The Whittington Hospital NHS
NHS Trust

SHOT REPORT 2005 – Recommendation and Action Plans CGSG/CRC July 2007

	RECOMMENDATIONS	ACTION REQUIRED	ACTION PLANS	ACTION BY	STATUS
1	Active participation in SHOT	Active reporting to SHOT/MHRA (the Competent Authority) for Serious Adverse Event and Serious Adverse Reaction	Regular monitoring, assessment and investigate the root cause analysis, liaise with the Risk management office and report electronically to SHOT/MHRA	Abdul Adamu/ Risk Management Officer	From 11/2005 to date 9 near misses has been reported
2	Development of an open learning and improvement	Effective education and training for all staff involve in transfusion process	Develop and Maintain educational programme for all clinical and supportive staff. Carry out training drive across the trust. Introduction of E-Learning for Nurses, Midwives, ODP'S, Junior doctors, and HCA/Porters. Induction programme for FY1 & FY2. Awareness Posters, leafleting, and Audit results presentation.	Abdul Adamu James Dalton Farrukh Shah	Much progress has been made on training programme. Preparation for installation of E-Learning package is underway
3	Ensure that appropriate and effective remedial action is taken following transfusion errors	Responsible clinical and management structures	Effective organisational structures are place. We have an active CGSC, CRC, HTC and HTT	Deborah Wheeler	Complied
4	Hospital transfusion team must be established and	A balance and active HTT/HTC	To have HTC/HTT that meet periodically to deal with transfusion	Abdul Adamu Dr F. Shah	HTT/HTC meet 4 times

	supported.		issues for maintaining standard of practice	James Dalton	per year as scheduled.
5	Sufficient blood bank laboratory staff for safe transfusion practice	Staffing level at acceptable numbers of practice	To have a stable and good professional team that work together and support each other lead by a good management team. New Pathology IT system in place	Teresa Marlow James Dalton	There has been a deterioration in adequate staffing numbers and continuity during the core routine hours of 9-5
6	Education and training are of key importance for safe and effective blood transfusion practice. An ongoing programme of education and training NEONATES & PAEDS	Transfusion guidelines including neonates and older children	Guidelines disseminated to all staff including paediatricians in 2004. Collaborative work and good communication between laboratory and clinical staff/paediatricians and shared care patients. In 'Partnership' with GOS/NMH regarding paediatric care. Link support trainers in clinical areas	DR F. Shah Abdul Adamu James Dalton	The training programme is currently being updated with the introduction of E-learning.
7	Mechanisms in place regarding special requirements	Indication on the blood request form and communication between clinicians and the laboratory staff	Clinical staff must be aware to tick the box in the blood request form for any patient special transfusion requirement. And also to phone and inform the transfusion lab of their request. Transfusion guidelines, Posters and staff awareness.	Abdul Adamu James Dalton	Blood request form Guidelines & Training

8	Appropriate use of blood must be promoted and Alternatives to transfusion evaluated	National guidelines on the indications for blood and blood products	Presentation of recent audit and research findings to clinical staff. Monitoring each request and indications for transfusion. Patient awareness	Abdul Adamu Laboratory staff Haematologist	All request and indications are checked and clarified
	SPECIFIC RECOMMENDATIONS - Based on reports in each category 2004				
1	All staff undertaking venepuncture for blood sampling should receive training and competency assessed and recorded.	IV study for nurses/midwives FY1 competency workbook Phlebotomy training	Whittington guideline clearly stated required training for all clinical staff before undertaking venepuncture for blood sample.	Ward & Clinical managers Medical Educational supervisor	Complied