SHOT Office Manchester, Blood Centre, Plymouth Grove, Manchester M13 9LL.
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@SHOTHV1

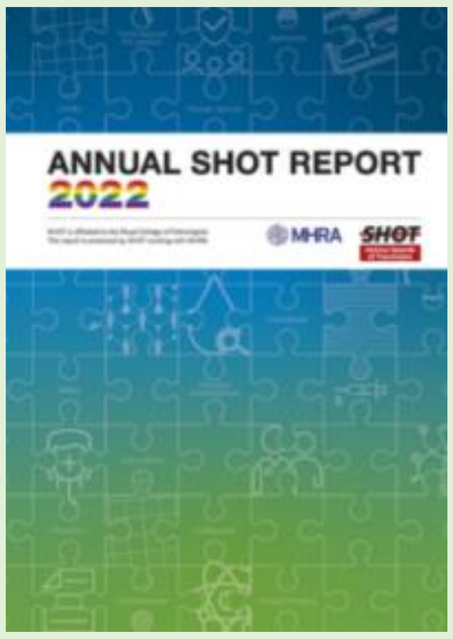
SnapSHOT Monthly Newsletter September 2023

News

2022 Annual SHOT reported printed version available to purchase

There will be a limited supply of printed copies of the 2022 Annual SHOT Report available for purchase. These can be purchased at a subsidised rate of £35 per copy (to go towards print costs), payable by credit or debit card only. Maximum 3 copies per order.

Click here to order your copy



Have your say on the Snapshot newsletter

Thank you for continuing to subscribe to the SHOT monthly newsletter, we hope that you find the newsletters useful and informative. We are currently reviewing the format of these newsletters and would like to take this opportunity to request some feedback by asking you to complete a short survey, either using the link here or in the email accompanying the SnapSHOT newsletter.

We want your ACE reports!

Did you know your can submit reports of acknowledging continuing excellence (ACE) through the SABRE portal by selecting 'Other-ACE'.

- ACE reports are not included in hospitals' participation data
- An ACE reporting guide and example reports can be found here
- The 2022 ACE chapter showing how to celebrate ACE within organisations and the benefits of ACE can be found here

https://www.istockphoto.com/

World Patient Safety Day (17th September)

SHOT are delighted to be celebrating world patient safety day and the theme **'Engaging patients for patient safety'** with the release of a safety culture toolkit. Look out for it's release and in the meantime, you can access many patient safety SHOT resources by accessing the SHOT Patient Page here.

World Patient Safety Day 17 September 2023

SHOT
Serious Hazards of Transfusion

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Resources update

The 2022 Annual SHOT Report Gap Analysis Tool has been released – see Spotlight section for more details!

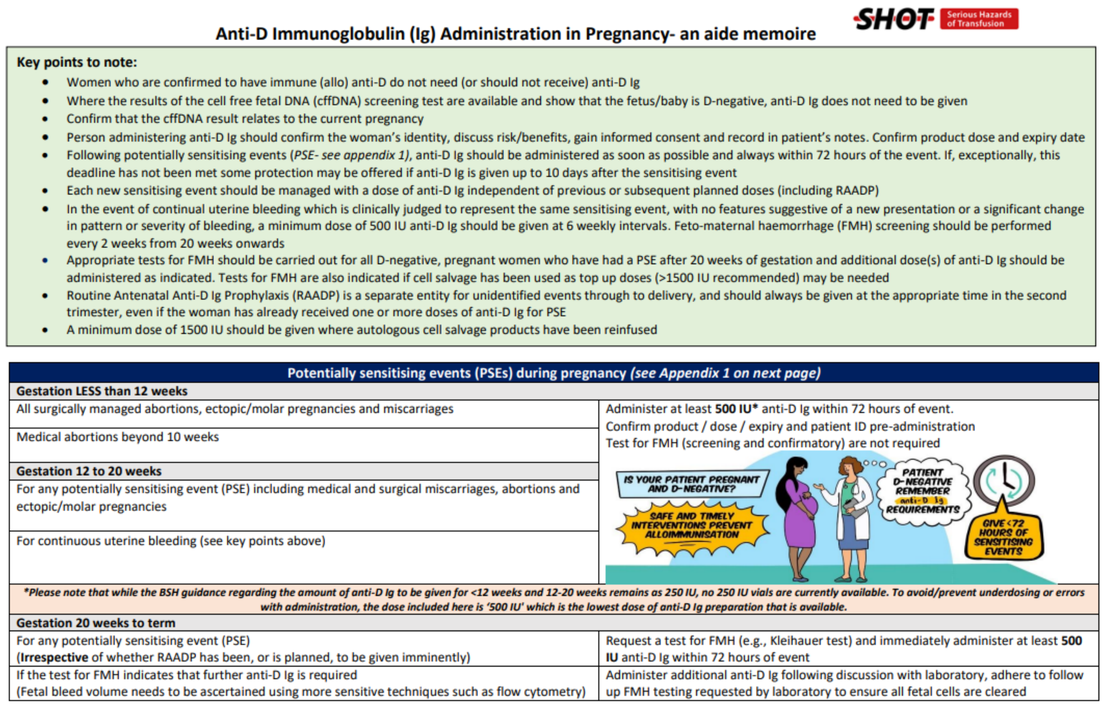
Updated Anti-D aide memoir is available

Following feedback received, the SHOT team and Working Expert Group have updated the document **Anti-D Immunoglobulin (Ig) Administration in Pregnancy- an aide memoire**.

Changes include:

- New section on anti-D Ig administration following use of intraoperative cell salvage
- Additional information on the use of anti-D Ig after potentially sensitising events and at delivery

Please discard any previous local versions of this document and replace with an updated copy



Anti-D Immunoglobulin (Ig) Administration in Pregnancy- an aide memoire

Key points to note:

- Women who are confirmed to have immune (allo) anti-D do not need (or should not receive) anti-D Ig
- Where the results of the cell free fetal DNA (cffDNA) screening test are available and show that the fetus/baby is D-negative, anti-D Ig does not need to be given
- Confirm that the cffDNA result relates to the current pregnancy
- Person administering anti-D Ig should confirm the woman's identity, discuss risk/benefits, gain informed consent and record in patient's notes. Confirm product dose and expiry date
- Following potentially sensitising events (*PSE- see appendix 1)*, anti-D Ig should be administered as soon as possible and always within 72 hours of the event. If, exceptionally, this deadline has not been met some protection may be offered if anti-D Ig is given up to 10 days after the sensitising event
- Each new sensitising event should be managed with a dose of anti-D Ig independent of previous or subsequent planned doses (including RAADP)
- In the event of continual uterine bleeding which is clinically judged to represent the same sensitising event, with no features suggestive of a new presentation or a significant change in pattern or severity of bleeding, a minimum dose of 500 IU anti-D Ig should be given at 6 weekly intervals. Feto-maternal haemorrhage (FMH) screening should be performed every 2 weeks from 20 weeks onwards
- Appropriate tests for FMH should be carried out for all D-negative, pregnant women who have had a PSE after 20 weeks of gestation and additional dose(s) of anti-D Ig should be administered as indicated. Tests for FMH are also indicated if cell salvage has been used as top up doses (>1500 IU recommended) may be needed
- Routine Antenatal Anti-D Ig Prophylaxis (RAADP) is a separate entity for unidentified events through to delivery, and should always be given at the appropriate time in the second trimester, even if the woman has already received one or more doses of anti-D Ig for PSE
- A minimum dose of 1500 IU should be given where autologous cell salvage products have been reinfused

Potentially sensitising events (PSEs) during pregnancy *(see Appendix 1 on next page)*	
Gestation LESS than 12 weeks	
All surgically managed abortions, ectopic/molar pregnancies and miscarriages	Administer at least **500 IU*** anti-D Ig within 72 hours of event. Confirm product / dose / expiry and patient ID pre-administration Test for FMH (screening and confirmatory) are not required
Medical abortions beyond 10 weeks	
Gestation 12 to 20 weeks	
For any potentially sensitising event (PSE) including medical and surgical miscarriages, abortions and ectopic/molar pregnancies	
For continuous uterine bleeding (see key points above)	

**Please note that while the BSH guidance regarding the amount of anti-D Ig to be given for <12 weeks and 12-20 weeks remains as 250 IU, no 250 IU vials are currently available. To avoid/prevent underdosing or errors with administration, the dose included here is '500 IU' which is the lowest dose of anti-D Ig preparation that is available.*

Gestation 20 weeks to term	
For any potentially sensitising event (PSE) (**Irrespective** of whether RAADP has been, or is planned, to be given imminently)	Request a test for FMH (e.g., Kleihauer test) and immediately administer at least **500 IU** anti-D Ig within 72 hours of event
If the test for FMH indicates that further anti-D Ig is required (Fetal bleed volume needs to be ascertained using more sensitive techniques such as flow cytometry)	Administer additional anti-D Ig following discussion with laboratory, adhere to follow up FMH testing requested by laboratory to ensure all fetal cells are cleared

Additional Annual SHOT Report 2022 resources

Did you know that all of the written case studies contained in the Annual SHOT Report are available in one document on the SHOT Website? All of the graphs and figures have also been collated. Click here to access them!

Please feel free to use for educational purposes whilst crediting the source as SHOT.

2022 Annual SHOT Symposium feedback update

A total of **304** attendees

- 81.3% response rate to survey
- 42.0% Transfusion Practitioners
- 25.9% Biomedical Scientists

Rating for the event overall:
Excellent (61.5%) / Good (37.4%) / Satisfactory (1.1%)

Session most rated **excellent:**
Civility in healthcare (78.7%)

Session rated most **informative:**
Key highlights from the Annual SHOT Report (35.6%)

Many useful comments were received which will be built upon when planning the 2024 Annual SHOT Symposium

"The panel discussion was excellent, really interesting to hear different patient experiences and how they are all different and have different expectations"

"I would have preferred much more time on the interactive case study sessions which unfortunately had to be cut short"

Thank you to all who attended and kindly provided feedback. The symposium relies upon the involvement of hardworking transfusion professionals!

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SHOT Serious Hazards of Transfusion

Spotlight on – 2022 Annual SHOT Report Gap Analysis Tool

The Gap Analysis Tool is now available for all SHOT reporting organisations to help identify gaps in local clinical and laboratory practices and systems to help implement the recommendations from the 2022 Annual SHOT Report and enhance transfusion safety.

- The template has been pre-formatted with the SHOT recommendations. Both main and chapter recommendations are included

- The Gap Analysis Tool includes an Action Plan, allowing organisations to record, in narrative form, comparison of current services against SHOT recommendations, and to plan and monitor continuous improvement in patient safety

- This tool should be used in conjunction with the 2022 Annual SHOT Report . Organisations also have available a diverse range of tools and resources available on the SHOT website to help put the guidance into practice.

- The level of compliance sections is for organisations to judge, based on their current activity and evidence of compliance with the recommendation. This may include levels such as 'fully compliant', 'partially compliant' and 'not compliant'. This gap analysis tool is for local use and does not require returning to SHOT

To access the Gap Analysis tool please see SHOT Gap Analysis Tool 2022

Please email shot@nhsbt.nhs.uk with any queries relating to this.

SHOT Serious Hazards of Transfusion

2022 Annual SHOT Report recommendations Gap Analysis Tool – Instructions:

Putting SHOT recommendations into practice:

Published August 2023

This gap analysis tool can be used by organisations to evaluate whether their practice is in line with the recommendations in the 2022 Annual SHOT Report. It can also help organisations to plan activities to meet the recommendations to enhance transfusion safety.

This tool should be used in conjunction with the 2022 Annual SHOT Report found at https://www.shotuk.org/shot-reports/report-summary-and-supplement-2022/ and does not require returning to SHOT.

2022 Annual SHOT Report

The main recommendations with required actions are displayed in the first tab. Recommendations relating to the specific SHOT report chapters can be found in the second tab. Please refer to the 2022 Annual SHOT Report for further detailed information relating to the recommendations.

The data sheets contain all the recommendations from the 2022 Annual SHOT Report. Information can also be entered about current activity relevant to the recommendation, actions needed to meet the recommendation, deadlines, and the names for the responsible leads. The content in the second tab can be filtered according to the chapter from the 2022 SHOT Report. Additionally, we have added a R/A/G status to the last column on the first and second tab so that progress can be monitored and updated accordingly. The data fields containing the recommendations cannot be edited but the compliance fields can be edited with the information relevant to the organisation.

Organisations may like to make use of the tools and resources available on the SHOT website to help put the guidance into practice.

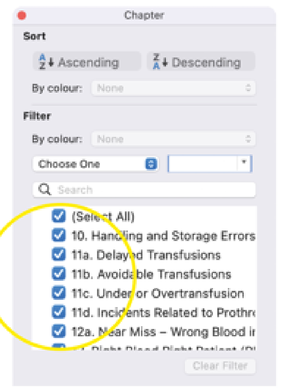
SHOT Tools and Resources

The level of compliance sections is for organisations to assess, based on their current activity and evidence of compliance with the recommendation. This may include levels such as 'fully compliant', 'partially compliant' and 'not compliant'.

We welcome any feedback or suggestions for improvement for future gap analysis tools. Please email us at shot@nhsbt.nhs.uk

INSTRUCTIONS TO FILTER BY CHAPTER

Step 1: Click the dropdown arrow in the red 'Chapter' header bar:



Step 2: Select the Chapter(s) you would like to view the recommendations for:

SHOT Serious Hazards of Transfusion

Chapter	Action by	Actions required
04. Key Messages and Recommendations	Hospital management should:	• Ensure adequate support for clinical and laboratory teams with well-resourced services for treatment of anaemia, including haematinic deficiencies
		• Ensure regular audits of blood usage, use of cell salvage and other patient blood management measures
		• Provide services that support effective identification, assessment and management of pre-operative anaemia, including intravenous iron as appropriate in a timely manner. Patients scheduled for elective surgery should be screened for anaemia far enough in advance of surgery to allow appropriate correction of anaemia
		• Ensure provision of a properly resourced cell salvage programme where the need is identified
		• Ensure policies, procedures and training are in place to avoid delays in transfusion where this would cause patient harm
		• Engage with primary care teams to facilitate early anaemia screening, investigations, referrals when relevant and appropriate management including support with haematinics
	Clinical staff should:	• Be supported by training and tools that includes knowledge to identify, investigate and manage patients with anaemia following haematinic deficiencies
		• Use decision- support tools, such as Blood Assist, to avoid unnecessary transfusions
		• Proactively involve patients in their care (monitoring, follow up, making choices regarding treatment) with shared decision-making and provide leaflets, signpost videos and aApps as relevant relating to transfusion support
	Transfusion laboratory staff should:	• Have processes in place to question potentially unnecessary transfusions
		• Have training and processes to avoid delays in provision of blood components in life threatening anaemia

Action by (lead name)	Target date	Status (R/A/G)
A. Manager	05/01/2024	Amber
T. Practitioner	15/12/2023	Red
N/A	N/A	Green

Upcoming Events -SHOT

HSJ Patient Safety Congress

Manchester Central, Manchester , 18th & 19th September 2023

Now in its 16th year, the HSJ Patient Safety Congress and Awards bring together over **1000 NHS and independent** health and social care leaders, clinicians, patients and patient representatives each September. Through acknowledging the current healthcare environment in the UK, the Congress challenges the status quo on safety with dynamic and honest discussions on how to improve patient care across the system.

Talk to us at the SHOT exhibition stand

IBMS Institute of Biomedical Science

IBMS Congress 2023 is an important forum for progressing your professional skills and knowledge, supporting career development and promoting the profession.
Learn from the leading voices in biomedical science and network with professionals across the field.

25th -28th September 2023. The International Convention Centre (ICC), Birmingham

SHOT posters and presentation 26th September: 10:30

National Haemovigilance Office

The National Haemovigilance Office (NHO) Conference 2023
Croke Park Conference Centre, Dublin on Tuesday 3rd October 2023

The target audience for this event include Hospital based Haemovigilance Officers, Medical / Laboratory Staff working in Transfusion, Consultant Haematologists and representatives from various transfusion related disciplines within the health services. The draft programme for this event will be made available in the coming weeks.

If you have any queries, please contact Haemovigilance@ibts.ie or 01 432 2731.

SHOT presentation 3rd October: 12:20

2023 BBTS Conference

The BBTS 40th Anniversary Conference 2023
Harrogate Convention Centre, 10th – 12th October.

Tailored to the specific needs of the transfusion professional, BBTS 2023 brings together delegates from around the globe to share ideas, learn from peers and develop professional contacts.

SHOT will be attending with exhibition stand and posters, plus our mini symposium: 12th October

- 9.30-9.50 Simon Carter-Graham and Jane Oldham: ABOi cases reported to SHOT – what can we learn from them?
- 9.50–10:10 Dr Jennifer Davies: Learning from transfusion related deaths reported to SHOT
- 10:10–10:30 Nicola Swarbrick: SCRIPT – overview and resource
- 10.30-10.45 Victoria Tuckley: ACE Reporting – learning from excellence

We look forward to seeing UK transfusion professionals and talking all things haemovigilance!

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IHN webinar Pathophysiology of transfusion reactions
October 24th 2023 at 14:00 CET

IHN Webinar

The meeting is free of charge but you must register to participate

SHOT presentations:
14:40 Pathophysiology of Hyperhaemolysis - Dr Anicee Danaee SHOT working expert group (WEG) member
15:15 Case of hyperhaemolysis in a non-sickle cell disease patient - Dr Joseph Sharif and Tracey Tomlinson – SHOT WEG members

North West RTC Autumn Symposium,
November 10th 9:00-16:00 Haydock Park Racecourse
The day will begin with the NW RTC Business Meeting followed by presentations on Patient Safety Incident Reporting Framework and Haemovigilance. This is a free event and open to clinical, laboratory and medical staff working in Blood Transfusion

SHOT presentations on PSIRF and incident investigation

Upcoming Events –Other

ISBT Cape Town 2023

Join the 34th Regional ISBT Congress in Cape Town, South Africa, November 18-21

This highly anticipated transfusion medicine congress will bring together experts and professionals from all over the world to share their latest research, ideas, and experiences in the field. Come join us and be part of this exciting opportunity to learn from and network with the best in the transfusion medicine community.

Midlands RTC presents Haemoglobinopathies,
November 22 12:00- 13:30 MS Teams

The meeting is free of charge but you must register to participate

Putting the lab into collaboration – Dr Tom Bullock *Consultant Clinical Scientist* NHSBT
Haem Match project – Dr Sarah Trompeter C*onsultant Haematologist* NHSBT and UCLH
Case studies – Dr Shiavn Pancham C*onsultant Haematologist* SWBH
– Dr Sarah Nicolle C*onsultant Haematologist UHCW*

Feedback is always welcome on all SHOT resources so they are accurate and useful to transfusion healthcare professionals. Please **email** shot@nhsbt.nhs.uk with any queries
Contact us by mail: SHOT Office, NHS Blood & Transplant, Manchester Blood Centre, Plymouth Grove, M13 9LL **Tel:** 0161 423 4208

Thank you for reading!

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.