



DIAGNOSTIC SERVICES  
OF MANITOBA



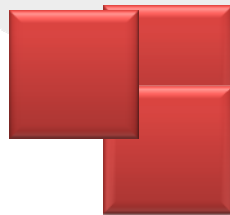
WRHA Blood Conservation Service  
WRHA Transfusion Practice Committee

Manitoba

Health and Healthy Living



Canadian Blood Services  
*it's in you to give*



## **TEAM TRANSFUSION**

### **How to Report an Adverse Event**

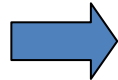


# Presentation Overview

- Form Completion
  - Case 1 – Mr. DY
  - Case 2 – Mr. HH
  - Case 3 – Ms. KZ
- Manitoba Adverse Event Reporting System
  - Info
  - Info
  - Info

# Lost in Translation ?

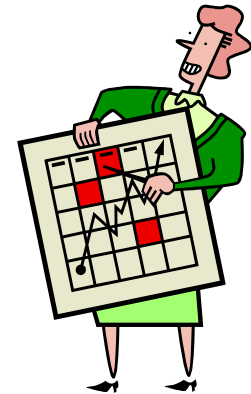
Adverse Event



Form Completion



Reporting



# Case 1 – Mr. DY

## Clinical Information

- Patient Demographics
  - Name – DY
  - PHIN – 999 888 777
  - DOB – 01JAN1975 (34yr)
  - Male
- Premeds
  - Acetomenophen 650mg
  - Benadryl 25 mg
- Clinical Signs/Symptoms
  - > 1 ec
  - Shivering/Myalgia
- Pre Transfusion VS
  - BP98/60
  - P 90
  - T 36.9 – 37.9
- Post Transfusion VS
  - BP 160/80
  - P 120
  - T 38.4
- Measures
  - Transfusion restarted

**CANADIAN BLOOD SERVICES**  
777 William Ave. Winnipeg, MB R3E 3R4  
**TRANSFUSION REACTION INVESTIGATION**

Reason for Transfusion \_\_\_\_\_

Reaction Date \_\_\_\_\_ Time \_\_\_\_\_

Facility \_\_\_\_\_

Form Completed By \_\_\_\_\_

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Name of Physician \_\_\_\_\_ Time \_\_\_\_\_

Authorizing Investigation \_\_\_\_\_

Transfusion/Obstetrical History  
Transfusions  Yes <3 mo.  Yes >3 mo.  No  Unknown

Premedication:  No  Yes  
(If Yes, Specify Drug(s): \_\_\_\_\_)

Clinical Signs and Symptoms  
 Chills/Rigors  Hemoglobinuria  Nausea/Vomiting  Shock  
 Fever  Hemorrhage  Tachycardia  Oliguria  
 Urticaria  Hypotension  Shortness of Breath  
 Other Skin Rash  Hypertension  Pain, Specify: \_\_\_\_\_  
 Jaundice  Hypoxemia  Other \_\_\_\_\_

Transfused Under Anesthesia:  No  Yes  General  Local/Regional

Pre transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
Post transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Measures Taken  
 None Required  Analgesics  Antibiotics  Supplementary O<sub>2</sub>  Other, Specify: \_\_\_\_\_  
 Transfusion Stopped  Antipyretics  Diuretics  Vasopressors  
 ICU Required  Antihistamines  Steroids  Patient Blood Culture Ordered  
 Chest X-Ray  Transfusion Restarted  Mechanical Ventilation

**Blood Component Transfusion Reaction (eg. Red Cells, Plasma, Platelets, Cryo)**

Donor ABO/Rh	Product Type	Donor Unit # (including Centre Code)	Volume Given (mL)	Date/Time Started	Date/Time Finished	Expiry Date	Product Code #	Product Modifiers

**Derivative Transfusion Reaction (eg. Albumin, IVIG, Factor Concentrates)**

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (V/M)	Frequency	Time Started	Time Finished	Expiry Date

Nursing Clerical Check  
Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

Facility Blood Bank Clerical Check  
Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Blood Components Cancelled**  
• All reactions, other than rash and/or urticaria, to any type of blood component, result in immediate cancellation of all crossmatched blood components remaining on the current Request for Blood Components requisition.

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# Case 1 – Mr. DY

## Product Information

- Donor unit ABO/Rh
- Product type: RBC
- Donor unit #
  - C0 0540 09 7775453\$
- Volume given: 139 mL
- Infusion date/time (start & stop)
- Expiry date (donor unit expiry)
- Product Code – E
- Modifiers (none)

**CANADIAN BLOOD SERVICES**  
777 William Ave, Winnipeg, MB R3E 3R4  
**TRANSFUSION REACTION INVESTIGATION**

PLEASE USE NAME PLATE OR PRINT

Reason for Transfusion \_\_\_\_\_

Reaction Date \_\_\_\_\_ Time \_\_\_\_\_

Facility \_\_\_\_\_

Form Completed By \_\_\_\_\_

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Name of Physician \_\_\_\_\_ Time \_\_\_\_\_

Authorizing Investigation \_\_\_\_\_

Male  Female

Transfusion/Obstetrical History

Transfusions  Yes <3 mo.  Yes >3 mo.  No  Unknown

Prog. Miscarriages  Yes <3 mo.  Yes >3 mo.  No  Unknown

Premedication:  No  Yes

If Yes, Specify Drug(s): \_\_\_\_\_

Clinical Signs and Symptoms

Chills/Rigors  Hemoglobinuria  Nausea/Vomiting  Shock

Fever  Hemorrhage  Tachycardia  Oliguria

Urticaria  Hypertension  Shortness of Breath

Other Skin Rash  Hypertension  Pain, Specify: \_\_\_\_\_

Jaundice  Hypoxemia  Other \_\_\_\_\_

Transfused Under Anesthesia:  No  Yes  General  Local/Regional

Pre transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Post transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Measures Taken

None Required  Analgesics  Antibiotics  Supplementary O<sub>2</sub>  Other, Specify: \_\_\_\_\_

Transfusion Stopped  Antipyretics  Diuretics  Vasopressors

ICU Required  Antihistamines  Steroids  Patient Blood Culture Ordered

Chest X-Ray  Transfusion Restarted  Mechanical Ventilation

Blood Component Transfusion Reaction (eg. Red Cells, Plasma, Platelets, Cryo)

Donor	Product	Quantity	Expiry Date	Time Started	Time Finished	Expiry Date

Derivative Transfusion Reaction (eg. Albumin, IVIG, Factor Concentrates)

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (IV/IM)	Frequency	Time Started	Time Finished	Expiry Date

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

Facility Blood Bank Clerical Check

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Blood Components Cancelled**

• All reactions, other than rash and/or urticaria, to any type of blood component, result in immediate cancellation of all crossmatched blood components remaining on the current Request for Blood Components requisition.

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# Case 1 – Mr. DY

## Clerical Checks

- Nursing
  - Check all information
    - Donor unit/tag
    - CBS Progesa Report or DSM BTS Report
    - Order, Chart information
- Blood Bank
  - Lab Log
    - Patient Progesa/DSM BTS report
    - Donor unit information
    - Packing Slip (as applicable)

**CANADIAN BLOOD SERVICES**  
777 William Ave. Winnipeg, MB R3E 3R4  
**TRANSFUSION REACTION INVESTIGATION**

PLEASE USE NAME PLATE OR PRINT

Reason for Transfusion \_\_\_\_\_

Reaction Date \_\_\_\_\_ Time \_\_\_\_\_

Facility \_\_\_\_\_

Form Completed By \_\_\_\_\_

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Name of Physician \_\_\_\_\_  
Authorizing Investigation \_\_\_\_\_ Time \_\_\_\_\_

**Transfusion/Obstetrical History**

Transfusions  Yes <3 mo.  Yes >3 mo.  No  Unknown  
 Preg. Miscarriages  Yes <3 mo.  Yes >3 mo.  No  Unknown

Premedication:  No  Yes

If Yes, Specify Drug(s): \_\_\_\_\_

**Clinical Signs and Symptoms**

Chills/Rigors  Hemoglobinuria  Nausea/Vomiting  Shock  
 Fever  Hemorrhage  Tachycardia  Oliguria  
 Urticaria  Hypotension  Shortness of Breath  
 Other Skin Rash  Hypertension  Pain, Specify: \_\_\_\_\_  
 Jaundice  Hypoxemia  Other \_\_\_\_\_

Transfused Under Anesthesia:  No  Yes  General  Local/Regional

Pre transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Post transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

**Measures Taken**

None Required  Analgesics  Antibiotics  Supplementary O<sub>2</sub>  Other, Specify: \_\_\_\_\_  
 Transfusion Stopped  Antipyretics  Diuretics  Vasopressors  
 ICU Required  Antihistamines  Steroids  Patient Blood Culture Ordered  
 Chest X-Ray  Transfusion Restarted  Mechanical Ventilation

**Blood Component Transfusion Reaction (eg. Red Cells, Plasma, Platelets, Cryo)**

Donor ABO/Rh	Product Type	Donor Unit # (including Centre Code)	Volume Given (mL)	Date/Time Started	Date/Time Finished	Expiry Date	Product Code #	Product Modifier

**Derivative Transfusion Reaction (eg. Albumin, IVIG, Factor Concentrates)**

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (IV/IM)	Frequency	Time Started	Time Finished	Expiry Date

**Nursing Clerical Check**  
 Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Facility Blood Bank Clerical Check**  
 Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Blood Component Consistency**

• All reactions, other than rash and/or urticaria, to any type of blood component, result in immediate cancellation of all crossmatched blood components remaining on the current Request for Blood Components requisition.

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# Case 2 – Mr. HH

## Clinical Information

- Patient Demographics
  - Name – HH
  - PHIN – 777 888 999
  - DOB – 01JAN1960 (50yr)
  - Male
- Clinical Signs/Symptoms
  - SOB
  - Distressed
- Pre Transfusion VS
  - BP 120/75
  - P 100
  - T 37.5
- Post Transfusion VS
  - BP 140/95
  - P 100
  - T 37.8
- Measures
  - Physician consult

**CANADIAN BLOOD SERVICES**  
777 William Ave. Winnipeg, MB R3E 3R4  
**TRANSFUSION REACTION INVESTIGATION**

PLEASE USE ADHESIVE PLATE OR PRINT

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

FACILITY: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

Reason for Transfusion \_\_\_\_\_

Reaction Date \_\_\_\_\_ Time \_\_\_\_\_

Facility \_\_\_\_\_

Form Completed By \_\_\_\_\_

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Name of Physician \_\_\_\_\_ Authorizing Investigation \_\_\_\_\_ Time \_\_\_\_\_

Transfusion/Obstetrical History

Transfusions  Yes <3 mo.  Yes >3 mo.  No  Unknown

Prog. Miscarriages  Yes <3 mo.  Yes >3 mo.  No  Unknown

Premedication:  No  Yes

If Yes, Specify Drug(s) \_\_\_\_\_

**Clinical Signs and Symptoms**

Chills/Rigors  Hemoglobinuria  Nausea/Vomiting  Shock

Fever  Hemorrhage  Tachycardia  Oliguria

Urticaria  Hypotension  Shortness of Breath

Other Skin Rash  Hypertension  Pain, Specify: \_\_\_\_\_

Jaundice  Hypoxemia  Other \_\_\_\_\_

Transfusion Reaction Sample Collected at

Facility \_\_\_\_\_ Ward/Unit \_\_\_\_\_

Phlebotomist

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Collection Date \_\_\_\_\_ Time \_\_\_\_\_

Equipment Used

Bedside Filter  Blood Warmer

Pump  Reinfusion Device

Pressure Device

Equipment Problems  No  Yes

If Yes, Type: \_\_\_\_\_

Lot # \_\_\_\_\_

Pre transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Post transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

None Required  Analgesics  Antibiotics  Supplementary O<sub>2</sub>  Other, Specify: \_\_\_\_\_

Transfusion Stopped  Antipyretics  Diuretics  Vasopressors

ICU Required  Antihistamines  Steroids  Patient Blood Culture Ordered

Donor ABC/Gr.	Product Type	Donor Unit # (including Corne Cuts)	Volume Given (mL)	Date/Time Started	Date/Time Finished	Expiry Date	Product Code #	Product Modifiers

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (IV/IM)	Frequency	Time Started	Time Finished	Expiry Date

Nursing Clerical Check

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

Facility Blood Bank Clerical Check

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Blood Components Cancelled**

• All reactions, other than rash and/or urticaria, to any type of blood component, result in immediate cancellation of all crossmatched blood components remaining on the current Request for Blood Components requisition.

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# Case 2- Mr. HH

## Product Information

- Donor unit ABO/Rh
- Product type (3):
  - RBC
  - Albumin
  - Plasma (FFP)
- Donor unit #
  - **RBC:**
    - C0 0540 09 5555720\$
    - C0 0540 09 5555820#
  - **Albumin:**
    - 26NCNT1
    - 26NCNT1
  - **Plasma (FFP):**
    - C0 540 09 12345620\*
    - C0 540 09 12345720%
- Volume given: state volume for each
- Infusion date/time (start & stop) for each
- Expiry date (donor unit expiry) for each
- Product Code – E for each
- Modifiers (none)

**CANADIAN BLOOD SERVICES**  
777 Wilson Ave. Wilmslow, MB R2E 3R4  
**TRANSFUSION REACTION INVESTIGATION**

PLEASE USE BLOCK PLATE OR PRINT

Reason for Transfusion \_\_\_\_\_

Reaction Date \_\_\_\_\_ Time \_\_\_\_\_

Facility \_\_\_\_\_

Form Completed By \_\_\_\_\_

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Name of Physician \_\_\_\_\_  
Authorizing Investigation \_\_\_\_\_ Time \_\_\_\_\_

**Transfusion/Obstetrical History**

Transfusions  Yes <3 mo.  Yes >3 mo.  No  Unknown  
 Preg. Miscarriages  Yes <3 mo.  Yes >3 mo.  No  Unknown

Premedication:  No  Yes  
 If Yes, Specify Drug(s): \_\_\_\_\_

**Clinical Signs and Symptoms**

Chills/Rigors  Hemoglobinuria  Nausea/Vomiting  Shock  
 Fever  Hemorrhage  Tachycardia  Oliguria  
 Urticaria  Hypotension  Shortness of Breath  
 Other Skin Rash  Hypertension  Pain, Specify: \_\_\_\_\_  
 Jaundice  Hypoxemia  Other \_\_\_\_\_

Transfused Under Anesthesia:  No  Yes  General  Local/Regional

Pre transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Post transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

**Measures Taken**

None Required  Analgesics  Antibiotics  Supplementary O<sub>2</sub>  Other, Specify: \_\_\_\_\_  
 Transfusion Stopped  Antipyretics  Diuretics  Vasopressors  
 ICU Required  Antihistamines  Steroids  Patient Blood Culture Ordered  
 Chest X-Ray  Transfusion Restarted  Mechanical Ventilation

**Blood Component Transfusion Reaction (eg. Red Cells, Plasma, Platelets, Cryo)**

ABO/Rh	Type	Donor Unit # (Including Lot#s)	(mL)	Date/Time Started	Date/Time Finished	Expiry Date	Product Code #	Product Modifiers

**Derivative Transfusion Reaction (eg. Albumin, IVIG, Factor Concentrates)**

Product Type	Product Name	Manufacturer	Lot #	Dose (mL)	Frequency	Time Started	Time Finished	Expiry Date

**Nursing Clerical Check**

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Facility Blood Bank Clerical Check**

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Blood Components Cancelled**

• All reactions, other than rash and/or urticaria, to any type of blood component, result in immediate cancellation of all crossmatched blood components remaining on the current Request for Blood Components requisition.

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# Case 2 – Mr. HH

## Clerical Checks

- Nursing
  - Check all information
    - Donor unit/tag
    - CBS Progesa Report or DSM BTS Report
    - Order, Chart information
- Blood Bank
  - Lab Log
    - Patient Progesa/DSM BTS report
    - Donor unit information
    - Packing Slip (as applicable)

**CANADIAN BLOOD SERVICES**  
777 William Ave. Winnipeg, MB R2E 3R4  
**TRANSFUSION REACTION INVESTIGATION**

PLEASE USE NAME PLATE OR PRINT

Reason for Transfusion \_\_\_\_\_

Reaction Date \_\_\_\_\_ Time \_\_\_\_\_

Facility \_\_\_\_\_

Form Completed By \_\_\_\_\_

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Name of Physician \_\_\_\_\_  
Authorizing Investigation \_\_\_\_\_ Time \_\_\_\_\_

**Transfusion/Obstetrical History**

Transfusions  Yes <3 mo.  Yes >3 mo.  No  Unknown  
 Preg. Miscarriages  Yes <3 mo.  Yes >3 mo.  No  Unknown

Premedication:  No  Yes  
 If Yes, Specify Drug(s): \_\_\_\_\_

**Clinical Signs and Symptoms**

Chills/Rigors  Hemoglobinuria  Nausea/Vomiting  Shock  
 Fever  Hemorrhagic  Tachycardia  Oliguria  
 Urticaria  Hypotension  Shortness of Breath  
 Other Skin Rash  Hypertension  Pain, Specify: \_\_\_\_\_  
 Jaundice  Hypoxemia  Other \_\_\_\_\_

Transfused Under Anesthesia:  No  Yes  General  Local/Regional

Pre transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Post transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

**Measures Taken**

None Required  Analgesics  Antibiotics  Supplementary O<sub>2</sub>  Other, Specify: \_\_\_\_\_  
 Transfusion Stopped  Antipyretics  Diuretics  Vasopressors  
 ICU Required  Antihistamines  Steroids  Patient Blood Culture Ordered  
 Chest X-Ray  Transfusion Restarted  Mechanical Ventilation

**Blood Component Transfusion Reaction (eg. Red Cells, Plasma, Platelets, Cryo)**

Donor/ABO/Rh	Product Type	Donor Unit # (Including Centre Code)	Volume Given (mL)	Date/Time Started	Date/Time Finished	Expiry Date	Product Code #	Product Modifiers

**Derivative Transfusion Reaction (eg. Albumin, IVIG, Factor Concentrates)**

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (V/IM)	Frequency	Time Started	Time Finished	Expiry Date

**Nursing Clerical Check**  
 Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Facility Blood Bank Clerical Check**  
 Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Blood Components Cancelled**

• All reactions, other than rash and/or urticaria, to any type of blood component, result in immediate cancellation of all crossmatched blood components remaining on the current Request for Blood Components requisition.

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# Case 3 – Ms. KZ

## Clinical Information

- Patient Demographics
  - Name – KZ
  - PHIN – 123 456 789
  - DOB – 01JAN1990 (20yr)
  - Female
- Clinical Signs/Symptoms
  - Back pain
  - Other: Feeling “funny”
  - Hemoglobinuria
- Pre Transfusion VS
  - BP 120/72
  - P 72
  - T 37.3
- Post Transfusion VS
  - BP 98/50
  - P 110
  - T 37.5
- Measures
  - Physician consult

**CANADIAN BLOOD SERVICES**  
777 William Ave. Winnipeg, MB R3E 3R4  
**TRANSFUSION REACTION INVESTIGATION**

Reason for Transfusion \_\_\_\_\_

Reaction Date \_\_\_\_\_ Time \_\_\_\_\_

Facility \_\_\_\_\_

Form Completed By \_\_\_\_\_

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Name of Physician \_\_\_\_\_

Authorizing Investigation \_\_\_\_\_ Time \_\_\_\_\_

**Transfusion/Obstetrical History**

Transfusions  Yes <3 mo.  Yes >3 mo.  No  Unknown

Preg. Miscarriages  Yes <3 mo.  Yes >3 mo.  No  Unknown

Premedication:  No  Yes

**Clinical Signs and Symptoms**

Chills/Rigors  Hemoglobinuria  Nausea/Vomiting  Shock

Fever  Hemorrhage  Tachycardia  Oliguria

Urticaria  Hypotension  Shortness of Breath

Other Skin Rash  Hypertension  Pain, Specify: \_\_\_\_\_

Jaundice  Hypoxemia  Other \_\_\_\_\_

Pre transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Post transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

None Required  Analgesics  Antibiotics  Supplementary O<sub>2</sub>  Other, Specify: \_\_\_\_\_

Transfusion Stopped  Antipyretics  Diuretics  Vasopressors

ICU Required  Antihistamines  Steroids  Patient Blood Culture Ordered

Chest X-Ray  Transfusion Restarted  Mechanical Ventilation

**Blood Component Transfusion Reaction (eg. Red Cells, Plasma, Platelets, Cryo)**

Donor ABO/Rh	Product Type	Donor Unit # (Including Centre Code)	Volume Given (mL)	Start/Time Started	Date/Time Finished	Expiry Date	Product Code #	Product Modifiers

**Derivative Transfusion Reaction (eg. Albumin, IVIG, Factor Concentrates)**

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (IV/IVC)	Frequency	Time Started	Time Finished	Expiry Date

**Nursing Clerical Check**

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Facility Blood Bank Clerical Check**

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Blood Components Cancelled**

• All reactions, other than rash and/or urticaria, to any type of blood component, result in immediate cancellation of all crossmatched blood components remaining on the current Request for Blood Components requisition.

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# Case 3 – Ms. KZ

## Product Information

- Donor unit ABO/Rh
- Product type: RBC
- Donor unit #:
  - C0 0540 09 5551212\$
  - C0 0540 09 5551413#
- Volume given: state volume for each
- Infusion date/time (start & stop) for each
- Expiry date (donor unit expiry) for each
- Product Code – E for each
- Modifiers (none)

**CANADIAN BLOOD SERVICES**  
777 William Ave. Winnipeg, MB R2E 3R4  
**TRANSFUSION REACTION INVESTIGATION**

PLEASE USE NAME, PLATE OR PRINT

Reason for Transfusion \_\_\_\_\_

Reaction Date \_\_\_\_\_ Time \_\_\_\_\_

Facility \_\_\_\_\_

Form Completed By \_\_\_\_\_

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Name of Physician \_\_\_\_\_ Time \_\_\_\_\_

Authorizing Investigation \_\_\_\_\_

Transfusion/Obstetrical History

Transfusions  Yes <3 mo.  Yes >3 mo.  No  Unknown

Preg. Miscarriages  Yes <3 mo.  Yes >3 mo.  No  Unknown

Premedication:  No  Yes

If Yes, Specify Drug(s): \_\_\_\_\_

Clinical Signs and Symptoms

Chills/Rigors  Hemoglobinuria  Nausea/Vomiting  Shock

Fever  Hemorrhage  Tachycardia  Oliguria

Urticaria  Hypertension  Shortness of Breath

Other Skin Rash  Hypotension  Pain, Specify: \_\_\_\_\_

Jaundice  Hypoxemia  Other \_\_\_\_\_

Transfusion Reaction Sample Collected at

Facility \_\_\_\_\_ Ward/Unit \_\_\_\_\_

Phlebotomist

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Collection Date \_\_\_\_\_ Time \_\_\_\_\_

Equipment Used

Bedside Filter  Blood Warmer

Pump  Reinfusion Device

Pressure Device

Equipment Problems  No  Yes

If Yes, Type: \_\_\_\_\_

Model/Lot #: \_\_\_\_\_

Transfused Under Anesthesia:  No  Yes  General  Local/Regional

Pre transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Post transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Measures Taken

None Required  Analgesics  Antibiotics  Supplementary O<sub>2</sub>  Other, Specify: \_\_\_\_\_

Transfusion Stopped  Antipyretics  Diuretics  Vasopressors

ICU Required  Antihistamines  Steroids  Patient Blood Culture Ordered

Chest X-Ray  Transfusion Restarted  Mechanical Ventilation

Donor ABO/Rh	Product Type	Donor Unit # (Including Centre Code)	Volume Given (mL)	Date/Time Started	Date/Time Finished	Expiry Date	Product Code #	Product Modifiers

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (IV/IM)	Frequency	Time Started	Time Finished	Expiry Date

Nursing Clerical Check

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

Facility Blood Bank Clerical Check

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Blood Components Cancelled**

• All reactions, other than rash and/or urticaria, to any type of blood component, result in immediate cancellation of all crossmatched blood components remaining on the current Request for Blood Components requisition.

CHART COPY

CM105 (10/06)

# Case 3 – Ms. KZ

## Clerical Checks

- Nursing
  - Check all information
    - Donor unit/tag
    - CBS Progesa Report or DSM BTS Report
    - Order, Chart information
- Blood Bank
  - Lab Log
    - Patient Progesa/DSM BTS report
    - Donor unit information
    - Packing Slip (as applicable)

**CANADIAN BLOOD SERVICES**  
777 William Ave. Winnipeg, MB R3E 3R4  
**TRANSFUSION REACTION INVESTIGATION**

PLEASE USE NAME PLATE OR PRINT

Reason for Transfusion \_\_\_\_\_

Reaction Date \_\_\_\_\_ Time \_\_\_\_\_

Facility \_\_\_\_\_

Form Completed By \_\_\_\_\_

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Name of Physician \_\_\_\_\_ Time \_\_\_\_\_  
Authorizing Investigation \_\_\_\_\_

**Transfusion/Obstetrical History**

Transfusions  Yes <3 mo.  Yes >3 mo.  No  Unknown  
 Preg. Miscarriages  Yes <3 mo.  Yes >3 mo.  No  Unknown

Premedication:  No  Yes  
 If Yes, Specify Drug(s): \_\_\_\_\_

**Clinical Signs and Symptoms**

Chills/Rigors  Hemoglobinuria  Nausea/Vomiting  Shock  
 Fever  Hemorrhage  Tachycardia  Oliguria  
 Urticaria  Hypotension  Shortness of Breath  
 Other Skin Rash  Hypertension  Pain, Specify: \_\_\_\_\_  
 Jaundice  Hypoxemia  Other \_\_\_\_\_

Transfused Under Anesthesia:  No  Yes  General  Local/Regional

Pre transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Post transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

**Measures Taken**

None Required  Analgesics  Antibiotics  Supplementary O<sub>2</sub>  Other, Specify: \_\_\_\_\_  
 Transfusion Stopped  Antipyretics  Diuretics  Vasopressors  
 ICU Required  Antihistamines  Steroids  Patient Blood Culture Ordered  
 Chest X-Ray  Transfusion Restarted  Mechanical Ventilation

**Blood Component Transfusion Reaction (eg. Red Cells, Plasma, Platelets, Cryo)**

Donor ABCDE	Product Type	Donor Unit # (Including Ceme Code)	Volume Given (mL)	Date/Time Started	Date/Time Finished	Expiry Date	Product Code #	Product Modifiers

**Derivative Transfusion Reaction (eg. Albumin, IVIG, Factor Concentrates)**

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (IV/IM)	Frequency	Time Started	Time Finished	Expiry Date

**Nursing Clerical Check**

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Facility Blood Bank Clerical Check**

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Blood Components Cancelled**

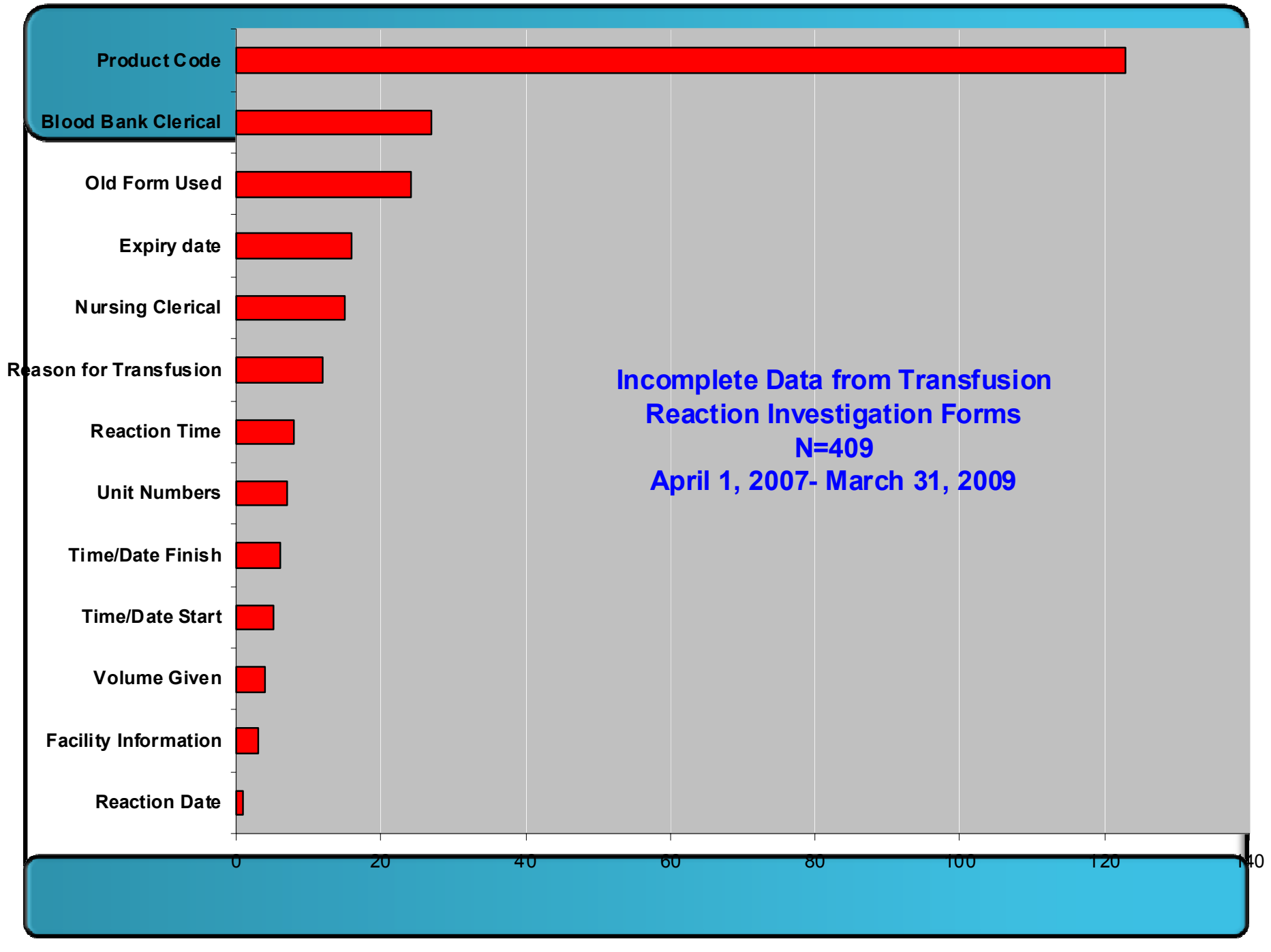
• All reactions, other than rash and/or urticaria, to any type of blood component, result in immediate cancellation of all crossmatched blood components remaining on the current Request for Blood Components requisition.

**CHART COPY**

CM105 (10/06)

# Manitoba's Adverse Event Reporting System

- Benefits
  - Maintain province wide standardization of adverse reaction policies and procedures.
  - Determine the potential and actual risk of adverse reaction events and their impact on the recipient.
  - Monitor trends to identify changes in the magnitude of known transfusion risks.
  - Assess the magnitude of new transfusion risks including emerging pathogens



**Incomplete Data from Transfusion  
Reaction Investigation Forms  
N=409  
April 1, 2007- March 31, 2009**



C0521 09 123456  $\approx$  M

Blood Centre Name & Address  
Établissement / Centre de collecte d'organes



5100

Volunteer Donor. This product may transmit infectious agents. See circular of information for indications, contraindications, cautions and methods of infusion. Donneur bénévole. Ce produit peut transmettre des agents infectieux. Voir la notice d'accompagnement pour les indications, contre-indications, mises en garde et méthodes de perfusion.

**0**

Rh POSITIVE



Collected on  
Prélevé le

0091661425  
15 JUN 2009 14:25



Expires on  
Périmé le

0092082359  
27 JUL 2009 23:59



E6050V00

**RED BLOOD CELLS**  
CULOT GLOBULAIRE  
LEUKOCYTES REDUCED/PART. DÉLEUCOCYTE



639999999399999199  $\approx$  CMV -

Volume: 358 mL  
From/Idé 480 mL CPD WB/ST  
SAGM added/ajouté  
Store at/Conserver à 1 - 6° C

C+ E- c- e+ K- Jka -



Comp Code  
Code produit

06050



2109



Donation Number  
Numéro du don

3123456



27 JUL 2009

Expires on  
Périmé le

510

O Rh POSITIVE

**Product Code**

**Expiry Date**

**Donor Unit #  
All 16 characters  
MUST BE  
RECORDED**



C0521 09 123456  $\approx$  M

Reason for Transfusion

Reaction Time

**CANADIAN BLOOD SERVICES**  
777 William Ave. Winnipeg, MB R2E 2B4

**TRANSFUSION REACTION INVESTIGATION**

PLEASE USE NAME PLATE OR PRINT

Reason for Transfusion \_\_\_\_\_

Reaction Date \_\_\_\_\_ Time \_\_\_\_\_

Facility \_\_\_\_\_

**Form Completed By**

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Name of Physician \_\_\_\_\_

Authorizing Investigation \_\_\_\_\_ Time \_\_\_\_\_

Male  Female

**Transfusion/Obstetrical History**

Transfusions  Yes <3 mo.  Yes >3 mo.  No  Unknown

Preg. Miscarriages  Yes <3 mo.  Yes >3 mo.  No  Unknown

**Premedication:**  No  Yes

If Yes, Specify Drug(s): \_\_\_\_\_

**Clinical Signs and Symptoms**

Chills/Rigors  Hemoglobinuria  Nausea/Vomiting  Shock

Fever  Hemorrhage  Tachycardia  Oliguria

Urticaria  Hypotension  Shortness of Breath

Other Skin Rash  Hypertension  Pain, Specify: \_\_\_\_\_

Jaundice  Hypoxemia  Other \_\_\_\_\_

**Transfused Under Anesthesia:**  No  Yes  General  Local/Regional

Pre transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Post transfusion Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

**Equipment Used**

Bedside Filter  Blood Warmer

Pump  Reinfusion Device

Pressure Device

Equipment Problems  No  Yes

If Yes, Type: \_\_\_\_\_

Model/Lot #: \_\_\_\_\_

**Transfusion Reaction Sample Collected at**

Facility \_\_\_\_\_ Ward/Unit \_\_\_\_\_

**Phebotomist**

Print Name \_\_\_\_\_ Classification \_\_\_\_\_ Initials \_\_\_\_\_

Collection Date \_\_\_\_\_ Time \_\_\_\_\_

**Measures Taken**

None Required  Analgesics  Antibiotics  Supplementary O<sub>2</sub>  Other, Specify: \_\_\_\_\_

Transfusion Stopped  Antipyretics  Diuretics  Vasopressors

ICU Required  Antihistamines  Steroids  Patient Blood Culture Ordered

Chest X-Ray  Transfusion Restarted  Mechanical Ventilation

**Blood Component Transfusion Reaction (eg. Red Cells, Plasma, Platelets, Cryo)**

Donor ABO/Rh	Product Type	Donor Unit # (Including Centre Code)	Volume Given (mL)	Date/Time Started	Date/Time Finished	Expiry Date	Product Code #	Product Modifiers

**Derivative Transfusion Reaction (eg. Albumin, IVIG, Factor Concentrates)**

Product Type	Product Name	Manufacturer	Lot #	Dose	Route (IV/IM)	Frequency	Time Started	Time Finished	Expiry Date

**Nursing Clerical Check**

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

**Facility Blood Bank Clerical Check**

Print Name \_\_\_\_\_ Date/Time \_\_\_\_\_ Discrepancies  No  Yes If Yes, Specify \_\_\_\_\_

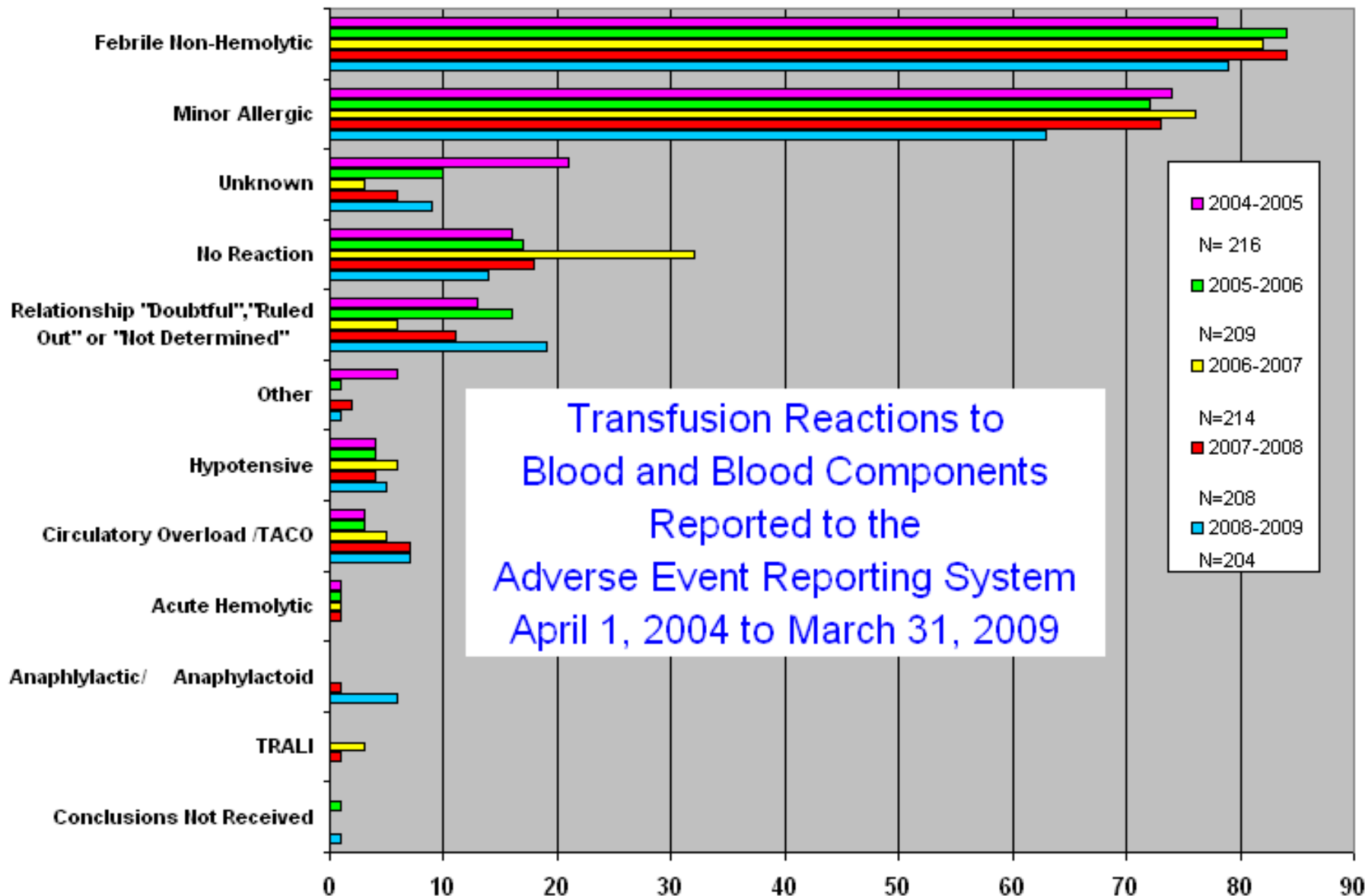
**Blood Components Canceled**

- All reactions, other than rash and/or urticaria, to any type of blood component, result in immediate cancellation of all crossmatched blood components remaining on the current Request for Blood Components requisition.

Nursing Clerical Check

Blood Bank Clerical Check

CM105 Version 10/06



**Thank you**

**Questions?**