



SHOT Newsletter May 2025

Annual SHOT Symposium 2025

Friday 11 July , Hilton Birmingham Metropole, Birmingham B40 1PP



Early bird rate of **£120** is available when registration information and payment received before **30th May 2025**.



30 Abstracts received, with thanks!

Thank you to all those who have submitted abstracts for the symposium. They are now with our judges.



Thank you to those who applied for a free bursary place. We will be in touch by Monday 19 May to let you know our decision.



Last few remaining spaces for exhibitors!
If you know of anyone who may be interested, please ask them to contact SHOT.symposium@nhsbt.nhs.uk

Don't forget to register now and pay the early bird rate!

[Click here to register now!](#)





Annual SHOT Symposium 2025

Join us for an engaging and inspiring event, featuring insightful discussions, presentations from expert speakers, and valuable networking opportunities.

This symposium will be relevant to all health care professionals involved in transfusion – Laboratory Staff, Clinicians, Transfusion Practitioners and Haemovigilance Specialists, as well as Quality Assurance Professionals.

This year's **Debate question** will be: Should written consent be mandatory for patients receiving elective transfusions? Will it improve shared decision making? With Dr Cath Booth & Dr Damien Carson



2024 Annual
SHOT Report
official launch!

SHOT Team will
present interactive
case studies

Dr Shruthi Narayan (SHOT
Medical Director) will present
key highlights

Other sessions will include:

- Insights from patients and donors
- Introduction to CODONET
- Just-a-Minute Poster Session
- Paediatric Haemovigilance
- Staff fatigue





MTE Virtual Sessions



Join us for interactive 'Meet The Experts' sessions on Zoom

**Incorrect Blood Component Transfused
Wednesday 21 May 2025 at 13:00 BST**

**Click here to register
for this event**

**Near Miss Reporting & WBIT
Monday 09 June 2025 at 13:00 BST**

**Click here to register
for this event**



A 20-minute overview of chapter content:

Including trends, highlights and example cases



Followed by 40-minute Q&A:

We want to hear from you!

- What are your urgent questions?
- How have you improved practice in your area?



Important note: To get the most out of the session, please read the relevant chapter from the latest [Annual SHOT Report](#), come prepared with any queries you have for our experts, or email them to the SHOT team beforehand: shot@nhsbt.nhs.uk



Recordings: To access the recordings of previous Meet The Experts sessions, [please click here](#).





Cautionary Tales

The SHOT team have launched a new series of educational material called 'Cautionary Tales', which will highlight specific areas of practice. These may include cases that are not yet published in Annual SHOT Reports. The intention is to learn from the past to shape a safer future.

These anonymised cautionary tales highlight real-life issues and offer valuable lessons to improve transfusion safety and promote shared learning. Please cascade widely – every lesson learned can save a life.

SHOT Serious Hazards of Transfusion

SHOT Cautionary Tales

No 1. Transfusion of Damaged Components (April 2025)

Sharing learning from events reported to SHOT across the transfusion pathway

Background

- Concerning practice has been identified, where a blood component pack was unintentionally damaged, but the transfusion of that component continued
- This poses risk of contamination (microbiological and others)
- This topic is being highlighted following a pattern of deviations from safe practices, and repeated incidents reported within a short timeframe

Case Descriptions

Note: The patients in the cases below did not suffer any adverse clinical consequences. Appropriate escalation, investigation and corrective actions have been taken locally.

Case 1: Leaking platelet pack plugged with finger during transfusion

When hanging a unit of platelets for routine transfusion, two nurses noticed the pack was leaking. With the intention of avoiding wastage, the nurse took turns with a supernumerary student nurse to block the holes with their gloved fingers whilst the transfusion completed for approximately 30 minutes. The patient was informed that the pack was leaking and that was why the nurses were holding it. The empty unit was returned to the laboratory post-transfusion to identify the source of the leakage, which was found to be a second port being opened.

Case 2: Non-sterile clamp used to seal pierced blood component during an emergency

During an emergency transfusion for an upper gastrointestinal bleed, a unit of fresh frozen plasma was administered which had been pierced during initial spiking. A non-sterile clamp was used to seal the puncture, and the second port was used for administration. The giving set was also noted to be leaking during transfusion, and this was replaced with a non-blood giving set. The decision to continue with the transfusion was made by the doctor considering the emergency situation.

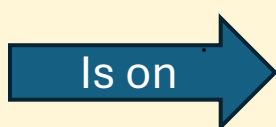
Case 3: Surgical tape used to cover leaking platelet pack

During the administration of platelets in the emergency department, a bank staff member accidentally punctured a hole in the pack with the giving set. Instead of discarding the platelets, they placed a piece of surgical tape over the hole to avoid the 'platelets dripping on the floor' and continued with the transfusion.

SAFETY IS PARAMOUNT. IT IS EVERYONE'S RESPONSIBILITY. ALWAYS PUT SAFETY FIRST.

SHOT Serious Hazards of Transfusion

Social Media



Please [follow us on LinkedIn](#) to stay up to date on news, resources, and all latest information on haemovigilance and blood transfusion safety.





Forthcoming events

Forthcoming events where SHOT is presenting sessions, posters and/or oral abstracts. Click on the images for more information.



BBTS Annual Conference
14-16 October 2025
Harrogate Conference
Centre






IHN webinar focus on donor vigilance

**Tuesday 10 June 2025
12:30 to 14:00 CEST**

Enhancing donor safety, strengthening healthcare

Join us for an engaging webinar!

Don't miss this opportunity to connect with experts, learn about key topics, such as

- serious cardiovascular and neuromuscular events in blood donors and
- donor adverse events related to plasma donations

Connect! Ask questions! Make a difference!



International Haemovigilance Network

Follow the link below to register



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.

