

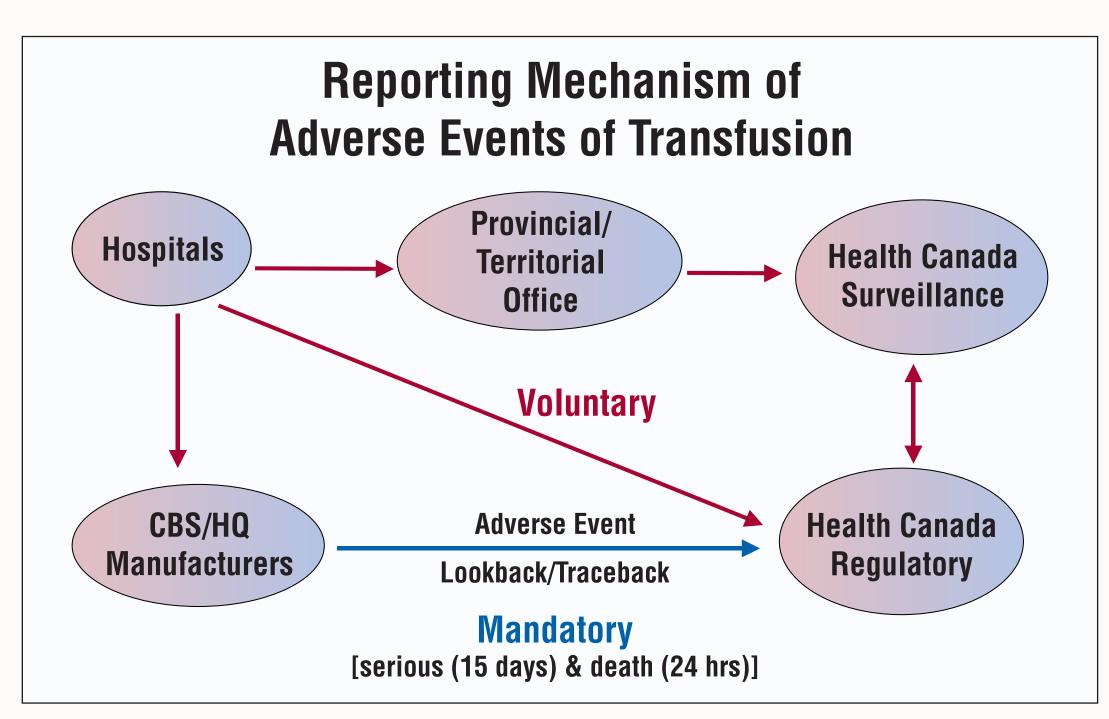
The Canadian National Transfusion Transmitted Injuries Surveillance System (TTISS)

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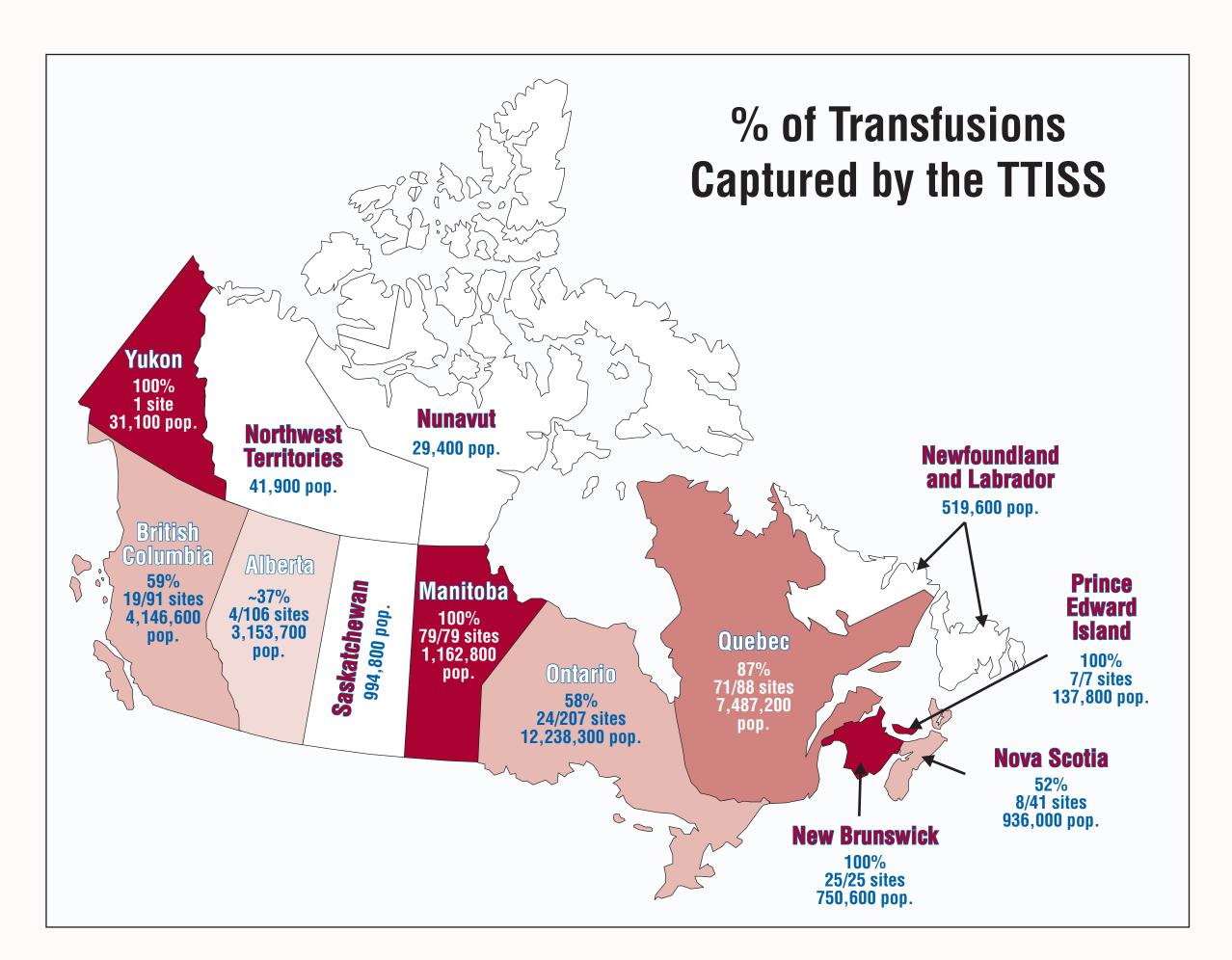
A collaborative project of the Division of Blood Safety Surveillance and Health Care Acquired Infections¹, Marketed Health Products Directorate², Biologics and Genetic Therapies Directorate², Health Canada, Ottawa, Ontario; Provincial/Territorial Blood Surveillance Offices² and Canadian Blood Manufacturers²

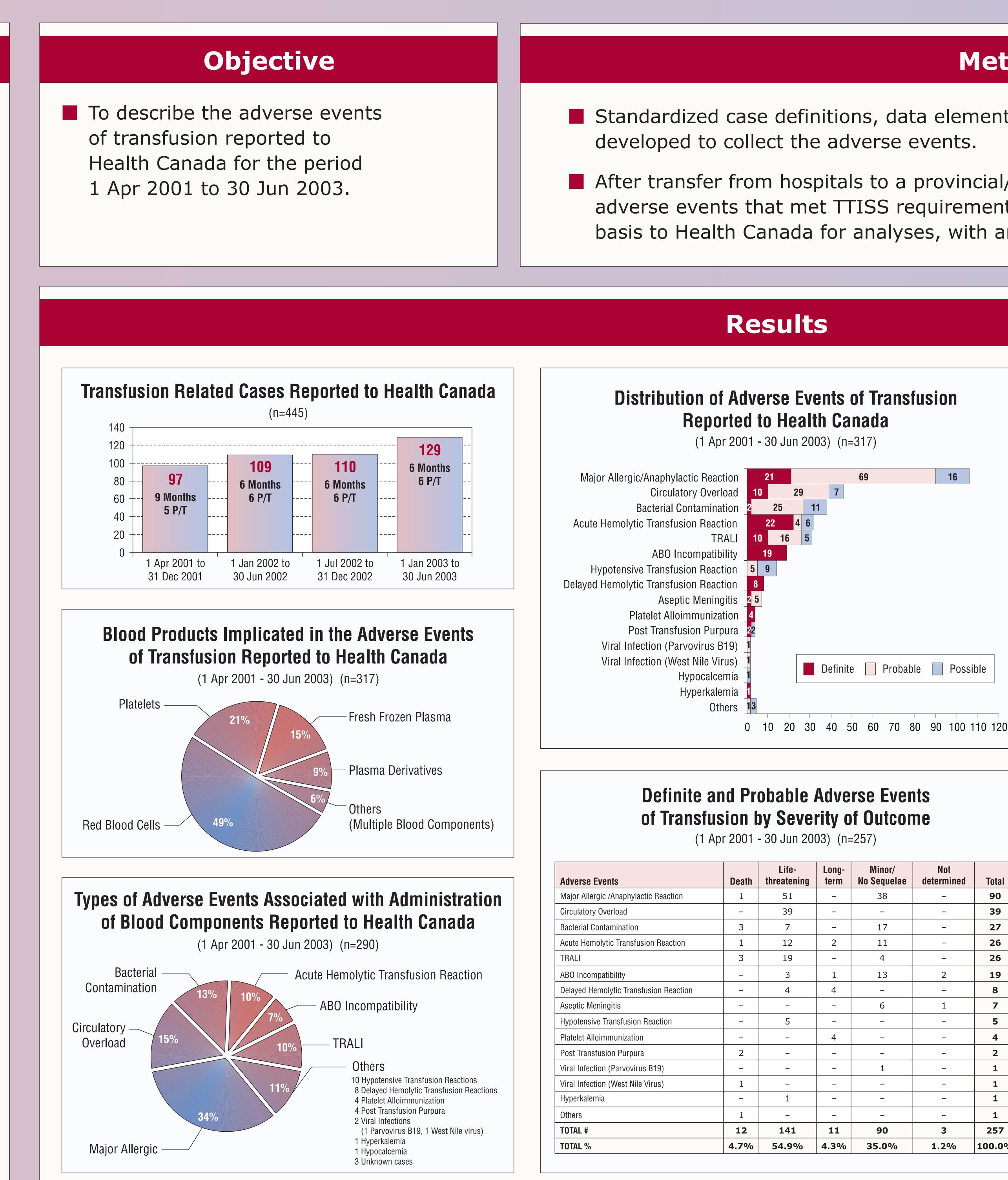
Background

- Transfusion of blood components and plasma derivatives may occasionally pose a risk of adverse events.
- In Canada, serious transfusion related adverse events must be reported to the regulatory branch of Health Canada by the Blood Manufacturers [Canadian Blood Services (CBS) and HÉMA-QUÉBEC (HQ)].
- However, these establishments rely on voluntary reporting of these adverse events from Hospitals and Health Care Professionals.



- To improve reporting of adverse events, a pilot Transfusion Transmitted Injuries Surveillance System (TTISS) was developed and implemented in 1999 in 4 Canadian provinces: British Columbia, Quebec, Nova Scotia and Prince Edward Island.
- The system was then expanded to other provinces and territories and now for the first time Canada has a national surveillance system for monitoring adverse events of transfusion.



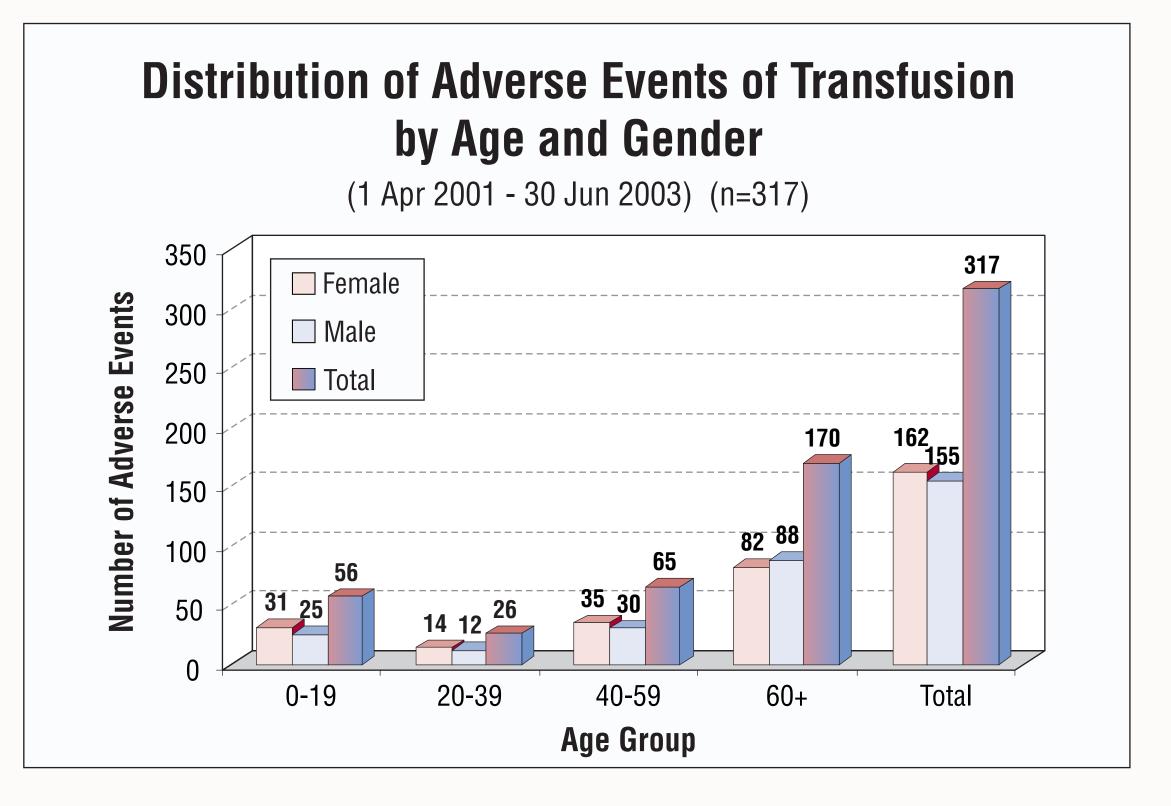


Methods

Standardized case definitions, data elements, a reporting form and a database were

After transfer from hospitals to a provincial/territorial (P/T) office, validated, non nominal adverse events that met TTISS requirements were reported electronically on a quarterly basis to Health Canada for analyses, with an ongoing review of the data.

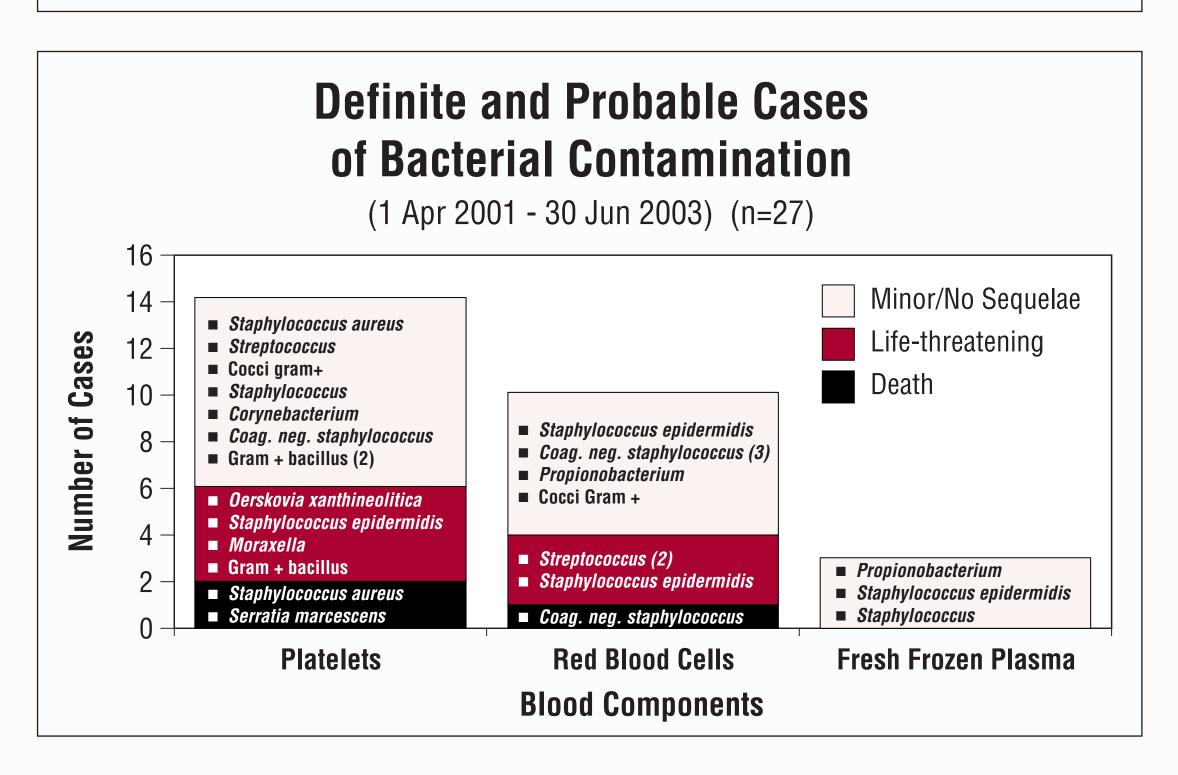
| Life- threatening | Long- term | Minor/ No Sequelae | Not determined | Total |
|----------------------|---------------|-----------------------|-------------------|--------|
| 51 | _ | 38 | _ | 90 |
| 39 | _ | _ | _ | 39 |
| 7 | _ | 17 | _ | 27 |
| 12 | 2 | 11 | _ | 26 |
| 19 | _ | 4 | _ | 26 |
| 3 | 1 | 13 | 2 | 19 |
| 4 | 4 | _ | _ | 8 |
| _ | _ | 6 | 1 | 7 |
| 5 | _ | - | _ | 5 |
| _ | 4 | _ | _ | 4 |
| _ | _ | _ | _ | 2 |
| _ | _ | 1 | _ | 1 |
| _ | _ | - | _ | 1 |
| 1 | _ | - | _ | 1 |
| _ | _ | _ | _ | 1 |
| 141 | 11 | 90 | 3 | 257 |
| 54.9% | 4.3% | 35.0% | 1.2% | 100.0% |



Fatal Adverse Events of Transfusion **Reported to Health Canada**

(1 Apr 2001 - 30 Jun 2003) (n=11)

| | Relationship to Transfusion | | |
|--------------------------------------|-----------------------------|----------|-------|
| Adverse Events | Definite | Probable | Total |
| Anaphylactic Reaction | _ | 1 | 1 |
| Acute Hemolytic Transfusion Reaction | 1 | _ | 1 |
| Bacterial Contamination | 1 | 2 | 3 |
| Post Transfusion Purpura | 1 | 1 | 2 |
| TRALI | 1 | 2 | 3 |
| Other (Severe Hypertension) | - | 1 | 1 |
| TOTAL # | 4 | 7 | 11 |





Conclusions

- The TTISS has been successfully implemented in Canada. Since then the voluntary reporting of adverse events has increased. This is the first national system implemented in Canada.
- This collaborative project has provided the opportunity for the development of a standardized infrastructure for reporting transfusion related adverse events to all stakeholders.

To enhance the system:

- Denominator data will be provided by the provinces/territories for the calculation of risks of adverse events per products transfused.
- An error surveillance system to capture near misses and transfusion errors will be implemented in the current year.
- Methods to capture delayed adverse events related to transfusion are being addressed.

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|--------------------------------------|---|--|--|
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| | | | |

Transfusion Transmitted Injuries Section's Website

http://www.hc-sc.gc.ca/pphb-dgspsp/hcai-iamss/tti-it/index.html

Système de surveillance de incidents transfusionnels May 2004

<u>TTISS</u>