96 - THE NURSE IN SENTINEL HOSPITAL PROJECT: REPORT OF EXPERIENCE IN HAEMOVIGILANCE

MAISA ARANTES DA SILVA;
ANA ELZA OLIVEIRA DE MENDONÇA;
MARIA CLEIA DE OLIVEIRA VIANA;
RODOLPH VINICIUS SIQUEIRA PESSOA;
GILSON DE VASCONCELOS TORRES
Programa de Pós-Graduação em Enfermagem/UFRN - Natal/RN, Brasil
E.mail: maisa.arantes@uol.com.br

INTRODUCTION

During recent decades, the safety of transfusions has been rigorously evaluated in many countries, since the procedure involves risks. In front of this scenario and motivated by the increasing awareness of people about their rights, several priority programs were developed.

The major impetus for this change was due to advent of acquired immune deficiency syndrome (AIDS) (FERNANDES, 2001). As a result, several countries, especially those more developed, established strict rules to improve the safety of blood transfusion, including introducing a new concept: that of haemovigilance, designed to facilitate, through the investigation of adverse transfusion reactions, the determination of their causes for prevention of recurrences.

In this context, "blood and blood products", was one of the topics discussed at the 8th. Health Conference because of its importance and with popular participation, the topic deserved sequentially to be expanded in the state conferences in major debates.

In this context, the Ministry of Health in 1998, starts its participation in the Brazilian Program of Quality and Productivity (PBQP), of the Presidency of the Republic, and chose a mobilizer target national of the health sector: "Blood with quality assurance throughout the process until 2003", and thus began a discussion of deploying a disease surveillance system (BRASIL, 2000).

Accordingly, the National Health Surveillance Agency (ANVISA), as responsible for monitoring health in the country, as proposed strategies, in 2001, the project Sentinel Hospitals, which formalized a partnership with hospitals in large, primarily, the public university, for the deployment of the monitoring of inputs used in hospitals such as: doctor-hospital articles, laboratory kits and equipment through the tecnovigilance; medicines for pharmacovigilance; blood and blood through the haemovigilance.

The University Hospital Onofre Lopes (HUOL / UFRN) was inserted in this project in August 2001, firstly working in the area of pharmacovigilance. In February 2003, under new management, started to work in the areas of tecnovigilance and haemovigilance.

According to ministerial instructions, haemovigilance is characterized by a system of evaluation and alert, organized with the purpose of collecting and assessing information about the side effects and / or unexpected use of blood to prevent the emergence or recurrence of such effects (BRASIL, 2004).

Therefore, the system haemovigilance deals with the process of the transfusion chain and was rightly proposed to monitor and generate action to correct any non-conformities. For deployment of a system haemovigilance and its success, you should be aware of the monitoring process and standardized data collection, data analysis and dissemination of results, thus enabling calculate the frequency of adverse events, determine its causes and prevent its occurrence in receivers as well as the involvement of professionals responsible for transfusion in the active participation of the notification process.

Another key aspect for a system of haemovigilance concerns to ensure the traceability of a blood, i.e. precisely in those who were transfused the blood and that blood transfused patients received (BRASIL, 2004).

Accordingly, all services of blood, which perform procedures incorporating the process of the blood cycle, should be organized to take control of the computerized process of the blood cycle, the distribution and use of the exchange of blood (BRASIL, 1999).

This report aims to disseminate the actions undertaken in the service of haemovigilance, identify the problems with blood transfusions and show the importance of nurses in this area of expertise.

METHODOLOGY

This is a story of experience lived by the team of haemovigilance service of HUOL-UFRN in the period from November 2003 to July 2008, where various educational and informational activities were undertaken in all sectors where they are executed HUOL blood transfusions.

RESULTS AND DISCUSSION

In the reporting period were conducted 23,281 blood transfusions and 53 reports of incidents transfusion. We blood transfused on average 408 per month. It is estimated that 1 to 3% of blood transfusion lead to a transfusion reaction (AABB, 2002). We can see that we have a low number of reported incidents transfusion which suggests an underreporting.

At the beginning of the haemovigilance service, several actions were developed, was first made a diagnosis of disease as was the practice in HUOL. With the description of nonconformance, listed in Table 1, it was possible to propose actions to address them.

The team responsible for the haemovigilance in the hospital centers investigates and notifies incidents and accidents related to blood transfusions. As a result of this, the haemovigilance aims to detect the early appearance or the recurrence of a problem linked to blood and blood products (BRASIL, 2004).

Table 1. Description of non-conformance related to transfusion practices in HUOL-UFRN in 2003.

NON-CONFORMANCE
Process of working without rules or routines Absence of officials within 24 hours, in place of storage and distribution of blood components in HUOL
Lack of capacity building and training for the performers
Inadequate heating of packed red blood cells
Samples with incomplete identification
Request inadequately fulfilled
Lack of records in records
Infusions of red cell concentrates exceeding 4 hours
Infusions of blood components in the same direction with other solutions
Infusions of blood components are checking identification of receiver / scholarship
Packaging components of irregular blood as a platelet concentrate in a freezer
Fresh frozen plasma is thawed under benches, and in temperatures exceeding 37 ° C
Infusion of blood components without checking vital signs before and after transfusion
Indicating the taboos against blood transfusion such as fever, hypotension, patient feeding themselves, the environment with air conditioning switched on and so forth.
Requirements without the volume and duration of infusion
Corticosteroids as a routine use of blood transfusion
No use of thermal boxes for transport of samples and components of blood

Source: Haemovigilance Service – HUOL - UFRN

To organize the service and ease the nonconformance, some actions have been developed, described in Table 2. The non-conformities found during the transmission process increases the risks to patients. In order to adapt the procedures and standardize the actions, using the resolution of Collegiate Directors (DRC) No 153 of June 4, 2004, followed by the principles of modern blood (BRASIL, 2004a). The technical procedures applied in blood should carefully follow the rules applicable federal and state, seeking to compliance and quality of care the health service in technical procedures haemotherapy.

The role of nurses in the setting of haemovigilance is fundamental, involves a lot of responsibility, clarifying doubts, minimizing the fears, providing security for recipients. Monitor, promote and disseminate preventive health measures and curative through continuing education by ensuring the quality of blood.

Table 2. Description of the activities undertaken by the staff of the haemovigilance service in HUOL - UFRN from 2003 to 2008.

DEVELOPED ACTIONS
Manual elaboration of Standard Procedure of Service (POPs)
Placed officials working in three shifts (24h) in storage and distribution of blood components service of HUOL
Provided to all nurses and sectors educational and information materials
Biannual training for health professionals
Performed moments of sensibilization
Exchange of information with the healthcare staff
Changing the form of solicitation of blood components
Active search of incidents on transfusions
Analysis of reports of incidents on transfusion
Make a detailed history of transfusion with the patient
Check the records: indication of transfusion and medical prescription; conference of the blood requested, sent and administered; and conditions of administration.
Collect the results of all examinations performed
Complete the form of incident of transfusion and make a conclusion
Transmission of notifications to the National Agency for Sanitary Surveillance
Adopt corrective measures

Source: Haemovigilance service of HUOL - UFRN

FINAL CONSIDERATIONS

In the context of activities related to monitoring in health, haemovigilance represents part of an effort to improve safety in blood transfusions, with particular emphasis on incidents transfusion.

The nurse won a significant space in haemovigilance, developing various activities related to service and providing care to patients during the pre, intra and post transfusion.

With training, sensitization and active search of the incidents managed to reduce transfusion problems identified, but due to high turnover of pupils in hospital and health professionals, it is difficult to adherence to the standards of haemovigilance.

REFERENCES

AABB - American Association of Blood Banks. **Technical Manual**. 14th ed. Bethesda (MD); 2002.

BRASIL. Ministério da Saúde. Resolução RDC nº ?29, de 24 de dezembro de 1999: estabelece que instituições executoras de atividades hemoterápicas, públicas e privadas, deverão encaminhar à direção estadual do SUS, os dados de sua produção a cada mês, por meio de anexo a esta resolução. **Diário Oficial da República Federativa do Brasil**, Brasília, 27 dez 1999. Seção I.

BRASIL. Ministério da Saúde. Secretaria Executiva. **Programa de qualidade do sangue: sangue e hemoderivados**. Brasília, 2000.

BRASIL. Ministério da Saúde. Agência Nacional de Vigilância Sanitária. **Manual Técnico de Hemovigilância**. Brasília, 2004.

BRASIL. Agência Nacional de Vigilância Sanitária. Resolução da Diretoria Colegiada nº 153, de 4 de junho de 2004. **Princípios da Moderna Hemoterapia,** Brasília, 2004a.

FERNANDES, M.F.A. **Hemovigilância: análise das informações disponíveis para sua implantação, de acordo com a (re) investigação de casos de AIDS associados à transfusão**. São Paulo; 2001. 121p. (Dissertação de Mestrado) - Faculdade de Saúde Pública, Universidade de São Paulo, 2001.

THE NURSE IN SENTINEL HOSPITAL PROJECT: REPORT OF EXPERIENCE IN HAEMOVIGILANCE

ABSTRACT

The Sentinel Hospitals Project was created in 2001 by the Management of Surveillance in Health Services and has as main goal to build a network of hospitals across the country. This report aims to disseminate the actions undertaken in the service of haemovigilance, identify the problems with blood transfusions and show the importance of nurses in this area of expertise. Methodology: This is a story of lived experience, the team of haemovigilance HUOL in the period from November 2003 to July 2008. Result: The non-compliances were: incomplete requests; transported samples and inadequately identified; undue packing of blood; warming of packed red blood cells, platelets concentrate freezing, thawing of fresh plasma on benches; routine pre-prescription medicine without a prior history incident of transfusion; infusion of blood in patients exchanged, without limitation the volume of infusion; labels incomplete and / or illegible, among others. The actions taken to reduce the non-compliances were up to standard procedure manual service (POP); placed officials in three shifts of work (24h) in the storage area and distribution of the blood HUOL; provided to all nurses and sectors closed educational materials and information; biannual training for health professionals; held moments of awareness; active search of transfusion incidents, among others. Conclusion: With the training, sensitization and active search of the incidents managed to reduce transfusion problems identified, but due to high turnover of pupils in hospital and health professionals, it is difficult to adherence to the standards of haemovigilance.

Key words: surveillance, blood transfusion.

L'INFIRMIÈRE À L'HÔPITAL SENTINELLE PROJET: RAPPORT DE L'EXPÉRIENCE ACQUISE DANS D'HÉMOVIGILANCE

RESUMÉ

The Sentinel Hospitals Project a été créé en 2001 par la Direction de la surveillance dans les services de santé et a pour principal objectif de construire un réseau d'hôpitaux dans tout le pays. Ce rapport a pour objectif de diffuser les actions entreprises au service de l'hémovigilance, identifier les problèmes avec hemotranfusões et de montrer l'importance des infirmières dans ce domaine d'expertise. Méthodologie: Il s'agit d'une histoire de l'expérience vécue, l'équipe est HUOL d'hémovigilance au cours de la période de Novembre 2003 à Juillet 2008. Résultat: Le non-conformités ont été les suivants: les demandes incomplètes; échantillons transportés et insuffisamment identifiées, l'emballage excessif de sang; réchauffement des culots globulaires, les plaquettes se concentrer gel, dégel des frais de plasma sur des bancs; routine pré-médicaments sans antécédents incident de la transfusion, de

perfusion de sang chez les patients échangées, sans limitation du volume de perfusion; étiquettes incomplètes et / ou illisible, parmi autres. Les mesures prises pour réduire les non-conformités ont été la mise aux normes de service manuel de procédure (POP); fonctionnaires en trois équipes de travail (24h) dans la zone de stockage et de distribution du sang HUOL; fournis à tous les infirmières et les secteurs fermés matériel éducatif et de l'information; semestriel de formation pour les professionnels de la santé a tenu des moments de sensibilisation; recherche active de la transfusion incidents, entre autres. Conclusion: Avec la formation, de sensibilisation et de recherche active des incidents réussi à réduire la transfusion problèmes identifiés, mais en raison de la forte rotation des élèves à l'hôpital et les professionnels de la santé, il est difficile d'adhérer aux normes de l'hémovigilance.

Mots clés: vigilance, transfusion sanguine.

LA ENFERMERA EN EL PROYECTO HOSPITAL SENTINEL: INFORME DE LA EXPERIENCIA EN HEMOVIGILANCIA

RESUMEN

El Proyecto Hospital Sentinel fue creado en 2001 por la Dirección de Vigilancia de los Servicios de Salud y tiene como principal objetivo construir una red de hospitales en todo el país. El presente estudio tiene por objeto difundir las acciones emprendidas en el servicio de la hemovigilancia, identificar los problemas con hemotranfusion y mostrar la importancia de los enfermeros en este ámbito de especialización. Metodología: Se trata de una historia de la experiencia vivida, el equipo de la hemovigilancia HUOL en el período comprendido entre noviembre de 2003 a julio de 2008. Resultados: La incumplimientos fueron los siguientes: las solicitudes incompletas; muestras transportadas y mal consignadas; indebida de embalaje de la sangre; calentamiento de concentrado de hematíes, las plaquetas se concentran congelación, descongelación de plasma fresco en los bancos; rutina pre-medicina con receta sin una historia previa incidente de la transfusión, perfusión de la sangre en pacientes intercambiaron, sin limitación, el volumen de infusión, etiquetas incompletas y / o ilegibles, entre otros. Las medidas adoptadas para reducir los incumplimientos se ajusta a las normas procedimiento manual de servicio (POP), los funcionarios colocados en tres turnos de trabajo (24 horas) en el área de almacenamiento y distribución de la sangre HUOL, siempre a todas las enfermeras y los sectores cerrados materiales educativos e información; semestral de formación para los profesionales de la salud; celebrada momentos de conciencia; búsqueda activa de casos de transfusión, entre otros. Conclusión: Con la capacitación, sensibilización y búsqueda activa de los incidentes gestionados para reducir la transfusión problemas identificados, pero debido a la alta rotación de los alumnos en el hospital y los profesionales de la salud, es difícil la adhesión a las normas de la hemovigilancia.

Palabras clave: vigilancia, transfusión sanguínea .

O ENFERMEIRO NO PROJETO HOSPITAL SENTINELA: RELATO DE EXPERIÊNCIA NA HEMOVIGILÂNCIA

RESUMO

O Projeto Hospitais Sentinela, foi criado em 2001 pela Gerência de Vigilância em Serviços de Saúde, tem como principal objetivo construir uma rede de hospitais em todo o país. Este relato tem como objetivos divulgar as ações desenvolvidas no serviço de hemovigilância, identificar os problemas com hemotranfusões e mostrar a importância do enfermeiro nesta área de atuação. **Metodologia:** Trata-se de um relato de experiência vivenciado, pela equipe hemovigilância do HUOL no período de novembro de 2003 a julho de 2008. **Resultado:** As não conformidades encontradas foram: solicitações incompletas; amostras transportadas e identificadas inadequadamente; acondicionamentos indevidos dos hemocomponentes; aquecimento de concentrado de hemácias; congelamento de concentrado de plaquetas, descongelamento de plasmas fresco sobre bancadas; prescrição rotineira de pré-medicamento sem história previa de incidente transfusional; infusão de hemocomponentes em pacientes trocados; prescrição sem o volume de infusão; rótulos incompletos e/ou ilegível, entre outros. As ações desenvolvidas para reduzir as não conformidades foram: confeccionado manual de procedimento padrão do serviço (POP); colocado funcionários nos três turnos de trabalho (24hs) no local de armazenamento e distribuição de hemocomponentes do HUOL; fornecido a todos os enfermeiros e setores fechados material educativo e informativo; treinamento semestral para os profissionais de saúde; realizado momentos de sensibilização; busca ativa dos incidentes transfusionais, entre outros. **Conclusão:** Com os treinamentos, sensibilizações e busca ativa dos incidentes transfusionais conseguimos reduzir os problemas identificados, mas devido a grande rotatividade no hospital dos alunos e profissionais de saúde torna-se difícil aderência às normas de hemovigilância.

Palavras-chaves: vigilância, transfusão de sangue.