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	\checkmark	SHOT: ATR MHRA: SAR (Serious Adverse Reaction)
Evidence of haemolysis post transfusion (eg. failure to increment Hb / positive DAT / raised bilirubin)	\checkmark	SHOT: HTR (Haemolytic Transfusion Reaction – Acute or Delayed) MHRA: SAR
Wrong digit recorded by collection staff from pack number		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)	\checkmark	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)	\checkmark	SHOT: TAGvHD and MHRA: SAR
Incorrect Blood Component Transfused with no clinical harm	\checkmark	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)	\checkmark	SHOT: IBCT (SRNM) If lab error providing non-compliant units then MHRA: SAE too
Wrong blood component signed for in register		MHRA: SAE
Undertransfusion leading to adverse patient outcome		SHOT: ADU (Avoidable/Delayed/Undertransfusion)
Avoidable transfusions leading to a transfusion reaction	\checkmark	SHOT: ADU and MHRA: SAR
Transfusion of an expired component / incorrectly stored component / prolonged transfusion		SHOT: HSE (Handling & Storage Error)

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	 SHOT: RBRP SHOT: NM (Near Miss) if not actually transfused
Errors detected before transfusion commences	 SHOT: NM (Near Miss)
Post Transfusion Purpura (PTP)	 SHOT: PTP

Reactions to anti-D immunoglobulin	Х	Reportable to MHRA via Yellow Card scheme
Individual is involved in the transfusion process but is not trained or signed off as competent	Х	No category for this
'Against local policy' errors	Х	No category for this
Post transfusion flushing of the giving set	Х	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	Х	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	Х	No category for this
No vital signs recorded at 15 minutes for red blood cell transfusion	Х	No category for this
No vital signs recorded at end of transfusion	Х	No category for this

A complete list of the SHOT reporting definitions is available on the SHOT website <u>www.shotuk.org</u>

If in doubt, please contact the SHOT Office for advice: 0161-423-4208 <u>shot@nhsbt.nhs.uk</u>