



Serious Hazards
of Transfusion

What year did SHOT publish its first annual report?

- A 1995
- B 1996
- C 1998
- D 1999

How many of the 3,326 errors reported to SHOT in 2018 were laboratory errors?

A 885

B 976

C 1,002

D 1,506

HD is stated on a Group & Save request.
What is it likely to stand for?

- A Haemolytic Disease
- B Hodgkin's Disease
- C Heart Disease
- D Haemodialysis

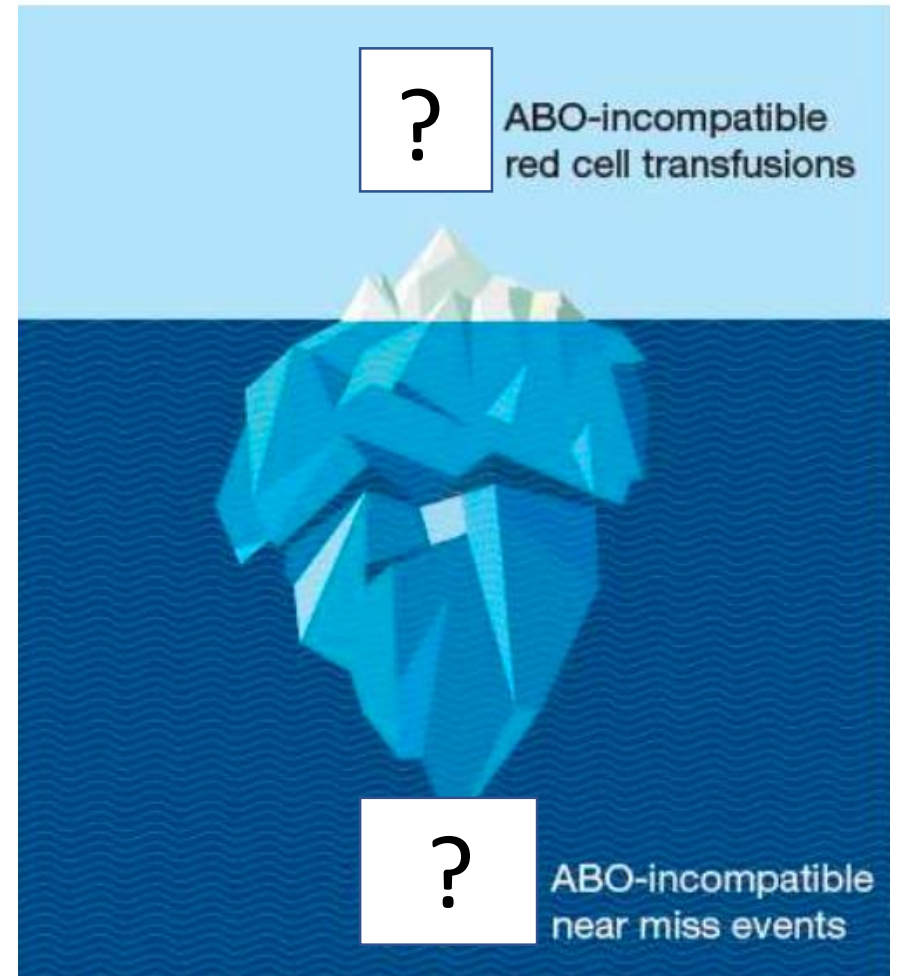
This shows ABO incompatible red cell transfusions and ABO incompatible near miss events in 2018. What are the missing numbers?

A 4 & 903

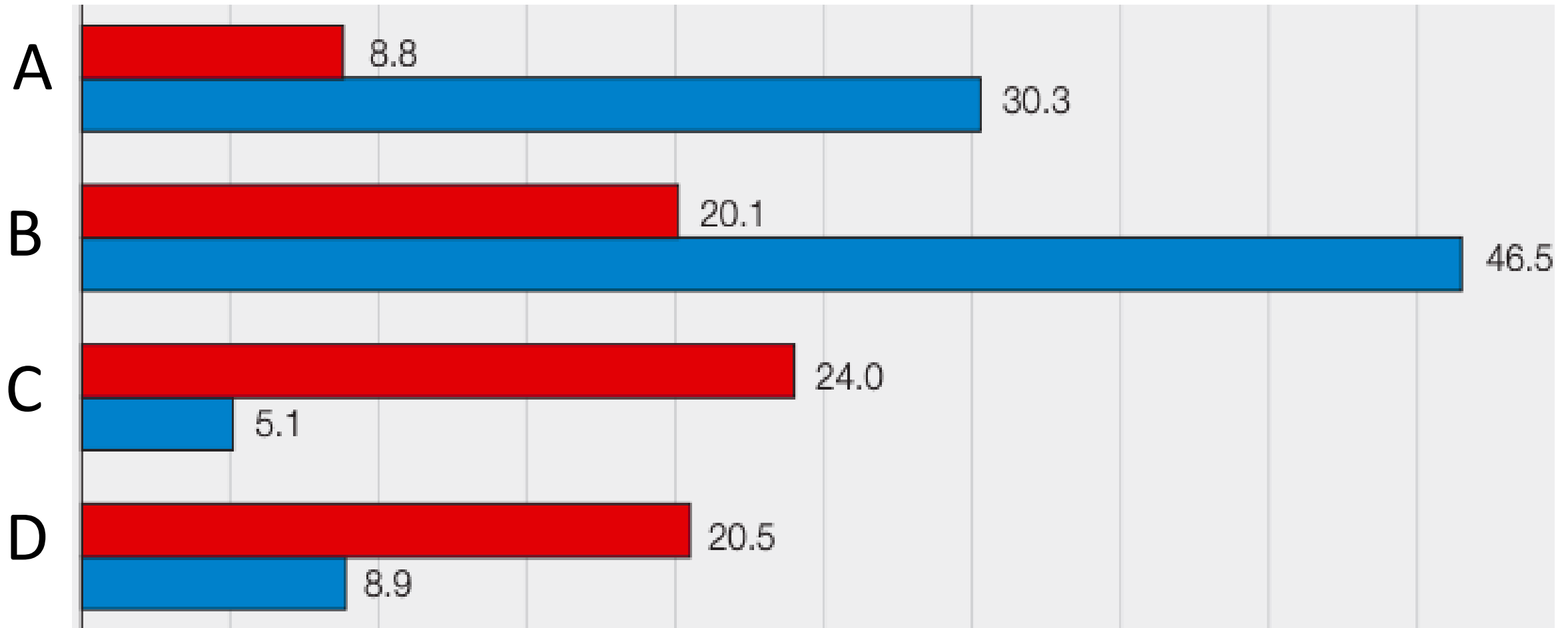
B 6 & 926

C 7 & 913

D 8 & 907



This graphic shows % of samples taken (blue bar) vs % of Wrong Blood in Tube incidents (red bar) by different staff groups. Which letter represents Medics?



Male, 84, Hb 77 with haematuria and ischaemic heart disease. A RBC unit was prescribed at 19:00, nursing staff decided not to give the transfusion overnight. Is this the correct decision?

A Yes

B No

C Maybe, need more information

In 2018, SHOT reported 272 Incorrect Blood Components Transfused incidents. Bars show location of the error – lab or clinical.

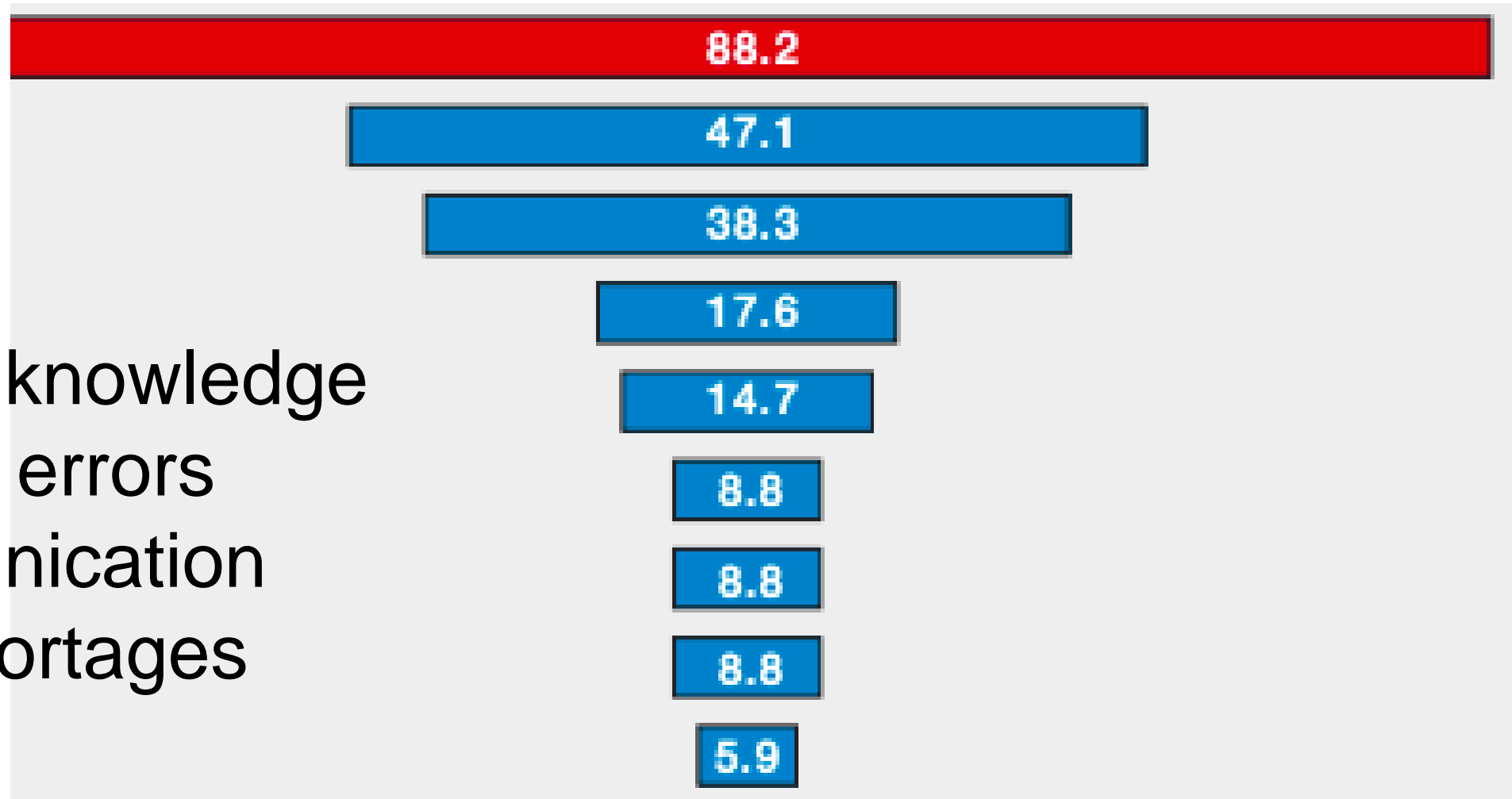


Who made more errors?

A Laboratory

B Clinical

This shows factors (%) that contribute to errors relating to MH police. What does the red bar represent?



- A Lack of knowledge
- B Sample errors
- C Communication
- D Staff shortages

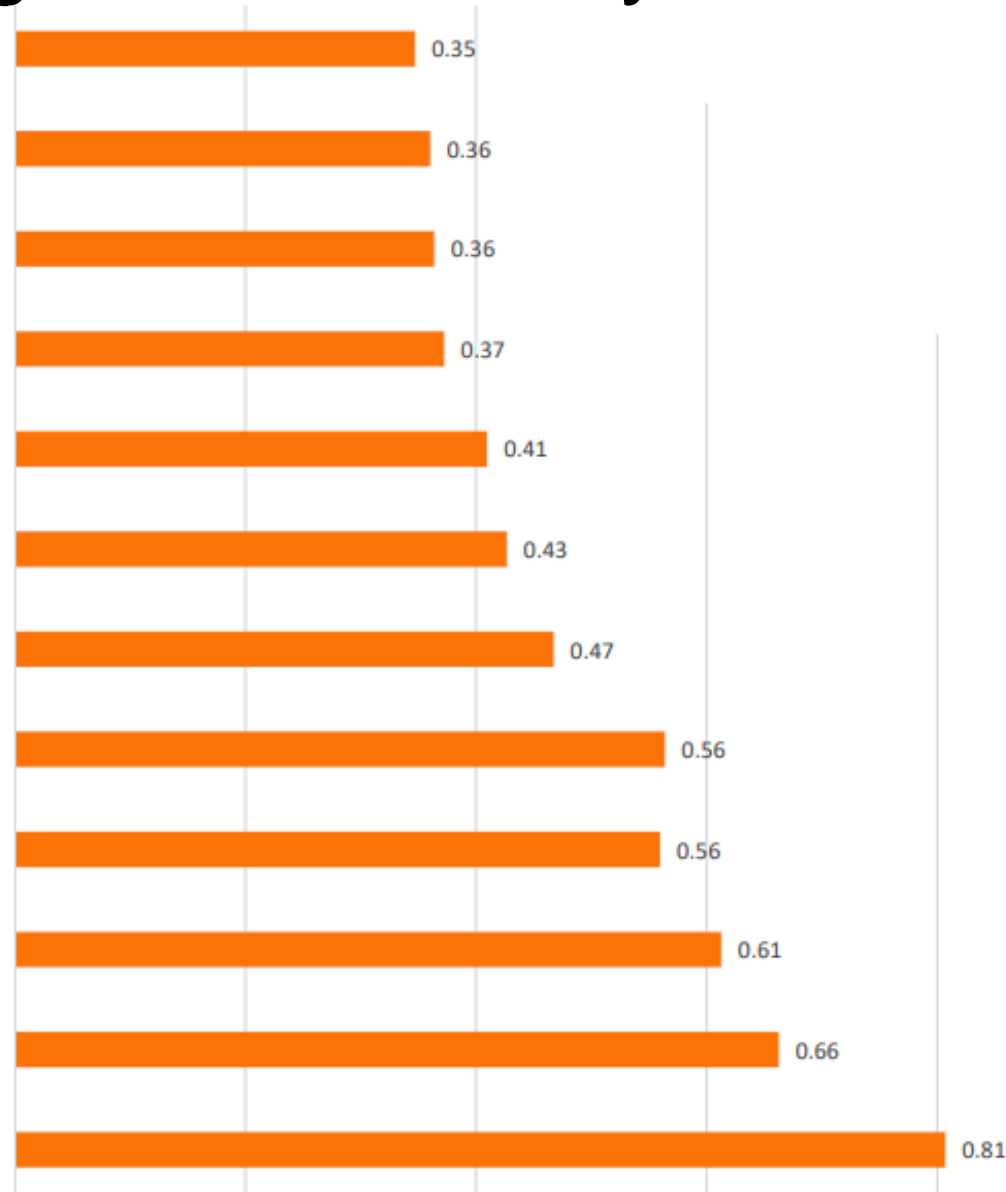
This graph shows Serious events per 1,000 components issued for each region. How many do SCRTC have?

A 0.37

B 0.47

C 0.56

D 0.81



Delays and over transfusion errors occur due to inability to estimate blood loss. How much blood is shown in this photo?

- A 531
- B 754
- C 1009
- D 1447

