Introduction

Patients often require care that involves more than one hospital, department, or team. This is known as shared care.

Safe shared care relies on multiple interconnected factors, including effective communication, well-informed staff, accurate documentation, and seamless interoperability of information systems.

When these systems don't function as intended, shared care issues can contribute to transfusion incidents that can adversely impact patients.

Shared care errors can impact certain patient groups disproportionately, for example patients with haemoglobinopathies and those undergoing transplants.

SHOT data

- Shared care errors occur consistently within SHOT reports. Most contribute to incorrect blood component transfused-specific requirements not met (IBCT-SRNM) errors (Figure 1)
- These mainly result in patients not receiving irradiated or phenotyped/antigen negative red cells when required (Figure 2)
- Other categories impacted by suboptimal shared care include IBCT-wrong component transfused (IBCT-WCT) and avoidable, delayed and under/over transfusion errors (ADU)

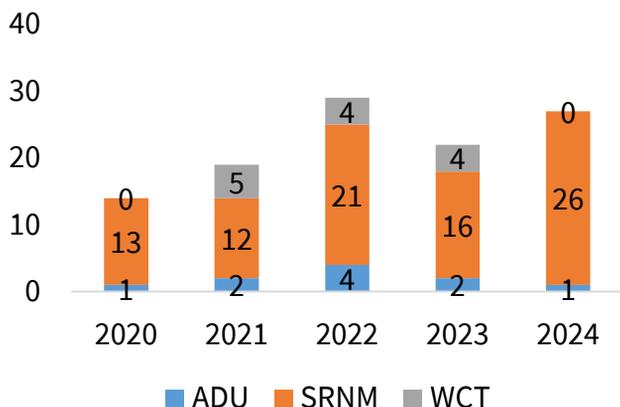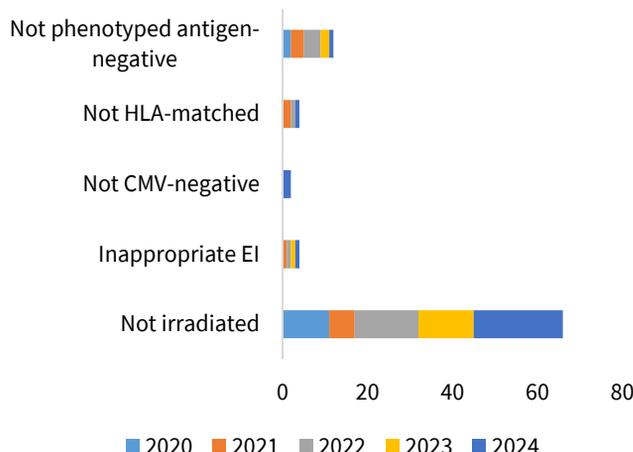Figure 1: SHOT reports where shared care influenced event 2020-2024 (n=111)

Figure 2: IBCT-SRNM shared care errors 2020-2024 (n=88)

Illustrative learning case

A patient with sickle cell disorder was admitted to an out-of-area hospital. Red cells were requested for two transfusions, but the laboratory was not informed of the diagnosis nor had access to previous transfusion records. As a result, blood components transfused did not meet sickle cell-specific requirements. The patient developed a delayed haemolytic transfusion reaction and required admission to the high dependency unit.

Factors contributing to shared care-related patient safety incidents

Communication 💬
- Multiple organisations, multilayered differing systems
- Insufficient or incomplete transfer of information

Information technology 🦠
- Systems with different data rules
- No interoperability and access to information

Knowledge 💡
- Lack of underpinning knowledge or support
- Single point of failure within teams

Shared care solutions for transfer of information between teams

Timely and clear communication 💬
Establish standardised communication protocols between hospitals.
Use secure messaging or shared platforms for urgent transfusion-related updates.
Information should go to teams rather than individuals with processes to ensure IT systems are updated in a timely manner

Strong safety culture 🛡️
Ensure effective transfer of relevant information to support safe transfusion care.
Encourage reporting and learning from near-misses.
Regular multidisciplinary safety meetings involving clinicians, nurses, and transfusion specialists.

Staff education 👨‍🏫
Train staff on recognising/managing transfusion specific requirements and documentation pathways.

Discharge records to include relevant transfusion details 📄
Ensure discharge summaries include details about transfusions given, specific requirements and adverse reactions, if any.

Interoperability of IT Systems ☁️
Implement systems that allow transfusion data to flow between hospitals and support safe transfusions.
Consider integration with relevant national databases where possible.

Consulting relevant databases and setting up relevant alerts 📁
Check national databases for specific patient groups (e.g., Sp-ICE for haemoglobinopathy patients).
Use electronic alerts for patients with special requirements (e.g., rare antibodies).

Involving haematology teams 💧
Engage haematology specialists early for complex cases.
Create shared care pathways that define roles and responsibilities.

Patient centred care 💬
Provide patients with clear information about their transfusion history, special requirements and transfusion risks.
Culture of listening to patients and acting on relevant information

Resources

💡 https://www.shotuk.org/resources/informed-patient-consent-and-shared-decision-making-for-blood-transfusion/
https://www.shotuk.org/transfusion-safety/transfusion-safety-standards/