

It is not always possible to include an experienced transfusion specialist BMS assessor to routine hospital blood banks. CPA assessors are required to conduct an audit of transfusion medicine incident reporting during the assessment visit to this type of laboratory. This audit shall include Serious Hazards of Transfusion (SHOT).

We are requesting that the assessors focus on SHOT reporting under the standard H2.1d.

The emphasis in the audit should be in establishing whether there is a framework and a culture in the laboratory within which errors are:

- Reported to senior staff
- Fully investigated to root cause if appropriate
- Corrective action put in place
- Lessons learned
- A report submitted to SHOT

The emphasis should not be on the errors themselves. Areas of laboratory practice in which errors reported to SHOT have occurred include the following:

- ABO grouping errors using manual techniques
- Failure to consult historical records leading to failure to provide antigen negative red cells for patients with previously documented allo-antibodies or failure to provide for special transfusion requirements e.g. for irradiated blood
- Selection and issue of unsuitable components e.g. for neonates, due to lack of awareness of guidelines and lack of 'flagging' system
- Numerous instances of failure to follow SOPs
- Poor stock management leading to issue of expired units, particularly from satellite blood refrigerators.