We have compiled the following list from typical questions asked by reporters:

Incident Type	SHOT or NOT?	Category
Acute / severe transfusion reactions (ATR) Eg. febrile / allergic / anaphylactic reactions	1	SHOT: ATR MHRA: SAR (Serious Adverse Reaction)
Evidence of haemolysis post transfusion (eg. failure to increment Hb / positive DAT / raised bilirubin)	$\sqrt{}$	SHOT: HTR (Haemolytic Transfusion Reaction – Acute or Delayed) MHRA: SAR
Wrong digit recorded by collection staff from pack number	$\sqrt{}$	SHOT: RBRP (Right Blood Right Patient)
Delay in transfusion that impacts on the patient (clinical harm or patient has to return at a later date for the transfusion)	$\sqrt{}$	SHOT: ADU (Avoidable/Delayed/Undertransfusion)
Transfusion-associated Circulatory Overload (TACO)	√	SHOT:TACO and MHRA: SAR
Transfusion Related Acute Lung Injury (TRALI)		SHOT: TRALI and MHRA: SAR
Transfusion Associated Graft versus Host Disease (TAGvHD)		SHOT: TAGvHD and MHRA: SAR
Incorrect Blood Component Transfused with no clinical harm	$\sqrt{}$	SHOT: IBCT-WCT (Wrong Component Transfused)
Incorrect Blood Component Transfused with clinical harm		SHOT: IBCT-WCT and MHRA: SAR
Specific Requirements Not Met (SRNM) (eg. Irradiated, CMV-, antigen-selected, sample not valid)	$\sqrt{}$	SHOT: IBCT (SRNM) If lab error providing non-compliant units then MHRA: SAE too
Wrong blood component signed for in register	V	MHRA: SAE
Undertransfusion leading to adverse patient outcome	V	SHOT: ADU (Avoidable/Delayed/Undertransfusion)
Avoidable transfusions leading to a transfusion reaction	V	SHOT: ADU and MHRA: SAR
Transfusion of an expired component / incorrectly stored component / prolonged transfusion	$\sqrt{}$	SHOT: HSE (Handling & Storage Error)

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Use of incorrect administration set	√	SHOT: HSE
Patient receives the correct blood component despite missing or incorrect identification, or labelling errors / transposition of labels or incomplete prescription	V	SHOT: RBRP SHOT: NM (Near Miss) if not actually transfused
Errors detected before transfusion commences	1	SHOT: NM (Near Miss)
Post Transfusion Purpura (PTP)	V	SHOT: PTP

Reactions to anti-D immunoglobulin	X	Reportable to MHRA via Yellow Card scheme
Individual is involved in the transfusion process but is not trained or signed off as competent	X	No category for this
'Against local policy' errors	X	No category for this
Post transfusion flushing of the giving set	X	No category for this
Administration too slow or too fast	X	Unless patient develops TACO or patient harm SHOT HSE if prolonged >5hrs
Transfusion started >30 mins after removal from cold storage	X	National guidance states only that transfusion must be completed within 4hrs of removal from cold storage
Vital signs recorded more than one hour pre transfusion	X	No category for this
No vital signs recorded at 15 minutes for red blood cell transfusion	X	No category for this
No vital signs recorded at end of transfusion	X	No category for this

A complete list of the SHOT reporting definitions is available on the SHOT website www.shotuk.org
If in doubt, please contact the SHOT Office for advice: 0161-423-4208
shot@nhsbt.nhs.uk