAT is negative at the time of testing. The implicated unit is found to be crossmatch incompatible by immediate spin.

Conclusion: It is determined that the nursing home accidently faxed the results for a different patient, also named Smith, to the ER at Hospital A, resulting in the erroneous assignment of her blood group. Ms. Smith was placed on chronic dialysis and her family was informed of the error.

Question to Ponder: In the absence of a licensed laboratory at hospital A, which facility should be held responsible for ensuring that appropriate transfusion policies are in place at hospital A?

Please refer to our website www.transfusionontario.org February 29, 2012 for a posting of a discussion paper on this case study. Compare your answers to the question posed.

Upcoming Educational Events Calendar

<table>
<thead>
<tr>
<th>Event</th>
<th>Where</th>
<th>When</th>
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<tbody>
<tr>
<td>Annual ORBCoN/CBS Spring Symposium</td>
<td>Toronto, ON</td>
<td>March 23-24, 2012</td>
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<tr>
<td>Annual Videoconference Symposium</td>
<td>Sudbury/OTN</td>
<td>April 18, 2012</td>
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<tr>
<td>CSTM Annual General Meeting and Expo</td>
<td>Halifax</td>
<td>May 24 -27, 2012</td>
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<tr>
<td>LABCON 2012</td>
<td>Gatineau</td>
<td>June 2-4, 2012</td>
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For a complete list of upcoming events please visit www.transfusionontario.org

Quote
Our greatest glory is not in never falling but rising every time we fall.
~ Confucius

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