Serious Hazards of Transfusion (SHOT) 2021 Key Recommendations Survey

Survey aims and response rate

The Key Recommendations Survey aims to understand progress made in implementing Key SHOT Recommendations in UK Trusts/Health Boards. This survey was circulated 7 months following the release of the 2021 key recommendations. The electronic survey (Online surveys) was sent to all registered Serious Adverse Blood Reactions and Events (SABRE) reporters in Feb 2023 and was available for 14 weeks. Questions were either single or multiple-choice. One response was requested per Trust/Health Board. A total of 51 responses were received in full, with representation from England, Scotland and Wales. This represents a lower response rate than previous years and SHOT have acknowledged potential reasons for this, for future survey planning.

Acknowledging Continuing Excellence in Transfusion (ACE)

Increased awareness of the *Acknowledging Continuing Excellence in Transfusion (ACE)* chapter was evident this year with 96% respondents being aware of the chapter, and 90% reported that their healthcare organisation has an option to submit excellence reports.
SHOT ACE resources can be found here: https://www.shotuk.org/reporting/ace-reporting/

SHOT Resources – Availability and Use

- Resources are used for training and education, self-learning, team-learning
- Webinars were viewed by 90% of respondents, videos by 86%
- SHOT Bites remain a well used resource used by 96% of respondents
- SHOTcasts and audio summaries are the least used SHOT resources
- Time constraints, competing priorities and staffing pressures were cited as major barriers to accessing resources
- Cumulative data was used by 73% and participation data by 64%, SHOT have increased promotion of these over the last 12 months

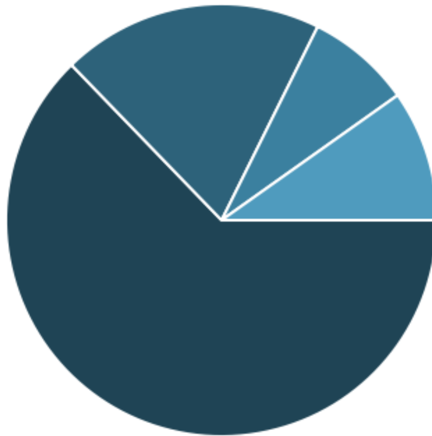
Suggestions and feedback for resources, training and topics included:

- SHOT resources are excellent and valued. Sometimes less is more (in terms of the site not becoming overwhelming)
- A SHOT Bite on Handling and Storage errors/ transport of blood between hospitals
- An aide memoire or checklist for collection of blood from the lab to help prevent errors later in the process i.e at the bedside

Key Recommendation 1

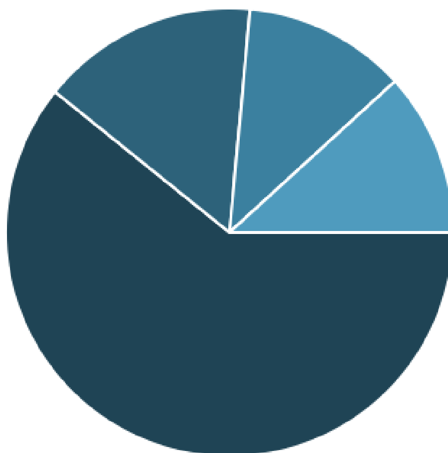
Patients as safety partners. Staff must ensure that they involve, engage and listen to patients as ‘partners’ in their own care, including transfusion support

Ensure that organisational systems and processes are designed to be patient-centred - Progress with implementation



- Already in place – please state how achieved **32** (62.7%)
- Working towards implementation - please indicate expected target date for completion **10** (19.6%)
- Difficulties with implementing – please detail any barriers to implementation **4** (7.8%)
- No plans to implement currently – please detail justification **5** (9.8%)

Develop/implement policies and procedures for engaging patients, families, and carers in their own care as well as in quality improvement patient safety initiatives and healthcare design - Progress with implementation



- Already in place – please state how achieved **31** (60.8%)
- Working towards implementation - please indicate expected target date for completion **8** (15.7%)
- Difficulties with implementing – please detail any barriers to implementation **6** (11.8%)
- No plans to implement currently – please detail justification **6** (11.8%)

Responses indicate:

- Guidelines and policies are in place in some Trusts/Health boards to allow patients to make informed decisions
- Training to listen to patients, and communicate effectively using structured communication tools is included in transfusion or organisational training programmes
- Provision of written information is encouraged and forms part of the transfusion consent process

Some key barriers to implementation were that engagement was needed from a higher level and that discharge teams should be more involved in providing appropriate patient information on discharge

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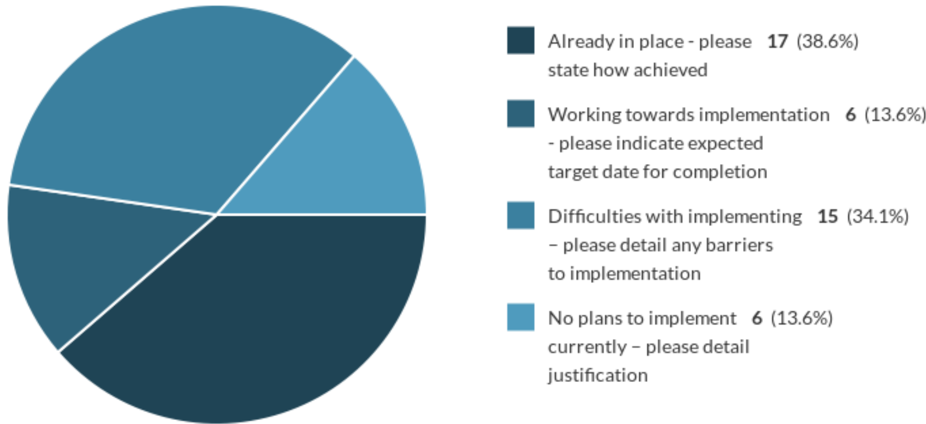
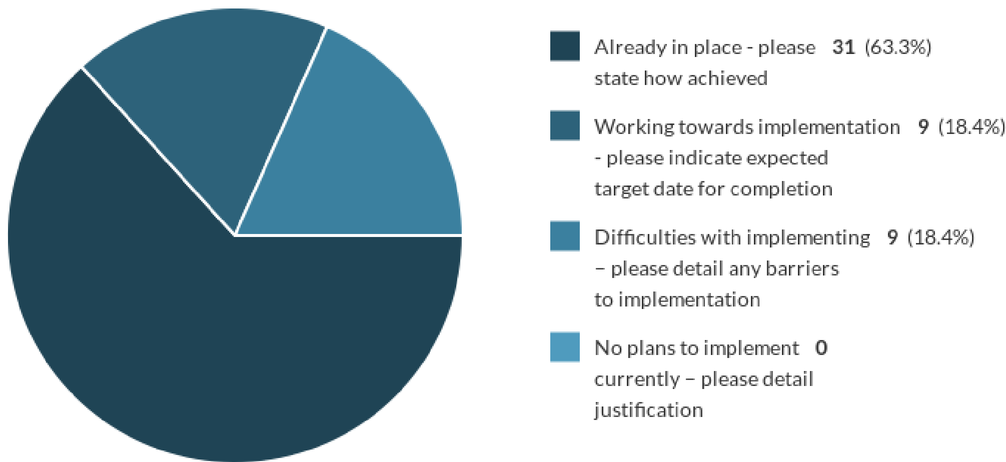
“Our systems encourage staff to involve patients in decision making however we cannot force them to do so - the lead on this needs to come from the various medical colleges”

Key Recommendation 2 : Healthcare leaders must ensure that systems are designed to support safe transfusion practice and allocate adequate resources in clinical areas to support the following: safe staffing levels staff training in technical and non-technical skills; appropriate equipment, including IT equipment

Minimum staffing levels should ideally be based on the overall workload, the acuity and complexity of work involved, considering the 3 previous years' data, for all absences including sickness, mandatory training, annual leave, and maternity leave - Progress with implementation in CLINICAL AREAS



Minimum staffing levels should ideally be based on the overall workload, the acuity and complexity of work involved, considering the 3 previous years' data, for all absences including sickness, mandatory training, annual leave, and maternity leave - Progress with implementation in LABORATORY AREAS



Key barriers to implementation were cited that respondents did not have access to this information due to it being held at Trust level or lack of engagement at executive level. Difficulties in recruiting and retaining trained and experienced staff

"Difficulty in getting engagement with clinical areas outside of Transfusion""

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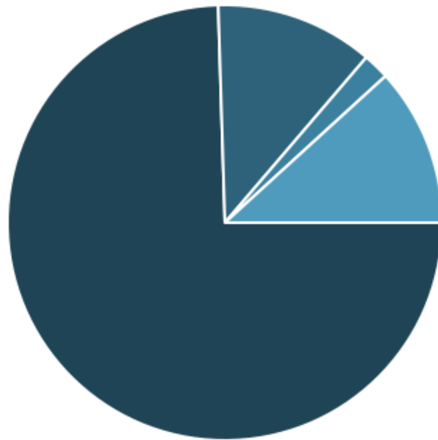
Key Recommendation 3

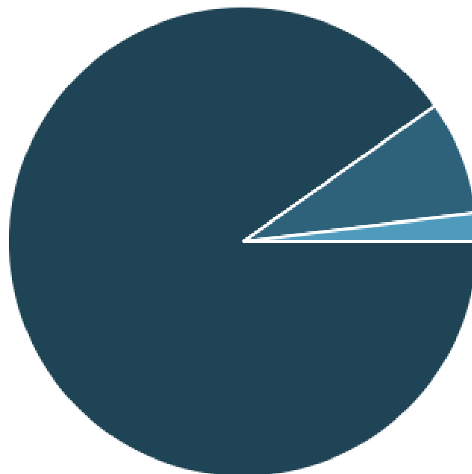
All healthcare leaders must promote a just, learning safety culture with a collective, inclusive, and compassionate leadership. Effective leaders must ensure staff have access to adequate training, mentorship, and support. Staff in clinical and laboratory areas have a responsibility to speak up in case of any concerns and help embed the safety culture in teams.

Ensure staff feel able to talk about their concerns and report when things go wrong - Progress with implementation in CLINICAL AREAS



- Already in place - please detail how this is achieved **38** (74.5%)
- Working towards implementation - please indicate expected target date for completion **6** (11.8%)
- Difficulties with implementing - please detail any barriers to implementation **1** (2%)
- No plans to implement - please detail justification **6** (11.8%)

Ensure staff feel able to talk about their concerns and report when things go wrong - Progress with implementation in LABORATORY AREAS

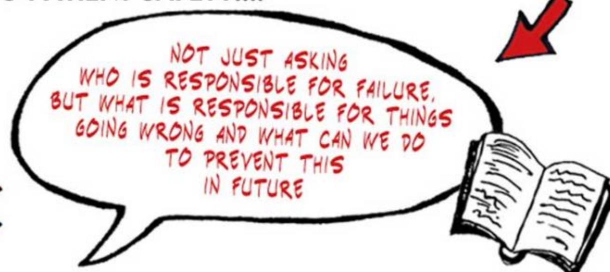


- Already in place - please detail how this is achieved **46** (90.2%)
- Working towards implementation - please indicate expected target date for completion **4** (7.8%)
- Difficulties with implementing - please detail any barriers to implementation **0**
- No plans to implement - please detail justification **1** (2%)

Key barriers to implementation included staff being allocated time for training due to short staffing and work pressures. Lack of engagement from executive teams was also cited.

"It is very clear within SOP's & Policies not to place 'blame' but to look at causes, external factors and personal influences, to enable appropriate actions to be put in place whether education, financial or implementing change to prevent recurrences"

A JUST AND LEARNING CULTURE IS FUNDAMENTAL TO PATIENT SAFETY....



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Summary

- 51 responses were received in full representing England, Scotland and Wales.
- A lower response rate than previous years was received
- Potential reasons include survey length, transfusion teams not having access to information required from their wider organisation to fully respond and difficulties engaging executive teams
- For future survey planning SHOT have acknowledged feedback and difficulties to review and inform survey design and target audience
- Due to the survey length not all responses and information has been included in this summary
- If further specific information on responses is required SHOT can be contacted at shot@nhsbt.nhs.uk

How to engage the clinical area or hospital management- hints and tips

- Respondents commented that SHOT should produce three or four achievable key recommendations
- SHOT provides a gap analysis tool for key recommendations to support audit and senior management engagement

SHOT continually develops haemovigilance resources for education and training, including SHOT Bites, webinars, videos and SHOTcasts.

All the resources are available on the website (shotuk.org/resources/) and can be accessed on the SHOT app (search SHOTUK or use the QR codes on the left).

The SHOT team would like to thank everyone who took the time to complete the survey. Your feedback is very useful, will help inform future activities and is sincerely appreciated. The full Annual SHOT Report 2021 is available at https://www.shotuk.org/shot-reports/report-summary-and-supplement-2021/