

HAEMOVIGIL

A Step Towards Safe Blood Transfusion To The Bedside

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Introduction & Objectives

- Serious, potentially fatal, issues exist in the transfusion process due to **human/clerical factors**
- Studies have indicated that bedside errors contribute between 80-85 % of transfusion errors
- A number of studies and reports from national haemovigilance programs (SHOT, UK, and HVPI, India) have indicated that the risk of mistransfusion is many times greater than the risk of transfusion transmitted infections and typically result from errors made at bedside.
- It is sad that the transfusion process has traditionally received less attention.
- Patient Safety Initiatives needs to focus more on the **bedside.**

AIM OF THE STUDY

Highlight the importance of Haemovigil which is a set of surveillance procedures of the whole transfusion chain that ensures patient identification and reduces identification related errors of transfusion.

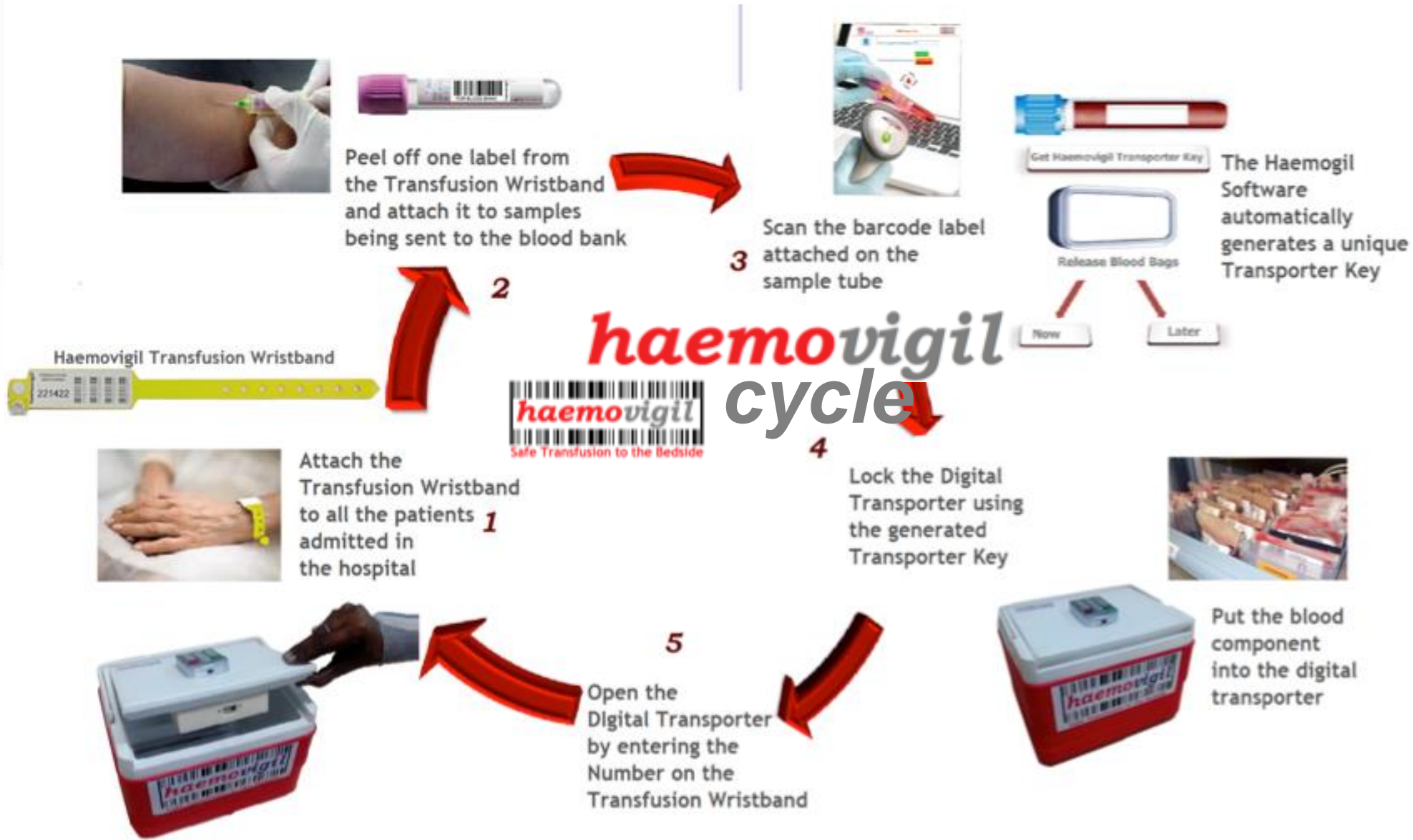


Methodology

Haemovigil system comprises of

1. **Wristbands**, which consist of a unique 6 digit number and 4 peel off labels with encrypted codes to be affixed on the specimen tubes.
2. **A Software** which decrypts the code from the peel off labels on specimen tubes and generates the same 6 digit number as on the wristband.
3. **A Digital transporter** which is an insulated reusable box with a digital lock to carry blood units which can be locked by entering the unique 6-digit number generated by software and opened only by the same number present on the Haemovigil wristbands.





Results and Discussion

- In our study Haemovigil system was able to bring down blood transfusion sampling errors to 0(0%) from 71(0.79%).
- No wrong blood transfusion was reported
- We found in our study that the Haemovigil™ Transfusion Safety System ensures that even when similar named patients are admitted in a ward no wrong transfusion will be given as specific wrist code is attached to the concerned patient.
- If a nurse/clinician in the ward tries to open the Haemovigil digital transporter box with the wristband code of a similar named patient, the Haemovigil digital transporter box will not open.
- This will indicate that he/she was going to a wrong patient for transfusion and due to the Haemovigil™ System an undue/near miss event will be prevented.

Conclusion



Haemovigil system is the need of the hour as -

It helps in curtailing the blood transfusion errors to 0%

It is also a cost effective and easy method that makes use of a combination of a hardware and software.

It ensures a final and repeat check of the patient identification before blood transfusion.

It does not hamper the blood transfusion workflow process.



**Prepare and Prevent.
Don't repair and repent**

THANK YOU