# Serious Hazards of Transfusion (SHOT) 2019 Key Recommendations Survey

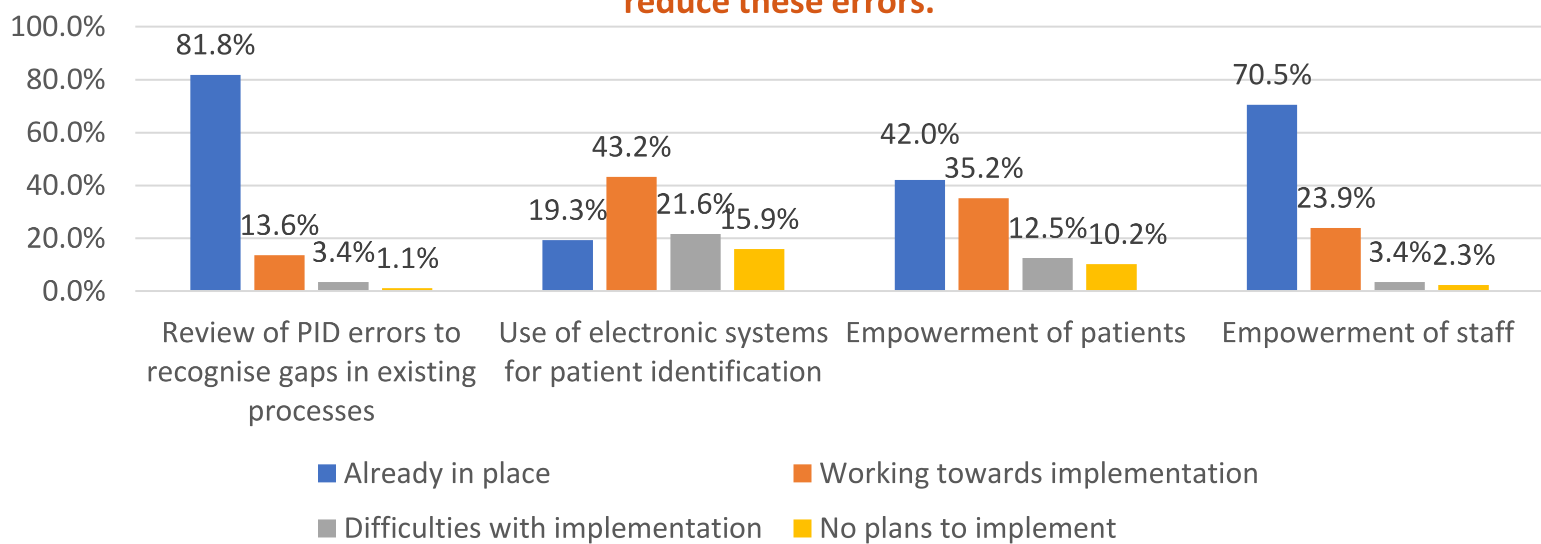
## Survey Aims and Response Rate

The Key Recommendations survey aims to understand progress with implementing Key SHOT Recommendations in NHS Trusts/Health Boards. This was circulated in April 2021 following the release of the 2019 Annual SHOT Report.

The electronic survey (Online surveys) was emailed to all registered Serious Adverse Blood Reactions and Events reporters in April 2021 and was available for 4 weeks. Questions were either single or multi-choice. One response was requested per Trust/Health Board. A total of 88 responses were received in full, with representation from all countries of the United Kingdom.

## Key Recommendation 1

**Accurate patient identification is fundamental to patient safety. Organisations must review all patient identification errors and establish the causes of patient misidentification. Recognising gaps in existing processes, use of electronic systems, empowerment of patients and staff will reduce these errors.**




Responses indicate that:

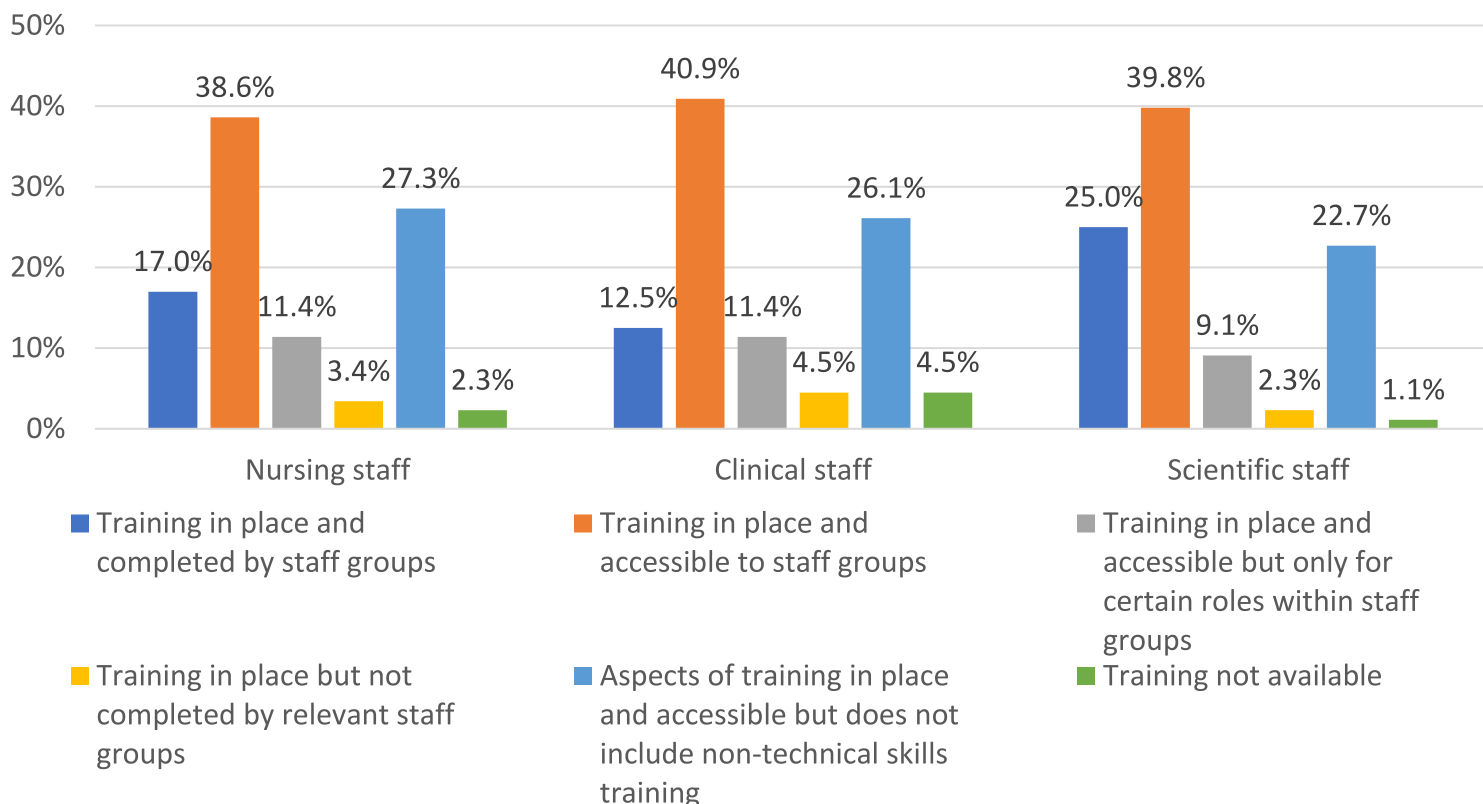
- Lack of funding and engagement are the main barriers to implementation of electronic systems
- COVID-19 pandemic had delayed some plans to move forward with this recommendation
- Where electronic systems are present they do not always cover all aspects of the transfusion process
- Patient empowerment needs to be led at an organisational level

**Patient identification (PID) errors are well investigated and staff empowered to report incidents**

**"More work should be done to improve processes for patient empowerment at an organisational level"**

# Key Recommendation 2

**Clinical and laboratory staff should be trained in fundamentals of transfusion, human factors, cognitive biases, investigating incidents and patient safety principles. Such a holistic approach will ensure safe, high-quality, patient-centred care and help embed an organisation-wide culture of learning from patient safety incidents.**

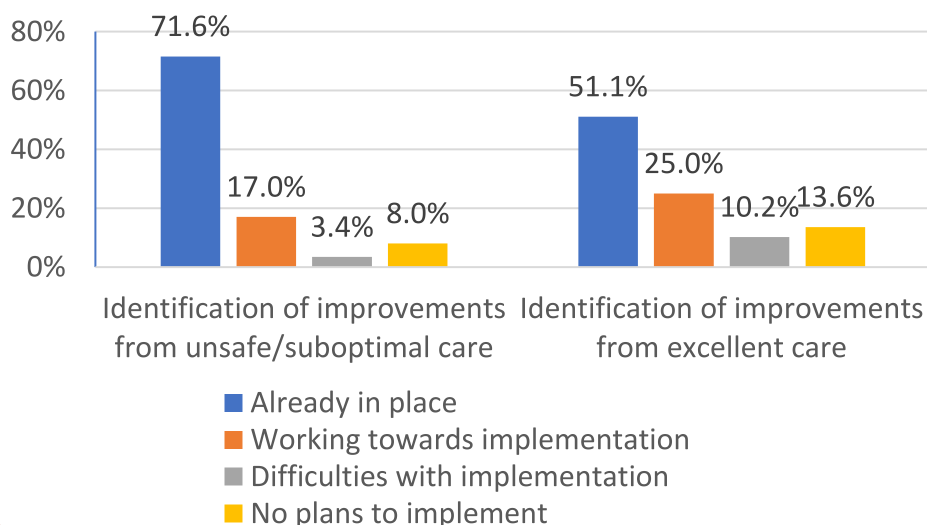



**"Training has been difficult during the pandemic. No face to face training and staff redeployed."**

Competing training priorities, time allocation, staffing levels and engagement were key themes in barriers to provision of a holistic approach.

# Key Recommendation 3

**All healthcare organisations should incorporate the principles of both Safety-I and Safety-II approaches to improve patient care and safety. Healthcare leaders should proactively seek signals for improvement from unsafe, suboptimal as well as excellent care.**



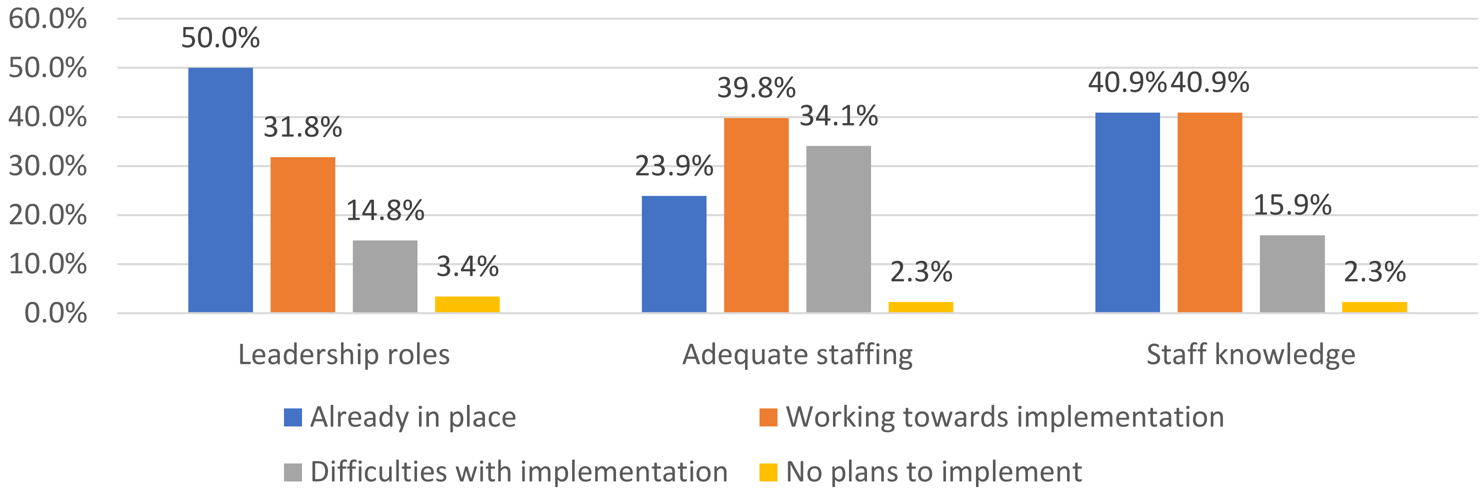

Processes are in place in many organisations for identifying improvements from excellent care.

Awards are being used to recognise excellence.

**Electronic reporting systems are being utilised to capture learning from excellence**

# Key Recommendation 4

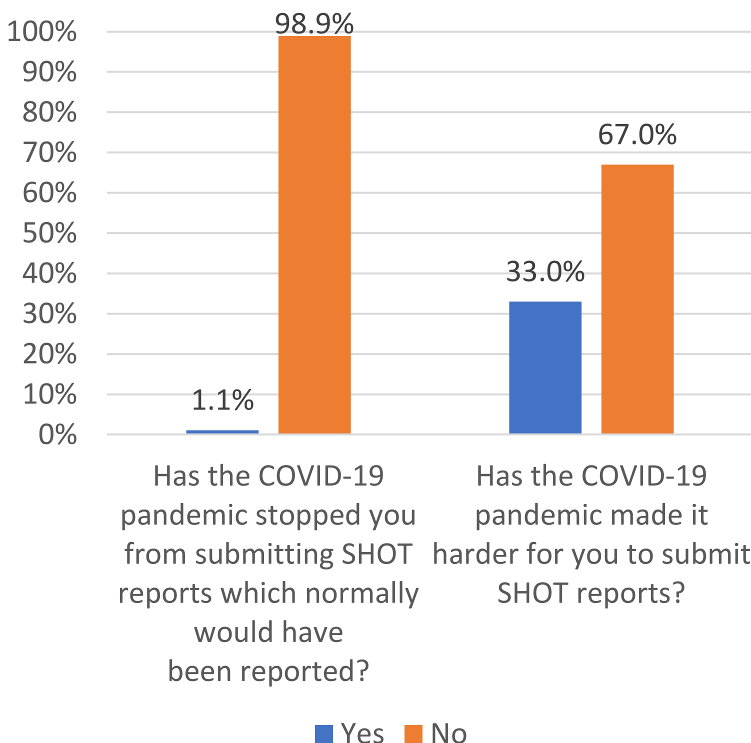
**Healthcare management must recognise that safety and outcomes are multifaceted, a linear view of safety does not fully acknowledge the interdependencies of resources including their leadership, adequate staffing and knowledge. Healthcare leaders should ensure these are all in place to improve patient safety.**




**Some respondents felt unable to influence this recommendation as it is outside the transfusion remit**

Inadequate staffing levels was the key theme raised as a barrier to compliance with this recommendation.
Staffing levels impact on ability to train and educate others.

## Has the COVID-19 pandemic stopped you from submitting SHOT reports which normally would have been reported, or made it harder to report?



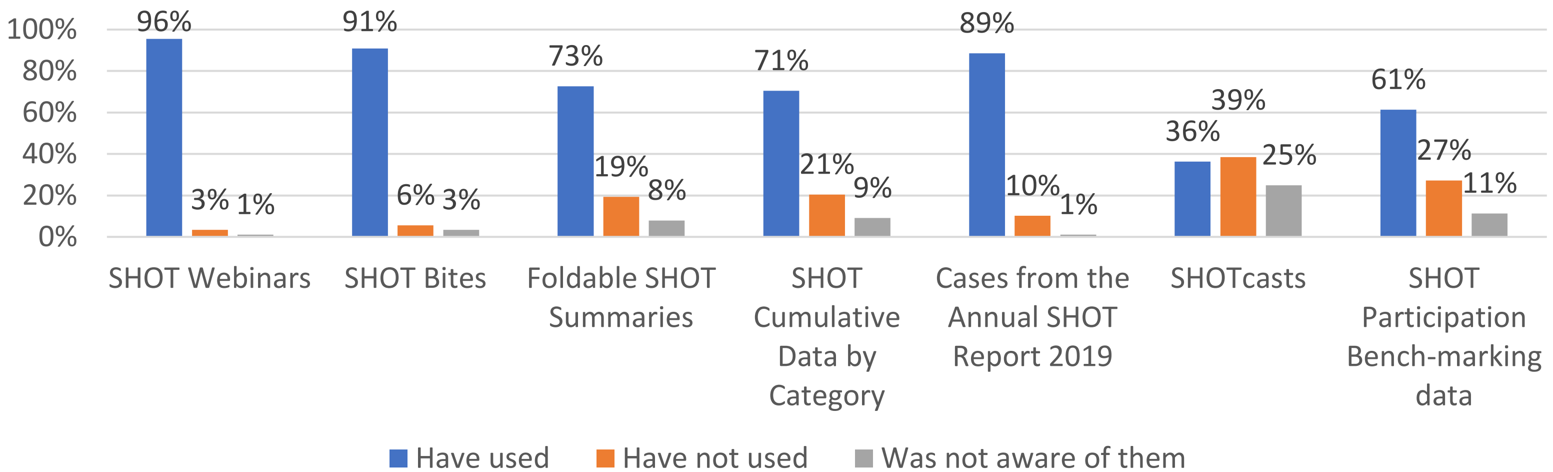

**"Has made some of the investigations trickier in terms of access to clinical areas. Attempted throughout the pandemic to maintain the embedded Haemovigilance culture."**

Despite the pressures of the pandemic the vast majority of organisations continued to report to SHOT and the MHRA.

Incident reporting was affected by:

- Accessibility to clinical areas - this was the main issue with incident reporting
- Staff redeployment, staffing levels and access to staff involved in incidents

# SHOT resources – Availability and use




- SHOTcasts and participation bench-marking data are the least well used SHOT resources
- Time constraints were cited as a major barrier to accessing SHOT resources
- SHOT resources are used widely in teaching and self-learning

**Further topics suggested were: major haemorrhage protocols, inappropriate transfusion, tips on engaging clinical teams and implementing SHOT recommendations**

The response rate to this survey was lower than in previous years with 88 responses from 171 reporting organisations (51.5%). The reasons for this are unknown but are likely to be linked to the challenges faced during the pandemic. SHOT are grateful to all those who responded to the survey, and encourage all organisations to engage with national surveys as the information from these is used to drive improvements in transfusion.

**"More assistance on how to implement them as they are often larger than what the transfusion team can deal with"**

- A number of reporters stated that the recommendations were too vague and not within the power of transfusion staff to achieve. SHOT has taken this on-board with the recommendations in the 2020 report
- SHOT provide suggestions for key personnel to action relevant recommendations
- SHOT are providing a gap analysis template for the 2020 recommendations to support audit and senior management engagement

SHOT are continually developing more resources, including: SHOT Bites, webinars, videos, and SHOTcasts. These resources are on topics related to haemovigilance and can be used for education and training purposes.

All the resources are available on the website (https://www.shotuk.org/resources/) and can be accessed on the SHOT app (search SHOTUK or scan the barcodes on the left).

**The SHOT team would like to thank everyone who took the time to complete the survey. Your feedback is very useful and is sincerely appreciated. The full Annual SHOT Report 2019 is available at** https://www.shotuk.org/shot-reports/report-summary-and-supplement-2019/