

The SHOT team are delighted to announce the launch of the new website! This project represents a significant step forward in making it easier for reporters, patients, stakeholders, and the broader healthcare community to access information about haemovigilance reports, events, and resources.

Please let us know if you have any feedback to improve the website by emailing <u>SHOT@nhsbt.nhs.uk</u>



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Join us for interactive 'Meet The Experts' sessions on Zoom

Laboratory ErrorsClick here to registerThursday 06 March 2025 at 13:00 GMTfor this event

Paediatric Cases Wednesday 09 April 2025 at 12:00 GMT

Click here to register for this event

Near Miss Reporting & WBIT Monday 09 June 2025 at 13:00 GMT Click here to register for this event

ANAT

A 20-minute overview of chapter content: Including trends, highlights and example cases



Followed by 40-minute Q&A:

We want to hear from you!

- What are your urgent questions about laboratory errors?
- How have you improved practice in your area?



Important note:

To get the most out of the session, please read the relevant chapter from the latest Annual SHOT Report, come prepared with any queries you have for our experts, or email them to the SHOT team beforehand: shot@nhsbt.nhs.uk



New SHOT Definitions 2025 now available

The SHOT Definitions are a guide to what events are reportable to SHOT. These are reviewed and updated on an annual basis, with new definitions published every January.

You can find the definitions by <u>clicking</u> <u>here</u> or on the image

Definitions of current SHOT reporting categories & what to report



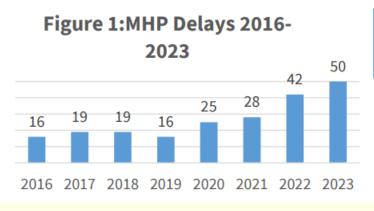
Please make sure you discard any previous versions and use the current version.

For additional guidance see: <u>SHOT Bite No 22 – SHOT or NOT guide to reporting – Serious Hazards of Transfusion</u> <u>SHOT Laboratory reporting guide</u>

Updated SHOT Bite no.8 now available

SHOT Bite No. 8 Massive haemorrhage – delayed transfusion

The number of reports of transfusion delays with patient harm, including in major haemorrhage (MH), are increasing every year (Figure 1). Common themes include poor communication, gaps in knowledge and failure to activate or follow the major haemorrhage protocol (MHP) correctly.



215 MHP related delays reported from 2016-2023. Of these, 22 resulted in patient death and 20 in major morbidity

-SHOT

Serious Hazards of Transfusion

February 2025

Between 2016-2023, delays were reported in 52 obstetric and 12 paediatric cases

Poor communication is a leading cause of transfusion delays

SHOT Videos Update

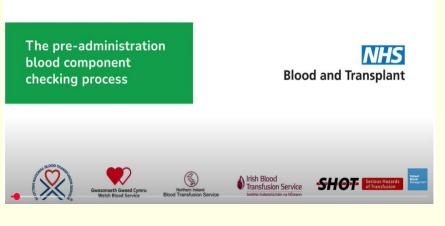
This video highlights the key steps to safely completing the pretransfusion blood sampling process.

These critical checks



are the first step in preventing transfusion of an incorrect blood component to a patient.

The video was produced through collaboration between the UK and Ireland Blood Services and SHOT. It replaces the previous versions, produced by the NHS Blood and Transplant (NHSBT) Patient Blood Management (PBM) Team, released in 2019 and 2020.



This video highlights the key steps for completing the preadministration bedside check of blood components. This critical check is the final opportunity to prevent transfusion of an incorrect blood component to a patient.

This resource can be played in full or paused at particular points to support training and knowledge of this final step.

The video was produced through collaboration between the UK and Ireland Blood Services and SHOT. It replaces the previous versions, produced by the NHS Blood and Transplant (NHSBT) Patient Blood Management (PBM) Team, released in 2018 and 2020.

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

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