

# SHOT

## Summary of Results from the SHOT Survey sent to Transfusion Practitioners

Dec 2004

# Survey to Transfusion Practitioners

## ➔ Why?

➔ The SHOT team wanted to know what hospitals think about the SHOT reporting system

➔ To find out who reports SHOT incidents

➔ To establish how many incidents are being reported compared to the number seen

➔ To gain a better understanding of how SHOT can help hospitals

# Survey to Transfusion Practitioners

## ➔ How?

➔ A questionnaire was designed

➔ It was piloted in January 2004 in the Northwest

➔ Results were collected and sent to the Steering Group for comment in April 2004

## ➔ Results from the pilot:

- ➔ 15/20 TP's replied - all report to SHOT
- ➔ Incidents not always reported, as staff unsure what category to put the incident in
- ➔ They do not always report near misses as there are too many!
- ➔ TPs and BBMs usually fill the forms in
- ➔ Some suggestions made were actually already available e.g. group reporting of near misses
- ➔ Request for more denominator data
- ➔ Want SHOT to have more power to implement it's recommendations

## Survey to Transfusion Practitioners

- ➔ Pilot results discussed at the Steering Group meeting in April 2004
- ➔ Questionnaire altered to include a new question asking if there were any transfusion incidents that TPs felt were important, but did not fit into a SHOT category, and if so, to give examples
- ➔ New questionnaire then sent out to all TPs in England in July 2004

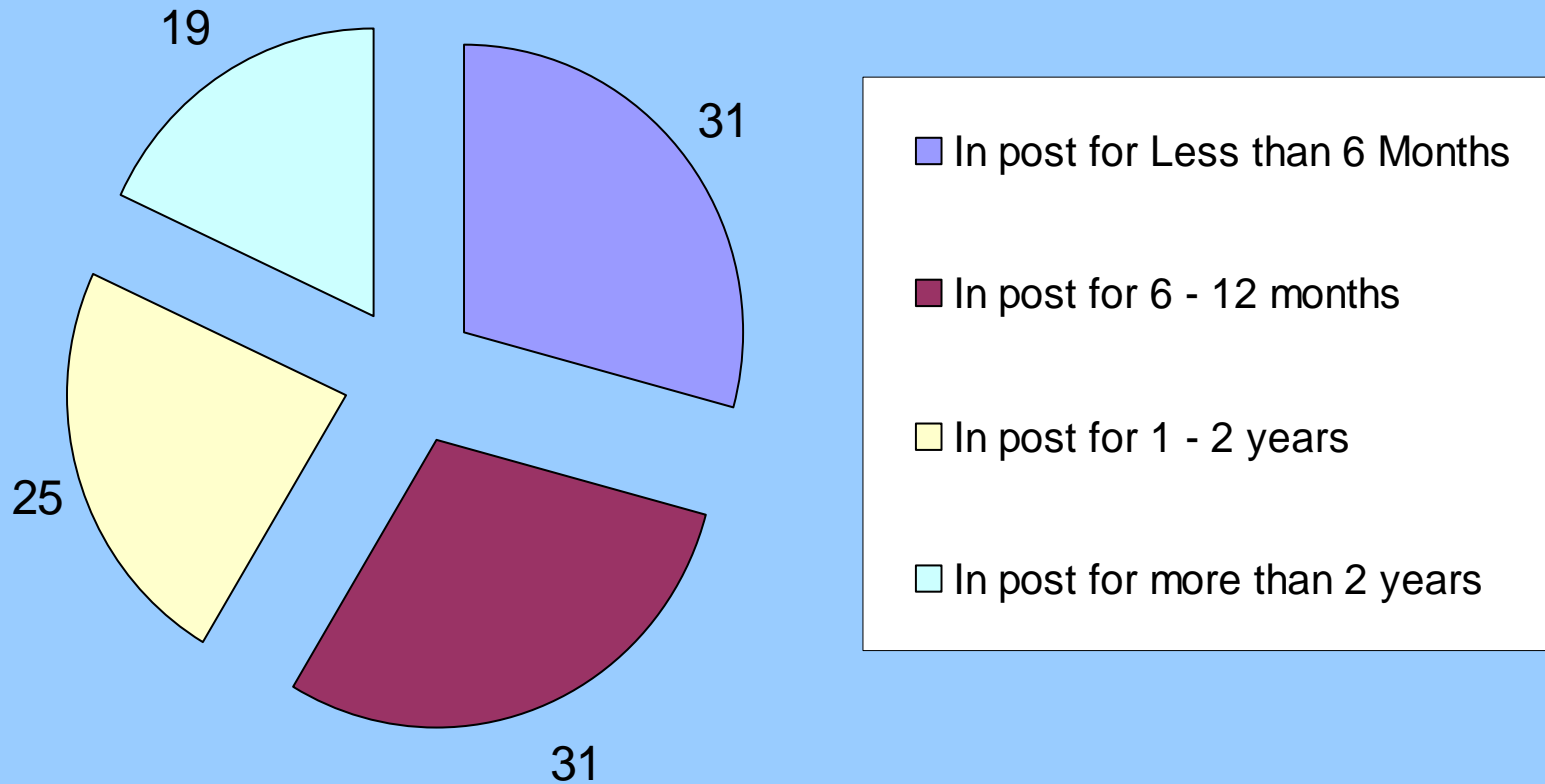
# Survey to Transfusion Practitioners

## ➔ Results from national survey:

➔ 111 replies received from 125 TPs surveyed (89% response rate)

➔ The TPs had been in post for varying lengths of time and so had varying amounts of experience with SHOT reporting and completing the forms

## Length of time TP been in post



# Adverse event reporting

- ➔ All TPs said their hospitals took part in SHOT
- ➔ 98% said they have sent in SHOT reports
- ➔ 76% report **all** incidents to SHOT
- ➔ The others report between 1 and 95% of known incidents

# Adverse event reporting

- ➔ Main reasons for not reporting incidents:
  - ➔ lengthy questionnaires/too time consuming to complete (9)
  - ➔ difficult to categorise the incident (2)
  - ➔ HTT not made aware of incidents (2)
  - ➔ only serious incidents are reported (2)

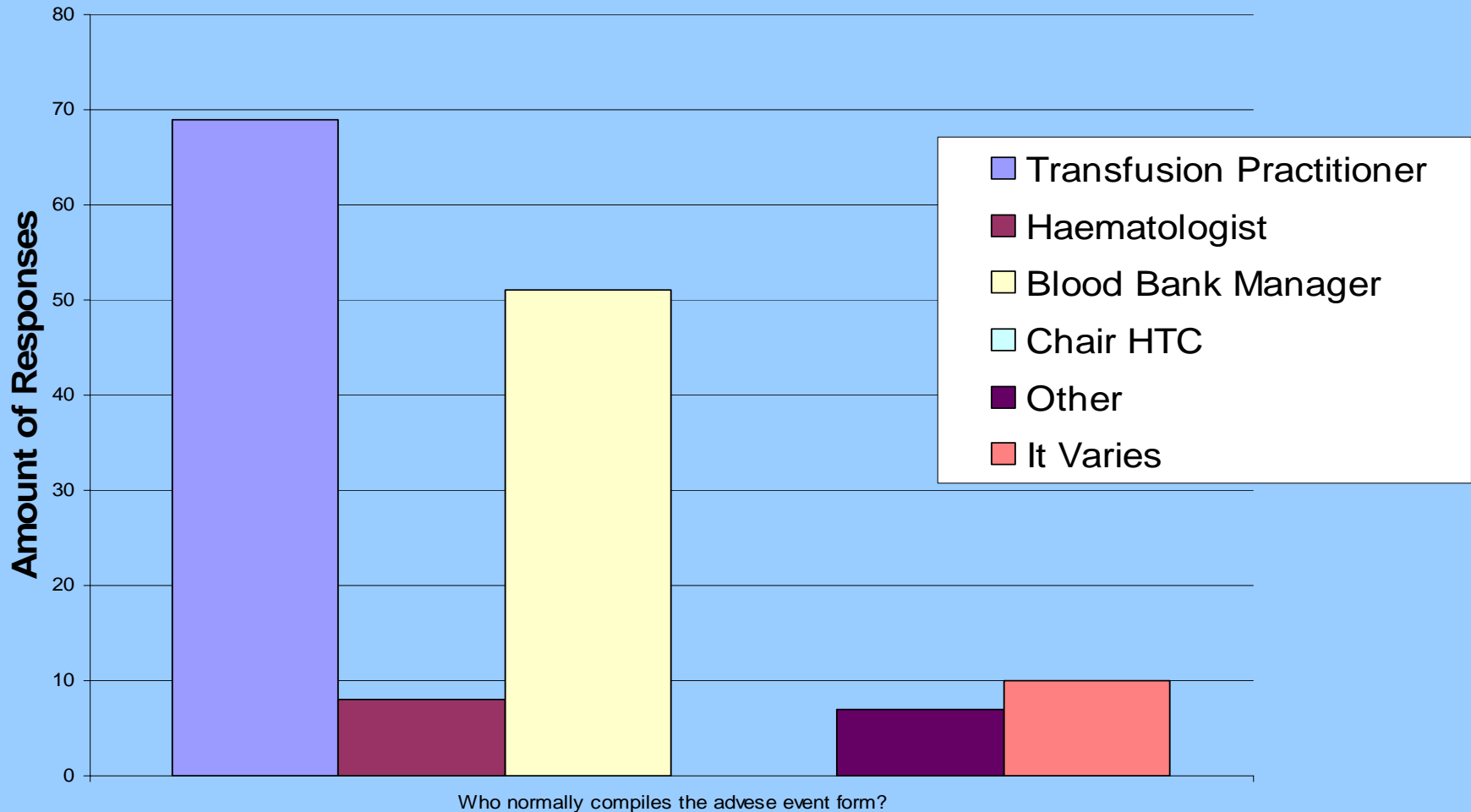
**55% said there were incidents they felt were important, but they did not fit into a category:**

- ➔ use of anti D (13)
- ➔ inappropriate use (6)
- ➔ right blood to right patient incidents (6)
- ➔ labelling errors (5)
- ➔ non adherence to local policy (4)
- ➔ storage errors (4)
- ➔ wastage through inappropriate ordering (3)
- ➔ minor transfusion incidents (3)
- ➔ when patient in theatre and blood not ready (3)

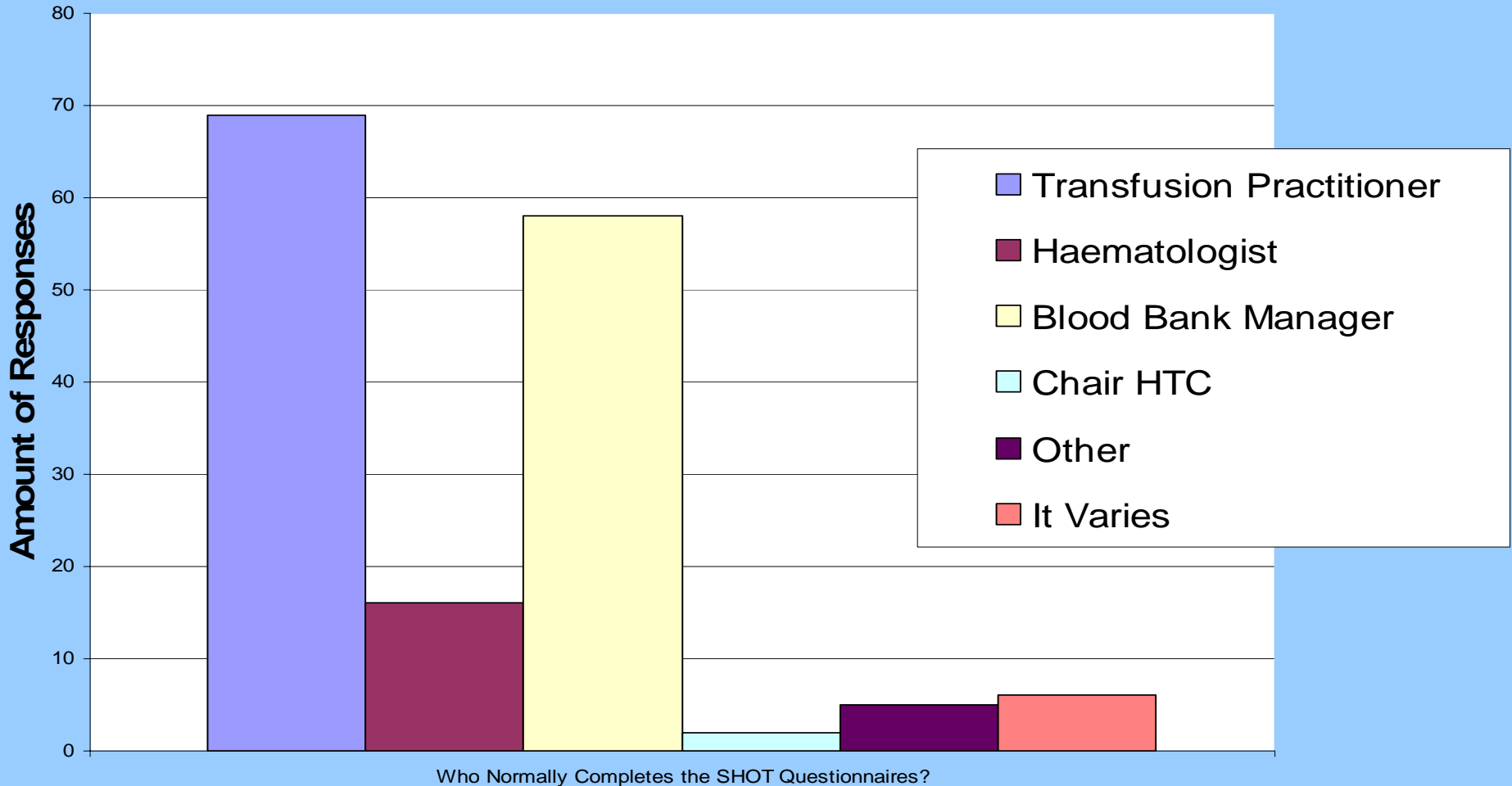
# Near Miss reports

- ➔ 92% send in near misses to SHOT
- ➔ 45% report **all** known near misses
- ➔ others report between 2 and 90%
- ➔ under reporting due to:
  - ➔ lack of time to complete the forms (6)
  - ➔ not made aware of them by ward staff (5)
  - ➔ only report serious ones (5)
  - ➔ too many to report (4)
  - ➔ unsure of definition of 'near miss' (4)

# Who normally completes the initial adverse event form?



# Who normally completes the SHOT questionnaire?



# What can SHOT do to help hospitals participate in SHOT?

- ➔ make the questionnaires shorter and simpler (12)
- ➔ more IT/on-line applications (9)
- ➔ clearer definitions (4)
- ➔ education/training/increased awareness of transfusion incidents and SHOT in hospitals (11)

## Additional comments:

- ➔ staff are always friendly and helpful (7)
- ➔ questionnaires too long/time consuming (7)
- ➔ the scheme is excellent (6)
- ➔ reports are easy to read and great for educating staff (4)
- ➔ questionnaires are getting easier to use (4)
- ➔ SHOT helps change practice (2)
- ➔ amount of lab data requested seems unnecessary (2)
- ➔ want on-line reporting system (2)
- ➔ data out of date by the time it is published (2)

# Main Conclusions

- Hospitals with a TP are more likely to report incidents than those without a TP
- Main reason for under-reporting is lack of time
- Some TPs have difficulty categorising incidents
- Near misses are less well reported
- It is usually the TP or BBM who completes the forms

# Main Recommendations

- SHOT categories and definitions to be reviewed
- SHOT questionnaires to be made shorter
- More education/training/heightened awareness of transfusion incidents and SHOT required at all levels in hospitals
- Need for more regular/up-to-date feedback
- Need to investigate application of on-line reporting

# Acknowledgements

- Dr Dorothy Stainsby and Hilary Jones from SHOT
- Ben Armstrong, Hospital Liaison Administrator

# Your views and comments are welcome

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