SHOT Newsletter
April 2026

SHOT Symposium 2026

Registration open: 2026 Annual SHOT Symposium

The 2026 SHOT Symposium will take place on **Friday, 10 July 2026**, at the **Hilton Birmingham Metropole Hotel, Birmingham**.

This will be a very special year, as the symposium marks 30 years of SHOT**,** celebrating three decades of excellence in haemovigilance and transfusion safety. Professionals from across the transfusion community will come together to share insights, learning, and best practice. Full programme details will be released soon!

Click here to register and attend the 2026 Annual SHOT Symposium

Abstract submission: We warmly invite you to submit an abstract for the 2026 Annual SHOT Symposium. This is a great opportunity to share your work with others, whether you're presenting an audit, a service improvement initiative, an educational project, or new research in haemovigilance and transfusion safety. Registration closes on 17th April.

Click here for abstract submission

Click the link - All abstracts should be submitted by 17th April 2026

Areas of interest are:

- Transfusion IT improvements including AI
- Transfusion education
- Staff wellbeing initiatives • Innovation, research & audit
- Clinical and laboratory transfusion practise including patient engagement
- Optimising learning from safety incidents

Click here for abstract submission instructions

SHOT/MHRA Haemovigilance Workshops-England

Registration is now open for **England's** joint haemovigilance workshops delivered by SHOT and the MHRA. The free, full-day, in-person sessions offer interactive learning on key haemovigilance and transfusion safety topics. The programme will be identical for both venues and can be accessed here

Last few spaces remaining, register to secure your spot!

Dates and venues (both events will run from 08:00-16:30)

- 13 May 2026 – The Lowry Hotel, Manchester (Registration closes 30th April)
- 28 May 2026 – Holiday Inn, London (Registration closes 14th May)

Key Information

- These events are free-to-attend for staff from SHOT/MHRA reporting organisations only (line manager approval required)
- Places are limited – please register only if you plan to attend

Feedback on previous haemovigilance workshops:

84%
84% of attendees rated the event excellent for educational content, with 16% rating good

75%
75% of attendees rated the content for new ideas and information as excellent, and 25% as good

76%
76% of attendees rated the event excellent for relevance to day-to-day practice, and 24% good

100%
100% responders stated the learning from the workshop would influence their future practice

100%
100% stated they would recommend future sessions to their colleagues

100%
100% stated they would attend a similar event in 2 years time

"My first SHOT workshop. I wanted to thank you. It has given me a much clearer understanding of my role within quality, and I now feel better equipped with the resources and toolkits you've highlighted on your SHOT website."

"I found the day very useful and very engaging. I found it beneficial that there were multiple talkers so that it wasn't just one voice all day"

Manchester Workshop The Lowry Hotel	**Wednesday 13th May**	**Click on each venue to register**
London Workshop Holiday Inn Bloomsbury	**Thursday 28th May**	**Click on each venue to register**

SHOT wins IHN award

We are incredibly proud to share that SHOT has been awarded the 2026 International Haemovigilance Network Award!

This recognition honours individuals/organisations that have made a significant contribution to advancing haemovigilance worldwide. It's a truly special moment for us.

This award belongs to so many people. We'd like to say thank you to:

- Blood donors – whose generosity underpins everything we do
- Patients – at the heart of all our efforts
- Transfusion practitioners, clinicians, and laboratory teams – whose vigilance, expertise, and reporting drive learning and improvement
- The SHOT team – who continue to drive meaningful change across the field of blood transfusion safety
- Everyone involved in SHOT – for your dedication, perseverance, and commitment to making haemovigilance possible

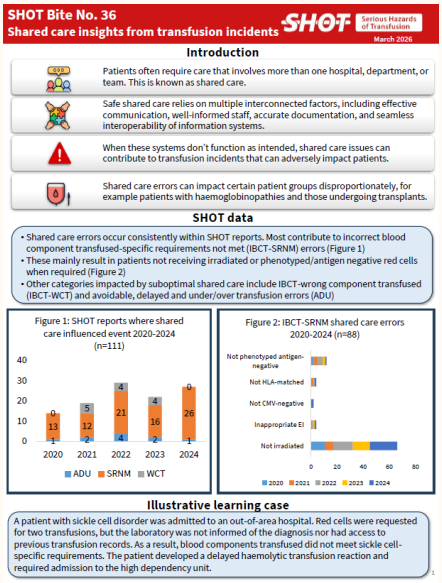
Shared care SHOT bite

We have released a new SHOT bite:
SHOT Bite No.36: Shared care insights from transfusion incidents.

This SHOT bite covers:

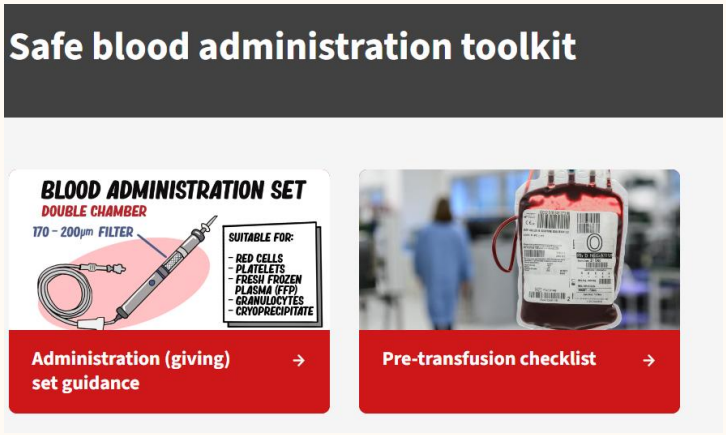
- SHOT data on shared care
- An illustrative case
- Factors contributing to shared care safety incidents
- Safer shared care solutions

Click on this link or the image to access this new SHOT bite!


SHOT Bite No. 36
Shared care insights from transfusion incidents
SHOT Serious Hazards of Transfusion
March 2026
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)
2020 2021 2022 2023 2024
ADU SRNM WCT
Figure 2: IBCT-SRNM shared care errors 2020-2024 (n=88)
Not phenotyped antigen-negative
Not HLA-matched
Not CMV-negative
Inappropriate EI
Not irradiated
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.

Safe administration toolkit

A new toolkit has been launched to gather SHOT administration guidance in one place! The SHOT safe administration toolkit currently contains links to the pre-transfusion checklist and administration set guidance.



Watch this space, many more transfusion administration resources will be added in coming months

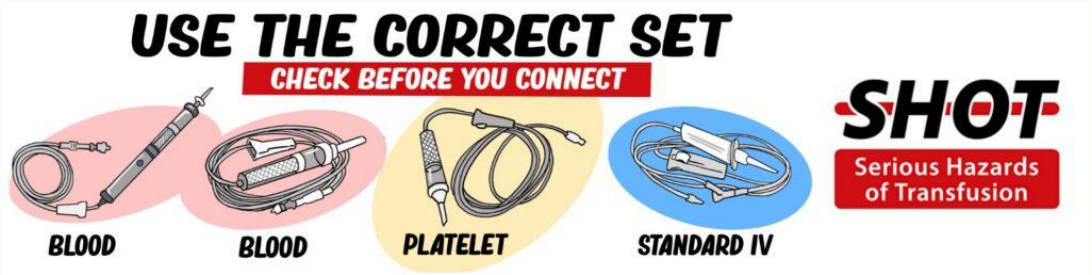
The administration set guidance page brings together 3 new resources to aid with the correct selection and use of transfusion administration (giving) sets.

Click here to access all documents together on the administration set guidance page

Cautionary Tale No. 2: Optimising Blood Administration Set Safety
This cautionary tale details an event where the wrong blood administration set (also known as giving set) was used and provides guidance on safe administration set use.
Click here to view.

SHOT Bite No.35: Learning from SHOT administration set errors
This SHOT bite reviews SHOT data on blood administration set errors and provides guidance on their use.
Click here to view.

Blood and IV fluid administration set poster
This poster shows examples of different administration sets (also called giving sets) commonly used for blood components and IV fluid.
Click here to view.



Spotlight: Case study

D-negative mother of D-negative baby given anti-D immunoglobulin (Ig)

A woman with a predicted D-negative fetus had a potentially sensitising event (PSE). Anti-D Ig was issued despite the D-negative cell-free fetal deoxyribonucleid acid (cffDNA) prediction being available. The woman gave birth a few hours after the PSE. At this point an order was placed in the clinical computer system for a Kleihauer, cord bloods and anti-D Ig. The system flagged a warning stating the fetus was D-negative and asking if anti-D Ig was required. The midwife on duty instructed a registered nurse caring for the woman to administer anti-D Ig. The anti-D Ig that had been issued for the antenatal PSE was used. Neither healthcare professional had noted the earlier error or heeded the warning on the information technology system.

This case highlights how warning messages can be overlooked and overridden. It is not clear if the person administering the anti-D Ig had observed the system warning or had reviewed the woman's notes before administering anti-D Ig. This would have given another opportunity for the earlier error and warning message to be recognised. The woman accepted the anti-D Ig, which underlines the importance of birthing parents and their support people understanding all aspects of their care, to enable them to make informed decisions.

The 2026 National Comparative Audit of the use of prophylactic anti-D Ig in pregnancy is now live. Click here for information.

Upcoming educational events

You'll meet members of the SHOT team hosting workshops, presenting abstracts, or hosting an exhibition stands at many upcoming educational events. To find out more about all upcoming educational events and webinars visit our events page by clicking on this link

Celebrate 30 years of SHOT!

SHOT would not be possible without the dedication of our vigilant reporters! We would love you to help us celebrate 30 years of SHOT by sharing what SHOT means to you in 5 words.

Either fill in this form, or engage with our linked in post