SERIOUS HAZARDS OF TRANSFUSION – (SHOT)

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Serious Hazards of Transfusion

- Aims of this Session

- SHOT – What is it?

Aims & objectives

Reportable categories

SHOT examples – lessons to be learned

What is SHOT??

SHOT in baseball terms
refers to “a home run”

What is SHOT?

The Serious Hazards of Transfusion is

- Voluntary
- Confidential
- Anonymised
- Professionally led
- Launched in 1996

What is SHOT?

Collects and analyses information on transfusion related events and reactions from **all** establishments involved in transfusion within the UK.

- Red Cells
- Platelets
- Granulocytes
- Fresh Frozen Plasma (FFP)
- Cryoprecipitate
- Autologous (ICS) (2009)
- Anti-D

The Aims of SHOT are:-

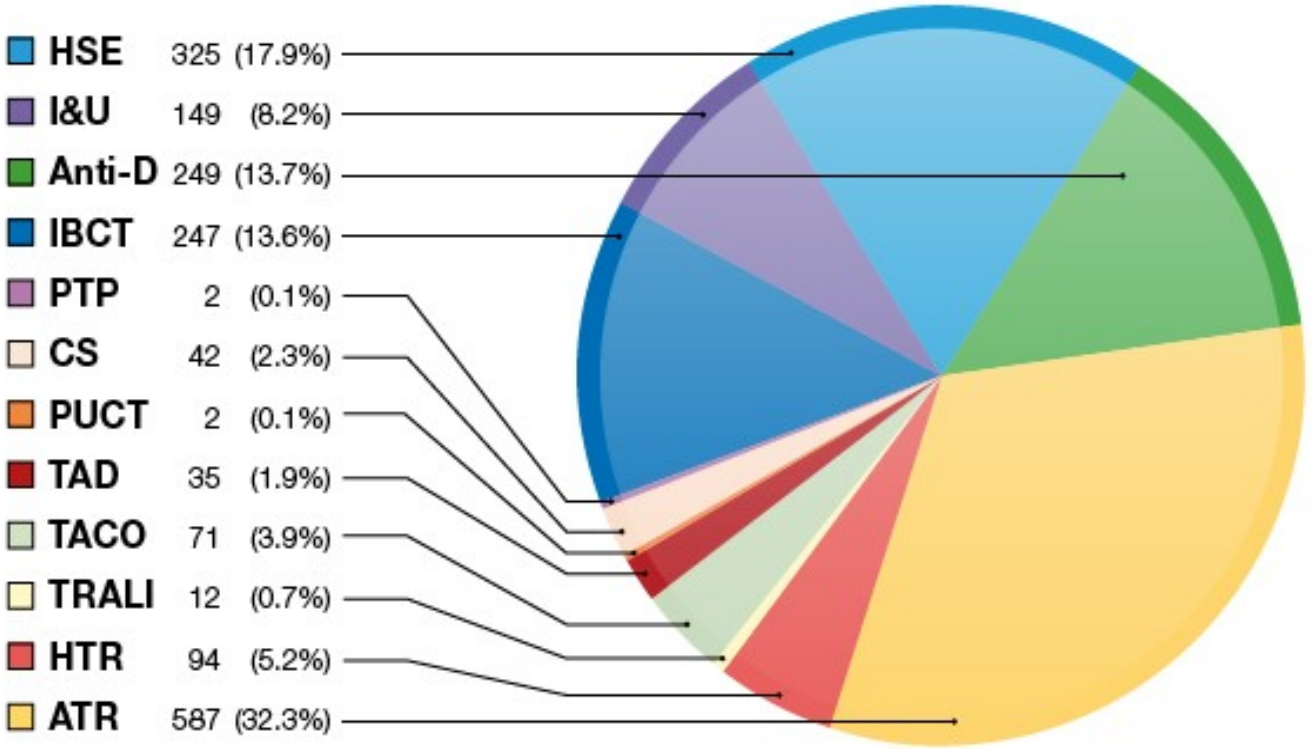
- To INFORM policy within the Blood Services
- IMPROVE standards of hospital practice
- EDUCATE users on hazard prevention
- Aid production of CLINICAL GUIDELINES

2011 SHOT incidents

Figure 4.1

Cases reviewed in 2011 (excluding near miss and instances where the patient received a correct component despite errors having occurred – RBRP)

n=1815

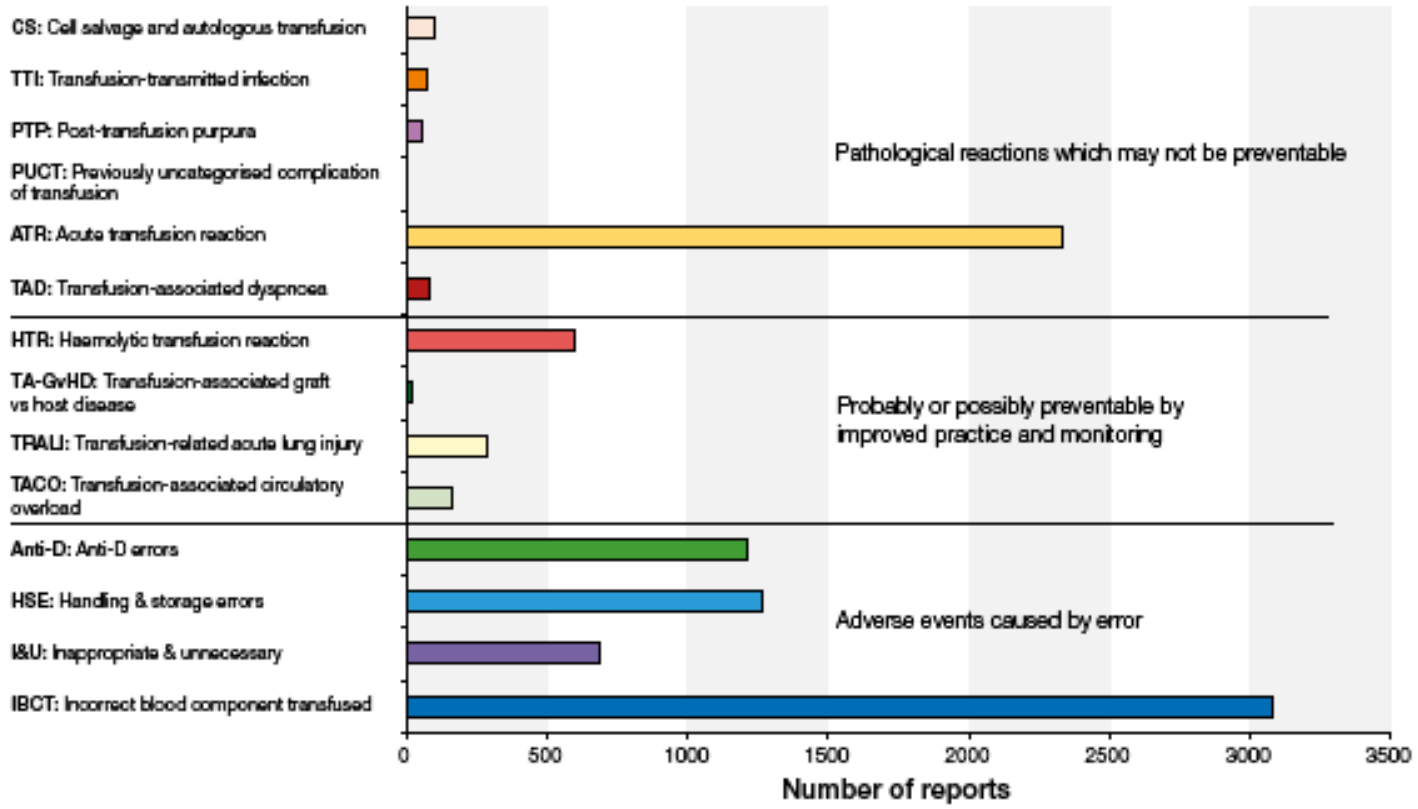


SHOT data 1996 - 2011

Figure 4.2

Cumulative data for SHOT categories 1996/7-2011

n=9925



SHOT – Blood Sampling

40 yr old undergoing surgery needed urgent tx. Sample received in lab labelled for patient A. Blood grp did not match historical record. Lab contacted theatre who identified patient B was the one in theatre who needed urgent tx, but her samples had been labelled as pt A (previously in theatre).

What can you do?

SHOT – Blood Sampling (2)

- Patient X bled into a pre-labelled sample tube with patient Y's details
- Patient Y (23 year old) experienced a post-op haemorrhage
- Patient Y was Group O and received a unit of group A red cells
- Patient complained of loin pain - transfusion reaction queried but transfusion continued
- Patient developed renal failure
- Patient died as a direct result of incompatible transfusion

SHOT Case

- Red cell Tx commenced in theatre using wrong giving set
- Recovery nurse noticed the error and changed the set piercing the blood bag in the process
- With agreement of the anaesthetist the bag was patched with a gauze swab and tape and the Tx continued
- Ward staff discarded the blood when the patient returned to the ward

What should have happened?

Scenario – What would you do?

- ICS is being used in a case in theatres
- The manual button has accidentally been hit on the machine
- Collected blood has spilled over into the waste bag
- Would you/could you suck the blood back up and wash it for use?
- What are your options?

Serious Hazards of Transfusion - SHOT

Thank You!!!