ANNUAL SHOT REPORT 2016 SUMMARY

**Critical points where positive patient identification is essential**

**Key SHOT Message**

ABO-incompatible transfusions are the tip of the iceberg; they most commonly result from failure to identify the patient at the time of blood sampling (wrong blood in tube) or administration to the wrong patient.

**Key recommendation 1** – Be like a pilot: use a bedside checklist as standard of care, this will prevent administration errors and is the final opportunity to detect errors made earlier.

**Key recommendation 2** – use a TACO checklist

Pulmonary complications, particularly transfusion-associated circulatory overload (TACO), cause the most deaths and major morbidity. Delayed transfusions are an important cause of death, 25/115 (21.7%) 2010 to 2016.

See full SHOT Report (www.shotuk.org) for additional recommendations in the following chapters: Incorrect Blood Component Transfused, Information Technology Incidents, Adverse Events Related to Anti-D Immunoglobulin, Immune Anti-D in Pregnancy, Acute Transfusion Reactions, Cell Salvage and Paediatric Summary.

www.shotuk.org
@shothv1
Additional key SHOT messages

Many errors in transfusion, some with serious clinical consequences, relate to poor communication between teams, shifts and interfaces. The infrastructure needs improvement to facilitate exchange of results within and between hospitals. IT errors contributed to 1 in 5 SAE reported. IT is not infallible, it makes transfusion practice safer by helping to control and support the task, but does not replace knowledge about the task.

Errors with anti-D immunoglobulin

Key SHOT messages for laboratory staff

- Understaffing and poor knowledge and skills featured in many reports in 2016: 10.0% (103/1027) of SAE reported to the MHRA result from errors made when the workload was considered to be too high or staffing too low. This was also reflected in SHOT reports
- Appropriate use and management of LIMS are essential for patient safety
- Gap analyses should be performed against national transfusion guidelines and SOP amended to correct deficiencies and to identify any necessary alterations to laboratory procedures

Overview of 2016 Reports

Near miss reports 1283/3091, 41.5%

Errors

Near miss IBCT-WCT cases n=881

Wrong blood in tube incidents are detected at testing

Most near miss incidents are clinical errors

Poor practice

- Patient not identified
- Sample not labelled at bedside
- Sample not labelled by person taking blood
- Prelabelled bottle

In increasing numbers of errors with transplants

23 ABO and D transplant errors in 2016; 19 in haemopoietic stem cell transplants 4 in solid organ transplants