SHOT Bite No. 22
SHOT or NOT Guide to reporting

SHOT Serious Hazards of Transfusion

August 2022

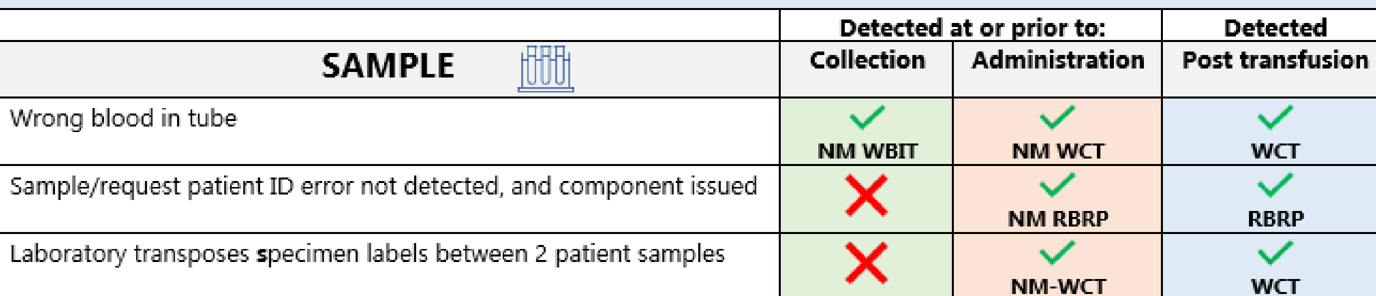
The aim of this SHOT or NOT guide is to assist reporters in determining if a transfusion incident or reaction is reportable to SHOT. It is separated into stages of the transfusion process to help identify under which category a report should be submitted. Please note that reporting is through the SABRE portal and cases may still need to be reported to MHRA, please use the latest SABRE/SHOT reporting guidance, and SHOT definitions in conjunction with this document. Examples included are for illustrative purposes and are not an exhaustive list.

Please email shot@nhsbt.nhs.uk if you need any further information or clarification, or visit the SHOT website: https://www.shotuk.org/reporting/ for the current SHOT reporting definitions

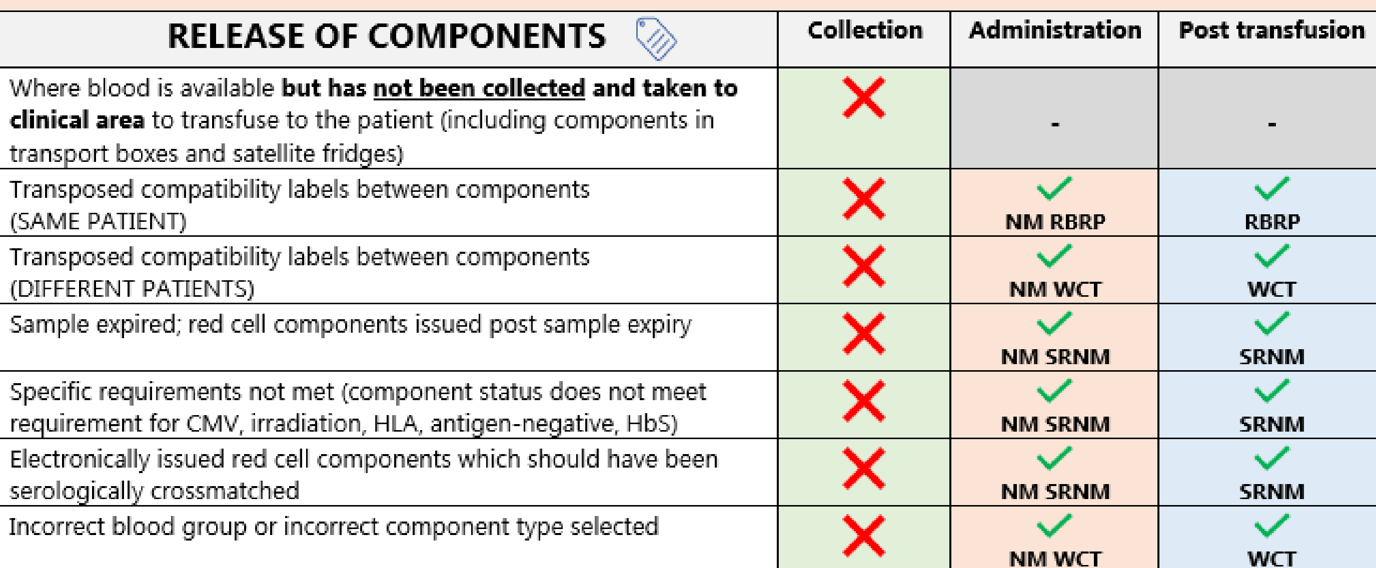
KEY TO REPORTING CATEGORIES:	**NOT** SHOT reportable	✗	SHOT reportable	✓

SHOT Categories (NOTE: where categories include near miss reporting this is denoted by NM in the tables)

ACE	Acknowledging Continuing Excellence	**HTR**	Haemolytic Transfusion Reaction	**TRALI**	Transfusion-Related Acute Lung Injury
ADU	Avoidable, Delayed and Under/overtransfusion	**PTP**	Post-Transfusion Purpura	**TTI**	Transfusion-Transmitted Infection
ANTI-D Ig	Anti-D Ig	**RBRP**	Right Blood Right Patient	**UCT**	Uncommon Complications of Transfusion
CS	Cell Salvage	**SRNM**	Specific Requirements Not Met	**WBIT**	Wrong Blood In Tube
FAHR	Febrile, Allergic, and Hypotensive Reactions	**TACO**	Transfusion-Associated Circulatory Overload	**WCT**	Wrong Component Transfused
HSE	Handling and Storage Error	**TAD**	Transfusion-Associated Dyspnoea		



SAMPLE	**Detected at or prior to: Collection**	**Administration**	**Detected Post transfusion**
Wrong blood in tube	✓ NM WBIT	✓ NM WCT	✓ WCT
Sample/request patient ID error not detected, and component issued	✗	✓ NM RBRP	✓ RBRP
Laboratory transposes specimen labels between 2 patient samples	✗	✓ NM-WCT	✓ WCT



RELEASE OF COMPONENTS	**Collection**	**Administration**	**Post transfusion**
Where blood is available **but has not been collected and taken to clinical area** to transfuse to the patient (including components in transport boxes and satellite fridges)	✗	-	-
Transposed compatibility labels between components (SAME PATIENT)	✗	✓ NM RBRP	✓ RBRP
Transposed compatibility labels between components (DIFFERENT PATIENTS)	✗	✓ NM WCT	✓ WCT
Sample expired; red cell components issued post sample expiry	✗	✓ NM SRNM	✓ SRNM
Specific requirements not met (component status does not meet requirement for CMV, irradiation, HLA, antigen-negative, HbS)	✗	✓ NM SRNM	✓ SRNM
Electronically issued red cell components which should have been serologically crossmatched	✗	✓ NM SRNM	✓ SRNM
Incorrect blood group or incorrect component type selected	✗	✓ NM WCT	✓ WCT

HANDLING AND STORAGE ERRORS	Collection	Administration	Post transfusion
Where a component is available for collection after sample expiry	✗	✓ NM HSE	✓ HSE
Component expired but is still available for collection	✗	✓ NM HSE	✓ HSE
Storage device failure with temperature excursion where components have been collected	✓ NM-HSE	✓ NM-HSE	✓ HSE

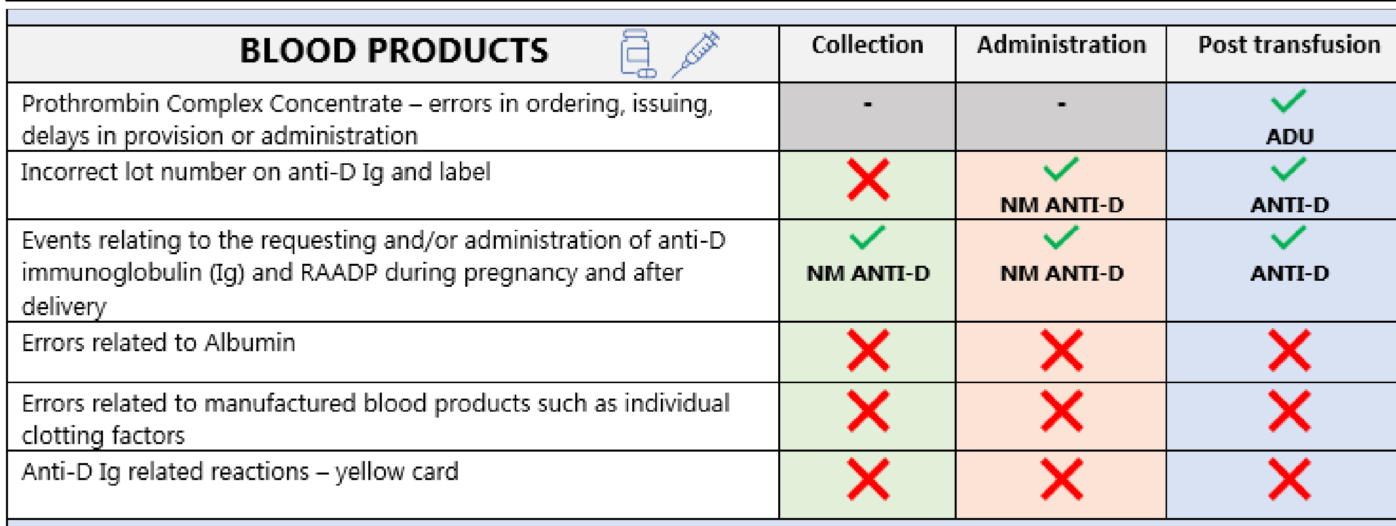
COLLECTION	Collection	Administration	Post transfusion
Component collected using paperwork without sufficient patient ID	✗	✓ NM RBRP	✓ RBRP
Component collected for the wrong patient	✗	✓ NM-WCT	✓ WCT
Wrong component collected but for the right patient	✗	✓ NM-WCT	✓ WCT

ADMINISTRATION		Collection	Administration	Post transfusion
Components transfused other than that prescribed e.g., platelets instead of red cells	Required, not prescribed	✗	✓ NM-RBRP	✓ RBRP
	Not required	✗	✓ NM-WCT	✓ WCT
Delay in provision or administration of a clinically indicated blood component that caused patient harm, resulted in admission, or required a return on a different occasion		✓ ADU		
Transfusion of patient in the absence of an ID band or equivalent risk-assessed alternative identification system		✗	✓ NM-RBRP	✓ RBRP
Transfusion of components due to erroneous or misinterpreted laboratory result or the misinterpretation of point of care test e.g., blood gas result		✗	✓ NM-ADU	✓ ADU
Excessive time to transfuse (> 5h from removal of red blood cells from cold storage to completion of transfusion)		**No patient harm**		✓ HSE
		Clinical harm (NOT pulmonary related)		✓ ADU
		Clinical harm (Pulmonary related)		✓ TACO
Over/Under transfusion with an inappropriate dose for the patient need leading to adverse patient outcome (excluding those who result in TACO)		-	-	✓ ADU
Avoidable transfusion of blood components e.g., transfusion of asymptomatic patient with haematinic deficiency		✗	✓ NM ADU	✓ ADU
Avoidable use of emergency group O blood where group specific or crossmatched blood was readily available		✗	✓ NM ADU	✓ ADU
Inappropriate giving set used		✗	✓ NM-HSE	✓ HSE
Transfusion of D Positive red cells components to an antigen negative woman of childbearing potential		✗	✓ NM-WCT	✓ WCT
Transfusion of K Positive red cells components to an antigen negative woman of childbearing potential		✗	✓ NM-SRNM	✓ SRNM

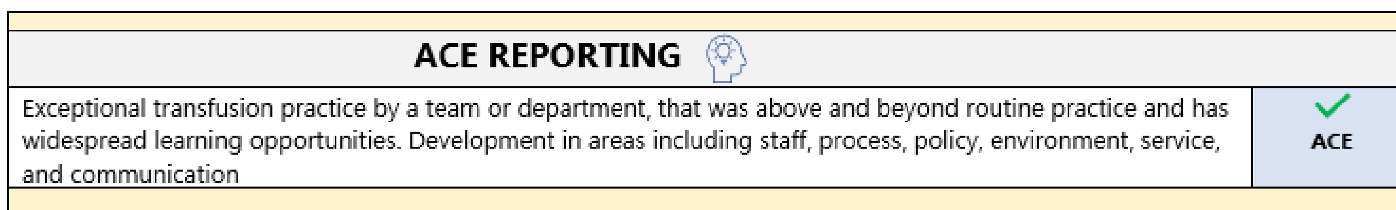
SHOT Bite No. 22
SHOT or NOT Guide to reporting

SHOT Serious Hazards of Transfusion
August 2022

POST TRANSFUSION		Collection	Administration	Post transfusion
Acute, severe, or moderate febrile, allergic, and hypotensive reactions		-	-	✓ FAHR
Post transfusion evidence of haemolytic transfusion reactions or evidence of severe haemolysis resulting in a decrease in Hb to below pre-transfusion levels-hyperhaemolysis	<24hrs of transfusion	✓ Acute HTR		
	>24hrs of transfusion	✓ Delayed HTR		
Evidence of transfusion-associated circulatory overload (TACO)		-	-	✓ TACO
Evidence of transfusion-related acute lung injury (TRALI)		-	-	✓ TRALI
Transfusion-associated dyspnoea (respiratory distress NOT related to TACO or TRALI)		-	-	✓ TAD
Transfusion-transmitted infection (TTI)		-	-	✓ TTI
Post transfusion purpura (PTP)		-	-	✓ PTP
Uncommon and new complications of transfusion (UCT)		-	-	✓ UCT
Issues related to use of cell salvage (CS)		-	-	✓ CS



BLOOD PRODUCTS	Collection	Administration	Post transfusion
Prothrombin Complex Concentrate – errors in ordering, issuing, delays in provision or administration	-	-	✓ ADU
Incorrect lot number on anti-D Ig and label	✗	✓ NM ANTI-D	✓ ANTI-D
Events relating to the requesting and/or administration of anti-D immunoglobulin (Ig) and RAADP during pregnancy and after delivery	✓ NM ANTI-D	✓ NM ANTI-D	✓ ANTI-D
Errors related to Albumin	✗	✗	✗
Errors related to manufactured blood products such as individual clotting factors	✗	✗	✗
Anti-D Ig related reactions – yellow card	✗	✗	✗



ACE REPORTING	
Exceptional transfusion practice by a team or department, that was above and beyond routine practice and has widespread learning opportunities. Development in areas including staff, process, policy, environment, service, and communication	✓ ACE