Serious Hazards of Transfusion (SHOT)
2022 Key Recommendations Survey Report

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 2022 key recommendations. The electronic survey (Online surveys) was sent to all registered Serious Adverse Blood Reactions and Events (SABRE) reporters in February 2023 and was available for 6 weeks. Questions were multiple-choice, with drop down options and some free text facility. One response was requested per Trust/Health Board. A total of 79 anonymised responses were received in with representation from Trusts/Health Boards across the UK.

Report Summary

- 79 anonymised responses were received in full representing UK organisations
- This was a higher response rate than the previous year
- There were some comments regarding the survey length, and need for fewer recommendations
- SHOT have acknowledged this feedback and continually strive to make improvements and review survey design based on user feedback
- Due to the survey length not all responses and information has been included in this summary
- If further specific data on responses is required SHOT can be contacted at shot@nhsbt.nhs.uk

Resources

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).

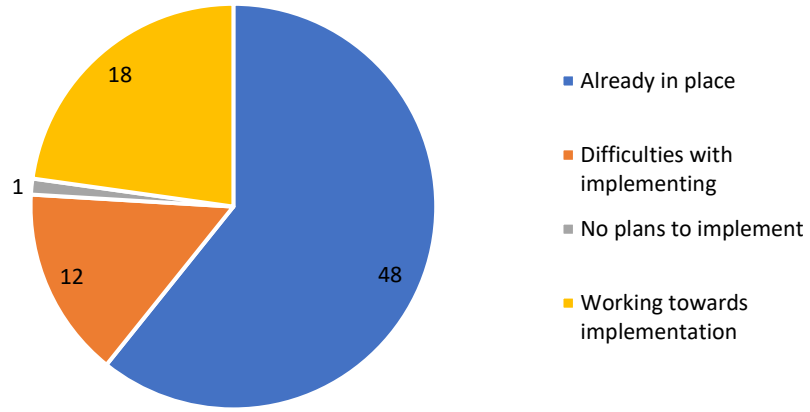
Download on the App Store

GET IT ON Google Play

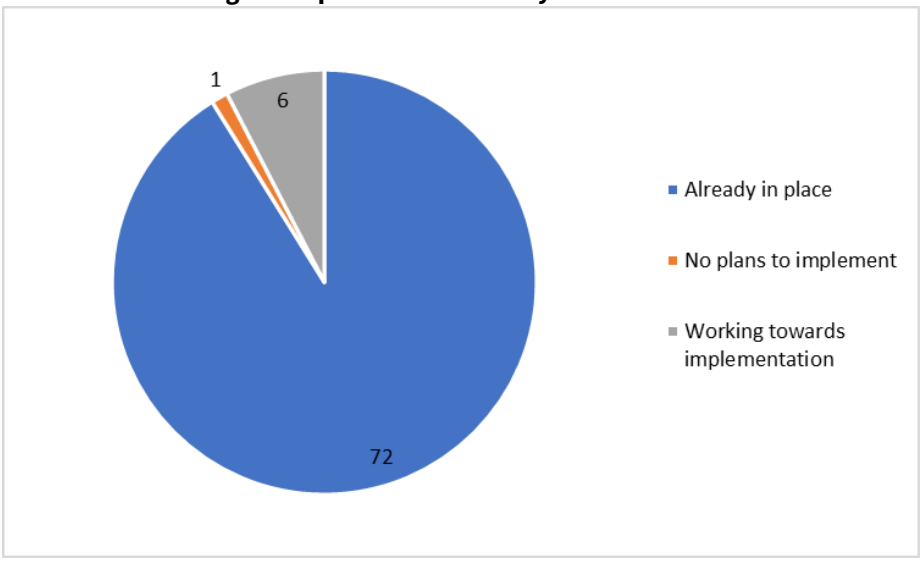
The SHOT team would like to thank everyone who took the time to complete the survey. Your feedback is very useful, will help inform future activities and is sincerely appreciated. The full Annual SHOT Report 2022 is available at Report, Summary and Supplement 2022 - Serious Hazards of Transfusion (shotuk.org)

Key Recommendation 1: Appropriate management of anaemia and making safe transfusion decisions.

Ensure adequate support for clinical and laboratory teams with well-resourced services for treatment of anaemia, including haematinic deficiencies

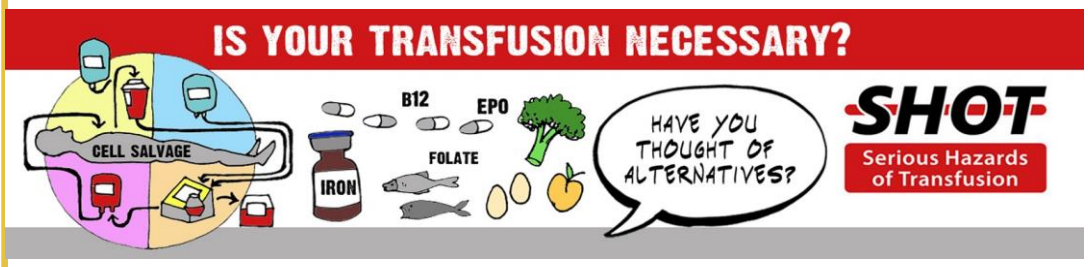


Ensure policies, procedures and training are in place to avoid delays in transfusion where this would cause patient harm



Responses indicate:

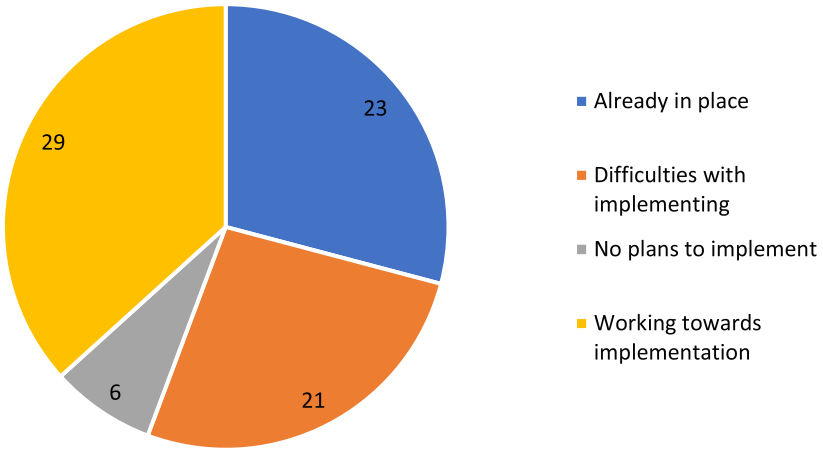
- 48/79 (61%) Trusts/Health boards had adequate support for clinical and laboratory teams with well-resourced services for treatment of anaemia, including haematinic deficiencies
- Guidelines and policies are in place in most Trusts/Health boards to avoid delays in transfusion where this would cause patient harm
- Patients are proactively involved in their care (monitoring, follow up, making choices regarding treatment)
- Some key barriers to implementation were competing priorities, lack of resources including staffing and financial, and difficulties engaging relevant department/staff outside transfusion



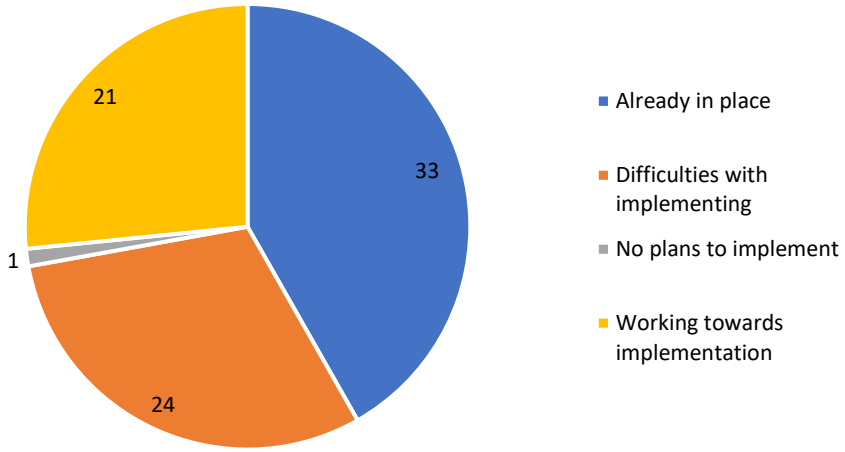
There were no additional comments made by respondents for this recommendation. It is encouraging that progress is being made, though resourcing difficulties persist in some organisations

Recommendation 2: Safe systems to ensure safe transfusions.

Ensure adequate funding and resources are available for implementation and maintenance of effective IT and automation at all stages of the transfusion process



Ensure adequate staffing levels, training and resources are available to support a systems- approach to safe practice, with emphasis on human factors and ergonomics



Responses indicate:

- Only 23/79 (29%) Trusts/Health boards had adequate funding and resources available for effective IT systems to be implemented
- Of the 29 organisations working towards IT implementation, 23/29 (79%) indicated that implementation would be ≥12 months away
- Where there were difficulties in implementation or no plans to implement IT systems, the main barrier was lack of financial resources
- Where there were difficulties in ensuring adequate staffing levels, training and resources to support a systems-approach the main barrier was lack of staff resources

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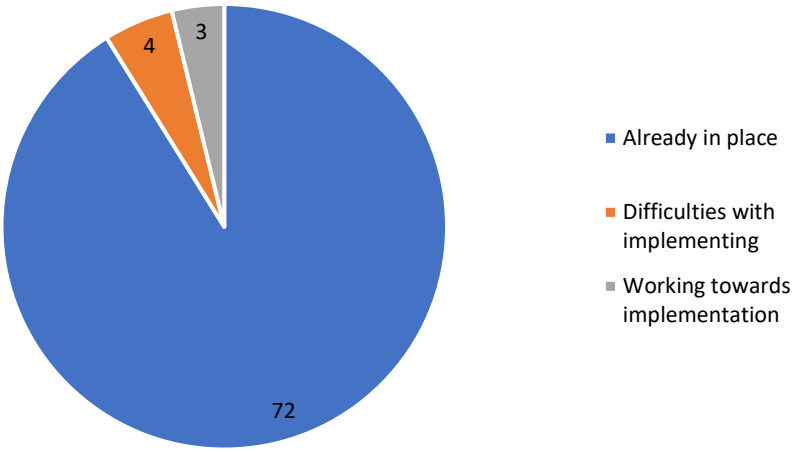
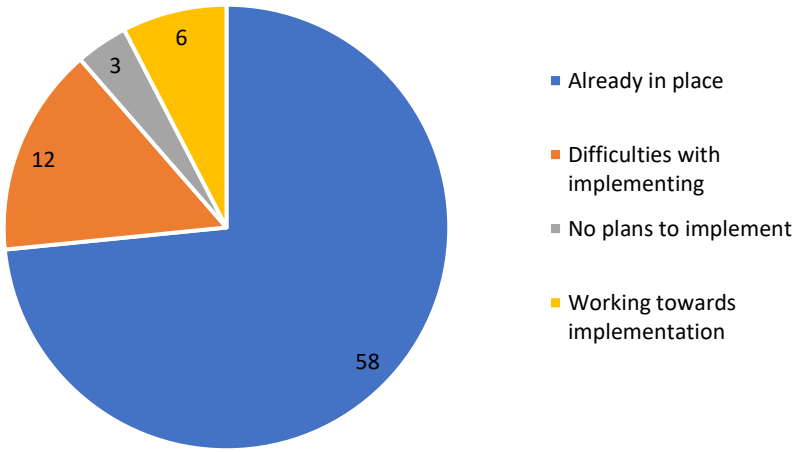
While there were no additional comments provided by respondents, it is apparent that lack of financial and staffing resourcing is hindering progress with implementation

Key Recommendation 3: Effective implementation of appropriate interventions following incident investigations.

Have an oversight of the incident investigation process including management of near misses within their teams



Ensure that staff are appropriately trained to carry out incident investigations and have access to the tools and resources for effective investigations



Responses indicate:

- 23/79 (29%) of the respondents do not review the incident investigation process at least annually for effectiveness
- Of those, 7/23 (9%) are working towards implementation and 10/23 (13%)are experiencing difficulties with implementing such as lack of engagement from executive teams and relevant departments outside transfusion or lack of resources
- 21/79 (27%) do not have in place a way to ensure that staff are appropriately trained to carry out incident investigations or protected to lead or participate in incident investigations Difficulties mentioned included competing priorities and lack of staff.
- Where implementation was not planned, the recommendation being outside of the scope of transfusion teams was given as a difficulty

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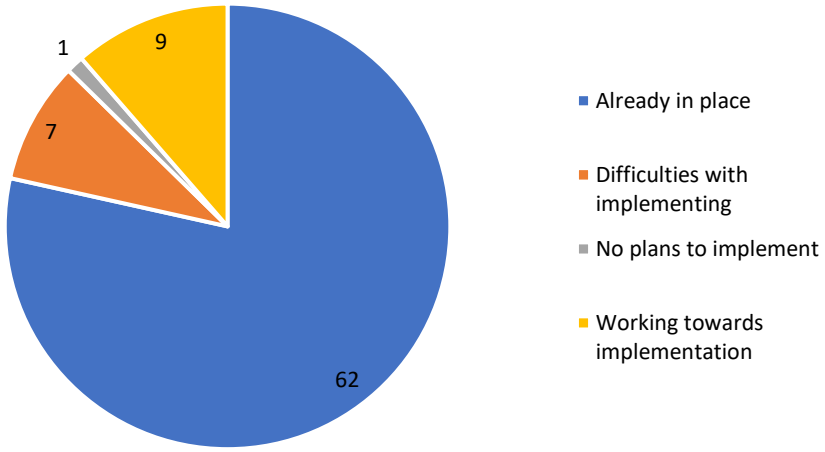
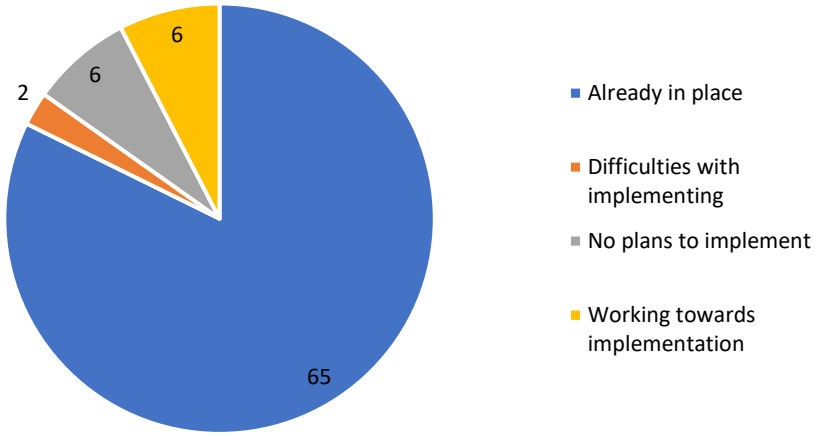
A comment for consideration/ reflection: "Although free basic human factors training is available, the Trust do not support staff to do it"

Key Recommendation 4: Learning from excellence and day-to day events. All healthcare organisations should incorporate the principles of both Safety-I and Safety-II approaches to improve patient care and safety.

Embed a proactive approach to safety within their teams across the organisation and learn not just from when things go wrong but from day-to-day events and excellence



Ensure local incident reporting systems also have the capability for excellence reporting



Responses indicate:

- 62/79 (78%) of the respondents already have a proactive approach to safety embedded within their teams including learning from day-to-day events and excellence
- Of those, 7/23 experiencing difficulties with implementation, 3/7 mentioned that is was outside of the scope of transfusion teams
- 65/79 (82%) respondents reported that their local incident reporting systems also have the capability for excellence reporting
- Many stated recommendations were outside their scope and were too many in number

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There were no additional comments made by respondents for this recommendation. It is encouraging that learning from excellence is high on responding organisations agendas.