



Welcome to the August 2024 SHOT Newsletter

ABO incompatible transfusions in 2023



There were **7** red cell ABOi transfusions reported in 2023



All due to clinical errors (**4** collection errors and **3** administration errors)



2 resulted in major morbidity, **1** minor morbidity, **2** deaths unrelated to transfusion and **2** patients had no clinical reaction



The **3** administration errors resulted from a lack of pre-transfusion safety checks which provide a final opportunity to detect mistakes prior to administration

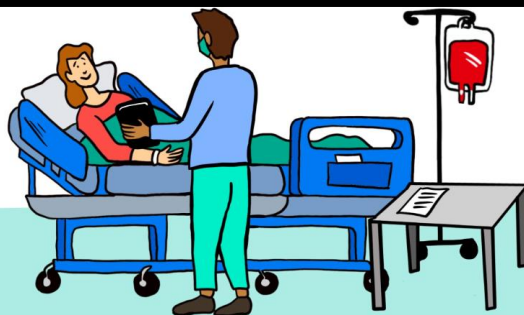


Worrying signals are emerging from the haemovigilance data with increasing numbers of preventable errors and potential harm incidents



Whilst it is encouraging to see improved haemovigilance reporting, it is evident that staff have absolutely no spare capacity and are stretched beyond breaking point with an increasing number at risk of burn out

PRE - TRANSFUSION SAFETY CHECKS PROVIDE THE FINAL OPPORTUNITY TO DETECT ERRORS AND ENSURE SAFE TRANSFUSIONS



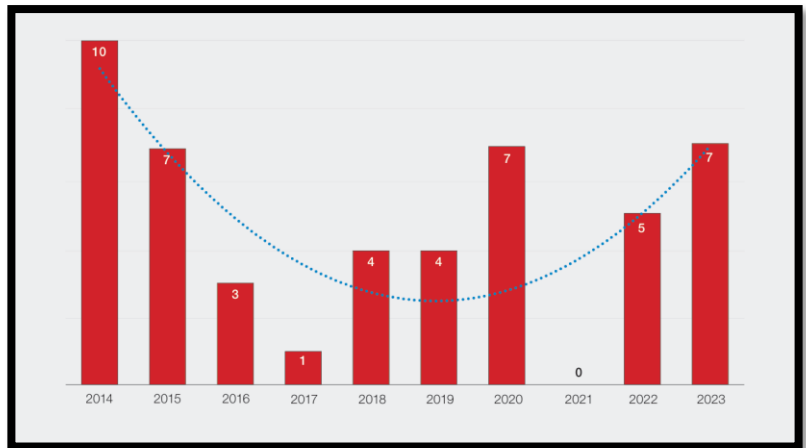
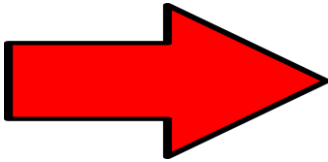
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Serious Hazards of Transfusion





This graph shows the concerning rise in ABOi red cell transfusions



Complete all the relevant checks when collecting the component and use a pre-administration checklist at the patient's side



Safe Transfusion Practice: Transfusion Checklist

Ensure that:	Signature to confirm
The reason for transfusion is documented in the patient record	
Details on the transfusion authorisation (prescription) sheet are completed and any specific requirements documented	
All fields on the transfusion request form are completed and the form is signed	
The identity details on the transfusion sample are completed correctly and samples labelled at the patient's bedside. These must be handwritten unless electronic systems are available that generate and print a label at the bedside from the patient ID band are available	
The patient has (and where appropriate family/carers have) received information, has agreed to the transfusion, and this is documented Or In cases where the patient is unconscious and/or unable to consent and the blood component is given in patient's best interest, ensure this is documented in the patient's notes, and information given retrospectively	
The laboratory is informed of the degree of urgency of the request	
Pre-Transfusion Checks	



P	PATIENT IDENTIFICATION Are all the details correct and match on sample/form/label/LIMS?
A	AUTHORISED Have all required tests been completed and authorised, including antibody investigation?
U	UNIT NUMBER Does the unit number match the compatibility label?
S	SELECTION OF COMPONENT Is it as requested? Is it ABO AND D compatible? Does it meet all specific requirements?
E	EXPIRY Will the unit expire before required date/time? Will sample expire before required date/time?

Look at your systems and what is in place to address any gaps

Are you reviewing and trending ABOi and WBITs?

PARTNERING WITH PATIENTS TO ENHANCE TRANSFUSION SAFETY



INFORM, INVOLVE, AND LISTEN TO PATIENTS TO IMPROVE SAFETY









Meet the Experts webinars

In a change from previous year's symposiums, the Meet the Experts sessions will be held as individual webinars throughout 2024/25.

Click [here](#) or in section below to register

Topic	Date	Time (GMT)	Register
Pulmonary Complications of Transfusion	Thursday 5 th September	13:00 - 14:00	https://us06web.zoom.us/j/92114967106
Transfusion-Transmitted Infections	Tuesday 29 th October	13:00 - 14:00	https://us06web.zoom.us/j/92114967106
Avoidable, Delayed & Under or Overtransfusion	Tuesday 12 th November	13:00 - 14:00	https://us06web.zoom.us/j/92114967106
Information Technology	Tuesday 17 th December	13:00 - 14:00	https://us06web.zoom.us/j/92114967106



Here is the link to the MTE webinar flyer:

<https://www.shotuk.org/meet-the-experts-webinars/>





SHOT e-learning modules

Have you visited the SHOT e-learning modules?

These have been developed and are relevant for all healthcare staff, clinical and laboratory, involved in the transfusion process. They have been created with funding support from the Health Education England and are designed to increase awareness about patient safety related to transfusion and the role of haemovigilance in transfusion safety.



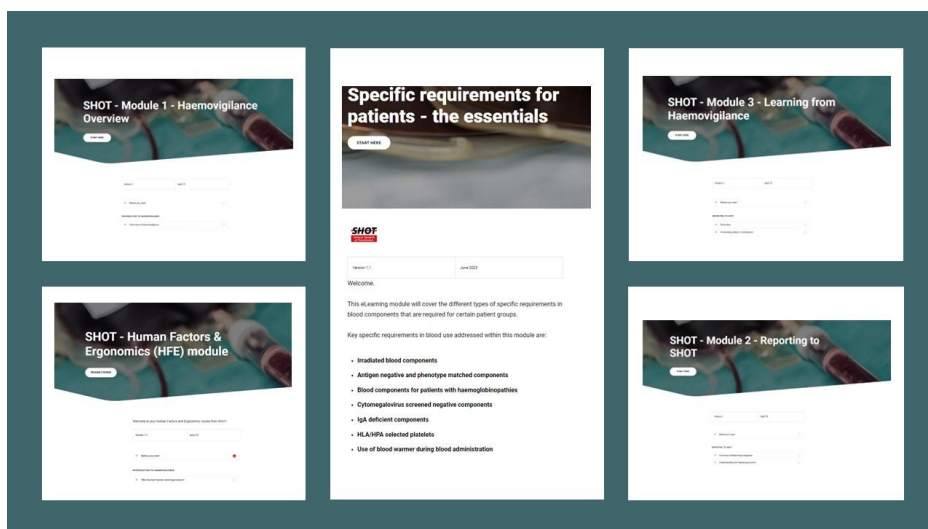
Available modules include:

Insights from SHOT for Safer Transfusion:

- Module 1 – Haemovigilance Overview
- Module 2 – Reporting to SHOT
- Module 3- Learning from Haemovigilance

Human Factors and Ergonomics (HFE) module

Specific requirements for patients – The essentials



The e-learning modules can be accessed on the **elfh Blood Transfusion Training programme** and on **ESR**. For more information please click here: [E-learning - Serious Hazards of Transfusion \(shotuk.org\)](https://www.shotuk.org)





2022 Key Recommendations Survey Report published



The Key Recommendations Survey aims to understand progress made in implementing Key SHOT Recommendations in UK Trusts/Health Boards.

SHOT would like to extend our sincere thanks to all reporters and those that responded to the survey.

Link here:



[SHOT Surveys - Serious Hazards of Transfusion \(shotuk.org\)](https://www.shotuk.org/shot-surveys-serious-hazards-of-transfusion)

Gap analysis for the 2023 Annual SHOT Report

A gap analysis tool and action plan for the new 2023 Annual SHOT Report recommendations is now available for use on the report page

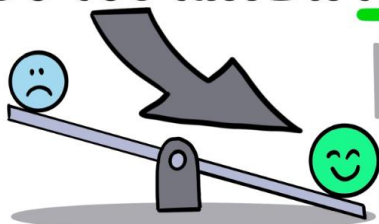
Link here: <https://www.shotuk.org/shot-reports/report-summary-and-supplement-2023/>

All the resources are available on the SHOT website and are free to access
[Home - Serious Hazards of Transfusion \(shotuk.org\)](https://www.shotuk.org)





DO YOU HAVE A RESTORATIVE JUST CULTURE?



WHO IS IMPACTED?

WHAT DO THEY NEED?

WHO IS GOING TO MEET THAT NEED?

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= STAFF CAN RAISE CONCERNS, SHARE INFORMATION OPENLY AND ARE TREATED FAIRLY

Look out for the SHOT team at the following events



HSJ PATIENT SAFETY CONGRESS 2024
16 - 17 September 2024 | Manchester Central, Manchester
The leading annual meeting for those at the forefront of safety, quality and clinical excellence

WE ARE PROUD EXHIBITORS

SHOT
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Find us at stand 34



2024 **BBTS** Conference

HSJ Patient Safety Congress
16 – 17 Sept. 2024
Manchester, UK

[Register](#)

Exhibition stand 34

BBTS Annual Conference
17 – 19 Sept. 2024
Glasgow, UK

[Register](#)

Exhibition stand, mini-SHOT Symposium

TODAY'S GOOD IDEA IS...



TOMORROW'S SAFER PRACTICE

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If you would prefer not to receive haemovigilance communications from SHOT, then please email SHOT.unsubscribe@nhsbt.nhs.uk and you will be removed from the distribution list.

