Quarantine Release Errors in Blood Establishments: A Public Workshop

When a patient receives a blood or platelet transfusion, they are trusting that the blood product they are receiving is safe and won't cause injury. What is being done to insure that blood released for patient transfusions is safe?

On September 13, 2011, the Food and Drug Administration's (FDA) Center for Biologics Evaluation and Research, America's Blood Centers, and the Office of the Assistant Secretary for Health, of the Department of Health and Human Services (DHHS) sponsored a one-day workshop on quarantine release errors (QREs) in blood establishments. The public workshop provided a forum for discussion of QREs and provided FDA and the industry with information necessary to reduce the rates of QREs. PDSA attended the workshop, held in Rockville, MD, in order to stay aware of safety issues pertaining to our nation's blood supply and issues that might relate to ITP patients.

A wide range of speakers including experts from the FDA, blood centers, several hospital transfusion services, and the American Red Cross explained quarantine release errors, discussed the causes, and described possible ways to decrease those errors in blood establishments in the future. QREs occur when collected blood is found to be contaminated, expired, or otherwise unsuitable for donation, yet through a range of errors, blood or blood product was inadvertently released to a patient anyway. This type of error can result in injury and even death to the recipient of improperly labeled or handled blood. The main cause of QREs has been determined to be human error. The workshop's effort was aimed at exploring possible strategies to address QREs and making blood collection and distribution safer for patients everywhere.

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