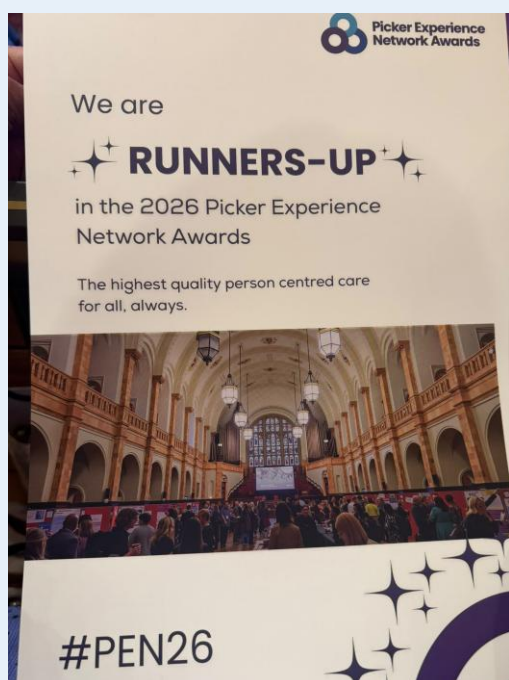


SHOT Newsletter October 2026

Award recognition for My Transfusion



SHOT are delighted to be named **runners-up** in the Picker Experience Network Awards 2026!

The My Transfusion app received this honour within the 'Patient Involvement in Patient Safety in Partnership with Patient Safety Learning' category and was also shortlisted within the category 'Partnership Working'.

We thank the organisers for this recognition and pass on our congratulations to the other winners and finalists.

HSJ PATIENT SAFETY AWARDS 2026

SHOT were honoured to be shortlisted in the HSJ Patient safety awards under the category 'Patient Involvement in Safety' for our My Transfusion app.



We wish huge congratulations to the winners Bolton FT and Bolton Deaf Society for their fantastic initiative: Martha's Rule - Equitable Access for Members of the Deaf Community

Scan the QR code or click the button to find out more about My Transfusion

[My Transfusion information](#)



New SHOT Bites: Fatigue

Staff fatigue is a critical but under-recognised threat to transfusion safety. While clinical and laboratory staff may recognise fatigue as a personal challenge, it is rarely acknowledged as a system-level safety hazard that requires organisational risk mitigation. SHOT have released 2 SHOT bites focusing on fatigue in transfusion safety.

Click the images below to access the SHOT bites.

SHOT Bite No.: 38a
Staff fatigue and transfusion safety: A hidden risk

Introduction: Staff fatigue is a critical but under-recognised threat to transfusion safety. Fatigue has been defined in several ways and in essence, refers to a feeling of lack of energy, exhaustion, or a feeling of "running on empty" and could be due to several causes ([Tiredness/fatigue in adults](#), [Health topics A to Z](#), [CPS](#), [NICE](#)). While clinical and laboratory staff/management may recognise fatigue as a personal challenge, it is rarely acknowledged as a system-level safety hazard that requires organisational risk mitigation. Despite fatigue being well-established as a contributory factor in other safety critical industries including patient safety healthcare incidents (see [HCSIB report](#)), it remains overlooked in transfusion event investigations.

Why is fatigue released so often?

- Cultural norms, peer pressure and presentations:** "heroism", "getting on with it" and pressure to keep pace with colleagues creates reluctance to acknowledge fatigue as affecting performance, particularly when speaking up is seen as letting others down.
- Blame and shame:** Staff fear disciplinary action if fatigue is mentioned as a contributory factor in incidents.
- Lack of awareness:** Sub-optimal training together with a lack of frameworks to identify and measure fatigue-related risks within organisations.
- Systemic invisibility:** Unlike technical failures, fatigue is treated as a personal responsibility rather than an organisational hazard.
- Inconsistent definitions:** There is no standardised, agreed definition of fatigue across healthcare, making systematic identification difficult.

The Healthcare Services Safety Investigations Body (HSSIB) investigation (2020) concluded: "Staff fatigue is beginning to be recognised as a risk, but understanding remains inconsistent and fragmented".

How can fatigue contribute to transfusion safety incidents?
Fatigue impairs the cognitive functions essential to ensure transfusion safety.

Cognitive impact	Transfusion safety risk examples (I don't think we can cover everything here)
Reduced attention	Errors in identifying correct patient/component compatibility/ antibody identification etc.
Slower task completion	Delays in urgent transfusions; rushed safety checks
Impaired decision-making	Not recognising contraindications; overlooking vital signs
Diminished situational awareness	Missed adverse reaction symptoms; ineffective communication
Emotional dysregulation	Team tensions; reduced compassion and civility affecting patient interactions and care
Poor memory	Incomplete documentation; forgotten steps in transfusion protocols and processes

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SHOT Bite No.: 38b
Staff fatigue and transfusion safety: Practical solutions

Practical solutions: How to start? Fatigue is a recognised patient safety risk that can affect performance, decision-making, and quality of care. The actions below provide practical ways for organisations to reduce fatigue-related risks, support staff, and promote safer transfusion practice.

For clinical areas:

- Include 'fatigue status' in team huddles and safety briefings
- Use a mix of brief pauses after 90-120 minutes of focused work and formal rest breaks in line with legal requirements (e.g. every six hours). For night shifts, consider scheduling breaks to support rest before the circadian low (around 03:00).
- Educate staff to recognise fatigue in themselves and colleagues. Staff should not just be able to identify fatigue but also know how to act/escalate

For laboratory areas:

- Assess overnight and extended rota sustainability, trial staggered shift patterns
- Implement quality checks after high-fatigue periods (e.g., shift end validation)
- Provide adequate break and rest facilities, and encourage their use
- End of shift check-in - include safe to drive?
- Include fatigue in competency review for critical tasks (blood grouping, crossmatching). Not sure this is possible?
- Ensure capacity plans consider the impact of fatigue and ensure staffing is sufficient to prevent it occurring

For all teams:

- Measuring fatigue states:** Suggest using well recognised scale for measuring fatigue state (Examples include: [Development and Validation of the Fatigue State Questionnaire: Preliminary Findings](#), [SchedoDirect](#) and [Simplified Scale: FFM's Developer Portal](#))
- Adjusting shift patterns:** Review and adjust shift patterns for staff, and flag consecutive long shifts. WISE guidance available for this [Shifting shift work, health and safety guidance - WISE](#). Assess and co-design shift patterns with staff representatives and union engagement
- Regular health assessments:** Staff who are regular night workers should have regular health assessment through occupational health (<https://www.gov.uk/night-working-hours/health-assessments>)
- Training:** Introduce mandatory fatigue awareness module covering the key Human Factors (CHAF) and Health Services Safety Investigations Body (HSSIB) findings (see links in the references section). Staff should be able to identify fatigue and know how to act/escalate
- Incident templates:** Add fatigue screening to incident investigation forms and templates, such as SEIPS
- Governance:** Include fatigue risk in quarterly transfusion safety reviews
- Staff voice:** Survey staff on fatigue factors; use findings to inform rota, workload, and workspace changes
- Add fatigue check prompts:** to bedside and lab checklists (e.g., "If 230 hours into shift or overnight: slow down—use read-back; second checker")
- Time-of-day rules:** Defer non-urgent complex tasks such as antibody investigations for non-urgent requests to alert periods, such as daytime, where feasible; for nights, introduce the requirement for second review prior to issue
- Handover discipline:** Structured documented checklist such as the SBAR template (Situation, Background, Assessment, and Recommendation) at shift changes for transfusion queues (pending samples, components reserved, special requirements)

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SHOT Bite 38a: Highlights why fatigue matters in transfusion practice, explores its contribution to safety incidents, and fatigue risk management.

SHOT Bite 38b: Gives practical solutions for recognising fatigue early, taking appropriate actions to reduce risk, strengthening safety culture, and improving patient outcomes.

Request SHOT support

Do you need to request SHOT:

- Involvement in a project
- Presentation or teaching session
- Review and feedback
- Use of SHOT resources

We have launched a new request for support form, which is available via the SHOT website: <https://www.shotuk.org/shot-request-for-support-form/>

Please use this form for any formal requests, we look forward to hearing from you!



SHOT Continuous Professional Development (CPD) Form

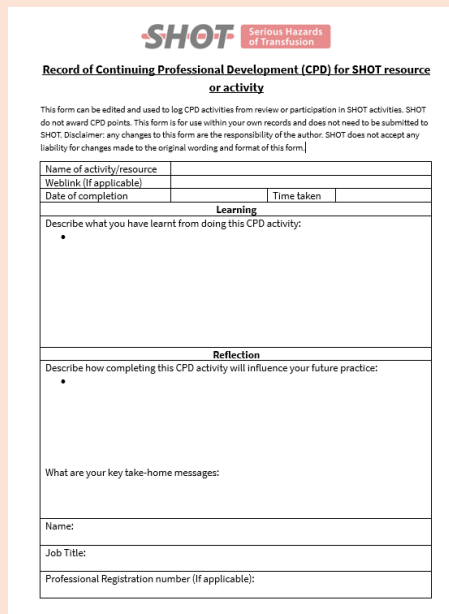


Struggling with content or time for continuing professional development (CPD)?

SHOT has a wide library of resources and educational tools available to keep your knowledge up to date!

We have also launched a SHOT specific CPD form to record your learning and reflections, which can be accessed here: <https://www.shotuk.org/resources/record-of-continuing-professional-development-cpd-for-shot-resource-or-activity/>

This form can be edited and used to log CPD activities from review or participation in SHOT activities. It is for use within your own records and does not need to be submitted to SHOT.



SHOT Serious Hazards of Transfusion

Record of Continuing Professional Development (CPD) for SHOT resource or activity

This form can be edited and used to log CPD activities from review or participation in SHOT activities. SHOT do not award CPD points. This form is for use within your own records and does not need to be submitted to SHOT. Disclaimer: any changes to this form are the responsibility of the author. SHOT does not accept any liability for changes made to the original wording and format of this form.

Name of activity/resource			
Weblink (if applicable)			
Date of completion		Time taken	
Learning			
Describe what you have learnt from doing this CPD activity:			
•			
Reflection			
Describe how completing this CPD activity will influence your future practice:			
•			
What are your key take-home messages:			
Name:			
Job Title:			
Professional Registration number (if applicable):			

Join the SHOT Working Expert (WEG) group

We are pleased to announce that Expressions of Interest for vacancies within the SHOT WEGs are now open. Full details of the available roles and the application process can be found on the SHOT website using this link: <https://www.shotuk.org/news/invitation-for-expression-of-interest-shot-working-expert-vacancies/>

The current vacancies are in the following areas:

- Pulmonary Complications (including TACO, TAD, and TRALI)
- Febrile, Allergic and Hypotensive Reactions (FAHR)
- Incorrect Blood Component Transfused (IBCT)
- Errors Related to Information Technology (IT)
- Right Blood, Right Patient (RBRP)

These non-remunerated roles provide a unique opportunity for individuals to contribute to national haemovigilance activities, support the development of the Annual SHOT Report, influence patient safety initiatives, and work alongside a multidisciplinary group of experts committed to improving transfusion safety across the UK.

The closing date for applications is **Friday 9th October**



Chapter spotlight: Incorrect Blood Component Transfused (IBCT)

Key findings

- There has been a large increase in ABO-incompatible (ABOi) red cell transfusions from 2024, all due to clinical errors (2025 n=8, 2024 n=4). There was no change in the number of ABOi plasma transfusions due to laboratory errors (n=3).
- More patient harm has occurred from IBCT events than in 2024 (8 cases of major morbidity).

SPECIFIC TRANSFUSION REQUIREMENTS MUST BE DOCUMENTED ON:

- ✓ REQUESTS
- ✓ AUTHORISATION DOCUMENTATION
- ✓ PATIENT RECORDS



ENSURE BLOOD COMPONENTS MEET THE PATIENT'S NEEDS

Gaps identified

- Collection and administration are weak points in ABOi red cell transfusion events.
- Communication gaps, insufficient skills and knowledge, and mismatches between workload and staffing levels continue to contribute to IBCT events.
- Lack of functionality and interoperability between information technology (IT) systems.

Good practice

- Implementation of checklists helped identify and prevent IBCT events, including ABOi red cell transfusions.
- Introduction of IT for collection and administration steps identified errors prior to administration.



Case 10.1: Transfusion of ABO-compatible red cells to the wrong patient significantly impacts wellbeing

Patient 1 (A D-positive) received blood intended for patient 2 (O D-positive) who was located in the next bed, due to a lack of pre-administration checks. The unit was checked against paper handover notes in the ward's treatment room and not by the patient's side. The error was identified by the patient during administration, who immediately alerted the ward staff. Although the unit was ABO-compatible (group O red cells to a group A recipient), this event caused severe distress to the patient. They experienced an acute stress response requiring medical intervention including chlorphenamine, salbutamol, hydrocortisone and adrenaline. The patient made a full recovery.

Next steps

- Implementation of the new SHOT pre-administration checklist may help strengthen safety checks.

Read the chapter in full at: <https://www.shotuk.org/chapter-10-incorrect-blood-component-transfusion-ibct-2025/>

Registration open– SHOT HFE course12th November fully
booked!

19th November 2026

10:00-15:30 GMT

Online MS Teams

SHOT HUMAN FACTORS AND ERGONOMICS (HFE) IN TRANSFUSION COURSE

The Serious Hazards of Transfusion (SHOT) team are excited to announce our HFE in transfusion interactive educational courses. Places are limited to 50 participants per course and will be allocated on a first-come, first-served basis.

Free for UK delegates

Non -refundable cost for international delegates: £50

**What do the courses include?**

The role of HFE in improving transfusion safety, application of HFE to incident investigation using the SHOT Human Factors Investigation Tool (HFIT); identification of contributory factors and effective corrective actions, human-centred design principles and safer systems of work

**How will the course be delivered?**

SHOT team -led presentations, interactive polling and discussion, practical transfusion case studies, and facilitated small-group exercises applying HFE principles and the HFIT.

**Who are the courses for?**

Any healthcare professional involved in transfusion, quality assurance and patient safety. No prior HFE training is required.

**How do I record my learning?**

Any way you like, through participation and reflective practice. A certificate will be issued to attendees who attend the full day.

**Is there anything else I need to know before registering?**

The courses are identical, only register for one date. This is an interactive course, and attendance is required for the full day (10:00 to 15:30). This course is free for UK delegates. Payment for international delegates is by credit card only.

Last spaces
remaining for 19th
November!

[Click this link to register: SHOT Human Factors and Ergonomics \(HFE\) in Transfusion Virtual Courses](#)

New advice for Jehovah's Witnesses patients

The Jehovah's Witnesses governing body has decided that individuals can decide whether to receive blood components. They can also decide whether to donate blood where the blood will be split into components. The position on whole blood is unchanged. [See the statement here.](#)

The Royal College of Surgeons produced [a guide to caring for patients who refuse blood transfusions](#) which includes exploring alternative options such as cell salvage, iron supplementation, tranexamic acid and erythropoietin.



SHOT accepts reports for ANY patient (regardless of religious belief) who is transfused blood despite withholding consent. These cases are reported in the avoidable transfusion category.

SHOT and RCPATH webinar



New advice for Jehovah's Witnesses patients

SHOT are pleased to participate in the:
Advances in Transfusion Medicine Symposium 2026

- Wednesday 25th Nov 2026 09:30-13:00
- Thursday 26th Nov 2026 09:30-13:00

These webinar will run as two half-day virtual sessions via Zoom with interactive Q&A.

There are exciting developments in transfusion medicine and science with high-quality research supporting evidence-based practice. This symposium brings together experts from various clinical disciplines and also leaders in transfusion science to provide an update on key developments

The event is relevant to consultant haematologists, nursing and laboratory staff, transfusion practitioners, trainees and all other healthcare professionals working in the field of transfusion.

This event is being supported by the RCPATH Oliver Memorial Fund and SHOT. There is no cost for participation, but pre-registration is essential and separate registration is required for each day.

For more information, including programme and registration links click here:
<https://www.shotuk.org/events/advances-in-transfusion-medicine-symposium-2026-organised-by-rcpath-and-shot/>