

***TOOLS TO ASSIST HOSPITAL***

***PRACTITIONERS WHEN***

***GATHERING DATA FOR A***

***TRANSFUSION REACTION /***

***EVENT INVESTIGATION IN***

***A HOSPITAL***

## Introduction

Some cases of transfusion reaction and event will require the review of extensive amounts of information from different sources. These tools will assist hospital Haemovigilance Officer (HVOs) to gather, collate and present this information within the hospital or to the NHO. These tools can be adapted to suit local requirements.

### 1. Gathering data

Information should be gathered about what happened from the patient's record – medical and nursing notes, daily record charts e.g. vital signs, fluid balance, drugs kardedex, and laboratory and radiology information. Both the nursing and medical teams looking after the patient may have further information. The HVO should be aware of the critical information for each type of serious adverse reaction as outlined in the current version of the Haemovigilance Handbook.

A sequence or chronology of events should be recorded by the HVO. This is especially useful when examining a case which involves a complex history e.g. a suspected TRALI, or transfusion transmitted viral infection.

Use of a tool such as **Appendix 1** is recommended.

### 2. Mapping and collating the information

The information gathered should be ordered in a useful manner. This will clarify what is known and identify further information needs to be identified.

The following tools will be useful in to complete this: information.

- Timeline: chronologically maps the critical events involved in an incident (SAR /SAE) – See **Appendix 2**. The usual presentation of the timeline is via the diagrammatic format, including only critical information in an event. A timeline should either begin at the point at which the chain of events leading to the incident started, or at the point of incident occurrence and work backwards to the agreed start point.
- Several transfusion reaction investigations involve a review of extensive laboratory or clinical results. In some hospitals, this information is available in the patient's electronic record in the laboratory information system. However, this may not always be the case. Templates for specific SAR are presented as follows

### Appendix 3- Acute / Delayed Haemolytic Transfusion Reactions

### 3. Review and analysis of information

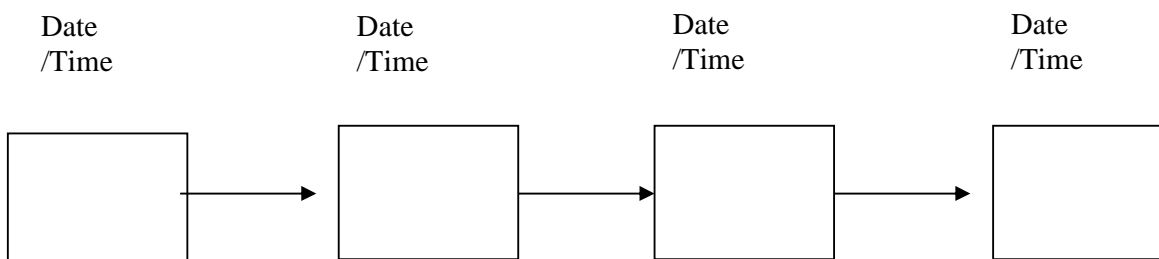
This information should be presented for review by haemovigilance team, including the HVO, Medical Scientists and Consultant Haematologist. Following this review, decisions will be made on some /all of following;

- the type of SAR,
- Follow up action for the patient e.g. future requirements
- Feedback to medical team
- Reporting to NHO

## Appendix 1: Sequencing of events.

Date /Time	Event and Information

## Appendix 2: Timeline



## Appendix 3; Template for mapping results for a suspected Acute / Delayed Haemolytic Transfusion Reactions

Local identifier								
Blood Results	Pre transfusion		Post transfusion					
	Date	Date	Date	Date	Date	Date	Date	Date
DAT								
Antibodies								
HB								
Haptoglobins								
Bilirubin								
LDH								
Urea								
Creatinine								

Templates available for use on National Haemovigilance Office WebPages