SHOT Newsletter January 2025

Happy New Year!

As we begin a new year, SHOT would like to wish everyone in the transfusion community a very Happy New Year!

Thank you to all our reporters who completed and closed off any outstanding SHOT reports before the end of 2024. It is much appreciated and ensures these cases can be included in the 2024 Annual SHOT Report data. The SHOT Team and our Working Experts are now collating and reviewing all reports, and preparing the 2024 Annual SHOT Report, due for release July 2025!

Meet the Experts Webinars

Do NOT miss the first SHOT webinar of 2025!

Click here to register

Meet the Experts: Human factors and Ergonomics in SHOT Error Incidents

Monday 20 January 2025 at 13:00 GMT

Join us for the next interactive meet the experts session on Zoom

A 20-30 min overview of chapter content:
Including trends, highlights and example cases

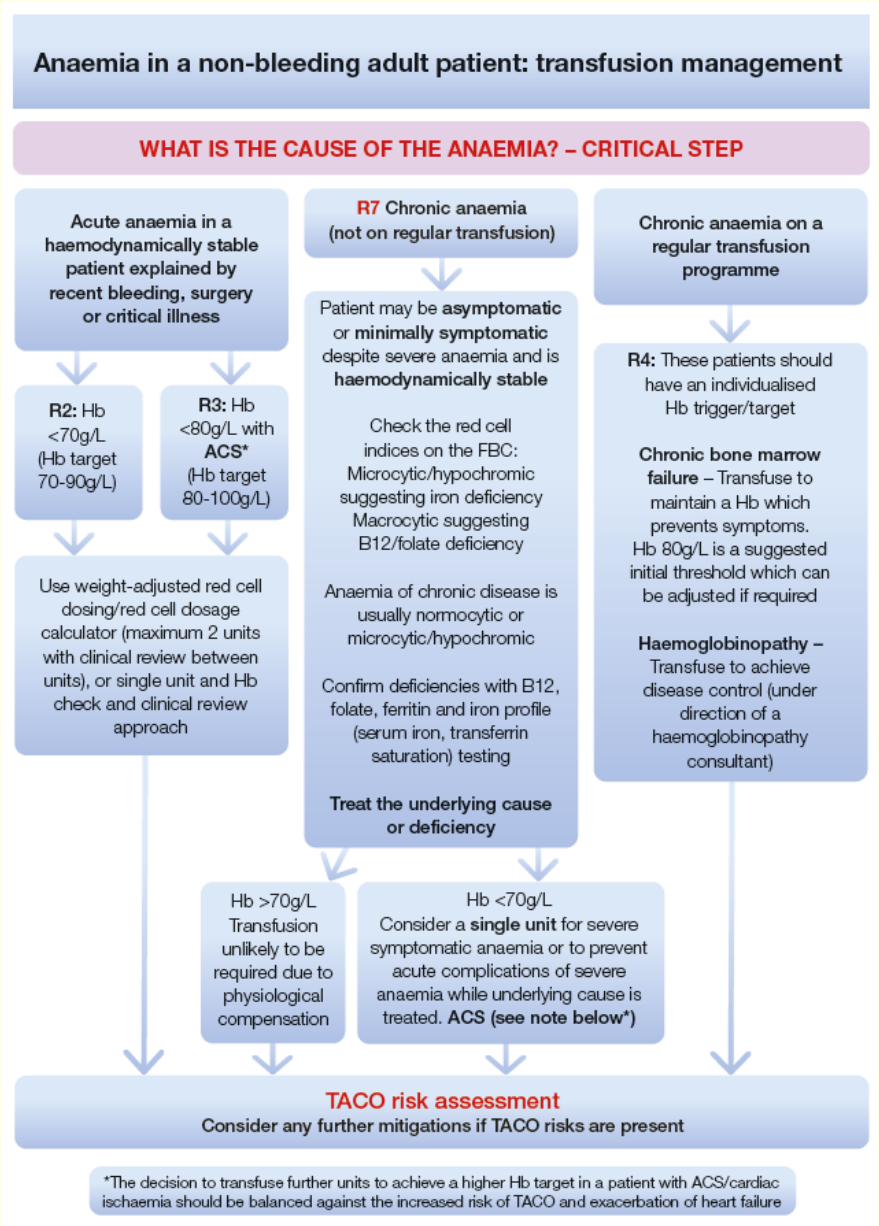
Followed by 30-40 minute Q&A:
We want to hear from you! Do you have any ideas about the human factors investigation tool, or our human factors resources?

New TACO anaemia management resource

The NBTC indication codes were recently reviewed against current evidence and republished.

The red cell codes R1-R6 have refreshed descriptions but remain broadly the same. **The main change is the addition of the R7 code which was introduced to highlight the appropriate management of patients with severe chronic anaemia**. It was clear from SHOT data that more needed to be done to help protect this vulnerable patient group from TACO.

Therefore, SHOT have produced a new TACO anaemia management resource, which comprises a decision flow-chart and explanatory text. This can be accessed by clicking on the image below or found in the TACO Cumulative Data page.



SHOT Bites

New SHOT Bite No.33 now available! Click the image below to access.

SHOT Bite No. 33
Plasma components & plasma products

SHOT Serious Hazards of Transfusion

January 2025

This document provides a summary of the plasma components and plasma products available for transfusion in the UK. It also provides guidance on how to report serious adverse reactions (SAR) and events (SAE) from transfusion of plasma components and plasma products according to the current SHOT reporting criteria i.e., cryoprecipitate, standard fresh frozen plasma (FFP) and solvent-detergent FFP (SD-FFP). In the UK, SD-FFP is currently available as a medicinal product licensed as OctaplasLG®.

Blood components versus blood/plasma-derived products: Donated blood is separated out into its various components where it is manufactured and tested via a blood establishment for patient use. Blood components are defined as a therapeutic constituent of blood such as FFP. Blood products are therapeutic substances derived from human blood and are usually produced commercially and packaged as plasma-derived medicinal products such as prothrombin complex concentrate & SD-FFP.

Specifications and clinical indications	PLASMA COMPONENTS		PLASMA PRODUCTS
	Standard FFP	Cryoprecipitate	OctaplasLG®
Donors per pack	1 donor	1 donor (pack) 5 donors (pool)	< 1520 donors
Storage & shelf-life (frozen)	≤ -25°C; < 3 years	≤ -25°C; < 3 years	≤ -18°C; < 4 years
Storage & shelf-life (thawed)	24 hours if stored at 4°C±2°C (pre-thawed FFP: <120 hours, only for unexpected major haemorrhage)	Room temperature (RT) (**NOT refrigerated**), must be used < 4hours, once thawed	5 days if stored at 2-8°C or 8 hours if stored at RT
Thawing temperature	33°C-37°C	33°C-37°C	30°C-37°C
Clinical indications (where to find it?)	British Society for Haematology guidelines on the spectrum of fresh frozen plasma and cryoprecipitate products: https://doi.org/10.1111/bjh.15167		

Haemovigilance reporting guidance

To whom should I report these cases?	SHOT	MHRA*
Serious adverse events (SAE) relating to FFP transfusion?	Yes	Yes *(if laboratory or BE▽ error)*
Serious adverse reactions (SAR) relating to FFP transfusion?	Yes	Yes
SAE relating to cryoprecipitate transfusion?	Yes	Yes *(if laboratory or BE▽ error)*
SAR relating to cryoprecipitate transfusion?	Yes	Yes
SAE relating to Octaplas LG® transfusion?	Yes	Yes *(via Yellow Card Scheme)*
SAR relating to Octaplas LG® transfusion?	Yes	Yes *(via Yellow Card Scheme)*
Examples of other plasmas products in clinical use		
SAR/SAE relating to fibrinogen concentrate administration?	No	Yes *(via Yellow Card Scheme)*
SAR or SAE relating to LyoPlas administration?	No	Yes *(via Yellow Card Scheme)*

*Medicines and Healthcare Products Regulatory Agency; ▽Blood Establishment

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Good practice guidance document for managing indeterminate ABO blood groups

What is this document about?

This good practice guidance document is based on existing UK guidance highlighting the importance of correctly understanding the reason for an 'indeterminate' blood group, resolving the blood group where possible and making the correct decisions for patient safety. This includes illustrative example cases based on previous reports to SHOT related to this issue.

Who is this for?

This guidance document is particularly aimed at hospital transfusion laboratory managers; transfusion IT (Laboratory Information Management System/LIMS and Electronic Patient Records/LIMS) providers; haematology medical staff and transfusion practitioners.

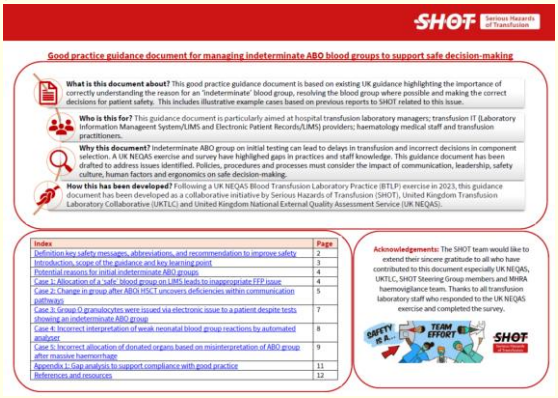
Why is this document needed?

Indeterminate ABO group on initial testing can lead to delays in transfusion and incorrect decisions in component selection. A UK NEQAS exercise and survey have highlighted gaps in practices and staff knowledge. This guidance document has been drafted to address issues identified. Policies, procedures and processes must consider the impact of communication, leadership, safety culture, human factors and ergonomics on safe decision-making.

How this has been developed?

Following a UK NEQAS Blood Transfusion Laboratory Practice (BTLP) exercise in 2023, this guidance document has been developed as a collaborative initiative by Serious Hazards of Transfusion (SHOT), United Kingdom Transfusion Laboratory Collaborative (UKTLC) and United Kingdom National External Quality Assessment Service (UK NEQAS).

Click on the image to access


SHOT Serious Hazards of Transfusion

Good practice guidance document for managing indeterminate ABO blood groups to support safe decision-making

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Index

	Page
Definition key safety messages, abbreviations, and recommendation to improve safety	2
Introduction, scope of the guidance and key learning point	3
Potential reasons for initial indeterminate ABO groups	4
Case 1: Allocation of a 'safe' blood group on LIMS leads to inappropriate FFP issue	4
Case 2: Change in group after ABO HSCT uncovers deficiencies within communication pathways	5
Case 3: Group O granulocytes were issued via electronic issue to a patient despite tests showing an indeterminate ABO group	7
Case 4: Incorrect interpretation of weak neonatal blood group reactions by automated analyser	8
Case 5: Incorrect allocation of donated organs based on misinterpretation of ABO group after massive haemorrhage	9
Appendix 1: Gap analysis to support compliance with good practice	11
References and resources	12

Acknowledgements: The SHOT team would like to extend their sincere gratitude to all who have contributed to this document especially UK NEQAS, UKTLC, SHOT Steering Group members and MHRA haemovigilance team. Thanks to all transfusion laboratory staff who responded to the UK NEQAS exercise and completed the survey.

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.