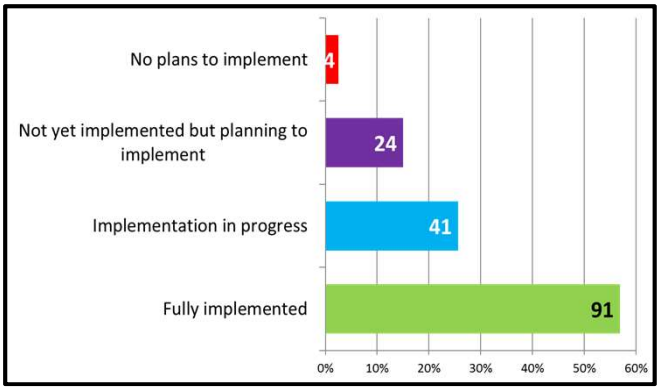
2016 SHOT Key Recommendations survey

SHOT has never formally asked organisations if they implement the SHOT annual recommendations. The purpose of this survey was to understand the progress with implementing the key recommendations six months following their publication in the 2016 SHOT annual report (July 2017)*. A link to the survey was sent to all reporters and one response was requested per Trust/Health Board. The response rate was 160/222 (72%). The numbers on the charts reflect the number of responses.

2016 Key Recommendation 1

A checklist must be used at the patient's side as a final administration check prior to transfusion as standard of care

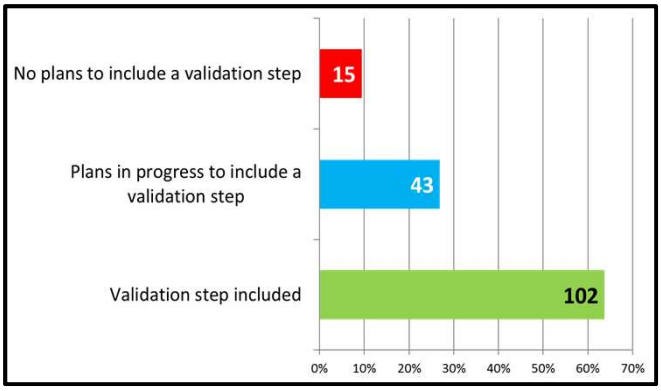


108 comments received describing progress with implementation of a bedside checklist

The majority of respondents 132/160 (83%) have either fully implemented a checklist or implementation is in progress. A further 24/160 (15%) are planning to introduce a checklist within the next few months but 4/160 (2.5%) had no plans to include a checklist as a final administration check.

2016 Key Recommendation 1 continued

Whatever bedside system is currently in place (including electronic) it should be assessed and include a validation step where someone has to sign to say that all steps have been followed

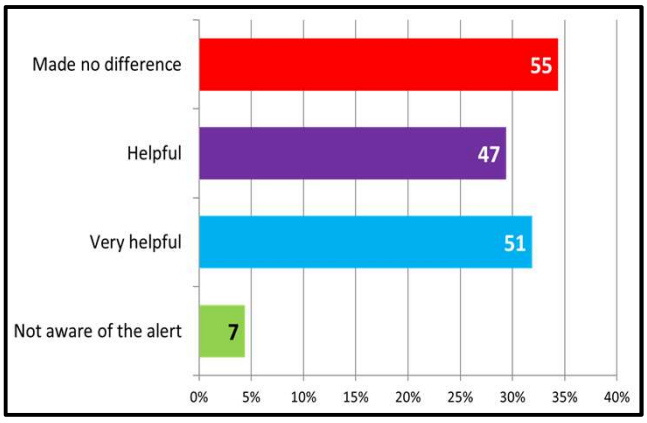


93 comments received describing where and how the validation step has been included and in some cases why it hasn't been included

'We realised that the validation used was not as all encompassing as we needed. We were alerted by the information in the SHOT report and revalidation is complete. Thank you.'

CMO/CNO CAS Alert

The alert was for immediate action, please indicate how helpful it was to support implementation of SHOT recommendation 1



86 comments received

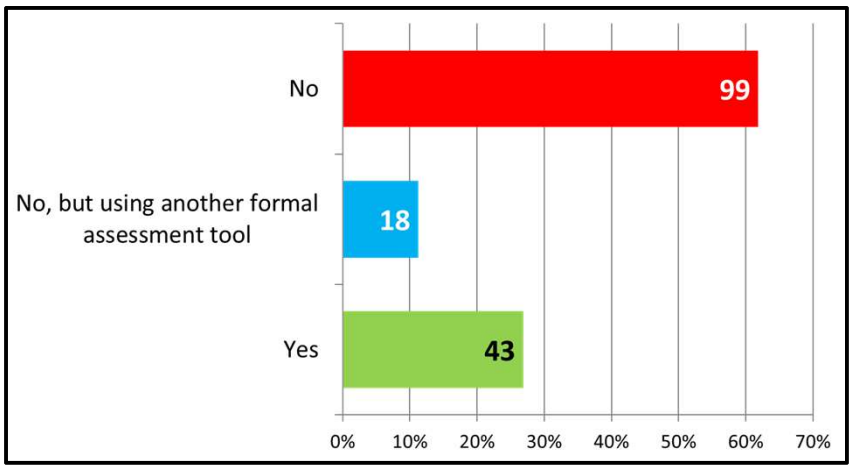
The 55/160 (34%) who stated it 'made no difference' the majority already had a checklist in place following the SHOT recommendation.

'This has given the opportunity to raise the profile of SHOT and the recommendations to the Trust. It has also put transfusion on the patient safety radar.'

*PHB Bolton-Maggs (Ed) D Poles et al. on behalf of the Serious Hazards of Transfusion (SHOT) Steering Group. The 2016 Annual SHOT Report (2017).

2016 Key Recommendation 2

Patients should be formally assessed for their risk of transfusion associated circulatory overload (TACO) whenever possible since TACO is the most commonly reported cause of death and morbidity. Have you implemented the use of the SHOT TACO checklist?



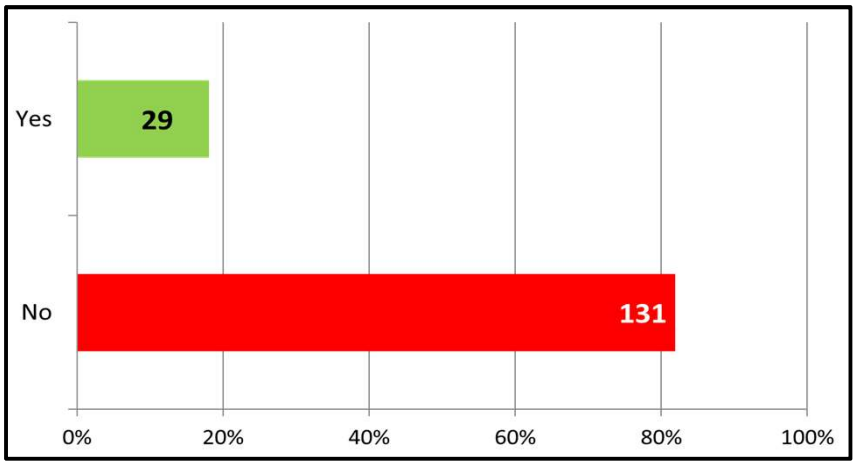
118 comments received describing progress with implementation of a TACO checklist

Many described the barriers/challenges to implementation, but were including assessment of patients for their risk of TACO in training, posters and local campaigns to raise awareness.

'Already in policy/teachings. Current prescription chart too full to allow incorporation of TACO checklist.'

What are we missing?

Should SHOT collect data on any other transfusion related incident?



32 comments received

The majority 131/160 (83%) agreed SHOT is not missing any data. Of the 29 who said yes, some suggestions fit better with Patient Blood Management or the MHRA, other suggestions will remain reportable at a local level.

26 further comments received:

'I cannot over emphasise how valuable the data is! And how approachable the organisation is! Thank-you.'

'The SHOT report remains essential to improving clinical and laboratory practice and keeping a focus.'

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Thank you to all who were able to take part in this survey