SHOT

Summary of Results from the SHOT Survey sent to Transfusion Practitioners

Dec 2004
Survey to Transfusion Practitioners

Why?

- The SHOT team wanted to know what hospitals think about the SHOT reporting system
- To find out who reports SHOT incidents
- To establish how many incidents are being reported compared to the number seen
- To gain a better understanding of how SHOT can help hospitals
Survey to Transfusion Practitioners

How?

- A questionnaire was designed
- It was piloted in January 2004 in the Northwest
- Results were collected and sent to the Steering Group for comment in April 2004
Results from the pilot:

- 15/20 TP’s replied - all report to SHOT
- Incidents not always reported, as staff unsure what category to put the incident in
- They do not always report near misses as there are too many!
- TPs and BBMs usually fill the forms in
- Some suggestions made were actually already available e.g. group reporting of near misses
- Request for more denominator data
- Want SHOT to have more power to implement it’s recommendations
Survey to Transfusion Practitioners

- Pilot results discussed at the Steering Group meeting in April 2004
- Questionnaire altered to include a new question asking if there were any transfusion incidents that TPs felt were important, but did not fit into a SHOT category, and if so, to give examples
- New questionnaire then sent out to all TPs in England in July 2004
Survey to Transfusion Practitioners

Results from national survey:

- 111 replies received from 125 TPs surveyed (89% response rate)

- The TPs had been in post for varying lengths of time and so had varying amounts of experience with SHOT reporting and completing the forms
Length of time TP been in post

- In post for Less than 6 Months: 19
- In post for 6 - 12 months: 31
- In post for 1 - 2 years: 25
- In post for more than 2 years: 31
Adverse event reporting

⇒ All TPs said their hospitals took part in SHOT
⇒ 98% said they have sent in SHOT reports
⇒ 76% report all incidents to SHOT
⇒ The others report between 1 and 95% of known incidents
Adverse event reporting

Main reasons for not reporting incidents:

- Lengthy questionnaires/too time consuming to complete (9)
- Difficult to categorise the incident (2)
- HTT not made aware of incidents (2)
- Only serious incidents are reported (2)
55% said there were incidents they felt were important, but they did not fit into a category:

- use of anti D (13)
- inappropriate use (6)
- right blood to right patient incidents (6)
- labelling errors (5)
- non adherence to local policy (4)
- storage errors (4)
- wastage through inappropriate ordering (3)
- minor transfusion incidents (3)
- when patient in theatre and blood not ready (3)
Near Miss reports

- 92% send in near misses to SHOT
- 45% report all known near misses
- Others report between 2 and 90%
- Under reporting due to:
  - Lack of time to complete the forms (6)
  - Not made aware of them by ward staff (5)
  - Only report serious ones (5)
  - Too many to report (4)
  - Unsure of definition of ‘near miss’ (4)
Who normally completes the initial adverse event form?

- Transfusion Practitioner: 70
- Haematologist: 10
- Blood Bank Manager: 20
- Chair HTC: 30
- Other: 5
- It Varies: 0

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**Who normally completes the adverse event form?**

- Transfusion Practitioner: 70
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- Other: 5
- It Varies: 0
Who normally completes the SHOT questionnaire?

- Transfusion Practitioner: 70 responses
- Haematologist: 15 responses
- Blood Bank Manager: 40 responses
- Chair HTC: 5 responses
- Other: 10 responses
- It Varies: 5 responses
What can SHOT do to help hospitals participate in SHOT?

- make the questionnaires shorter and simpler (12)
- more IT/on-line applications (9)
- clearer definitions (4)
- education/training/increased awareness of transfusion incidents and SHOT in hospitals (11)
Additional comments:

- Staff are always friendly and helpful (7)
- Questionnaires too long/time consuming (7)
- The scheme is excellent (6)
- Reports are easy to read and great for educating staff (4)
- Questionnaires are getting easier to use (4)
- SHOT helps change practice (2)
- Amount of lab data requested seems unnecessary (2)
- Want on-line reporting system (2)
- Data out of date by the time it is published (2)
Main Conclusions

• Hospitals with a TP are more likely to report incidents than those without a TP
• Main reason for under-reporting is lack of time
• Some TPs have difficulty categorising incidents
• Near misses are less well reported
• It is usually the TP or BBM who completes the forms
Main Recommendations

• SHOT categories and definitions to be reviewed
• SHOT questionnaires to be made shorter
• More education/training/heightened awareness of transfusion incidents and SHOT required at all levels in hospitals
• Need for more regular/up-to-date feedback
• Need to investigate application of on-line reporting
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