UK Blood Services: Definitions of current SHOT reporting categories & what to report

SHOT
Serious Hazards of Transfusion

The SHOT definitions document is reviewed and updated annually. Further information on reporting to SHOT can be found at this link: https://www.shotuk.org/reporting/. For any additional queries please email SHOT@nhsbt.nhs.uk.

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All items are hyperlinked to relevant parts of the document- please click on the item you wish to explore further.

Examples included under 'What to Report' are for illustrative purposes and are not an exhaustive list. Please contact us by emailing shot@nhsbt.nhs.uk if you are still unsure which category to report under after using this document.

Scope of SHOT Reporting by UK Blood Services

Consensus statement:

Errors that occurred in the diagnostic laboratories and issuing departments in the UK Blood Establishments that led to erroneous results given, or blood components issued to healthcare organisations with ***potential to cause harm*** *to patients.*

What is involved?

Any error made by blood services falling under the definitions as defined in this document requires reporting to SHOT, regardless of whether a component has been transfused, this includes incorrect clinical advice. If an error is not detected by the quality system prior to dispatch of a component from the blood service, then it should be reported to SHOT.

This includes errors which originate in:

- Diagnostic Laboratories (including red cell and platelet reference laboratories, and histocompatibility and immunogenetics laboratories)
- Issuing departments

The categories of error in which blood services are expected to report to SHOT will be reviewed in collaboration with blood services and may be subject to annual change. Please ensure you are using the most up to date version of definitions.

ACKNOWLEDGING CONTINUING EXCELLENCE		
TERM	**DEFINITION**	**WHAT TO REPORT**
ACE **(Acknowledging Continuing Excellence)**	Exceptional transfusion practice by a team or department, that was above and beyond routine practice and has widespread learning opportunities. Please do not name individuals within reports, the staff group (e.g., BMS, or Transfusion Practitioner) should be used where required. All reports should have been shared and discussed at the Senior Management Team, Senior Clinical Group (SMT/SCG) or at equivalent level before submitting to SHOT. *NB – SHOT encourage local processes to be put in place to recognise excellent contributions by individuals and sharing best practices between teams. Please focus on team or departmental excellence and avoid individual compliments unless they have widespread learning opportunities.* ***Reporting in this category will not be included in participation data for SAE and SAR. All SAE/SAR must also be reported to SABRE and SHOT as normal.***	This category currently includes excellence within: • Transfusion Practice - Clinical • Transfusion Practice – Laboratory • Education & Research • Audit • Patients, public, donors, stakeholders or hospitals engagement • Teamwork and collaboration with internal and external organisations Examples include: • Innovative solutions to previous adverse events (all SAE/SAR must also be reported to SABRE and SHOT as normal) • Implementation of new procedures with positive patient outcomes • Multidisciplinary collaboration and communication • Patient involvement in agreeing individual transfusion treatment plans For illustrative examples of ACE reports please visit https://www.shotuk.org/reporting/ace-reporting/

ADVERSE EVENTS		
TERM	**DEFINITION**	**WHAT TO REPORT**
IBCI-WCI **(Incorrect Blood Component Issued – Wrong Component Issued)**	Where a blood component was issued by blood establishments: a) of an incorrect blood ABO/D group b) which was incompatible with the recipient c) which was intended for another patient but was fortuitously compatible with the recipient d) other than that prescribed, e.g., platelets instead of red cells ***NB** – Cases involving failure to provide patient-specific requirements such as extended phenotype, irradiated or CMV-seronegative components should be reported in the IBCI-SRNM category.* *Do **NOT** report if the blood component was not issued or if clinical decision had been taken **BEFORE** any blood component was issued to knowingly provide components not meeting specification in view of clinical urgency.*	This category currently includes: • Blood component issued to a different patient to the one the order was intended for • Blood component of an incorrect group issued due to errors in the transfusion process • Incidents where a patient has a transfusion reaction as a result of an IBCI-WCI or IBCT-WCT, these are reported under IBCI-WCI by the blood establishments and under the relevant SAR category by hospitals (except for haemolytic reactions due to an ABO-incompatible transfusion, which hospitals should report as IBCT-WCT) Example of errors which may contribute to IBCI-WCI include: • Failure to provide appropriate blood group following allogeneic haemopoietic stem cell transplant or solid organ transplant (known history) • Testing and procedural errors associated with ABO/D grouping or crossmatching • Component selection errors including incorrect component selected from stock (includes adult units to neonates) • Failure to supply high titre negative group mismatched platelets or plasma components • D-positive component given inadvertently to D-negative patient (e.g., as a result of incorrect sex/gender allocation) • Distribution errors, for example blood dispatched to a different hospital than the one intended for

ADVERSE EVENTS		
TERM	**DEFINITION**	**WHAT TO REPORT**
IBCI-SRNM **(Incorrect Blood Component Issued – Specific Requirements Not Met)**	Where a blood component was issued by the blood establishment that did not meet the patient's specific transfusion requirements. *Do **NOT** report if the unit has not been issued or if clinical decision has been taken **BEFORE** any blood components were issued to knowingly provide components not meeting specification in view of clinical urgency.*	Issue of a blood component of inappropriate specification or that did not meet the patient's individual requirements – due to error in blood establishments Examples currently include *failure to provide:* • Cytomegalovirus (CMV)-negative components • Irradiated components • Human leucocyte antigen (HLA) or human platelets antigen (HPA)-matched platelets • Antigen-negative red cells for patients with known irregular red cell antibodies • Incorrect specification of component issued to a hospital as a result of incorrect sex/gender allocation (e.g., K negative not provided) • Failure to issue red cells of correct phenotype in accordance with national guidelines e.g., haemoglobinopathy, patients with childbearing potential • Failure to correctly identify a special requirement by the blood establishment Also: • Where full transfusion history is known, testing or release of components when the sample is not within recognised time frames for validity • Release of components prior to completion of laboratory testing (including internal quality control)

OTHER REPORTING CATEGORIES		
TERM	**DEFINITION**	**WHAT TO REPORT**
ANTI-D Ig errors for blood services	Events relating to errors with results and dosage of anti-D immunoglobulin (Ig) in the blood establishments that have the potential to cause D-immunisation or lead to unnecessary administration. ***Please note*** that this category now includes events relating to the administration of anti-D Ig following inadvertent transfusion of D-mismatched red cells or platelets, as per national guidance as well as D-mismatch solid organ transplants. ***NOT SHOT REPORTABLE*** • *Cases where the sample is received in a timeframe that prohibits the blood establishment to provide results within national guidance (late referral)* • *Cases where the blood establishments provided anti-D Ig to hospitals for stock replacement (not issued to specific patients)*	Examples include: **Omitted or administered late (>72 hours following Potentially Sensitising Event (PSE)) due to** • Delays in testing or in provision of results (excluding late referrals) to the referring hospital • Delays in stock replacement (NI only) **Incorrect/insufficient dosing advised or unnecessary administration due to** • Errors in testing including errors in IQC, methodology (e.g., incorrect gating), processes (e.g., second check not performed) or consumables • Errors in misinterpretation of results including misclassification of D variant and weak D patients • Transcription errors/transposed results leading to incorrect manual entry of results and/or dose advised to wrong patient • Miscommunication with clinical (e.g., blood services consultant) and/or blood transfusion laboratory teams • Failure to provide correct dosing following D-positive blood components transfusion or D-mismatch SOT • Inappropriate route of administration (IM/IV) advised • Inadequate advice regarding follow-up of fetal cell clearance post sensitising event or post delivery **To note:** Dosing differs between neonates/infants and adults; incidents where the incorrect dose was advised due to miscalculation or failure to consider correct dosing requirement as per national guidance are SHOT reportable

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