TRANSFUSION ERROR SURVEILLANCE SYSTEM (TESS), 2022

TESS project

TESS collects non-nominal data on errors that occur during the transfusion process for improving transfusion practices and patient safety.

2005 was when the surveillance system was initiated. Detailed methods of TESS can be found here.

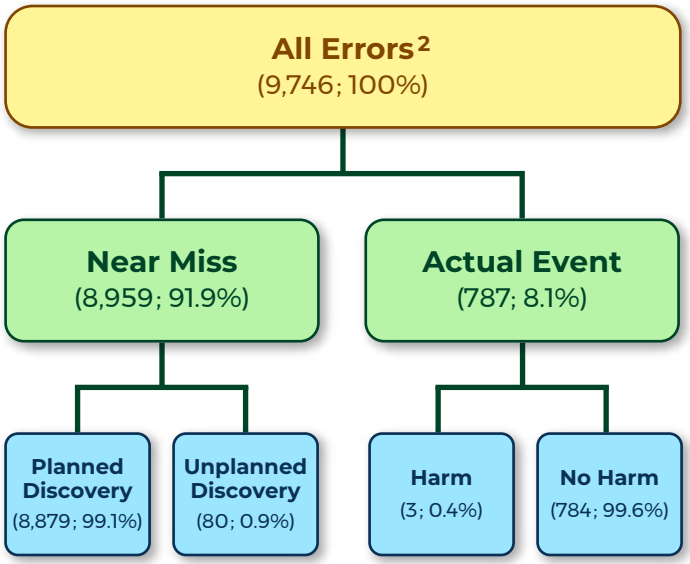
16% of blood transfusion activities are monitored through the four jurisdictions participating in TESS in Canada.

Surveillance data summary

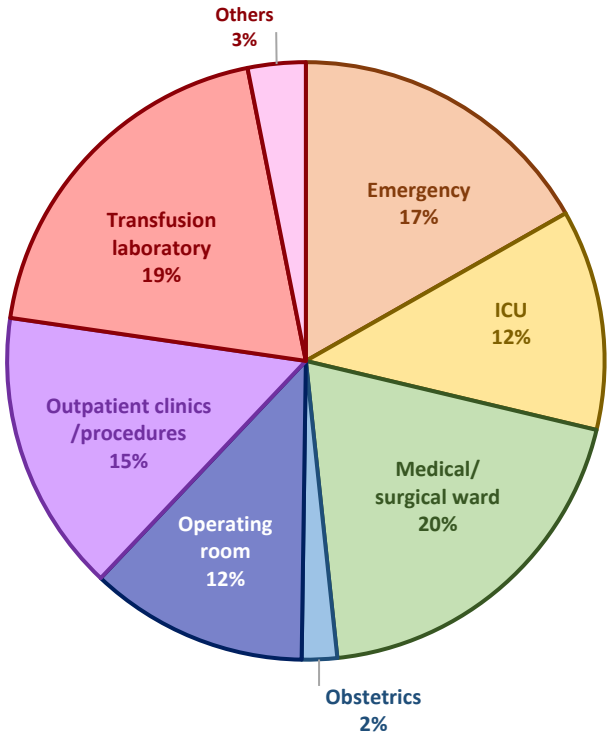
9,746[1] errors[2] (e.g. blood sample labelled with incorrect patient identification) were reported in the year of 2022.

0.03% of all reported errors (e.g. 3 / 9,746) resulted in harm [3] to the patient.

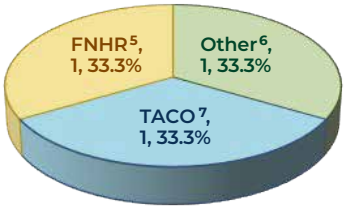
OVERALL COUNTS OF REPORTED ERRORS FOR 2022[4]



LOCATION OF ERROR OCCURRENCE



HARM CAUSED BY ERRORS, TESS 2022



Implication

Reporting and investigating errors in both transfusion services and clinical settings help identify and control risks before resulting in harm to the patient, thus providing valuable opportunities to improve transfusion safety.

LEARN MORE ABOUT TESS

Visit Canada.ca and search "Transfusion Error Surveillance System" and Follow us on Twitter @GovCanHealth

1 As a result of comparing dynamic data extracted from web-based databases, small discrepancies between PHAC and provincial or territorial numbers are expected.
2 The Transfusion Error Surveillance System (TESS): 2012-2016 report contains the definition of "error", "near miss", "actual event", "planned discovery", and "unplanned discovery".
3 "Harm": the patient had an unintended or inadequate response to transfusion or suffered a negative impact or adverse transfusion reaction as a result of the error.
4 Due to rounding, percentages may not always add up to 100%.
5 FNHR: febrile non-hemolytic reaction.
6 Other includes: 1 case of harm was associated with transfusion delay.
7 TACO: transfusion-associated circulatory overload.

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