



# Blood Services reporting to SHOT

Incorrect Blood Component Issued (IBCI) – Wrong  
Component Issued (WCI) questionnaire

The questionnaire is not to be used, shared or  
modified outside the remit of the project

# Page 1 – Blood Establishment – IBCT event

## Key details of the IBCT event

Question	Answer Options	Data Type
Was there an error	<ul style="list-style-type: none"> <li>• With the collection of the pre-transfusion sample (Wrong blood in tube)</li> <li>• In the hospital transfusion laboratory</li> <li>• In the blood establishment</li> <li>• In collecting the component from the hospital storage site</li> <li>• In the bedside administration of the component</li> </ul>	Multi choice
When selected 'in the blood establishment' in the question above the following question will appear		
What was the Blood Establishment error	<ul style="list-style-type: none"> <li>• Inappropriate component</li> <li>• Incorrect serology result</li> <li>• Unit wrongly labelled</li> <li>• Wrong clinical advice</li> <li>• In the request (frozen blood bank)</li> <li>• Other (please specify)</li> </ul>	Multi choice
Other error		Free Text
What was the outcome of the error	<ul style="list-style-type: none"> <li>• ABO incompatible</li> <li>• D mismatch</li> <li>• ABO non identical</li> <li>• ABO identical</li> <li>• Wrong component type</li> <li>• Other (please specify)</li> </ul>	Multi choice
Please specify other		Free Text
Was this patient the intended recipient	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>	Single choice
Was there a request for this patient	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>	Single choice
How was the error discovered	<ul style="list-style-type: none"> <li>• Acute adverse reaction (&lt;24 hours)</li> <li>• Delayed adverse reaction (&gt;24 hours)</li> <li>• Detected by ward staff</li> <li>• Detected by hospital laboratory staff</li> <li>• Detected by diagnostic laboratory staff in BE</li> <li>• Detected by issuing department staff in BE</li> <li>• Detected by patient</li> <li>• Detected by patient's relative</li> <li>• Other (please specify)</li> </ul>	Single choice
Specify how it was detected		Free Text

## Page 2 – Blood Establishment – IBCT event

Key details of the IBCT event cont...		
Question	Answer Options	Data Type
State the ABO group and D type of the patient who the component was issued for	<ul style="list-style-type: none"> <li>• A-</li> <li>• B-</li> <li>• AB-</li> <li>• O-</li> <li>• A+</li> <li>• B+</li> <li>• AB+</li> <li>• O+</li> <li>• Other (please specify)</li> </ul>	Single choice
Other		Free Text
State the ABO group and D type of the blood component which was issued	<ul style="list-style-type: none"> <li>• A-</li> <li>• B-</li> <li>• AB-</li> <li>• O-</li> <li>• A+</li> <li>• B+</li> <li>• AB+</li> <li>• O+</li> </ul>	Single choice
How many units of the 'wrong component' issues	<ul style="list-style-type: none"> <li>• 1 unit</li> <li>• 2 units</li> <li>• Other (please specify)</li> </ul>	Single choice
Specify other		Integer
Please give the expiry dates of the unit/s issue		Date
Was there an error in the diagnostic laboratory	<ul style="list-style-type: none"> <li>• <a href="#">No</a></li> <li>• <a href="#">Yes</a></li> </ul>	Single choice
Was there an error in the issuing department	<ul style="list-style-type: none"> <li>• <a href="#">No</a></li> <li>• <a href="#">Yes</a></li> </ul>	Single choice

The component issued		
Question	Answer Options	Data Type
Which were the correct intended component types	<ul style="list-style-type: none"><li>• Red cells</li><li>• Platelets</li><li>• Plasma products</li><li>• Granulocytes</li><li>• None</li></ul>	Multi choice
Decision Point – the following questions will be dependent on the answer to the question above		
Which were the correct intended red cell components	<ul style="list-style-type: none"><li>• Red cells</li><li>• Irradiated</li><li>• CMV negative</li><li>• Washed</li><li>• Whole blood</li><li>• For intra-uterine transfusion</li><li>• For neonatal use</li><li>• For exchange transfusion</li></ul>	Multi choice
Which were the correct intended platelet components	<ul style="list-style-type: none"><li>• Pooled</li><li>• Apheresis</li><li>• CMV negative</li><li>• Irradiated</li><li>• HLA matched</li><li>• HPA matched</li><li>• Hyperconcentrate for IUT</li></ul>	Multi choice
Which were the correct intended plasma components	<ul style="list-style-type: none"><li>• FFP</li><li>• Solvent detergent FFP</li><li>• Cryo-depleted FFP</li><li>• Cryoprecipitate</li></ul>	Multi choice
Which were the correct intended granulocyte component	<ul style="list-style-type: none"><li>• Buffy coat derived</li><li>• Apheresis</li></ul>	Multi choice
Was this type of component issued	<ul style="list-style-type: none"><li>• Yes</li><li>• No</li></ul>	Single choice
If answered 'no' to the question above the following question will appear		
Which wrong components were issued	<ul style="list-style-type: none"><li>• Red cells</li><li>• Platelets</li><li>• Plasma products</li><li>• Granulocytes</li></ul>	Multi choice
The following questions will appear depending on the answer to the question above		
Which wrong red cell components were issued	<ul style="list-style-type: none"><li>• Red cells</li><li>• Irradiated</li><li>• CMV negative</li><li>• Washed</li><li>• Whole blood</li><li>• For intra-uterine transfusion</li><li>• For neonatal use</li><li>• For exchange transfusion</li></ul>	Multi choice
Which wrong platelet components were issued	<ul style="list-style-type: none"><li>• Pooled</li><li>• Apheresis</li><li>• CMV negative</li><li>• Irradiated</li><li>• HLA matched</li><li>• HPA matched</li><li>• Hyperconcentrate for IUT</li></ul>	Multi choice
Which wrong plasma components were issued	<ul style="list-style-type: none"><li>• FFP</li><li>• Solvent detergent FFP</li><li>• Cryo-depleted FFP</li><li>• Cryoprecipitate</li></ul>	Multi choice
Which wrong granulocyte components were issued	<ul style="list-style-type: none"><li>• Buffy coat derived</li><li>• Apheresis</li></ul>	Multi choice

Issuing department errors		
Question	Answer Options	Data Type
What was the error in the issuing department	<ul style="list-style-type: none"> <li>• Component selection</li> <li>• Component labelling, availability, handling and storage</li> <li>• Other (please specify)</li> </ul>	Multi choice
Other issuing department error		Free Text
Was the member of staff lone working at the time of the incident	<ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> </ul>	Single choice
Does the department have a capacity plan	<ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> </ul>	Single choice
Was the capacity plan met on the day of the incident	<ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> </ul>	Single choice
Were there controls of exit checking	<ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> </ul>	Single choice
Have the staff received training in Human Factors	<ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> </ul>	Single choice
Was the competency up to date	<ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> </ul>	Single choice
Date of assessment		Date

Diagnostic Laboratory Errors		
Question	Answer Options	Data Type
What was the error in the diagnostic laboratory	<ul style="list-style-type: none"> <li><a href="#">Sample receipt and registration</a></li> <li><a href="#">Testing - ABO/D grouping error</a></li> <li><a href="#">Testing - Antibody screening error</a></li> <li><a href="#">Testing - Antibody identification error</a></li> <li><a href="#">Testing - Crossmatching error</a></li> <li><a href="#">Testing - Antigen typing error</a></li> <li><a href="#">Component selection error</a></li> <li><a href="#">Component labelling error</a></li> <li>Other (please specify)</li> </ul>	Multi choice
Other diagnostic laboratory error		Free Text
Indicate the professional status of the staff performing pre-transfusion testing/component issuing	<ul style="list-style-type: none"> <li>Laboratory scientist NOT normally working in diagnostic laboratory</li> <li>Laboratory scientist who normally works in diagnostic laboratory</li> <li>MLA (or equivalent) under supervision</li> <li>MLA (or equivalent) unsupervised</li> <li>Trainee</li> <li>Temporary, locum or agency staff</li> <li>Redeployed staff</li> <li>Other (please specify)</li> </ul>	Single choice
Please specify other staff member		Free Text
Was the member of staff lone working at the time of the incident	<ul style="list-style-type: none"> <li>No</li> <li>Yes</li> </ul>	Single choice
Does the department have a capacity plan	<ul style="list-style-type: none"> <li>No</li> <li>Yes</li> </ul>	Single choice
Was the capacity plan met on the day of the incident	<ul style="list-style-type: none"> <li>No</li> <li>Yes</li> </ul>	Single choice
Was a laboratory component labelling and exit check (or equivalent) used	<ul style="list-style-type: none"> <li>No</li> <li>Yes</li> </ul>	Single choice
Have the staff received training in Human Factors	<ul style="list-style-type: none"> <li>No</li> <li>Yes</li> </ul>	Single choice
Was the competency up to date	<ul style="list-style-type: none"> <li>No</li> <li>Yes</li> </ul>	Single choice
Date of assessment		Date

Diagnostic laboratory errors cont...		
Question	Answer Options	Data Type
What was the blood group result	<ul style="list-style-type: none"><li>A-</li><li>B-</li><li>AB-</li><li>O-</li><li>A+</li><li>B+</li><li>AB+</li><li>O+</li><li>Subgroup (please specify)</li></ul>	Single choice
Specify subgroup		Single choice
Was the grouping result correct for the sample being tested	<ul style="list-style-type: none"><li>Yes</li><li>No</li></ul>	Single choice
Following question will appear when question above is answered ‘no’		
If no, what was the correct grouping	<ul style="list-style-type: none"><li>A-</li><li>B-</li><li>AB-</li><li>O-</li><li>A+</li><li>B+</li><li>AB+</li><li>O+</li><li>Subgroup (please specifiy)</li></ul>	Single choice
Specify subgroup		Free Text

ABO/D grouping error		
Question	Answer Options	Data Type
If the grouping result was wrong was this because	<ul style="list-style-type: none"><li>• Transcription error</li><li>• Interpretation error</li><li>• Wrong sample tested</li><li>• Other (please specify)</li></ul>	Multi choice
Please specify other		Free Text
Has this patient been grouped before at the diagnostic laboratory	<ul style="list-style-type: none"><li>• Yes</li><li>• No</li></ul>	Single choice
Was the method used for blood grouping	<ul style="list-style-type: none"><li>• Manual</li><li>• Semi-automated</li><li>• Automated</li></ul>	Single choice
Was the blood group testing	<ul style="list-style-type: none"><li>• Routine</li><li>• Urgent</li></ul>	Single choice
Was the grouping result	<ul style="list-style-type: none"><li>• Routine</li><li>• Urgent</li></ul>	Single choice
Which technology was used for ABO/D typing	<ul style="list-style-type: none"><li>• Tile</li><li>• Tube</li><li>• Microplate</li><li>• Column</li><li>• Molecular</li><li>• Other (please specify)</li></ul>	Single choice
Other ABO/D testing		Free Text





Antibody screening errors		
Question	Answer Options	Data Type
Was an antibody screen performed	<ul style="list-style-type: none"><li>• Yes</li><li>• No</li></ul>	Single choice
If no, why not?		Free Text
What was the antibody screening error	<ul style="list-style-type: none"><li>• Transcription error</li><li>• Interpretation error</li><li>• Wrong sample tested</li><li>• Other (please specify)</li></ul>	Multi choice
Please specify other		Free Text
Was the antibody screening result	<ul style="list-style-type: none"><li>• Negative</li><li>• Positive</li></ul>	Single choice
What was the correct result	<ul style="list-style-type: none"><li>• Negative</li><li>• Positive</li></ul>	Single choice
Was the antibody screening done by	<ul style="list-style-type: none"><li>• Hospital transfusion laboratory</li><li>• Diagnostic laboratory in BE</li><li>• Other (please specify)</li></ul>	Single choice
Please specify other		Free Text
Was the method used for antibody screening	<ul style="list-style-type: none"><li>• Manual</li><li>• Semi-automated</li><li>• Automated</li></ul>	Single choice
Was the antibody testing	<ul style="list-style-type: none"><li>• Routine</li><li>• Urgent</li></ul>	Single choice
Was the antibody result	<ul style="list-style-type: none"><li>• Recorded manually</li><li>• Downloaded electronically</li></ul>	Single choice
Was the antibody sample	<ul style="list-style-type: none"><li>• Serum</li><li>• Plasma</li></ul>	Single choice
Methods for antibody screening used	<ul style="list-style-type: none"><li>• IAT</li><li>• Enzyme</li><li>• Other</li></ul>	Multi choice
Please specify other		Free Text



Antibody identification		
Question	Answer Options	Data Type
What antibodies were identified		Multi Choice or Free Text (TBC)
What was the antibody identification error	<ul style="list-style-type: none"><li>• Transcription error</li><li>• Interpretation error</li><li>• Wrong sample tested</li><li>• Other (please specify)</li></ul>	Multi choice
Please specify other		Free Text
What was the correct antibody identification		Multi choice or Free Text (TBC)
Was the sample for antibody identification	<ul style="list-style-type: none"><li>• Serum</li><li>• Plasma</li></ul>	Single choice
Methods of antibody identification used	<ul style="list-style-type: none"><li>• IAT</li><li>• Enzyme</li><li>• Enzyme IAT</li><li>• Other (please specify)</li></ul>	Multi choice



Component selection error		
Question	Answer Options	Data Type
What was the component selection error	<ul style="list-style-type: none"><li>• Wrong component type selected</li><li>• Wrong ABO/D type selected</li><li>• Right component or ABO/D type but not for intended patient</li></ul>	Single choice
Why was the incorrect component selected	<ul style="list-style-type: none"><li>• None available in time due to urgency</li><li>• Other (please specify)</li></ul>	Single choice
Other reason why incorrect components were selected		Free Text
Were the units	<ul style="list-style-type: none"><li>• Selected from the blood establishment centre</li><li>• Frozen blood bank</li></ul>	Single choice



Cross-matching error		
Question	Answer Options	Data Type
Was any crossmatch or electronic issues procedure done	<ul style="list-style-type: none"> <li>Yes</li> <li>No</li> </ul>	Single choice
If no, why was no crossmatch or electronic procedure done		Free Text
What was the crossmatch error	<ul style="list-style-type: none"> <li>Transcription error</li> <li>Interpretation error</li> <li>Wrong sample tested</li> <li>Other (please specify)</li> </ul>	Multi choice
Please give details of error		Free Text
Was the result	<ul style="list-style-type: none"> <li>Compatible</li> <li>Incompatible</li> <li>Suitable</li> </ul>	Single choice
Which crossmatch procedure was used	<ul style="list-style-type: none"> <li>IAT</li> <li>Immediate spin</li> <li>Electronic issue</li> <li>Other</li> </ul>	Multi choice
Other crossmatch procedure		Free Text
Was the crossmatch	<ul style="list-style-type: none"> <li>Manual</li> <li>Semi-automated</li> <li>Automated</li> </ul>	Single choice
If semi-automated or automated, give name of the analyser used		Free Text
Was this method	<ul style="list-style-type: none"> <li>Routine</li> <li>Urgent</li> </ul>	Single choice
Was the result	<ul style="list-style-type: none"> <li>Entered manually</li> <li>Downloaded through an interface</li> </ul>	Single choide



Blood component labelling		
Question	Answer Options	Data Type
What was the labelling error	<ul style="list-style-type: none"><li>• Labelled for the wrong patient</li><li>• Incorrect details on the label</li><li>• No label generated</li></ul>	Single choice
Was it wrong with respect to	<ul style="list-style-type: none"><li>• Patient name</li><li>• Hospital / NHS number</li><li>• Date of birth</li><li>• Donation number</li></ul>	Multi choice
Was the label	<ul style="list-style-type: none"><li>• Hand written</li><li>• Computer-generated</li></ul>	Single choice

Information Technology		
Question	Answer Options	Data Type
Did IT contribute to the error	<ul style="list-style-type: none"><li>• Yes</li><li>• No</li></ul>	Single choice
If answered answer 'Yes', all the following questions appear		
Was this primarily due to	<ul style="list-style-type: none"><li>• Failure to consult or identify historical record</li><li>• Failure to link, merge or reconcile computer records</li><li>• Warning flag in place but not heeded</li><li>• Warning flag not updated or disabled</li><li>• Failure to use flags and/or logic rules</li><li>• Incorrect results entered or accessed manually</li><li>• Computer or other IT systems failure</li><li>• Incorrect patient details selected from IT system</li><li>• Lack of functionality/algorithms in the system to support safe practice</li><li>• Lack of interfacing/interoperability</li><li>• System not configured correctly</li><li>• System not used correctly</li><li>• Printing error</li><li>• Other (please specify)</li></ul>	<ul style="list-style-type: none"><li>• Single choice</li></ul>
Other IT error		Free Text
What type of IT system was used	<ul style="list-style-type: none"><li>• Laboratory information management system (LIMS or LIS)</li><li>• Ordercomms</li><li>• Patient administration system</li><li>• Electronic patient record</li><li>• Electronic blood management system</li><li>• Bedside electronic ID system</li><li>• Electronic prescribing system</li><li>• Online blood ordering system</li><li>• Electronic results system (e.g., ICE, SpICE</li><li>• Temperature monitoring system</li><li>• Issuing and distribution system in BE</li><li>• Other (please specify)</li></ul>	Multi choice
Other type of IT system		Free Text
What was the name of the electronic system used		Free Text
Who was the supplier of the system		Free Text
Was the user trained and competent to use the system	<ul style="list-style-type: none"><li>• No</li><li>• Yes</li></ul>	Single choice
If no, please give details		Free Text
Could the error have been prevented by using IT	<ul style="list-style-type: none"><li>• No</li><li>• Yes</li></ul>	Single choice
Was this because the relevant IT was	<ul style="list-style-type: none"><li>• Not in place</li><li>• In place but not used</li></ul>	Single choice
The following questions will appear dependent of the answer to the question above		
Why was not in place	<ul style="list-style-type: none"><li>• Lack of funding to purchase</li><li>• Lack of capacity to implement</li><li>• Other (please give details)</li></ul>	Single choice
What was the reason for this not being used	<ul style="list-style-type: none"><li>• Staff not trained/no access</li><li>• IT downtime (planner or unplanned)</li><li>• Other (please give details)</li></ul>	Single choice
Please give further details		Free Text

# Page 9 - Handover

Handover		
Question	Answer Options	Data Type
Did handover between shifts/teams/individuals impact on the error	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
If answered answer 'Yes' all following questions appear		
Was the handover	<ul style="list-style-type: none"><li>Verbal</li><li>Written</li><li>Electronic</li></ul>	Single choice
Is there a structured handover	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Please provide further details of the handover		Free text

Transplant cases		
Question	Answer Options	Data Type
Was the patient a transplant recipient	<ul style="list-style-type: none"> <li>No</li> <li>Yes</li> </ul>	Single choice
If answered answer 'Yes' the following questions appear		
Was the patient	<ul style="list-style-type: none"> <li>Pre-transplant</li> <li>Post-transplant</li> </ul>	Single choice
What was the group of the patient before transplant	<ul style="list-style-type: none"> <li>A-</li> <li>B-</li> <li>AB-</li> <li>O-</li> <li>A+</li> <li>B+</li> <li>AB+</li> <li>O+</li> </ul>	Single choice
What was the group of the transplant received	<ul style="list-style-type: none"> <li>A-</li> <li>B-</li> <li>AB-</li> <li>O-</li> <li>A+</li> <li>B+</li> <li>AB+</li> <li>O+</li> </ul>	Single choice
What type of transplant did the patient receive	<ul style="list-style-type: none"> <li>Solid organ</li> <li>Haematopoietic stem cell transplant</li> </ul>	Single choice
The following questions will appear dependent of the answer to the question above		
Which organ was transplanted	<ul style="list-style-type: none"> <li>Heart</li> <li>Lung</li> <li>Kidney</li> <li>Liver</li> <li>Pancreas</li> <li>Other (please specify)</li> </ul>	Multi choice
Please specific transplanted organ		Free Text
Which type of HSCT?	<ul style="list-style-type: none"> <li>Autologous</li> <li>Allogeneic - haploidentical</li> <li>Allogeneic - sibling donor</li> <li>Allogeneic - unrelated donor</li> </ul>	Single choice



## Human Factors

As three quarters of all incidents reported to SHOT are related to errors, we would like to understand more about why these occur. Errors in transfusion practice may be related to workplace features, communication, and IT systems, and organisational pressures.

It is important to answer every question as this will allow SHOT to interpret practices, and gain understanding of all the factors involved.

SHOT has recognised how difficult it can be for reporters to score the human factors aspects of an incident, so we have prepared some self-learning material. You may want to save this incident report first if you are planning to access any training material now.

The Human Factors Tuition Package includes case studies and there are 2 short videos produced by SHOT for more information about Human Factors.

These resources can be accessed if you copy and paste this link to the Human Factors page on the SHOT website [www.shotuk.org/human-factors-tuition-package/](http://www.shotuk.org/human-factors-tuition-package/) into your internet browser.

By placing your cursor over each question in the subsequent tabs, you will be able to access tooltips which are pop up examples to assist you to complete the questions.

Question	Answer Options	Data Type
When investigating incidents do you apply any Human Factors principles or use a Human Factors framework or model?	<ul style="list-style-type: none"><li>• Yes</li><li>• No; but we are planning to</li><li>• No</li></ul>	Single choice
If answered answer 'Yes' the following questions appear		
Which framework or model do you use	<ul style="list-style-type: none"><li>• Fishbone</li><li>• In house Human Factors tool</li><li>• In house Root Cause Analysis tool</li><li>• SHOT Human Factors resources</li><li>• PSIRF (Patient Safety Incident Response Framework)</li><li>• SEIPS (Systems Engineering Initiative for Patient Safety)</li><li>• HFACS (Human Factors Analysis and Classification System)</li><li>• AcciMap</li><li>• SHELL (Software, Hardware, Environment, Liveware)</li><li>• SHEEP (Systems, Human Interaction, Environment, Equipment, Personal)</li><li>• PEAR (People, Environment, Actions, Resources)</li><li>• London Protocol</li><li>• YCFF (Yorkshire Contributory Factors Framework)</li><li>• Bowtie</li><li>• Other (Please specify)</li></ul>	Single choice
Please specify other HF framework or model		Free Text
Please give any additional relevant information		Free Text

Human Factors		
Question	Answer Options	Data Type
Section 1 – Situational Factors		
Does the cause of this incident include any failures in team function	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Were there any reasons this incident was more likely to occur with the particular staff involved	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Did task features make the incident more likely	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Were there reasons that this incident was more likely to occur to this particular patient	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Please give any additional relevant information for situational factors		Free Text

Human Factors		
Question	Answer Options	Data Type
Section 2 – Local Working Conditions		
Was there a mismatch between workload and staff provision around the time of the incident	<ul style="list-style-type: none"><li>• No</li><li>• Yes</li></ul>	Single choice
Was there any failure of team function in relation to leadership, supervision and roles	<ul style="list-style-type: none"><li>• No</li><li>• Yes</li></ul>	Single choice
Were there any difficulties obtaining the correct equipment and/or supplies	<ul style="list-style-type: none"><li>• No</li><li>• Yes</li></ul>	Single choice
Please give any additional relevant information for local working conditions		Free Text

Human Factors		
Question	Answer Options	Data Type
Section 3 – Organisational Factors		
Did the environment hinder work in any way	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Were there problems in other departments that contributed	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Did organisational pressures play a role in the incident	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Were there issues or gaps with staff skill or knowledge	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Please give any additional relevant information for organisational factors		Free Text

Human Factors		
Question	Answer Options	Data Type
Section 4 – External Factors		
Were there any characteristics about the equipment that were unhelpful	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Have any national policies or high-level regulatory issues influenced this incident	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Please give any additional relevant information for external factors		Free Text

Human Factors		
Question	Answer Options	Data Type
Section 5 – Communication and culture		
Did a lack of safety culture in your area contribute to this incident	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Did poor written, or verbal communication worsen the situation	<ul style="list-style-type: none"><li>No</li><li>Yes</li></ul>	Single choice
Please give any additional relevant information for communication and culture		Free Text

Human Factors		
Question	Answer Options	Data Type
Section 6 - Summary		
Which of these options do you consider to be the most important contributory factor for this incident	<ul style="list-style-type: none"><li>• Situational</li><li>• Local working</li><li>• Organisational</li><li>• External</li><li>• Communication and culture</li></ul>	Single choice
If you could change one thing to make this incident less likely to happen again, what would it be?		Free Text

Outcome		
Question	Answer Options	Data Type
If not already on ITU/HDU, did the patient require admission to ITU/HDU	<ul style="list-style-type: none"> <li>Yes</li> <li>No</li> <li>Not known</li> </ul>	Single choice
The next question will be dependent on the answer above		
If yes, did the adverse transfusion event contribute to the admission to ITU/HDU	<ul style="list-style-type: none"> <li>Yes</li> <li>No</li> </ul>	Single choice
If not already on dialysis, did the patient required dialysis	<ul style="list-style-type: none"> <li>Yes</li> <li>No</li> </ul>	Single choice
If answered yes, the following question will appear		
If yes, how many days did the patient spend on dialysis		Integer
Did the patient required admission to the ward from outpatients/day care	<ul style="list-style-type: none"> <li>Yes</li> <li>No</li> </ul>	Single choice
If answered yes, the following question will appear		
If yes, how many days did the patient spend on a ward		Integer
Other consequences/patient requirements		Free Text
Clinical outcome in relation to the transfusion episode	<ul style="list-style-type: none"> <li>Complete recovery</li> <li>Minor sequelae</li> <li>Serious sequelae</li> <li>Death related to the transfusion</li> <li>Not known</li> <li>None (Eg SAE with no adverse reaction in the patient)</li> </ul>	Single choice  Mandatory question
If minor or serious sequelae, please give details and time to resolution		Free Text
What is the likelihood of the blood component being the cause of the reaction (imputability)	Not assessable 0 - Excluded or Unlikely 1 - Possible 2 - Likely / probable 3 - Certain	Single choice  Mandatory question
If 0 – Excluded or Unlikely what was the reaction considered to have been caused by?		Free Text
If the patient died, please give the time and date of death		Data/Time



Procedural review		
Question	Answer Options	Data Type
Has this case been reviewed	<ul style="list-style-type: none"> <li>Yes</li> <li>No</li> </ul>	Single choice
The next questions will be dependent on the answer above		
If no, why has this case not been reviewed?		Free Text
If yes, which group has reviewed this case (please tick all that apply)	<ul style="list-style-type: none"> <li>Hospital Transfusion Team</li> <li>Hospital Transfusion Committee</li> <li>Regional body (please specify)</li> <li>Senior clinical group (SMG/SMT) or equivalent (blood establishments)</li> <li>National body (please specify)</li> <li>Other group (please specify)</li> </ul>	Multi choice
Please give details of any regional, national or other review body		Free Text
Please give details of the outcome of the review		Free Text
As a result, have there been recommended changes to transfusion procedures or policy	<ul style="list-style-type: none"> <li>Yes</li> <li>No</li> </ul>	Single choice
If answered yes, the following question will appear		
Please specific changes to transfusion procedures or policy		Free Text
Has a Root Cause Analysis, or other equivalent formal investigation, been carried out?	<ul style="list-style-type: none"> <li>Yes</li> <li>No</li> </ul>	Single choice
The next questions will be dependent of the answer above		
Why was no RCA or formal investigation carried out		Free Text
Has the anonymised RCA/Investigation been share by	<ul style="list-style-type: none"> <li>Upload to SABRE (MHRA)</li> <li>Upload to Dendrite (below)</li> <li>E-mail to SHOT</li> </ul>	Multi choice
<b>SHOT's primary focus is on improving patient safety, so additional information from your local investigation and root cause analysis may have important general lessons to share with others If you have any problems in uploading your anonymised RCA or investigations, then please contact the SHOT office for assistance</b>		
Please upload any relevant document e.g., Root Cause Analysis		Multimedia
Was any specific 'good practice' identified as a result of this incident? If so, please provide details		Free Text
Please give any other additional information which you think is relevant		Free Text
Is the questionnaire complete? Click 'Yes' to close the report	<ul style="list-style-type: none"> <li>Yes</li> <li>No</li> </ul>	Single choice