SHOT data 2009

Part 1

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The Lowry, Manchester
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• Inappropriate and unnecessary transfusion
• Handling and storage errors
• Anti-D related cases
• Participation data
• Key Messages 2009
New SHOT database

- Dendrite Clinical systems – team is here today
- Reporter needs to be registered with both SHOT and SABRE
- Initial notification of an incident via SABRE site (MHRA)
- Box ticked to notify SHOT simultaneously
- Reporter data goes from SABRE to new SHOT online database
- An email with a link to the newly created report on the Dendrite database is sent (overnight) to the reporter
- Data can be entered directly, mostly tick boxes
  - database leads you to correct pages for the case being reported
- Anonymised incident data is entered directly to SHOT database (source of report not anonymous)
- PATS allows detailed analysis by SHOT team and writing group– liaison with reporters by SHOT office if required
Number of cases 2008 and 2009

- Cases in 2008 Annual Report

<table>
<thead>
<tr>
<th>IBCT</th>
<th>I&amp;U</th>
<th>HSE</th>
<th>ANTI-D</th>
<th>ATR</th>
<th>HTR</th>
<th>TRALI</th>
<th>PTP</th>
<th>TA-GvHD</th>
<th>TTI</th>
<th>TACO</th>
<th>TAD</th>
<th>AUTO-LOGOUS</th>
<th>Totals</th>
</tr>
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<tbody>
<tr>
<td>262</td>
<td>76</td>
<td>139</td>
<td>137</td>
<td>300</td>
<td>55</td>
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<td>1</td>
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<td>6</td>
<td>18</td>
<td>1</td>
<td>28</td>
<td>1040</td>
</tr>
</tbody>
</table>

- Cases in 2009 annual report

<table>
<thead>
<tr>
<th>IBCT</th>
<th>I&amp;U</th>
<th>HSE</th>
<th>ANTI-D</th>
<th>ATR</th>
<th>HTR</th>
<th>TRALI</th>
<th>TACO</th>
<th>TAD</th>
<th>PTP</th>
<th>TA-GvHD</th>
<th>TTI</th>
<th>AUTO-LOGOUS</th>
<th>Total</th>
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<tbody>
<tr>
<td>282</td>
<td>92</td>
<td>196</td>
<td>186</td>
<td>400</td>
<td>47</td>
<td>21</td>
<td>34</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>14</td>
<td>1279</td>
</tr>
</tbody>
</table>
Total number of SHOT reports

- 1996-97: 142
- 1997-98: 188
- 1998-99: 246
- 1999-00: 289
- 2000-01: 283
- 2001-02 (15 months): 483
- 2002-03: 458
- 2003-04: 541
- 2004-05: 611
- 2005-06: 532
- 2006-07: 561
- 2007-08: 1040
- 2008-09: 1279

Number of reports over the years from 1996-97 to 2008-09.
SHOT cases 2009
Cumulative cases 1996 - 2009
Mortality 2009

- 1 death considered to be directly due to the transfusion
  - A proven case of transfusion transmitted of *Pseudomonas koreensis* infection in an elderly man undergoing palliative care.

- 12 further cases in which the transfusion contributed to a varying extent to the death of a patient who was already unwell
  - 3 incorrect blood component transfused (IBCT) events resulting in ABO incompatible transfusion (2 administration errors, 1 phlebotomy error)
  - 2 inappropriate and unnecessary transfusion (I&U)
  - 1 ATR
  - 2 TRALI
  - 4 TACO
Cases and definite mortality 1996 - 2009
Major Morbidity 2009

- IBCT – there were 3 cases of major morbidity
  - All 3 ABO incompatibility, 2 were also D incompatible
- Inappropriate and unnecessary transfusion – 2 cases
  - 1 over transfusion of a 1 year old, requiring venesection
  - 1 long term sequelae following delay in transfusing a neonate for extreme anaemia post delivery
- Anti-D – 127 cases of (potential) major morbidity – potential sensitisation of women of childbearing age to the D antigen
  - Plus 1 case of severe morbidity in a child who suffered HDN due to an assumption that anti D was immune
- A total of 67 cases of major morbidity in categories of physiological reaction (ATR, HTR, TRALI, TACO, TTI)
  - to be discussed in part 2
- Minor or no morbidity – 1193 cases
Errors overview 2009 (2008)

- Incorrect blood component transfused 282 (262)
  - Administration of wrong blood 40 (47)
  - Wrong blood in tube 4 (5)
  - Special requirements not met cmv / irradiation 115 (100)
  - Special requirements not met other 39 (17)
  - Laboratory errors 82 (93)
  - Miscellaneous 2 (0)

- Inappropriate or unnecessary transfusion 92 (76)
- Handling and storage errors 196 (139)
- Anti-D related errors 186 (137)

TOTAL 756 (614)
IT related errors

- Increasing number of reports relate to IT in two main ways
  - IT defective, inadequate or inappropriate for the task
  - IT used incorrectly by staff
IBCT
IBCT cases 2009

![IBCT cases 2009 chart]

Key
- All other IBCT cases
- ABO incompatible red cell transfusions

Number of reports

Year of report

1996-97: 50 (13 ABO incompatibility)
1997-98: 71 (36 ABO incompatibility)
1998-99: 105 (26 ABO incompatibility)
1999-00: 154 (34 ABO incompatibility)
2000-01: 156 (17 ABO incompatibility)
2001-02: 281 (22 ABO incompatibility)
2002-03: 226 (26 ABO incompatibility)
2003: 243 (19 ABO incompatibility)
2004: 242 (10 ABO incompatibility)
2005: 190 (8 ABO incompatibility)
2006: 152 (12 ABO incompatibility)
2007: 252 (10 ABO incompatibility)
2008: 268 (14 ABO incompatibility)

SERIOUS HAZARDS OF TRANSFUSION

SHOT
IBCT questionnaires 2008

Key
- I&U
- HSE
- All other IBCT cases
- ABO incompatible red cell transfusions

Number of reports

Year of report
- 1996-97
- 1997-98
- 1998-99
- 1999-00
- 2000-01
- 2001-02
- 2003
- 2004
- 2005
- 2006
- 2007
- 2008

Data for each year:
- 1996-97: 63 (50, 13)
- 1997-98: 107 (71, 36)
- 1998-99: 131 (105, 26)
- 1999-00: 188 (154, 34)
- 2000-01: 173 (156, 17)
- 2001-02: 303 (281, 22)
- 2003: 324 (226, 43)
- 2004: 372 (243, 56)
- 2005: 398 (242, 79)
- 2006: 323 (190, 34)
- 2007: 332 (152, 8)
- 2008: 477 (252, 12, 10, 13)
ABO and D incompatibility
2009 (2008)

• 14 cases ABO incompatible red cell transfusion of which 2 were also D incompatible (10)
  • 10 bedside administration errors (4)
  • 2 WBIT phlebotomy errors (3)
  • 2 laboratory errors (3)

• 5 cases of D incompatible red cell transfusion (plus 2 which were also ABO incompatible)
  • 1 clinical administration error (3)
  • 1 phlebotomy error
  • 3 laboratory errors (14)
    • 12 D typing (10)
    • 1 component selection (3)
Administration of wrong blood - 1

- 40 cases (40) – majority (42) involved nursing or midwifery staff as primary or sole checker
- 16 cases involved collection of the incorrect unit from the storage site (29)
  - 7 nurse/midwife (15)
  - 1 porters (8)
  - 2 unqualified nurse (1)
  - 1 ODA (1)
  - 2 healthcare assistant (1)
  - 2 doctors (1)
  - 1 unknown (2)
- All cases would have been prevented by a properly conducted patient ID check at the bedside
Administration of wrong blood - 2

- ABO incompatible transfusion 10 (4)
  - 7 involved collection of incorrect unit from storage
- D incompatible 1 (3)
  - (excluding 2 also ABO incompatible)
- Compatible wrong blood 21 (32)
  - 19 involved red cell, 2 platelets, 0 FFP
- Incorrect component type 1 (3)
  - 1 case red cells given when platelets prescribed
- Component given when not prescribed 2 (5)
- Unlabelled components delivered directly to clinical area and administered 3 (0)
Case

An elderly man with a GI haemorrhage was undergoing angiography and required emergency transfusion. A nurse took the correct documentation with her to collect the blood but did not formally check it and collected a unit for another patient with the same surname. This incorrect unit was handed to a nurse in theatre who checked it only against the accompanying compatibility form, not against the patients wristband. The patient, who was group B D negative received 150 mL of group A D positive red cells but did not suffer any adverse reaction.
Paediatric cases

- 5 administration errors were reported in the paediatric age group – 4 in neonates and 1 in a 3 month old infant
- All 5 related to administration on ‘flying squad’ blood
  - 3 neonates received adult flying squad blood although neonatal emergency blood was available
  - 1 neonate born to a woman with high levels of anti-c was given ‘flying squad’ group O D negative red cells in error
  - The infant, who had arrested, was transfused with what was thought to be flying squad blood, but which was in fact blood crossmatched issued, and labelled for another patient (also group O D negative)
Recurrent themes

- Higher number of administration errors occurring out of hours and/or in an emergency setting
- Initial error being the collection of the incorrect unit from the issue site
- ‘Checking’ the patient ID remotely from the patient
- ‘Checking’ against paperwork, including the compatibility form, instead of the patient
- Transfusion without a prescription
- Transfusion of unlabelled, unissued components delivered directly from BTS to clinical area
- Over-riding of electronic devices designed to enhance safety
Wrong blood in tube 2009

- Of the 4 cases 2 were ABO incompatible but D compatible, 1 was D incompatible but ABO compatible and 1 was fully ABO and D compatible.
- 2 cases of ABO incompatible transfusion led to severe reactions, and in 1 case the patient died with the ABO incompatible transfusion probably contributing to the death.
- 1 cases led to the detection of a previous phlebotomy error 2 years earlier, resulting in a 4 unit transfusion at that time of D incompatible red cells
- In the fourth case a junior doctor had bled the wrong patient but detected his error when he saw a different patient being transfused.
- In all 4 cases the protocol for transfusion sample labelling was not followed
- In only 1 of the 4 cases had the member of staff involved been trained (phlebotomist)
Case 1

• An elderly man in the ED was bled and crossmatched. The blood was administered once he was in ITU. After <100mL he developed fever, bronchospasm and hypotension and died a few hours later. The wrong patient, who was group A D negative, had been bled in the ED, while this recipient was group O D negative. A locum member of medical staff took the sample and did not know or follow the protocol for patient ID checking.
Case 2

- A patient receiving a transfusion on a day ward developed fever, rigors and bronchospasm after 50 mL and a respiratory arrest at 20 minutes. He was admitted and stabilise. The original G&S sample had been mislabelled by a trained phlebotomist using a bedside computed generated label, which was in fact for another patient, who was group A, while the patient transfused was group O. There was no transfusion history as it was the first transfusion for this patient.
Errors involved in WBIT

- Not checking patient ID either verbally or by wristband
- Labelling the tube away from the bedside
- Using a computer generated sticky ID label on a (pre-labelled) tube
- Deployment of locum staff not trained or familiar with standard procedures
- Reliance on bedside technology without full understanding
Special requirements not met

- 115 cases of CMV/irradiation requirement  (100)
  - Clinical errors and omissions  79
    - 69 irradiation
    - 5 CMV negative
    - 5 CMV negative and irradiation
  - Laboratory errors and omissions  36
    - 22 irradiation
    - 10 CMV negative
    - 4 CMV negative and irradiation

- 39 cases of ‘other’ requirement  (17)
  - Clinical  8
  - Laboratory  31
Clinical causes

• The most common categories of patients who did not receive the correct (irradiated) units are those receiving purine analogues and those with Hodgkin’s disease, and a range of other haematological malignancies.
• Clinicians ordering blood components are unaware of the criteria for special requirements
• Doctors not directly involved in the patients care are insufficiently familiar with the case to know what is needed
• The need was in some cases clearly documented in the notes, but not seen by staff admitting or treating the patient
Shared care - communication

- 15 of 87 clinical based cases of SRNM related to patients undergoing shared care between 2 hospital sites in same or separate trusts
  - 5 cases were emergency admissions via an ED
- Transfusion laboratories often not included in circulation of documentation, perhaps due to lack of awareness of implications of treatment on critical transfusion requirements
- Information not communicated included:
  - treatment with purine analogues
  - diagnosis of Hodgkin’s disease
  - requirement for HLA matched platelets
  - recent BMT or SCT
  - CMV neg requirement for patient on ECMO
Irradiation and TA-GvHD

- This year 91 reports were received by SHOT of patients who should have received irradiated components (BCSH guideline) but did not. None developed TA-GvHD.
- There have been no cases reported in the last 8 years, but a total of 13 cases have been reported to SHOT since 1996 all of which were fatal.
- Two cases have followed transfusion of leucocyte depleted components.
- The requirement to irradiate blood components is essential for patients at risk. Approx. 300,000 irradiated components were issued from UK blood services for at risk patients in 2008-2009, so the majority of at risk patients are receiving the indicated specification. Irradiation is a proven, effective intervention to prevent this universally fatal complication of blood transfusion. The absence of new cases, given the numbers involved, is a testament to its successful prevention, and it would be imprudent to use this as a sign that TAGvHD is not longer a risk.
Recommendation 2009

• The existence, and the importance, of special transfusion requirement must be taught to junior doctors in all hospital specialities. Local mechanisms for ordering components need to facilitate correct ordering and remind staff wherever possible.
# Events originating in the hospital transfusion laboratory

- **230 events altogether (200)**
  - IBCT  149 (132)
    - Wrong blood  21 (39)
    - Wrong group selected for SCT patient  13 (4)
    - Other pre-transfusion testing errors  48 (48)
      - Testing errors  9
      - Procedural errors  39
    - Special requirements not met  67 (41)
  - Anti D  38 (47)
  - Handling and storage errors  43 (21)
IBCT laboratory errors

- Lab errors account for 18% of all SHOT reports in 2009 and 53% of IBCT reports.
- 21 cases (9% of all lab errors) were wrong blood incidents, compared with 39 (20% of lab errors) in 2008.
- There was 1 case of major morbidity from an ABO incompatible transfusion because the wrong sample had been used for the cross match. The group O D positive patient received group A D negative cells.
- There were a number of cases involving IT systems which were misused, with alarms and flags over-ridden or ignored, as well as inappropriate use of electronic issue.
- There were 67 cases of SRNM:
  - 27 due to poor serological knowledge/failure to recognise the need for special requirements (phenotyped units, MB treated, pregnant patients etc)
  - 40 cases of failure to consult the patient records thoroughly (need for irradiation, CMV negative, HLA matched etc)
I&U cases 1996 - 2009

![Bar chart showing the number of reports per year from 1996 to 2009.](chart.png)
Inappropriate and unnecessary transfusion – 92 cases (76)

- Transfusions based on wrong Hb, platelet or coagulation result 53
  - Based on wrong Hb results 45
    - Clinical cause (inc. blood gas machine) 33
    - POCT cause 3
    - Lab cause 6
    - Unknown cause 3
  - Based on spurious platelet count 8
  - Based on incorrect coag result 0
  - Poor knowledge and prescribing 37
  - Under transfusion 2

- Poor knowledge and prescribing 37
- Under transfusion 2
Outcomes from I&U cases

• 0 deaths directly related to these cases
• 2 deaths in which the transfusion of red cells possibly or probably contributed to the patients death, though as the patients died very quickly after receiving the red cells full investigations were not performed.
• 2 cases of major morbidity
  • 1 in which an over transfused patient required venesection
  • 1 neonate who suffered long term sequelae from delayed and inadequate transfusion following massive feto-maternal haemorrhage
Case

• Following abdominal surgery a patient fell and fractured her femur. Her most recent previous Hb was 15.9 g/dL. A new FBC sample was tested and the BMS called the ward giving an Hb of 6.1 g/dL, requesting a repeat sample as he was concerned that it was incorrect. The result was passed to the medical team without the additional request for a new sample. On the basis of the erroneous result, despite no clinical evidence of extensive blood loss, a 4 unit transfusion was ordered and given without further review. The patient’s Hb was 20.2 g/dL the next day before surgery and the anaesthetist was aware of this. The patient developed cardiac failure and died.
Commentary

- There are a series of errors in this case....
- This year there were 5 cases in which a request for a repeat sample made by a BMS was ignored by doctors
- In addition there are other cases in which the BMS gave a result which s/he felt to be invalid
  - Includes cases of platelet clumping
  - If a result is thought by a BMS to be incorrect, a repeat sample should be requested but the result NOT be given
- Some wards have access to ‘unverified’ results on the computed, and doctors have acted on them while the lab was in the process of checking
- If there is platelet clumping the platelet count should not be given on the report
Poor knowledge and prescribing

- 37 cases this year – tip of the iceberg
- 8 cases of excessive transfusion of red cells to an infant or child
- 7 cases of transfusion of adults resulting in Hb in excess of upper limit of normal range
  - Poor clinical assessment of patient or blood loss
- 5 cases of excessive and unnecessary transfusion of patient with chronic iron deficiency anaemia
  - Some repeated demands by GP for a patient to be transfused
- Incorrect type or quantity of component prescribed in 14 cases
  - Excessive cryo (and platelets in 1 case) due to lack of familiarity with pooled packs
  - Wrong type of component requested eg FFP instead of Octaplas for TTP exchange
- 2 cases of under transfusion reported
  - Neonate following massive feto-maternal haemorrhage
  - Sickle patient following exchange red cell transfusion
Case

• A request was made for a top-up transfusion for a 1 year old with a Hb of 9g/dL. A dose of 110mL was calculated and prescribed. An adult unit was sent from the lab, and nurses did not see the volume prescribed and gave the entire 230 mL. the post transfusion Hb was 19 g/dL and the child required venesection.

• The reporting hospital suggested that the prescription chart could be improved to allow for clearer prescribing of blood component volumes for paediatric patients and others.
Handling and storage errors

- Further increased to 196 cases in this report from 139 in 2008 i.e. a 41% increase

<table>
<thead>
<tr>
<th>Error</th>
<th>Count</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical administration errors</td>
<td>12</td>
<td>(9)</td>
</tr>
<tr>
<td>Transfusion of expired red cells</td>
<td>31</td>
<td>(45)</td>
</tr>
<tr>
<td>Excessive time to transfuse</td>
<td>69</td>
<td>(24)</td>
</tr>
<tr>
<td>Cold chain errors</td>
<td>84</td>
<td>(61)</td>
</tr>
</tbody>
</table>

- Overall 43 (22%) were laboratory errors, up from 15% in 2008
HSE from 1006 to 2009
Changes in HSE reporting in 2008 and 2009

- **Transfusion of expired red cells**
  - 31 cases in 2009, a 31% reduction since 2008
  - In 12 cases the blood was issued within 8 hours of its expiry time
  - 7 cases involved platelets or cryoprecipitate

- **Excessive time to transfuse** (NB 30 minute rule)
  - 69 cases in 2009, a 150% increase since 2008
  - In 22 cases the over-run time was < 60 minutes, in 22 more cases was 1 – 2 hours, in 13 cases > 2 hours, in 5 cases up to 10 hours
  - 79% in core hours and 67% routine transfusion episodes

- **Cold chain errors**
  - 84 cases, an increase of 38% from 2008
  - 12 equipment related - fridge alarms and failures
Learning points

- Blood should only be removed from CTS when the transfusion is ready to commence, i.e. patient is available with venous access in place, and prescription made
- Clearing of all fridges must be done regularly by trained staff according to local SOPs under responsibility of laboratory
- Red cells should not be issued when there is less than 4 hours before the expiry date/time
- Expiry date/time must be checked by the laboratory staff issuing the component and by clinical staff administering
- Over-running units should be taken down at the expiry time as the product liability ends then
Anti-D
Categories of anti-D events

<table>
<thead>
<tr>
<th>Category of adverse event</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omission or late administration of anti-D immunoglobulin</td>
<td>127</td>
</tr>
<tr>
<td>Inappropriate administration of anti-D immunoglobulin</td>
<td>62</td>
</tr>
<tr>
<td>to a RhD positive patient</td>
<td>27</td>
</tr>
<tr>
<td>to a patient with immune anti-D</td>
<td>20</td>
</tr>
<tr>
<td>to a mother of a RhD negative infant</td>
<td>6</td>
</tr>
<tr>
<td>to the wrong patient</td>
<td>9</td>
</tr>
<tr>
<td>Wrong dose of anti-D immunoglobulin given according to local policy</td>
<td>6</td>
</tr>
<tr>
<td>Administration of expired or out of temperature control anti-D Ig</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>196</td>
</tr>
</tbody>
</table>
Anti-D reports 1998 - 2009
Commentary

• Number of reports to SHOT in this category has continued to increase, from 137 in 2008 to 186 in 2009
• There were 127 cases of omission or late administration of anti-D
• There was 1 case of a baby which suffered from HDN after an incorrect assumption by a laboratory that the antibody detected was prophylactic anti-D when in fact it was immune
• There were 3 reports in which this incorrect assumption was made
• In previous years approximately 2/3 of SHOT anti-D reports involved errors by clinical staff, and 1/3 from laboratory staff. In 2009 the proportion of clinical errors has increased to 80%
• SHOT records omission or late administration as ‘major morbidity’ because of the potential for sensitisation to the D antigen. Currently follow up data on these cases is sporadic. SHOT is developing a system in the new database to collect follow up results.
Recommendations 2009

• Trusts must ensure that there is representation from midwives and obstetricians on HTCs with the aim of jointly drawing up local protocols for the request, issue and use of anti-D based on established national guidance

• Cases of late administration, omission or inappropriate administration of anti-D must be the subject of internal follow-up within trusts/hospitals via established governance structures
Participation
• >90% of hospitals send cases to SHOT – the exact number will be clearer with the new database

• In 2009, 26 hospitals that are registered with SABRE sent no reports to MHRA (the majority are small independent hospitals)

• Patterns of reporting are variable, but the trends show continuing improvement
## Participation by UK country

**Total number of reports per 10,000 components by country 2006–2009**

<table>
<thead>
<tr>
<th>Country</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>4.3</td>
<td>4.6</td>
<td>7.7</td>
<td>8.1</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>5.3</td>
<td>6.6</td>
<td>10.0</td>
<td>10.5</td>
</tr>
<tr>
<td>Scotland</td>
<td>3.6</td>
<td>3.1</td>
<td>5.4</td>
<td>6.8</td>
</tr>
<tr>
<td>Wales</td>
<td>7.5</td>
<td>8.4</td>
<td>12.3</td>
<td>19.6</td>
</tr>
<tr>
<td><strong>United Kingdom</strong></td>
<td><strong>4.4</strong></td>
<td><strong>4.8</strong></td>
<td><strong>7.8</strong></td>
<td><strong>8.5</strong></td>
</tr>
</tbody>
</table>
Types of reports sent to SHOT

Analysis of types of incidents reported to SHOT

<table>
<thead>
<tr>
<th>Category</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisations which reported anti-D incidents only</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Organisations which reported physiological reactions only</td>
<td>12</td>
<td>11</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Organisations which reported errors and near misses only</td>
<td>117</td>
<td>116</td>
<td>103</td>
<td>32</td>
</tr>
<tr>
<td>Organisations which reported errors and near misses and physiological reactions</td>
<td>80</td>
<td>88</td>
<td>121</td>
<td>206</td>
</tr>
<tr>
<td>Organisations which had all reports withdrawn</td>
<td>8</td>
<td>7</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>223</td>
<td>225</td>
<td>237</td>
<td>255</td>
</tr>
</tbody>
</table>
Graph showing improved participation
2006 - 2009
One report?

- There are still some non-reporters, and some reporting organisations sending only 1 report to SHOT.
- It is hard to understand how any organisation involved in blood component transfusion can only have 1 incident (reaction, event or near miss) to report in a year.
- SHOT will be looking at reporting rates against blood usage denominator data for trusts as well as regions and countries and trying to identify the barriers to reporting.
- The number of organisations sending just 1 report has decreased from 51 in 2006, to 48 in 2007 and 29 in 2008 and 2009.
Graph showing reporting rates from English regions 2007 - 2009
What SHOT is doing

• Enlarged SHOT team
• Making it easy to report
  • New database
  • Guidance on what to report
• Engage with frontline staff
  • SHOT newsletter
  • SHOT stand at BGS, ScotBlood and BBTS
  • Regular attendance at RTCs, TAGs, transfusion education days
Key messages
SHOT Key Messages 2009

• Laboratory and clinical IT systems
  • Over-reliance on IT and believing that it circumvents human error can result in a decrease in understanding of and engagement with the transfusion process among the staff involved
  • Main recommendation this year. To be discussed in more detail in separate talk

• Pulmonary complications of transfusion
  • Main recommendation this year. To be discussed in Part 2 and by our guest speaker...
SHOT Key Messages 2009

• Patient identification
  • The patient identification check continues to be a critical point in the transfusion process where errors are made

Recommendation:

A patient education campaign should empower recipients of blood transfusion, and all patients undergoing tests, procedures and surgery, or receiving drugs and therapies, to ask the staff, before they carry out the intervention: ‘Do you know who I am?’
SHOT Key Messages 2009

• Clinical handover
  • A considerable number of cases have occurred out of hours, at times when staffing was reduced, or when shift working meant that junior doctors were caring for large numbers of patients with whom they were not familiar

Recommendation:

*Trusts should implement use of a documented clinical handover tool, such as the one developed by the Royal Colleges, as part of a formal patient handover system*

• Separate talk this afternoon
Thanks

- Writing group
- Steering Group and Working Expert Group
- Dr Hannah Cohen, Steering Group Chair
- David Mold, Operations Manager
- Hilary Jones, Data Analyst
- Tony Davies, SHOT transfusion liaison practitioner
- Julie Ball and Hema Mistry, incident specialists
- Kathryn Gradwell and Victoria Peake, SHOT office information officers
- NHSBT for accommodation in Manchester and London
- UK Forum for funding
- HTTs for reporting