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Definition:

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.

Introduction

Blood Services in the UK provide a wide range of routine diagnostic and specialist reference testing which supports hospital transfusion laboratories and the provision of blood components as part of the vein-to-vein process of blood transfusion. Historically, there has been variation in how errors arising during testing, component selection, or issue within these laboratories have been reported to the haemovigilance bodies, mainly due to the organisational structure of Blood Services laboratories in relation to hospital laboratories. Some UK Blood Services report to haemovigilance bodies directly for all relevant incidents as they also act as a blood bank with direct patient issuing for certain locations. Other UK Blood Services place the responsibility for reporting errors which occur in blood establishment diagnostics laboratories on the issuing blood transfusion laboratory.

In 2023, following a clinical audit undertaken by National Health Service (NHS) Blood and Transplant, which identified variation in haemovigilance reporting, the UK Blood Services forum recommended the creation of a new Blood Services SHOT reporting category. This category was established to capture errors in UK Blood Establishment diagnostic laboratories and issuing departments that resulted in incorrect results or inappropriate components being issued with potential patient harm. Additional aims for the establishment of this category were to standardise SHOT reporting across the UK Blood Services and to ensure that opportunities for improvement were not missed.

From the 5 August 2025, following a collaborative consultation process, four preliminary categories for the UK Blood Services were established. This had input from representatives from all four UK Blood Services diagnostics laboratories, quality assurance, SHOT, and the Medicines and Healthcare products Regulatory Agency (MHRA) haemovigilance bodies. The categories were:

- Incorrect blood component issued – wrong component issued (IBCI-WCI)
- Incorrect blood component issued – specific requirements not met (IBCI-SRNM)
- Anti-D immunoglobulin (Ig) errors for Blood Services
- Acknowledging continuing excellence in transfusion (ACE)

This development marks a significant step forward in strengthening haemovigilance monitoring, learning from, and improving transfusion safety across the system. The new reporting pathway will support a more complete picture of events across the blood supply chain and help identify opportunities for system-wide improvement and shared learning.

Deaths related to transfusion and major morbidity n=0

There were no deaths or major morbidity related to Blood Service errors reported under the current SHOT definitions in 2025.

Blood Service data 2025 n=3

One case has been reported and accepted in each of the following categories: IBCI-WCI, IBCI-SRNM and anti-D Ig errors for Blood Services. No cases were reported under the ACE category. Although low numbers pose a challenge for trending and anonymised learning, evidence of incomplete or insufficient handover of information was observed within these reports.

Blood Service delays

Although delayed transfusions are not currently reported under the established criteria for Blood Services, the contribution of Blood Services to transfusion delays reported by hospitals is discussed in more detail in Chapter 12, Delayed Transfusion. This includes an increase in the number of delays reported to be caused by Blood Services (n=18 in 2025, n=13 in 2024). Key recurring themes from these reports should inform improvement actions to address the gaps identified.

Translating learning from SHOT reports into practice

With only a small number of cases reported in the first 5 months of this category, it is challenging to draw broad conclusions, but some early themes have emerged. As stated, submitted reports showed that key information was not always communicated clearly during handover. Blood Services should therefore continue to prioritise strong communication and consistent handover processes. By reviewing and refining these procedures, services can help prevent similar errors and further strengthen patient safety. In future, as understanding of the reporting category evolves, there is scope to explore whether delays to transfusion with a significant Blood Service contribution should become a Blood Services reporting category in future iterations, ensuring that system-wide learning around the causes of delays is captured comprehensively.

Conclusion

The launch of specific reporting channels from the Blood Services to SHOT marks significant progress in collaboration, openness and haemovigilance practices within the UK. Additional reporting categories will be explored and established in the coming years to allow further learning and safety improvements to be made.

SHOT would like to extend its gratitude to all involved parties and Blood Services for their input and willingness to execute this project with the aim of improved patient safety.



Recommended resource

[Blood Services reporting criteria: definitions and information for Blood Services reporting to SHOT](#)

