2017 SHOT Key Recommendations survey

The purpose of this survey was to understand progress with implementing key recommendations six months following their publication in the 2017 SHOT Annual Report (Published July 2018).
A link to the online survey was sent to all reporters and one response was requested from each Trust/Health board. Reporters were given three weeks to respond. The survey was estimated to take <15 minutes to complete. A short extension was provided to increase the response rate.

KEY MESSAGE

There has been good progress made with implementing the 2017 SHOT key recommendations despite challenges and barriers to implementation. These were cited as, competing priorities, paucity of financial resources and lack of staff engagement.

RESPONSE RATE

126/222 (57%) compared to 160/222 (72%) preceding year

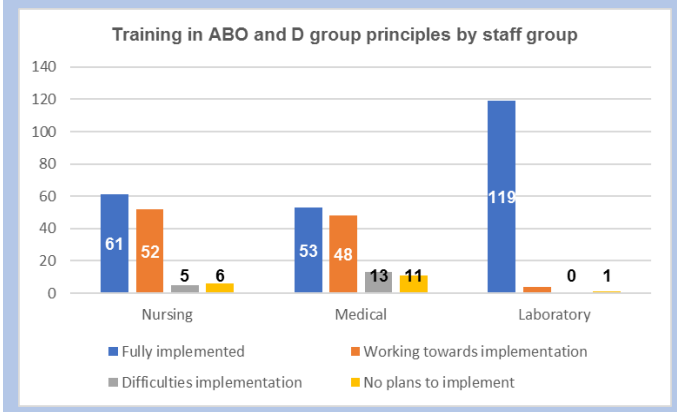
Multiple factors were thought to be contributory to a lower response rate, including several ongoing surveys and short staffing

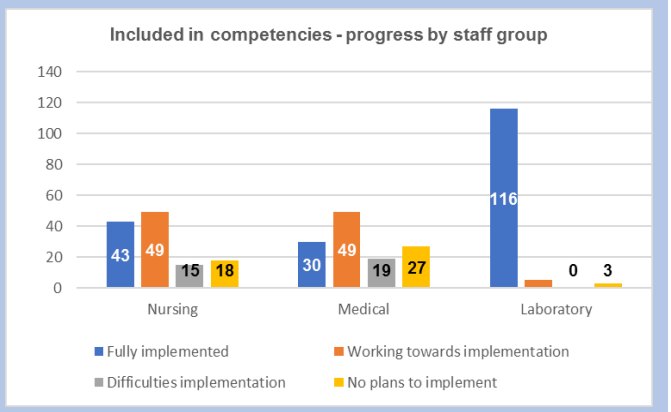
Response rate by reporting country

England (99) Scotland (12) Wales (8) Northern Ireland (7)
Trusts/Healthboards that covers paediatric transfusion (108)
Trusts/Healthboards that do not cover paediatric transfusion (18)

Progress with implementing Key Recommendation 1

Training in ABO and D group principles is essential for all laboratory and clinical staff with any responsibility from the transfusion process. This should form part of the competency assessment.





NB: Respondents answered all that applied

Any difficulties/barriers and timescales to completion of key recommendation 1 (text responses)

30 responses demonstrated success with implementation

5 responses believed it was the responsibility of the transfusion laboratory

12 responses didn't recognise the need for this recommendation

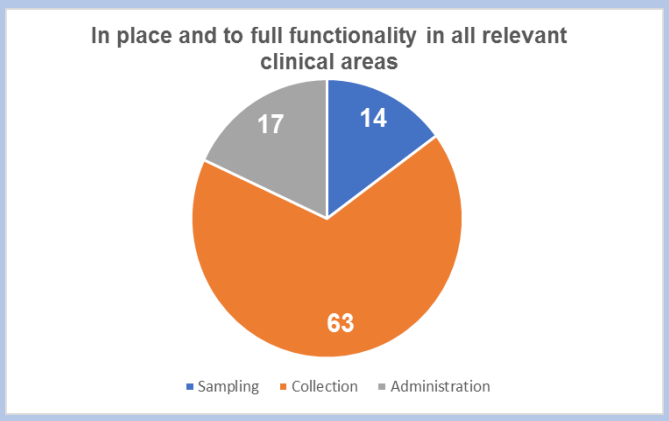
12 responses explained how difficult it was to implement training

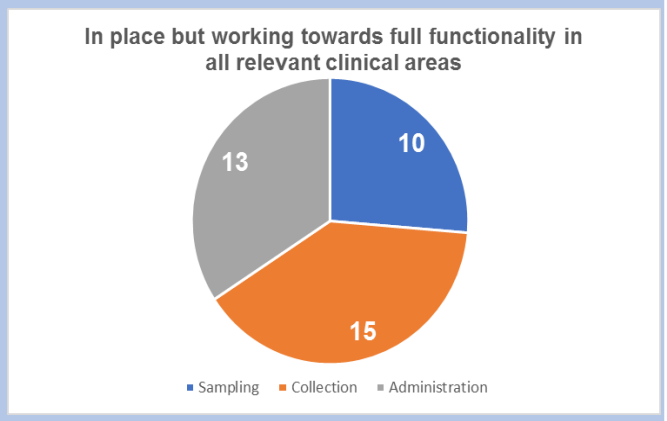
8 responses explained there were competing priorities and no current capacity to implement

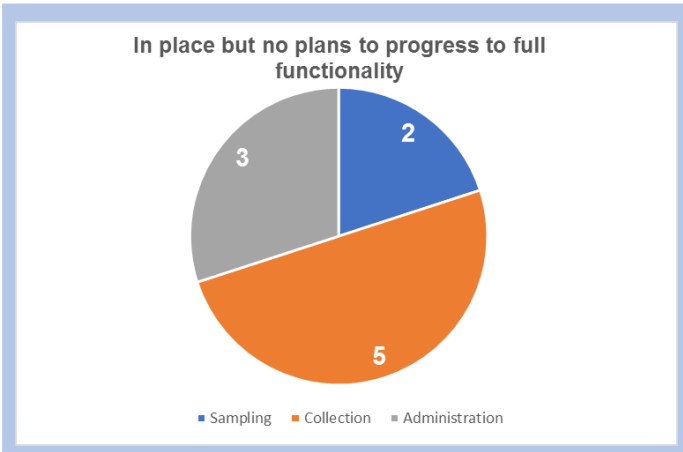
Progress with implementing key recommendation 2

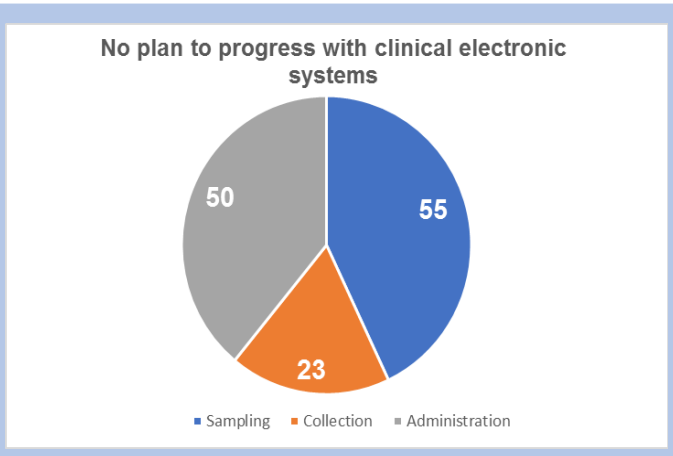
All available information technology (IT) systems to support transfusion practice should be considered and these systems implemented to their full functionality

Electronic blood management systems should be considered in all clinical settings where transfusion takes place. This is no longer an innovate approach to safe transfusion practice, it is the standard for all



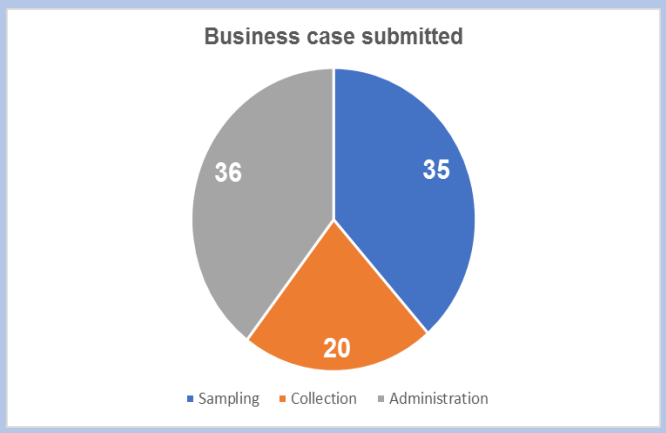






"Patient ID IT systems have been explored and quotes obtained from suppliers"

"Finance continues in all areas of transfusion to be a barrier"



"Priority is to have an improved LIMS"

"Go live 4th Feb for the whole hospital, sampling and bedside will be implemented as part of LIMS update next year"

Any difficulties/barriers and timescales to completion of key recommendation 2 (text responses)

9 responses explained that 'time' was a constraint to implementation

24 responses placed cost as the main barrier to implementation

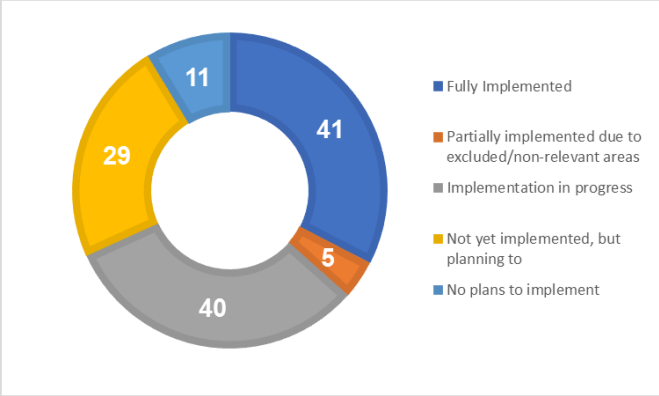
27 responses demonstrated their success with progress with implementing this recommendation

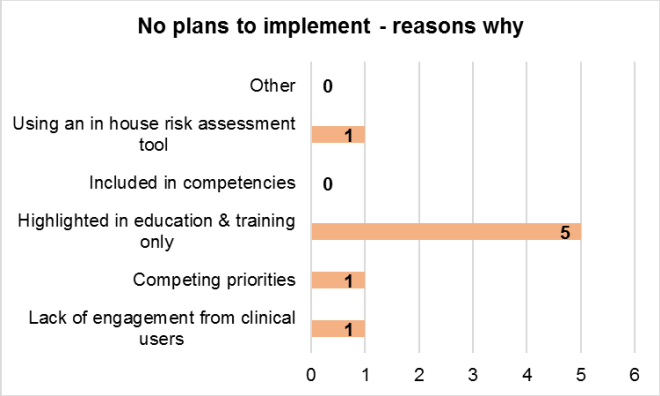
18 responses detailed how they had future plans to implement this recommendation

2 responses said competing priorities as a barrier to implementation

2 responses said they had risk assessed their process so not considering implementation

Progress with implementing key recommendation 3
A formal pre-transfusion risk assessment for TACO should be undertaken wherever possible, as TACO is the most commonly reported cause of transfusion related mortality and major morbidity





Any difficulties/barriers and timescales to completion of key recommendation 3 (text responses)

11 responses demonstrated success with implementing this recommendation

7 responses cited competing priorities as a barrier to implementing a TACO checklist

13 responses explained where and how they include the TACO checklist in the patient assessment

4 responses didn't recognise the need for a TACO checklist

4 responses cited lack of staff engagement as a barrier to implementation

15 responses explained future plans for implementation

"We are just beginning to look of possible ways to implement"

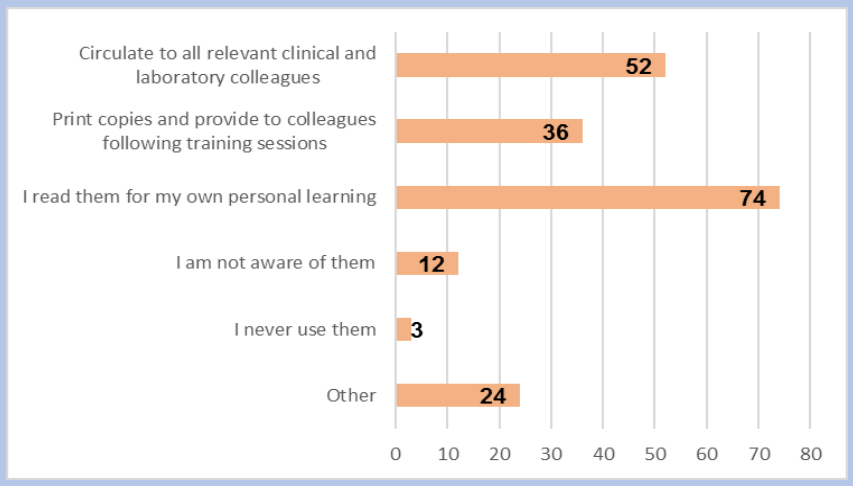
"Engagement with medical staff is challenging"

"Lack of concrete evidence and guide of TACO"

"We are competing with other checklists"

"TACO checklist included on blood authorisation form"

How do you use the 'SHOT Bites' resources?



We are asked for further suggestions for future 'SHOT Bites' and you provided us with many potential topics. These will be considered at the next SHOT steering group meeting.

Further comments received

"It should be highlighted that the SHOT recommendations are just that - the actions for each recommendation should highlight that they are for consideration."

"SHOT Reports are useful tools for training"

"Make people more aware of things like SHOT bites and other resources"

"Not sure I support recommendations based on one incident"

Thank you for your participation in this survey