

Working together-Phase 1:

On Monday 5th October 2015, changes were made to the MHRA SABRE database to enable all Serious Adverse Reactions (SAR) to be confirmed by SHOT after completion of the relevant SHOT database questionnaire (e.g. ATR, TACO, TAD, TRALI etc).

The changes included removal of the 'share with SHOT' and 'SHOT only' options, so all cases, including all Serious Adverse Events (SAE) can now be seen by both organisations, enabling better harmonisation and data reconciliation.

If you have any queries, or find anything that does not appear to be working as it should, please contact the SHOT office on 0161 423 4208.

The SHOT Team - Staff Changes

Hema Mistry, the SHOT Laboratory Incidents Specialist, is on maternity leave. **Joanne Bark** is currently working on a fixed term contract to cover the position.

The SHOT administration department was restructured in September 2014 with **Lisa Parker** joining the SHOT Team on a permanent basis in October 2014 as the Administration Office Manager. **Katie Leadbetter** joined in September 2015 as the Office Assistant in conjunction with Manchester College on the apprenticeship scheme.

Tony Davies Patient Blood Management Practitioner/SHOT retired in December 2015. His support and work within SHOT has been very valuable and he will be much missed.

We are very pleased to welcome **Jayne Addison** to the role from January 2016 and look forward to working with her in the future. She is well known to many of you through her work in the Patient Blood Management Team.

SHOT questionnaires

A pdf copy of all the SHOT questionnaires can be found on the first page of the SHOT database under the 'documents' tab. These documents can be downloaded/printed and used to inform the collection of information before submission of a SHOT report.



Save the date!

SHOT Symposium 2016

We look forward to returning to *The Lowry, Salford, Manchester, 7th July, 2016.*

- Our keynote speaker will be Professor Erik Hollnagel from Denmark who will discuss a different approach to errors and human factors – resilient health care
- Jo Howard (consultant haematologist in London) will talk on complications of Sickle Cell disease
- There will be an update on pulmonary complications particularly to discuss revisions in the definition of TACO
- We will be hearing from an inspiring patient
- We are including several presentations on your examples of good practice
- The abstract submission deadline is Friday 29th April 2016. The best abstract will be given as an oral presentation, and other successful submission as posters

SHOT website launch

The new SHOT website will be launched in mid January. It will continue to provide a range of educational and haemovigilance resource
www.shotuk.org

SHOT BITES



Log into the SHOT website for the new 'bite-size' SHOT learning flyers. These cover a range of topics including:

- Incident investigation
- Anti-D lessons and highlights 2015
- Quick reference guide to reporting
- Acute transfusion reactions
- Reporting FAQs
- Paediatric bites

UK Transfusion Laboratory Collaborative (UKTLC) Update

The UK Transfusion Laboratory Collaborative standards for staff qualifications, training, competency and use of information technology were published in 2014. This document sets the standards (previously branded as recommendations) that all hospital laboratories should be working towards.

A survey incorporating questions about the implementation of these standards was distributed to all transfusion laboratories in March 2015. The results of this survey have been analysed and the draft report was presented at the Transfusion Laboratory Managers meeting in September.

ready to work in the Blood Transfusion laboratory. This is a result of changes in training introduced by Modernising Scientific Careers.

A meeting of the UKTLC committee, new chair Rashmi Rook, was held on 4th November at the IBMS at which the preliminary results of the survey were discussed. Revised terms of reference will be produced and the membership is being updated.



SHOT RESOURCES ON THE WEB

Have you visited our website recently?

We have uploaded new resources including case studies, SHOT bites, an updated teaching slide set, and poster presentations from meetings in 2015

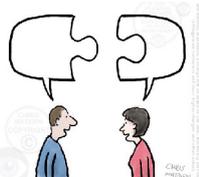
GO TO:
www.shotuk.org



This year's survey was a combination of 2 surveys. Previous UKTLC questions were addressed but also additional questions were included from the National Blood Transfusion Committee. This led to a survey being distributed which included 90 questions. The overall response rate was 204/324 (62%). However towards the end of the questionnaire, fewer questions were answered by approximately 120 reporters which possibly suggests questionnaire fatigue.

In brief, 157/204 (77%) of responses were from the technical lead on that day and the majority of these were at grade Band 8.102/204 (50%) of laboratories had noted an increase in workload compared to 2013, and coupled with the fact that 90/166 (54%) stated that they were carrying vacancies these results suggest increased pressure in the laboratory.

The ability to recruit new BMS staff was assessed in this survey, a question which had not been included previously. Most respondents felt that a newly registered BMS does not have an appropriate level of knowledge and understanding to be



Breakfast Meeting

SHOT symposium 2016



Due to the success of the **Breakfast meeting** for TPs last year at the ISBT meeting in London, we may hold a similar session on the morning of the Annual SHOT Symposium 2016 which will be open to all (i.e. biomedical scientists, TPs etc) and is likely to run from 8.00 to 9.30. Please contact the SHOT office to register your interest for this event and/or reply to the online survey.

SHOT shared learning area

Colleagues are invited to share their examples of good practice, particularly good root cause analyses, via the SHOT website. This area holds examples of documents provided by external colleagues who have authorised the sharing of these for learning purposes. Although not created by SHOT, these documents are covered by the SHOT confidentiality and copyright statements. Please feel free to send us any similar shared learning for publication in this area.

The area is password protected so please contact the SHOT office for more details.

<http://www.shotuk.org/resources/current-resources>



SHOT Symposium 2015

Excel, London

Highlights from the 2015 SHOT symposium 27th June 2015, London

The annual SHOT symposium 2015 was held in conjunction with the BBTS/ISBT Congress. The day was very well attended by more than 600 international delegates giving SHOT the opportunity to showcase the success of UK haemovigilance.

The SHOT Medical Director, Dr Paula Bolton-Maggs (UK) introduced the morning session with an excellent presentation 'SHOT 2014 What's new?'

Main headlines:

- **SHOT reporting participation** – 100% of NHS organisations are registered to report to SHOT
- **3017** SHOT reports were analysed in 2014
- **2346 (77.8%)** of SHOT reports are related to human error (including near miss and right blood, right patient)
- **15 deaths** where transfusion was causal or contributory
- **169 cases of major morbidity** - defined by SHOT as requiring immediate or life threatening intervention to prevent harm
- **10 ABO incompatible red cell transfusions** – all of them resulting from clinical errors
- **Multiple errors** - The median number of errors for individual incorrect blood component transfused reports was 3 (range 1 – 6)
- **Human factors** - SHOT recognises that human factors contribute to errors being made in the transfusion process and this appears to be an under-researched area requiring further investigation. The transfusion process will be audited (NCA) in 2016.

- **TACO (transfusion-associated circulatory overload)** remains the leading cause of patient morbidity and death (42/91 – 46.2%) in 2014. TACO is under reported. The ISBT revised definitions need further work as the SHOT analysis demonstrated that they do not adequately capture all the cases
- **Delayed transfusions:** the numbers reported continue to increase with particular concerns around use of massive haemorrhage protocols and communication
- **Recommendations 2015:** There were two recommendations this year:

1) Revised recommendation - Transfusion at night

In 2003 50% of incorrect blood component transfusion errors occurred out-of-hours resulting in the recommendation not to transfuse at night unless clinically essential. This has been used as a 'rule' resulting in reports of symptomatic patients failing to receive necessary transfusions with serious impact on some patients including major morbidity or death (Annual SHOT report 2013). Overall, most errors are now made within working hours (defined by SHOT as 08:00-20:00).

SHOT maintains the recommendation that transfusions at night **must** take place if clinically indicated and with the same standards of care and observation as core hours.

Regularly transfused patients (e.g. those with thalassemia major, some sickle cell patients and renal patients) prefer transfusions to be accessible out of regular hours. Some day case units are offering extended working hours to facilitate transfusions for these patients, allowing them to continue to work, study and pursue a 'normal' life. This should be encouraged as long as staffing is adequate to support it.

2) Recommendation – UK blood services should avoid the use of female plasma in the production of cryoprecipitate whenever possible

FAST FACTS

100%

The number of NHS organisations registered to report to SHOT

77.8%

The percentage of reports that were error related received by SHOT in 2014

76.0%

The percentage of total anti-D reports related to late or omitted anti-D immunoglobulin in 2014



One case of TRALI in 2014 received a cryoprecipitate pool containing donations from 3 female donors who had HLA antibodies with 6 concordant specificities.

All UK Blood Services now use male donors to provide 100% fresh frozen plasma (FFP) and plasma for platelet pooling. SHOT suggests that this practice should be extended to cryoprecipitate production across all UK Blood Services.

The day was a great success and we received feedback from 309 delegate evaluations by the deadline (about 50% of all registrants) with 250/297 (84%) rating the content as 'excellent' or 'good'. UK delegates accounted for 43.4% (134/309) of those who completed evaluations. Most, 75%, of the delegates had registered for the full ISBT event, and 25% for the SHOT/Academy day only.



End of reporting of instances of alloimmunisation

SHOT has been collecting data on alloimmunisation since 2010, although always in a voluntary reporting category. It was introduced partly because ISBT has a defined category for Delayed Serological Transfusion Reaction (synonymous with alloimmunisation), and partly because cases were being reported as HTRs and having to be withdrawn by SHOT.

Pre 2012, a patient with a new antibody and a positive DAT post transfusion met the SHOT definition of Haemolytic Transfusion reaction (HTR) even where there was no biochemical or clinical evidence of haemolysis. This was changed in 2012 to categorise such cases as alloimmunisation rather than HTR. The number of reports of alloimmunisation has increased each year, and is likely to be the tip of the iceberg, as new cases are only recognised if a new sample happens to be tested at some point post transfusion.

Some interesting data have emerged over the last 5 years, demonstrating a different profile of antibody specificities to those reported in the HTR category. However, this picture is similar each year, and with the exception of new cases of anti-D resulting from deliberate transfusion of D positive components to D negative recipients, there have been no useful learning points or recommendations to be made.

Following a review by the Working Expert Group, SHOT has decided to stop collecting reports of alloimmunisation from January 2016. Reporters are requested to report cases of new antibody formation as HTRs, only where there is biochemical or clinical evidence of haemolysis. A new immune anti-D detected at any point in pregnancy should continue to be reported via the questionnaire on the SHOT website

<http://www.shotuk.org/reporting/anti-d-immunisation-reporting/>

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Annual SHOT Symposium 2016

Thursday 7th July 2016.

The Lowry Theatre,

Salford, Manchester

Keynote Speaker:

Eric Hollnagel

Resilience in Healthcare

Delegate registration deadline:

Wednesday 29th June 2016

Poster abstract submission deadline:

Friday 29th April 2016

For abstract instructions please see the SHOT website

www.shotuk.org

DIARY DATES

International Haemovigilance Seminar

Paris 9th-11th March 2016

Abstract submission deadline:

Friday 15th January 2016, 18:00 hours

<http://ihs-seminar.org/registration>

British Society for Haematology

18th-21st April 2016

BGS

12th-15th April 2016, Reading