CSTM Conference

ST JOHN'S NEWFOUNDLAND

MAY 29-JUN 1, 2025

Conference Highlights According to Heather

The Workshops

- Held on Thursday before the main conference the workshops are an excellent educational resource.
- Smaller groups with varying topics, well moderated and most had three presenters.
- Topics included:
  - Nightmares in Transfusion medicine
  - Immune Transfusion reactions
  - New products: What to do when you are expecting
  - Complex serological case studies
  - Standards workshop- Inspections
  - Genomics Workshop

The Conference

- The main body of the conference always starts with the welcome and in Newfoundland's case the keynote speaker.
- Sessions run for 90 minutes with breaks and lunch
- First day highlight was Treating Immune platelet disorders mostly because I find the topic fascinating and Dr Prokopchuk was one of the presenters and she is an excellent speaker
- Poster presentations and Exhibitors reception followed in the evening. Posters are also one of my favorites as you get to grill the authors of the posters. Kudos to Kim Thomson and Dr Price on having excellent posters from Saskatoon.

Day 2

- The CSTM Annual general Meeting is held over breakfast and highlights all the financials and achievements the board has done over the last year.
- Starts with the various CSTM awards and is always impressive
- Another full day of sessions
- Posters are still up for conference participants to get a better look at them

Day 3

- Favorite session of the morning was Hemovigilance in Canada, this is my wheelhouse and the sun setting of the TTISS program brought a lot of lively discussion from those in attendance of this session
- This is a half day and I participated in the final session of the conference which was about the Diverse roles of non-MD staff supporting Transfusion Medicine
- Moderated by Becky Rock we had a great variety of TM professionals who had a lot of similar struggles, challenges and rewards for the roles they hold. As my last conference before I retire enjoyed meeting up with colleagues across Canada and meeting some very warm and welcoming people from Newfoundland.

The Extracurricular Activities

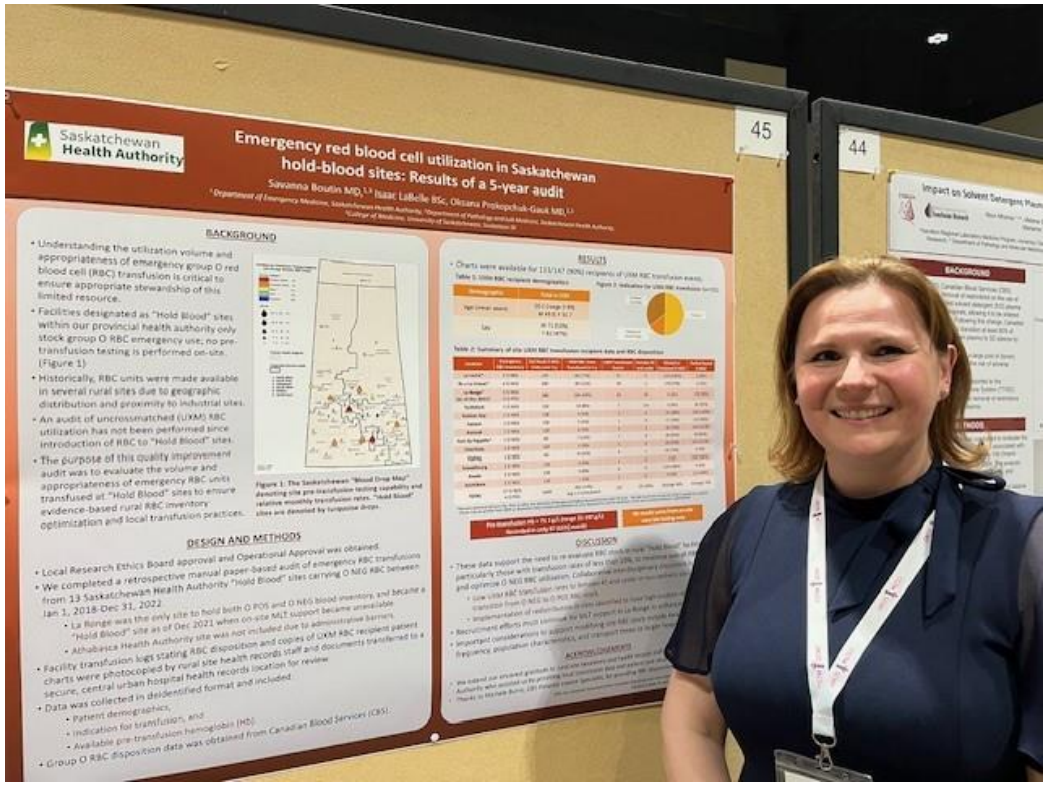
CSTM Conference Highlights Sheila

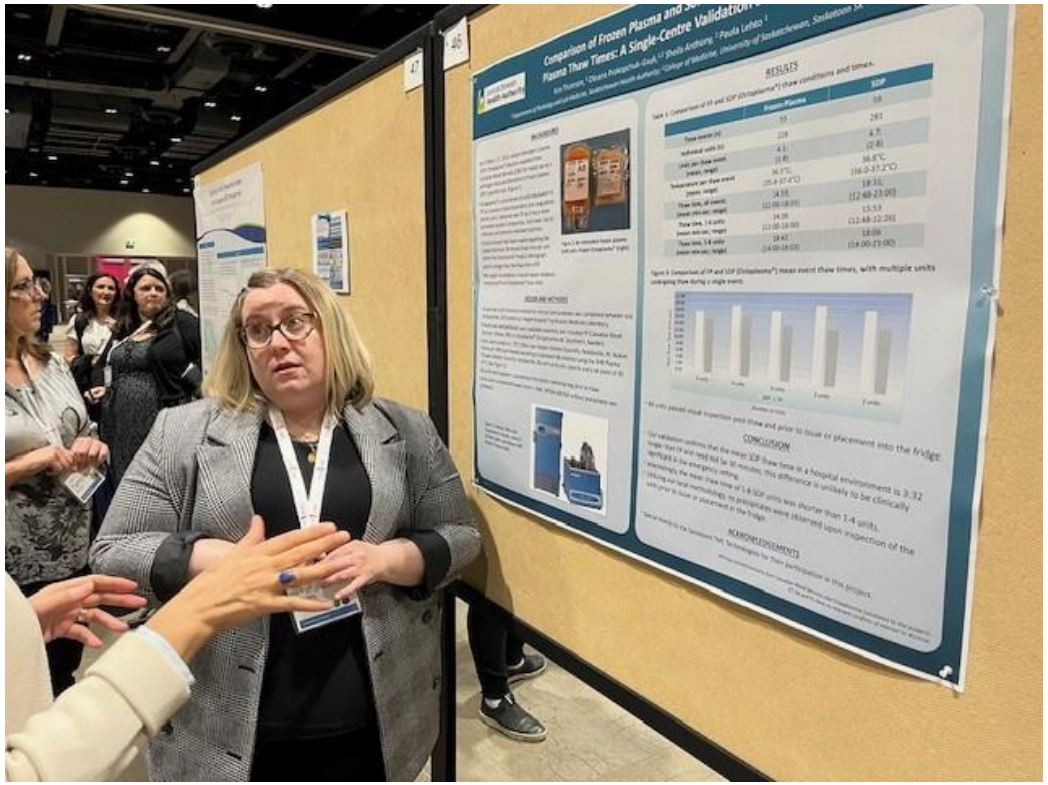
- one of my favorite sessions was Compliance with Krever Recommendations on the era iof out of hospital blood product infusion therapy in British Columbia
- Why? Because the tainted blood scandal and the Krever Commission is why I became a laboratory technologist
- The Exhibitor's had a lot of interesting booths with a wide variety of all things transfusion. Plus a lot of free swag!
- Heather says I have to say her panel discussion was also very informative

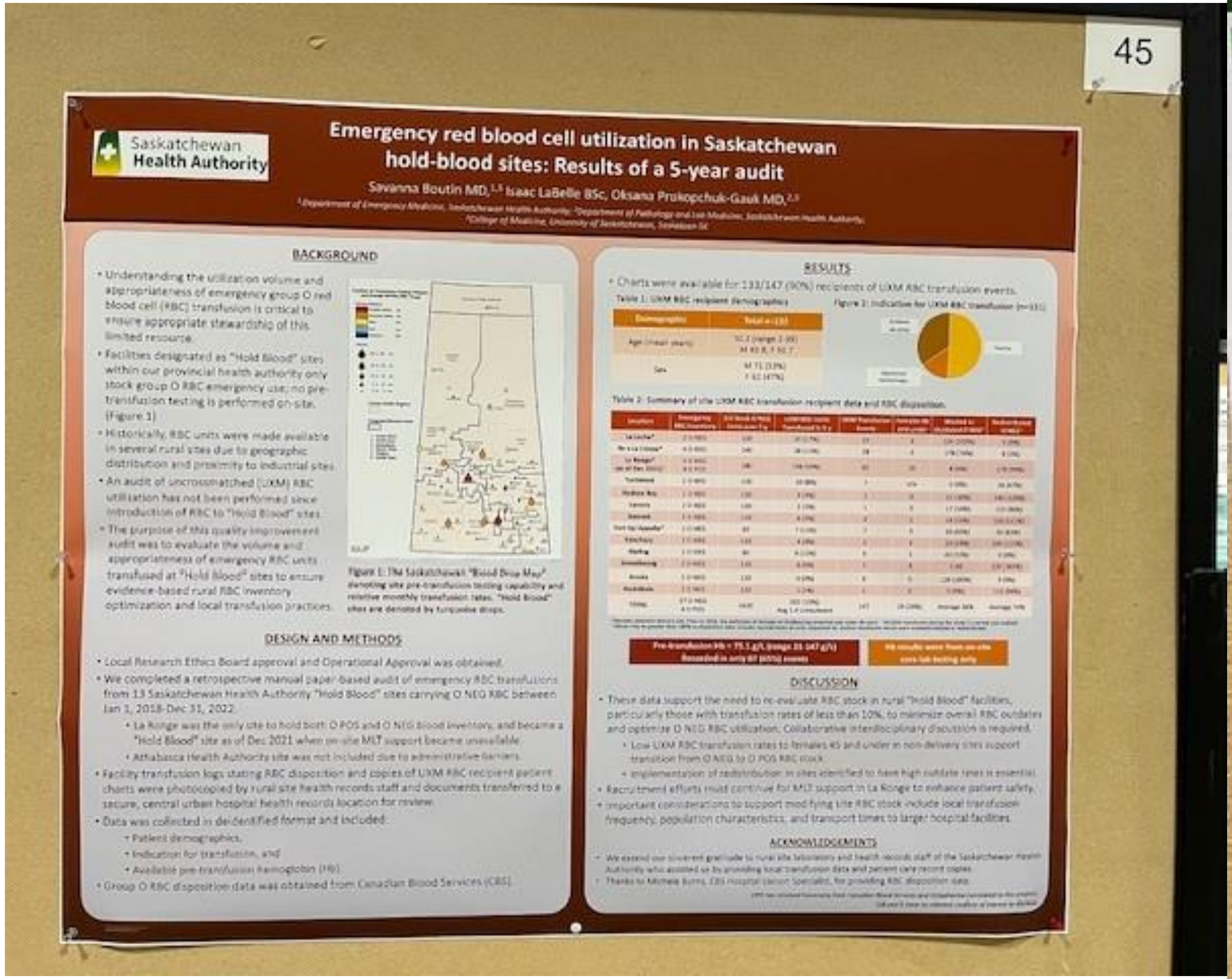
Volunteering has its rewards

Sharing our registration system from the Saskatoon conference with St John's and then offering to volunteer for a shift at their registration has its perks. Met some great people and got a new lanyard

The Posters- Saskatoon represented!!



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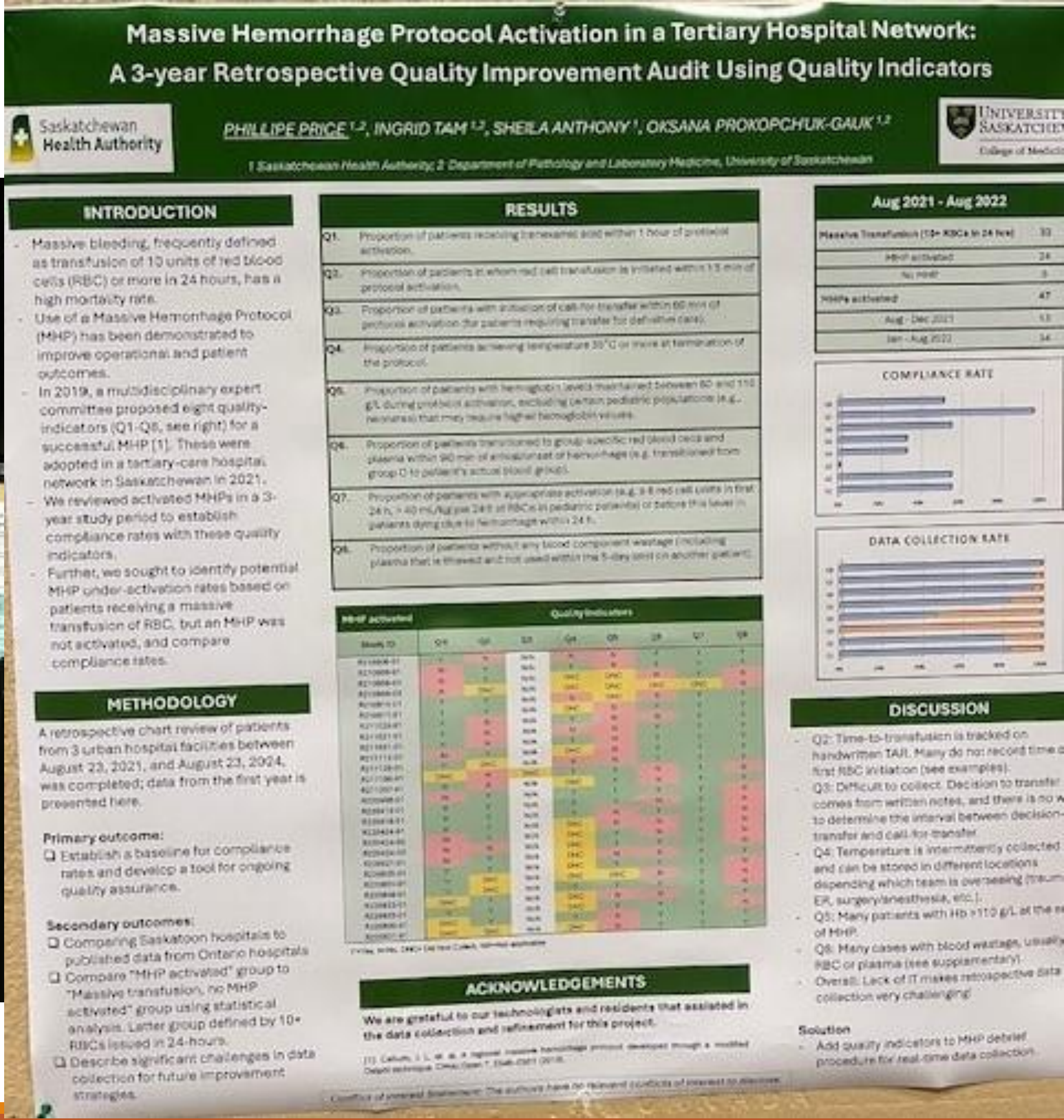
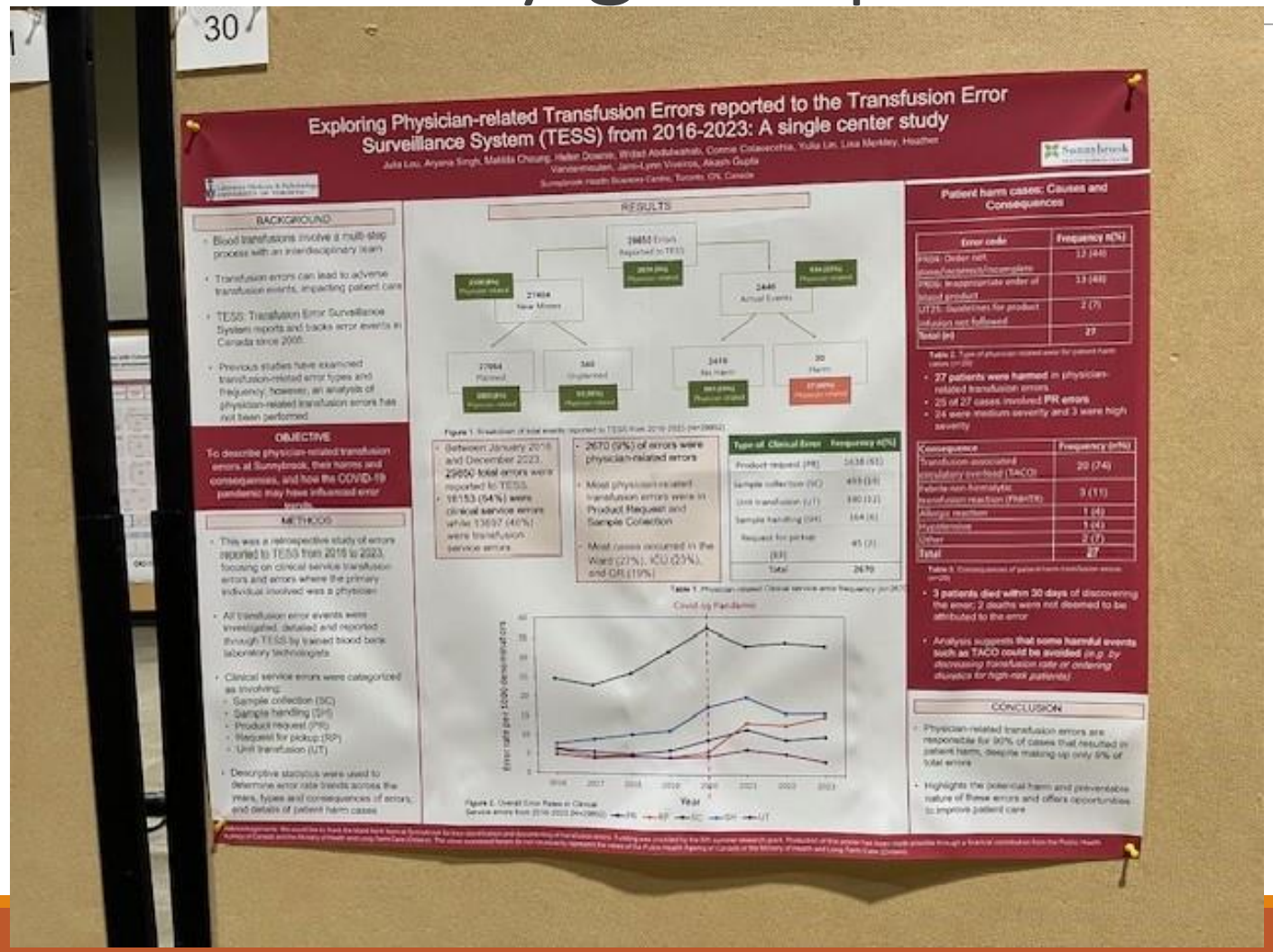
Saskatchewan Health Authority
Emergency red blood cell utilization in Saskatchewan hold-blood sites: Results of a 5-year audit
Savanna Boutin MD, Isaac LaBelle BSc, Oksana Prokopchuk-Gauk MD
BACKGROUND
Understanding the utilization volume and appropriateness of emergency group O red blood cell (RBC) transfusion is critical to ensure appropriate stewardship of this limited resource.
Facilities designated as "Hold Blood" sites within our provincial health authority only stock group O RBC emergency use; no pre-transfusion testing is performed on-site. (Figure 1)
Historically, RBC units were made available in several rural sites due to geographic distribution and proximity to industrial sites.
An audit of uncrossmatched (UXM) RBC utilization has not been performed since introduction of RBC to "Hold Blood" sites.
The purpose of this quality improvement audit was to evaluate the volume and appropriateness of emergency RBC units transfused at "Hold Blood" sites to ensure evidence-based rural RBC inventory optimization and local transfusion practices.
Figure 1: The Saskatchewan "Blood Drop Map" denoting site pre-transfusion testing capability and relative monthly transfusion rates. "Hold Blood" sites are denoted by turquoise drops.
DESIGN AND METHODS
Local Research Ethics Board approval and Operational Approval was obtained.
We completed a retrospective manual paper-based audit of emergency RBC transfusions from 13 Saskatchewan Health Authority "Hold Blood" sites carrying O NEG RBC between Jan 1, 2018-Dec 31, 2022.
Data was collected in deidentified format and included:
Patient demographics,
Indication for transfusion, and
Available pre-transfusion hemoglobin (Hb).
Group O RBC disposition data was obtained from Canadian Blood Services (CBS).
RESULTS
Table 1: UXM RBC recipient demographics
Figure 2: Indication for UXM RBC transfusion
Table 2: Summary of site UXM RBC transfusion recipient data and RBC disposition
DISCUSSION
ACKNOWLEDGEMENTS


Massive Hemorrhage Protocol Activation in a Tertiary Hospital Network:
A 3-year Retrospective Quality Improvement Audit Using Quality Indicators
Saskatchewan Health Authority
PHILLIPE PRICE 1,2, INGRID TAM 1,2, SHEILA ANTHONY 1, OKSANA PROKOPCHUK-GAUK 1,2
1 Saskatchewan Health Authority; 2 Department of Pathology and Laboratory Medicine, University of Saskatchewan
INTRODUCTION
Massive bleeding, frequently defined as transfusion of 10 units of red blood cells (RBC) or more in 24 hours, has a high mortality rate.
Use of a Massive Hemorrhage Protocol (MHP) has been demonstrated to improve operational and patient outcomes.
In 2019, a multidisciplinary expert committee proposed eight quality indicators (Q1-Q8, see right) for a successful MHP [1]. These were adopted in a tertiary-care hospital network in Saskatchewan in 2021.
We reviewed activated MHPs in a 3-year study period to establish compliance rates with these quality indicators.
Further, we sought to identify potential MHP under-activation rates based on patients receiving a massive transfusion of RBC, but an MHP was not activated, and compare compliance rates.
METHODOLOGY
A retrospective chart review of patients from 3 urban hospital facilities between August 23, 2021, and August 23, 2024, was completed; data from the first year is presented here.
Primary outcome:
Establish a baseline for compliance rates and develop a tool for ongoing quality assurance.
Secondary outcomes:
Comparing Saskatoon hospitals to published data from Ontario hospitals
Compare "MHP activated" group to "Massive transfusion, no MHP activated" group using statistical analysis. Latter group defined by 10+ RBCs issued in 24-hours.
Describe significant challenges in data collection for future improvement strategies.
RESULTS
Q1. Proportion of patients receiving tranexamic acid within 1 hour of protocol activation.
Q2. Proportion of patients in whom red cell transfusion is initiated within 15 min of protocol activation.
Q3. Proportion of patients with initiation of call for transfer within 60 min of protocol activation (for patients requiring transfer for definitive care).
Q4. Proportion of patients achieving temperature 35°C or more at termination of the protocol.
Q5. Proportion of patients with hemoglobin levels maintained between 60 and 110 g/L during protocol activation, excluding certain pediatric populations (e.g., neonates) that may require higher hemoglobin values.
Q6. Proportion of patients transitioned to group-specific red blood cells and plasma within 90 min of activation/onset of hemorrhage (e.g. transitioned from group O to patient's actual blood group).
Q7. Proportion of patients with appropriate activation (e.g. ≥ 6 red cell units in first 24 h, > 40 mL/kg per 24 h of RBCs in pediatric patients) or before this level in patients dying due to hemorrhage within 24 h.
Q8. Proportion of patients without any blood component wastage (including plasma that is thawed and not used within the 5-day limit on another patient).
MHP activated
Quality Indicators
Aug 2021 - Aug 2022
Massive Transfusion (10+ RBCs in 24 hrs)
MHP activated
No MHP
MHPs activated
Aug - Dec 2021
Jan - Aug 2022
COMPLIANCE RATE
DATA COLLECTION RATE
DISCUSSION
Q2: Time-to-transfusion is tracked on handwritten TAR. Many do not record time of first RBC initiation (see examples).
Q3: Difficult to collect. Decision to transfer comes from written notes, and there is no way to determine the interval between decision-to-transfer and call-for-transfer.
Q4: Temperature is intermittently collected and can be stored in different locations depending which team is overseeing (trauma, ER, surgery/anesthesia, etc.).
Q5: Many patients with Hb >110 g/L at the end of MHP.
Q8: Many cases with blood wastage, usually RBC or plasma (see supplementary).
Overall: Lack of IT makes retrospective data collection very challenging.
Solution
Add quality indicators to MHP debrief procedure for real-time data collection.
ACKNOWLEDGEMENTS
We are grateful to our technologists and residents that assisted in the data collection and refinement for this project.
Conflict of interest Statement: The authors have no relevant conflicts of interest to disclose.

So many great posters!



Food and Fun!!

We would like to thank the CSTM for their sponsorship to the St John's conference.