SERIOUS HAZARDS OF TRANSFUSION **SHOT**

SHOT NEWSLETTER WINTER 2016 TELEPHONE 0161 423 4208
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SHOT Team update

Katie Leadbetter has successfully completed her Level II Business Administration and apprenticeship with SHOT. Katie attended the 14th National Awards ceremony on 29th November 2016 and received a certificate from Ian Trenholm CEO (NHSBT).

Congratulations to **Debbi Poles** (Data Analyst) on successfully completing her MSc Information Technology

Julie Ball (Clinical Incidents Specialist) has been successful in securing a 12 month secondment with the Therapeutic Apheresis Service based at The Christie Hospital, Manchester.

National Indication Codes – update

The updated National Indication Codes have now been incorporated into the SHOT questionnaires.
The indication codes are available at:
http://www.transfusionguidelines.org.uk/uk-transfusion-committees/national-blood-transfusion-committee/responses-and-recommendations

They are also available in poster and bookmark format here:
http://hospital.blood.co.uk/media/28629/161019-27632-indication-codes-poster-blc6743-amendments-made.pdf

Also available in the app store – just search for NBTC codes

SHOT Breakfast Meeting 2016

Delegates had the opportunity to 'meet the experts' at the SHOT Breakfast Meeting prior to the main event. It was a chance for delegates to raise questions with SHOT experts, network, and share ideas and experience with transfusion colleagues.

SHOT Symposium 2016

Sarah Roden gave a moving account of her family's experience of husband Sam's journey through ECMO treatment to full recovery. They now offer support to other families via their website and have launched 'pledge a pint' as a way of sponsoring Sam's future sporting efforts www.pledgeapint.co.uk/ .

Paula Bolton-Maggs presented a whistle-stop tour of the 2015 SHOT report highlighting the importance of human factors in transfusion errors.

Safety and resilience were addressed by the keynote speaker **Professor Erik Hollnagel**. He indicated that we should think more about why things go right most of the time (resilience) and not only focus on the rare events when things go wrong. **Sandra Grey** presented an outline of the 'Right first time' study in Scotland showing how they had applied the science of Human Factors/ergonomics to investigate variances in the process of blood sampling, and how to develop resilience of the system to enhance patient safety.

SHOT reports have repeatedly identified that communication difficulties can contribute to errors. **Jo Lawrence** used a video to highlight the need for effective communication between clinicians and the laboratory staff during massive haemorrhage.

Several abstracts on 'best practice' were presented; this was an opportunity for transfusion colleagues to share their innovation and good practice. (Please see box for presenters and winners).

Jo Howard gave excellent insights into the complications of sickle cell disease and hyperhaemolysis.

Karen Shreeve (BBT Wales) presented an evaluation of the transfusion education programme for junior doctors in Wales. It showed the collaboration of all Welsh health boards to standardise an education package for junior doctors.

Transfusion-Associated Circulatory Overload definitions continue to be discussed at an international level through ISBT. **Sharran Grey** - a member of the ISBT working party - presented an update of the progress so far.

The day concluded with an interactive session chaired by **Fiona Regan**. The cases presented generated interesting discussions around HEV components and the management of paediatric exchange transfusion.

Overall, the evaluation of the event was very positive with 98.1% of 217 respondents rating the event as good or excellent.

Winners SHOT Symposium 2016

Oral Presentations

Best Practice Abstracts
Estimating blood loss – do we get it right?
Nicki Jannaway
Royal Cornwall Hospital (Truro)

Prevention of WBIT in intensive care
Tina Wright
Sherwood Forest NHS Foundation Trust

Who am I? Identification
Mary P McNicholl
Altnagelvin Hospital, WHSCT, NI

Safe sampling – a reliable answer?
Debbie Thomas
Royal Cornwall Hospital (Truro)

Poster Winner
Mary Marsden and colleagues
Minimising missed anti-D administration – trends, triumphs & tribulations
Central Manchester University Hospitals NHS Foundations Trust

Best practice or service improvement abstracts date extended to 30th December 2016

Best Practice: Abstracts are invited for oral presentation at the Annual SHOT Symposium, Wednesday 12 July 2017 at Rothampsted Centre for Research and Enterprise, West Common, Harpenden, Hertfordshire, AL5 2JQ. (The abstract deadline for other submissions is **Friday April 28, 2017**).
See the SHOT website news panel for more details and abstract instructions www.shotuk.org

FAST FACTS

100%

The number of NHS organisations registered to report to SHOT directly or indirectly

77.7%

The percentage of reports that were error related received by SHOT in 2015

46.1%

Percentage of TACO cases in 2015 which documented a poor outcome for the patient

Please complete your outstanding SHOT reports for 2016

SHOT reporting for the current calendar year ends 23rd December 2016.

Completed cases appear as green in your workspace;
incomplete cases appear yellow. Please sign into your SHOT database (Dendrite) workspace and try to complete any "yellow" cases before **Friday 23rd December 2016**.

Incomplete new registrations, those awaiting case notes or undergoing lengthy investigations can roll over to next year.

Please contact the SHOT office to discuss outstanding reports that are older than 6 months advise to on their progress.

Did you know..?

Additional information such as root cause analyses (RCA) coroner's reports and Hospital Transfusion Team conclusions are very helpful when analysing SHOT reports. Reports are often closed without this useful information being uploaded.

Reports can be re-opened if you wish to upload any supporting information at a later date. Please contact the SHOT office for assistance.

twitter

COMING TO SHOT SOON...!

Watch this space **#SHOTHV**

DIARY DATES 2016

Paediatric and neonatal transfusion – your questions answered

Thursday 2nd February 2016

Hilton Metropole, Birmingham

BSH Annual Scientific Meeting

27th – 29th March 2017

Brighton Centre, Brighton

Annual SHOT Symposium

Wednesday 12th July, 2017

Rothamsted Centre for Research and Enterprise

Serious Hazards Of Transfusion **SHOT**

Annual SHOT Symposium 2017

Wednesday 12 July

Rothamsted Centre for Research and Enterprise, Harpenden, Hertfordshire, AL5 2JQ

Please see overleaf for location details

Abstract submission deadline: Friday 28 April 2017

Update from the Chair of the UK Transfusion Laboratory Collaborative (UKTLC)

The UKTLC is a group of professionals represented by: IBMS, SHOT, MHRA, NBTC (and equivalents in devolved countries), UKAS, NEQAS and transfusion laboratory managers. The original objective of this group was to recommend standards of practice for hospital transfusion labs, and monitor laboratory changes that could have a negative impact on patient and staff safety. The UKTLC Standards were published in 2014 by Bill Chaffe and colleagues and are supported by both the MHRA and UKAS.

During 2017 the UKTLC are working on the following projects:

- To produce formal guidance on Staff Capacity Planning
- To review the educational requirements to meet the UKTLC Standards
- To promote better communication and conversations with stakeholders and laboratory staff.
- To monitor changes by means of the 2017 UKTLC survey

The UKTLC would really like to hear from you about concerns and good practice that could help colleagues. If you have any suggestions please contact the Chair of the UKTLC: Rashmi.Rook@sash.nhs.uk

The MHRA has recently set up " The Blood Forum" https://mhrainspectorate.blog.gov.uk/2016/11/01/launch-of-the-mhra-blood-forum/ It is easy to register and could be a very useful site for dialogue about better ways of meeting the demands of our profession and keeping up with requirements of both the regulations and ISO standards.