



December 2023 Newsletter

Season's greetings and Happy New Year 2024 from the SHOT team

One of the real joys this season is the opportunity to thank everyone and wish you all a festive December filled with joy and a New Year ahead brimming with hope, happiness and new beginnings.



As the year is ending, the SHOT team would like to take this opportunity to look back on the last 12 months. 2023 was a year full of challenges, accomplishments, and amazing collaboration with many healthcare professionals in the UK.

There were so many special moments throughout the year worth remembering and celebrating again. Key highlights from 2023 are presented below.



Let's dive in, shall we?



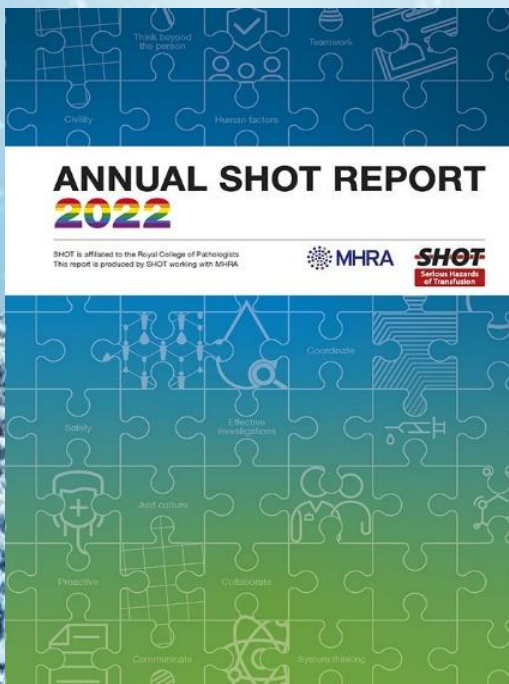
More than 300 delegates attended a diverse range of interesting sessions. The rapid-fire posters and the panel discussion were some of the highlights of the day which focussed on sharing the learning widely across healthcare professionals and organisations.



Preparations for the 2024 Annual SHOT Symposium are already in progress! Hope you are all able to join us!

SAVE THE DATE: Tuesday 09 July 2024 at the Mercure Manchester Piccadilly Hotel
<https://www.shotuk.org/annual-shot-symposium-2024/>

2022 Annual SHOT Report



The 2022 Annual SHOT Report was released at the SHOT Symposium. This collaborative report, co-written by the SHOT team and the SHOT Working Expert Group focussed on the key recommendations to enhance transfusion safety in the UK based on the incidents reported in 2022. The full report and related resources can be accessed on the SHOT website:

<https://www.shotuk.org/shot-reports/report-summary-and-supplement-2022/>

You can also order a printed copy using this link:
<https://www.shotuk.org/shot-reports/report-summary-and-supplement-2022/2022-annual-shot-report-order-form/>



Two new cumulative SHOT data pages: Near Miss and Paediatric Cases

An overview of the reports submitted to SHOT, since reporting began in the category, definitions, relevant resources and recent recommendations can be accessed via this link:
<https://www.shotuk.org/resources/current-resources/data-drawers/>



SHOT webinars

<https://www.shotuk.org/resources/current-resources/webinars/>

Do we know who they are?

Webinar on accurate and complete patient identification for safe transfusions in adults

- Your microphone is muted by the host and will remain muted throughout the session
- Please type any questions into the Q&A box below, do not use the chat facility for questions
 - Questions will either receive a response through Q&A or will be answered live
- Live captioning now available during the webinar, attendees can switch it off if not needed
- The session will finish with a poll for your immediate feedback

Thank you for attending!

Music: <https://www.bensound.com>

SHOT webinar in numbers

5 webinars

>1000 attendees

UKTLC survey and standards update – joint SHOT and UKTLC webinar

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Optimising learning from incidents – joint SHOT, MHRA and UKTLC webinar

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 - Questions will either receive a response through Q&A or will be answered live
- The session will finish with a poll for your immediate feedback

Thank you for attending!

Music: <https://www.bensound.com>

International community

Attendees from approximately 30 countries

Do we know who they are?

Webinar on accurate and complete patient identification for safe transfusions in children and neonates

- Your microphone is muted by the host and will remain muted throughout the session
- Please type any questions into the Q&A box below, do not use the chat facility for questions
 - Questions will either receive a response through Q&A or will be answered live
- Live captioning now available during the webinar, attendees can switch it off if not needed
- The session will finish with a poll for your immediate feedback

Attendees are encouraged to record their learning from this session and can enter 1 CPD point for this webinar.

Thank you for attending!

Music: <https://www.bensound.com>

SHOT Bites

<https://www.shotuk.org/resources/current-resources/shot-bites/>

SHOT Bite No. 23: Civility in Healthcare

Has ACE concepts been introduced in your transfusion department?

• If Yes, what more can be done to promote ACE? If No, how can ACE be introduced?

Introduce/promote the concept of learning from excellence to colleagues by using:

- Oral forms (internal or external sources) to capture excellence reports such as Grade or SHOT-ACE reporting and facilitate quality improvement based on these reports
- Use existing internal and external channels for promoting ACE such as team meetings, newsletters, or social media. These include regional transfusion committees or national transfusion working groups
- Encourage and explore collaborative options in creating a platform within an organisation to encourage ACE (e.g., monthly newsletters and encourage discussions on how to use these for service improvement)
- Staff surveys to assess safety culture and encourage a holistic approach to safety within the transfusion department and include both clinical and laboratory staff

Use data and evidence to monitor the impact of learning from excellence on quality, safety and satisfaction of patients and staff

- Quantitative measures e.g. number of ACE reports, excellence outcomes, feedback score
- Qualitative measures e.g. testimonials, stories and wellbeing/survey scores
- Apply quality improvement methods and tools such as Plan-Do-Act cycles, driver diagrams, run charts, etc.
- Apply water strategies for communication e.g. presentations, team discussions, publications, events, networks, conferences

Bloods morale, motivation and confidence. Positive feedback is a source of learning for both individuals and teams. SHOT-ACE encourages professional growth and promotes empowerment

- Being appreciative and expressing gratitude benefits staff wellbeing and helps develop relationships in high performing teams
- Recognising and celebrating staff achievements
- Informing improvement and innovation by identifying and learning from the factors that enable excellence to happen. Knowledge, culture, systems
- Inspires others, fosters multi-disciplinary collaboration and creates a positive work environment by sharing of excellence and insights across organisations or in different networks
- Produces better outcomes for patient through more engaged staff

Benefits of ACE

New SHOT Bites covering aspects of safety culture, cell free DNA and solid organ transplants

SHOT Safety Toolkit

SHOT Bite No. 23: Civility in Healthcare

SHOT Bite No. 24: Speaking up for safety

SHOT Bite No. 25: Safety-I and Safety-II

SHOT Bite No. 26: Acknowledging Continuing Excellence

SHOT Bite No. 27: Solid Organ Transplants (SOT)

The SHOT Bite provides a summary of all transfusion-related reports related to patients with solid organ transplants (SOT) from 2018 to 2022. SHOT-ACE reports are linked to any relevant transfusion incidents.

SHOT Bite No. 28: Cell-free fetal DNA (cffDNA) screening errors

Useful facts relating to the cffDNA screening test

- Fetal RhD screening service is available from 11th weeks gestation in Rh-negative pregnancies
- This test is not indicated for pregnant women with immune anti-D in their blood, samples should be tested for non-invasive fetal genotyping (diagnostic testing)
- The assay has sensitivity, with specificity of 99.3%, 98% confidence interval [CI] 0.96-0.997, and specificity of 98.4%, 98% CI 0.96-0.993 (Pillay et al., 2017), leading to a small risk of false-positive or false-negative cffDNA screening results
- False-positive and false-negative cffDNA screening results should be reported to SHOT and to the local provider to assess accuracy of the test
- False positives can be due to varying twin, obstetric history, or sample contamination, wrong blood in tube (WBIT), error (human or machine) in testing and presence of genes but antigen not expressed on red cell. False negatives can result from insufficient fetal DNA, WBIT or wrong maternal or placental blood
- Errors on interpretation, reporting by hospital or availability of cffDNA screening results should also be reported

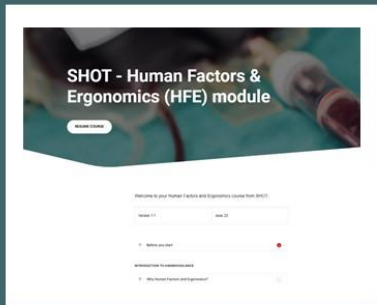
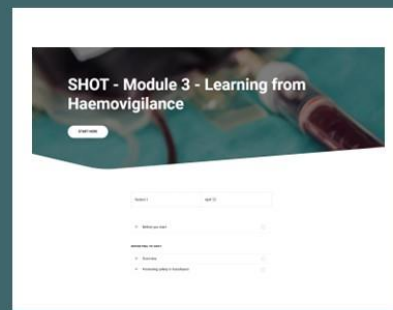
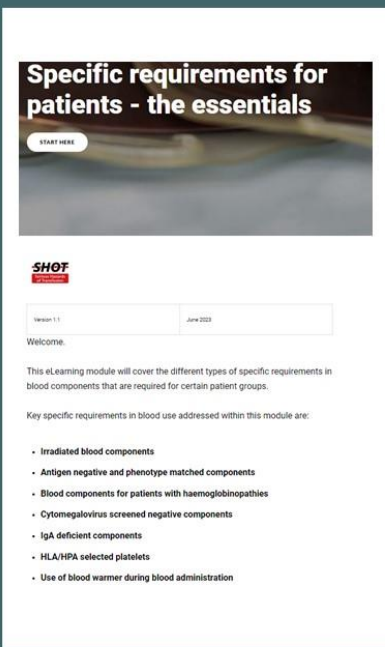
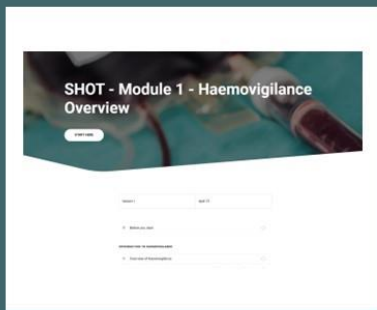
Year	From 2019 to 2022 SHOT analysed 127 cases relating to cffDNA screening	Count
2019	Failure to check cffDNA screening results prior to order, release or administration of anti-D Ig	47
2020	Cont Blood-D type discrepancy with predicted D-type – false negative leading to inappropriate administration of anti-D Ig to mother with D-negative fetus	34
2021	Cont Blood-D type discrepancy with predicted D-type – false negative leading to omission of anti-D Ig	24
2022	Misinterpretation or misunderstanding cffDNA screening results causing unnecessary administration or omitted administration of anti-D Ig	14
2019	Results not available to the clinical team due to a laboratory delay in entering cffDNA screening results into the laboratory information management system (LIMS) leading to inappropriate administration of anti-D Ig to mother with D-negative fetus	2
2020	The cffDNA result checked prior to administration of anti-D Ig was from a previous pregnancy causing unnecessary administration or omitted administration of anti-D Ig	2
2021	Mitochondria – incorrect advice from laboratory, WBIT (cord sample), transcription error and patient mislabelled on maternal anti-D Ig despite cffDNA screening predicting D-negative fetus	4



SHOT e-learning modules

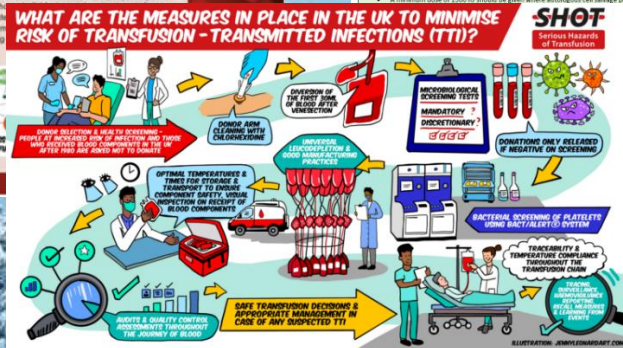
The SHOT e-learning modules have been developed in 2023 and are relevant for all healthcare staff, clinical and laboratory, involved in the transfusion process. The e-learning modules have been designed to increase awareness about patient safety related to transfusion and the role of haemovigilance in transfusion safety

<https://www.shotuk.org/e-learning-modules/>



Other resources

All resources from SHOT are free to access and available from the SHOT website and from the SHOT UK App which is free to download on any smart phone.



For all the available resources see <https://www.shotuk.org/>





Safety is a team effort!



The SHOT Team would like to take this opportunity to express our heartfelt gratitude to everyone in the transfusion community for all your amazing work this year. Your support and collaboration have been invaluable, and we sincerely appreciate your contributions. The SHOT team could not be prouder and more grateful for the achievements that 2023 delivered and are excited for the new year that fast approaches. Here's to a healthy and happy 2024 for all.



Shout out to all reporters: Ensure that any pending reports are closed before the end of the year to be included in the 2023 SHOT data!

Look out

In 2024 the SHOT reporting system (Dendrite) will have a new look!

SHOT aims to improve the reporting experience for all reporters.

Look out for the new features! Further details to follow in the New Year!

Upcoming events

SHOT team members are hoping to attend most of these events! Look out for posters, workshops, stands and much more from SHOT!



NATA24
24th Annual Symposium
8-20 April 2024
Bologna, Italy

BGS Transfusion
Conference
22-24 April 2024
Nottingham, UK

BSH – 64th Annual
Scientific Meeting
28-30 April 2024
Liverpool, UK

[Register](#)

[Register](#)

[Register](#)

SAFETY IS A...



TEAM EFFORT



If you would prefer not to receive haemovigilance communications from SHOT, then please email SHOT.unsubscribe@nhsbt.nhs.uk and you will be removed from the distribution list.

