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SERIOUS HAZARDS OF TRANSFUSION SHOT

NEWSLETTER

New SHOT database from Dendrite

In the very near future reporting to SHOT will be transferred from the online questionnaires on SABRE to the new SHOT online database. The initial reporting procedure will not change very drastically. Reporters will still make the initial report via SABRE and will agree to share their report with SHOT or they can make a SHOT only report. Within a couple of days of your initial report via SABRE you will receive an email from the new database containing a link to a record that will have already been created in the new database ready for you to fill in further details of your case.

In order for this to happen smoothly you will need to have registered with the new SHOT database using the email address that you use as the SABRE login. Ideally, all SHOT reporters should register with the new database in advance of sending their first report and quite a number of people have already done this having picked up registration forms at the SHOT symposium in June. If you haven't completed your form, please do so now and return it to the SHOT Office. If you haven't received a registration form, please contact the SHOT office and they will send you one.

The new online reporting system will make analysis of SHOT reports much faster and also allow much more detailed analysis to take place. The new system will also be collecting demographic data and some baseline data about numbers of units issued which are at the moment only going to MHRA.

Before the launch of the database, if you have returned a registration form you will receive a password for the database as well as user documentation for the database. Please note that copies of the documentation will be available via the database and from the SHOT website after the database is launched

Participation in SHOT

For the first time a chapter was published in the recent SHOT report (2008 Annual Report published June 2009) giving a breakdown of participation in SHOT by the four UK countries as well as the 10 regions from England. SHOT has been asked by the UK Forum to begin the process of de-anonymisation of SHOT data. Individual staff and patient identification remain utterly confidential but a breakdown of the number of reports by reporting organisation and within regions will now be developed. This will allow for benchmarking between comparable sized trusts or those with comparable speciality work loads. We anticipate that these data will enable individual HTTs as well as RTCs to identify the barriers to reporting and to try and encourage more comprehensive reporting. Data from SHOT over the last 12 years (also printed in the 2008 Annual Report) show the enormous benefit of gathering adverse incident data. The data shows how over time the number of serious incidents and the overall mortality rate from transfusion has dropped in spite of a year on year increase in the number of reports made to SHOT. This is the hallmark of an effective vigilance system, which will continue to become more and more effective with increasing participation in the scheme .

The data can be viewed in the SHOT report available online on the SHOT website: www.shotuk.org

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Inside this issue:

UK Transfusion Laboratory Collaborative

The recommended minimum standards for hospital transfusion laboratories have been published in the August edition of Transfusion Medicine (vol 19, p156-158) together with an editorial.

This is downloadable as an Open Access article from: http://www3.interscience.wiley.com/cgi-bin/fulltext/122573960/PDFSTART .

They have also been published in the Biomedical Scientist (vol 53, p 744-745). The paper contains 3 main groups of recommendations for hospital blood transfusion laboratories relating to staffing levels, technology, and training and competence. Copies are being sent with a covering letter to Chief Executive Officers of hospitals and trusts for action, Consultant Haematologists responsible for blood transfusion and Transfusion Laboratory Managers for information, as well as all other interested parties nationwide.

The standards are supported by the Chief Medical Officer of England and have been signed off by the key collaborators, i.e. the IBMS, Royal College of Pathologists, CMO's NBTC, UK NEQAS, BBTS and SHOT. It is expected that there will be a web based resource to support the implementation of and compliance with the recommendations of the laboratory collaborative. Until this is available, regular updates on and clarification about these recommendations will be made available to Laboratory Managers electronically and will be published in the *Biomedical Scientist*. At this stage, should you require further clarification or have specific comments, please email shot@nhsbt.nhs.uk.

Staff Update

During September, candidates for the Laboratory Incidents and Clinical Incidents Specialist posts were interviewed and we anticipate that these new staff will be in post before the end of the year. Apart from the day to day role in overseeing the incidents coming in to the new SHOT database in both clinical and laboratory categories, the new staff will be involved with specific studies and audits including prospective data collection in particular areas of concern which have been identified by SHOT reports. With these staff in place the SHOT team will be more comprehensive and we are looking forward to being able to produce additional and more informative data analysis.

NPSA & SPN 14

SHOT is working with NPSA and the CMO's NBTC to support trusts in the implementation of NPSA SPN 14 'Right patient, right blood' following feedback from the SPN support group. Key themes that have emerged include: a) competency assessment should not be onerous to those carrying out the training; b) a comprehensive database of all staff assessed needs to be maintained; and c) inclusion of competency assessment as an education governance key performance indicator. A toolkit to support transfusion practitioners, which will include examples of successful approaches, should be available in November 2009. A 'how to implement' guide and checklist for chief executives has been developed to get chief executives on board with the requirements of the SPN and need for support.

Previously Uncategorised Complications of Transfusion

The new Dendrite online reporting system for SHOT includes a category for 'previously uncategorised complications of transfusion'. This is very important as it allows for things not yet encountered or not previously thought of to be reported, so that early identification of a new trend may be possible. For example, this might be useful if a decision were made to introduce prion filters in the UK. It is possible that such filters could produce adverse events or reactions in some patients, but unless reporting of such new incidents is centralised a pattern is very difficult to identify.

If reactions and events relating to prion filters were reported to SHOT in the PUCT category any trend could be identified early.

If you have any odd reaction or event that does not fit into the other reporting categories please report it under PUCT, but if you are in any doubt about what to report or where to report it please contact the SHOT office staff on 0161 423 4208.

Reports of Under Transfusion

There has been a great deal of interest in patient morbidity and mortality resulting from under transfusion, particularly following a publication from France. (Survey of anesthesia-related mortality in France. Anesthesiology, 2006 105 (6) 1087– 1097). Those working in the clinical area may have been aware of cases in which under transfusion could have been contributory to poor patient outcome. For the first time in the 2008 Annual SHOT Report there was one case (in the inappropriate and unnecessary transfusion chapter) which related to under transfusion.

SHOT would very much like to develop this category and welcomes all reports of patient harm or suboptimal clinical outcome as a result of delayed transfusion or under transfusion. At present such reports should be reported in the inappropriate transfusion category.

Donor Adverse Events

MHRA, at its recent Blood Consultative Committee meeting in July, opted to request the donor adverse event data from those collecting it within the four UK blood services to collate it and submit it to the EU Commission. This will act as a starting point for collection of donor adverse event data under the EU Directive. At the present time the EU Commission has stated that sending of such data is entirely voluntary as it does not yet have a plan or a database for analysis of donor adverse incidents. MHRA are keen to get the ball rolling and see what sort of data we have and whether it is comparable with that produced across Europe. This will prove a positive exercise and will allow for standardisation of reporting categories allowing for meaningful comparisons to be made between European countries.

SHOT is actively considering collection of donor adverse event data in the future. This would involve a second phase of development from the donor perspective once the new database is fully operational from the patient point of view.

SHOT Symposium Report

The SHOT Annual Symposium took place on 30th June 2009 at the Royal Society of Medicine in central London. The meeting was very well attended and the venue was much praised by the delegates. The day was introduced by Dr. Lorna Williamson, Medical Director of NHSBT. There followed two talks presenting a summary of all the SHOT data from 2008, given by Dr. Hannah Cohen (SHOT Steering Group Chair) and Dr. Clare Taylor (SHOT Medical Director). In 2008 there were 85% more cases reported to SHOT than in 2007 i.e. a near doubling of the number of reports. This affected virtually every reporting category except for TTI. There was a continuing decrease in the number of serious adverse events and reactions reported and these two trends together are the hallmark of an effective vigilance system (i.e. the increase in the participation in the scheme with an increasing number of reports, but a concomitant decrease in the number of severe events reported). There was one death in 2008 as a direct consequence of transfusion, due to a transfusion transmitted bacterial infection from platelets. There were 9 deaths where a transfusion reaction was contributory to a patient's death, 2 in the inappropriate and unnecessary transfusion category, 4 acute transfusion reactions, 1 haemolytic transfusion reaction, 1 TACO and 1 other TTI. There were 10 ABO incompatible red cell transfusions which again is very low considering the big increase in reporting in 2008.

The Near Miss data in the 2008 SHOT report related to a pilot of samples rejected by laboratories because of inadequate or incomplete labelling. Overall 3.8% of samples are rejected across the UK transfusion laboratories, although the range of the number of rejections is very wide. Wrong blood in tube errors were detected in 74 of 90 cases by comparison with historical records. The involvement of junior doctors in cases involving erroneously labelled samples seemed disproportionately high.

The recommendations from the 2008 SHOT report particularly revolve around a need for standardisation of policy and practice across all institutions where transfusion is taking place. This includes awareness of criteria for reporting adverse events and reactions, a national minimum specification for transfusion laboratory IT systems, and a standardisation of the teaching of transfusion competency and competency assessment which should be transferable between different institutions.

The keynote session at the SHOT symposium was given by Dr. Deborah Gill from ACME, UCL who gave a lively and informative talk and demonstrated different teaching techniques which can be applied to large and small group lecturing and tutorials.

The session was enormously enjoyable and gave everybody in the auditorium food for thought and new techniques to try out, which many were very eager to do as soon as they got back to their base.

Anyone who is interested in further teaching skills training can find details at: www.ucl.ac.uk/silva/dome/acme

Academic Centre for Medical Education

During lunchtime there was poster viewing of the 10 posters which had been selected from those submitted to SHOT for the meeting. Professor Mike Murphy gave a summary of each of the posters in his post lunch talk and then awarded the prize for the best poster to Heather Daniels, Transfusion Practitioner, Monklands Hospital for her poster entitled "Changing the habits of a lifetime!" All the posters and their abstracts are viewable on the SHOT website.

There was a talk from Richard Haggas, BMS at Leeds General Hospital about effective participation and reporting to SHOT and SABRE. This fitted in very well with SHOT's current drive to improve participation and dissolve barriers to reporting both from hospital clinical areas and from laboratories. Dr. Dafydd Thomas then gave a talk about putting guidelines and recommendations into practice using the example of a massive haemorrhage protocol. The final talk of the day consisted of David Mold, SHOT Operations Manager, presenting participation data from UK haemovigilance. These data are still at an early stage of development but more detail will become available especially once data from the new database are being analysed.

All of the presentations are available on the SHOT website.

Heather Daniels, TP. Monklands Hospital, with Prof Mike Murphy

SHOT Steering Group Report

Details of the membership of the Steering Group (SG) are available on the SHOT website and the SHOT office staff are in the process of gathering brief biographical details along with a photograph of each member . All this will be available on the website shortly.

The SHOT Steering Group and Working Expert Group (WEG) meeting took place on April 2nd 2009 at the Royal College of Pathologists. New members to the SHOT Steering Group were welcomed and these can be found listed on the SHOT website. The terms of reference for the SG and the WEG were discussed and agreed and the final version should be signed off at the next meeting in October 2009. There was an update on recruitment to the two new posts for the SHOT office team, the Laboratory Incidents Specialist and the Clinical Incident Specialist and an update on the development of the new Dendrite web based data collection system.

Publications submitted and abstracts to external meetings were discussed as well as the progress of the report from the UK Transfusion Laboratory Collaborative.

There was an update on UK haemovigilance including the current position of the MHRA which is in the process of recruiting a Haemovigilance Specialist with clinical expertise together with the construction of an expert advisory panel. The afternoon of the meeting was devoted to a detailed discussion of all the draft chapters for 2008 Annual SHOT report which was published on 30th June 2009, the date of the SHOT Annual Symposium. A report of the SG meeting on 16th October 2009 will appear in the next Newsletter.

Discussion Forum

The use of aliases by hospital patients.

There has been ongoing concern from some of the RTCs (especially London) about the practice by patients of using alternative names in order to conceal their well known or celebrity status or occasionally because they do not wish medical records to be linked between hospitals. This problem has of course very worrying implications for transfusion practice in terms of patient identification and retrieval of historical transfusion data.

The broader picture has implications regarding prescriptions, investigations, and procedures and ultimately this is an issue for trusts, in relation to fraudulent use of NHS services in some cases.

PLEASE do report any transfusions to patients using aliases using the IBCT category. Send any comments on this subject by email to the SHOT mailbox.

Diary Dates

- AABB. 24th – 27th October 2009. New Orleans, America. AABB Home *(www.aabb.org)*
- IHN . 17th – 19th February 2010. Dubrovnik, Croatia. International Haemovigilance Network (previously European Haemovigilance Network) (*www.ehn-org.net)*
- NATA 8th – 9th April 2010. Barcelona, Spain. NATA > Welcome to the Network for Advancement of Transfusion Alternatives *(www.nataonline.com)*
- BSH 19th – 21st April 2010. Edinburgh, Scotland. British Society for Haematology (*www.b-s-h.org.uk)*
- EHA 10th – 13th June. Barcelona. Spain. E H A | European Hematology Association (*www.ehaweb.org)*
- ISBT 26th June – 1st July 2010. Berlin, Germany. ISBT-WEB.ORG *(www.isbt-web.org)*
- BBTS 9th-11th September 2010, Bournemouth, England. www.bbts.org.uk
- **SHOT Annual Symposium. Tuesday 6th July 2010. The Lowry, Manchester.** www.shotuk.org