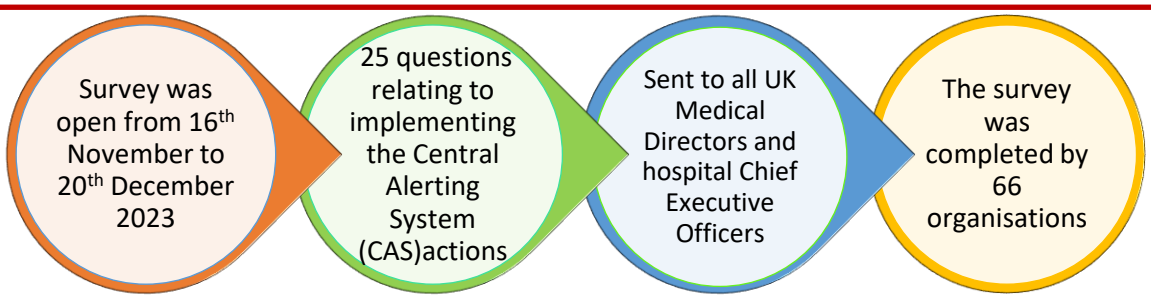
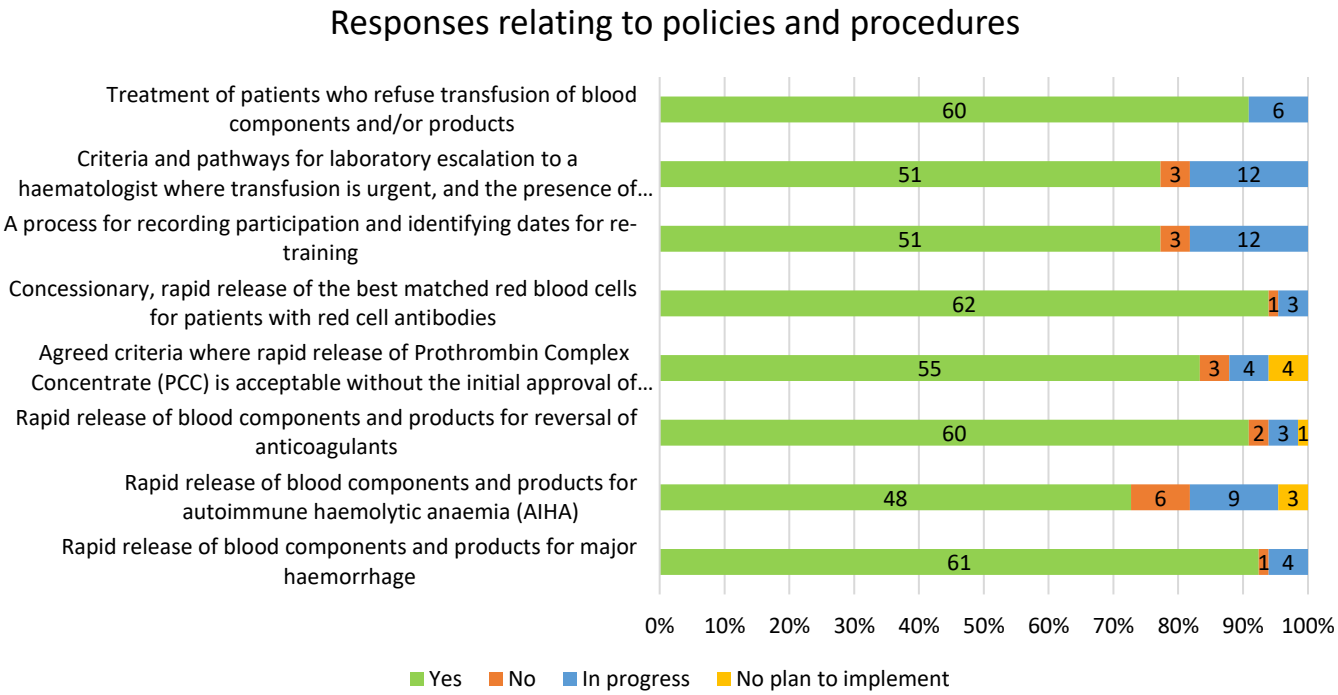
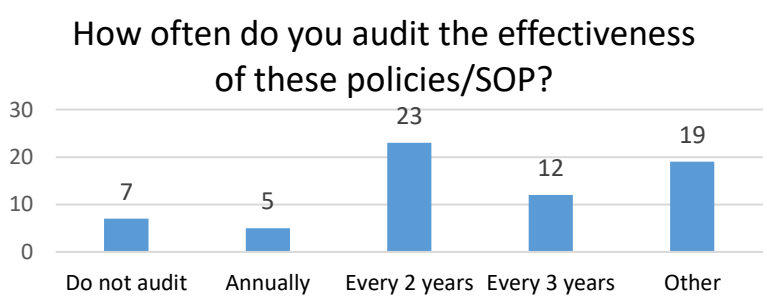
Post implementation survey for the UK wide national patient safety alert on preventing transfusion delays- a collaborative survey from SHOT and NBTC Emergency Planning Working Group

The purpose of the survey was to understand progress with implementing the actions outlined in the Preventing transfusion delays in bleeding and critically anaemic patients CAS alert, issued on 17th January 2022, to gain understanding of any barriers to implementation, to share successes and learning, and inform future alerts. The responses received were limited in numbers (n=66) but still provide a useful insight into progress and implementation of the alert actions across the UK.



Action 1: Local organisations must have reviewed and updated policies and procedures.





The majority of organisations that responded to the survey had reviewed and updated relevant policies. Those who hadn't, reported that the action was not deemed relevant due to the specialties or internal processes in place. Some respondents (23/66) audited the effectiveness of policies every 2 years.

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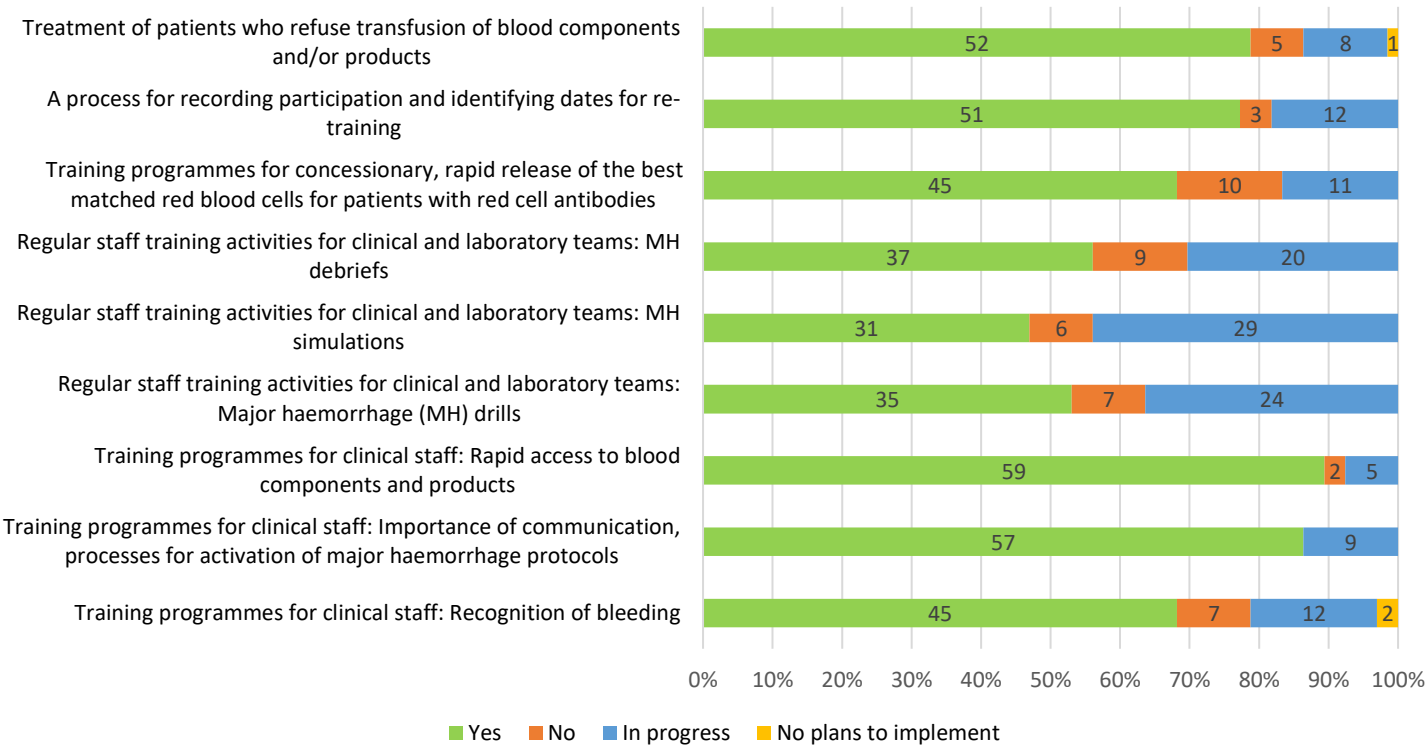
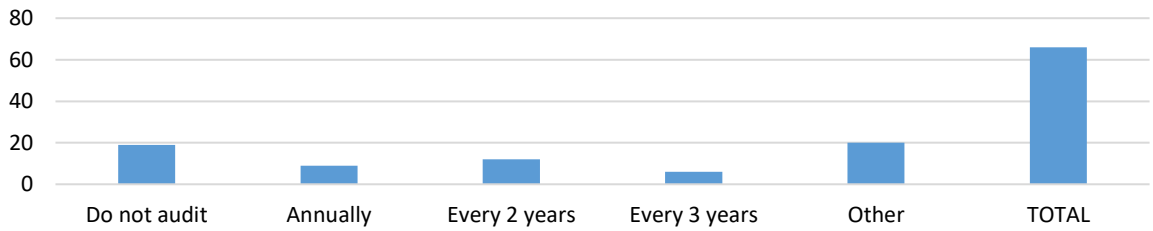
Action 2: Local organisations must have reviewed, updated, and implemented training programmes.

Responses relating to training programmes



How often do you audit the effectiveness of these training programmes?

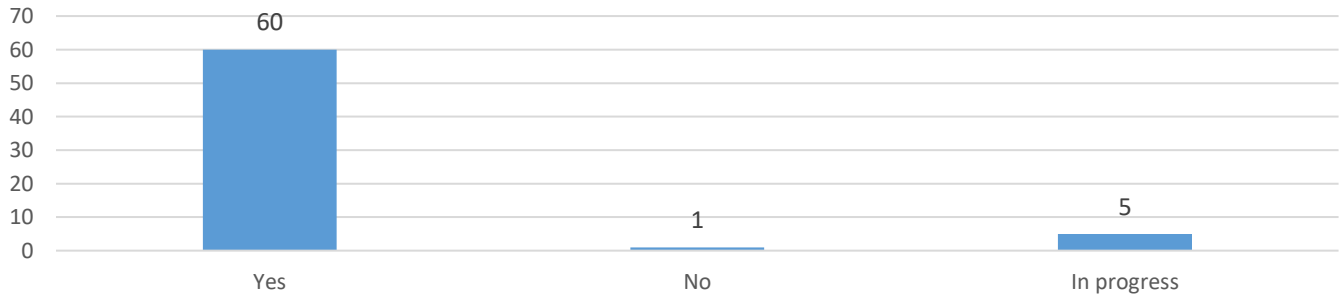


The majority of organisations that responded to the survey had reviewed, updated and implemented training programmes. Nine sites carry out audits annually, 12 biennially and 6 triennially. Where organisations answered that they do not audit the effectiveness of training programmes or other, they were asked to specify how effectiveness was measured. Responses included;

- Competency assessments for staff
- Feedback from training sessions
- Debrief sessions following MHP activations
- Monitoring of incidents for trends
- Review of compliance to training requirements
- During MHP drills/simulations
- Bespoke training as required

Action 3: Local organisations must have implemented processes to audit and investigate all transfusion delays.

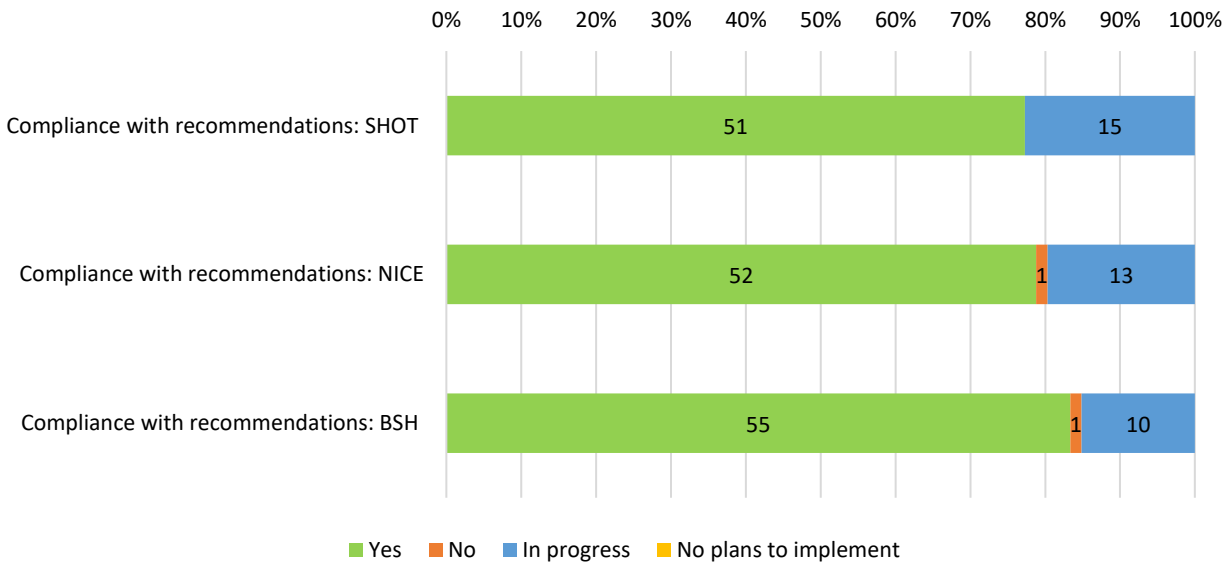
Implement processes to audit and investigate all transfusion delays, using appropriate investigation tools to identify system factors for improvement



Sixty organisations had implemented processes to audit and investigate all transfusion delays, and 5/66 responded that implementation was in progress.

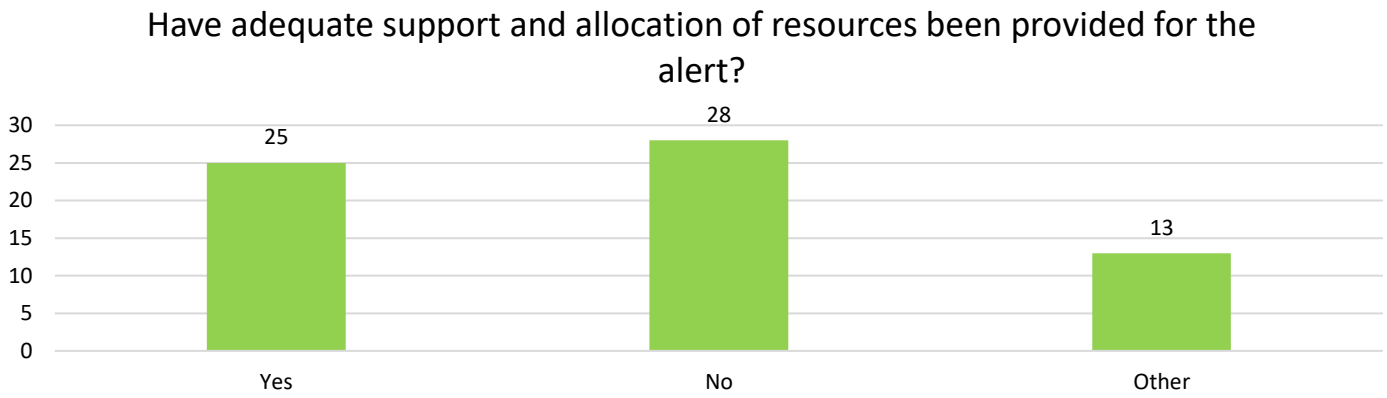
The survey asked respondents to state compliance with Serious Hazards Of Transfusion (SHOT), National Institute for Health and Care Excellence (NICE) and British Society for Haematology (BSH) recommendations

Responses relating to compliance with SHOT, NICE and BSH recommendations

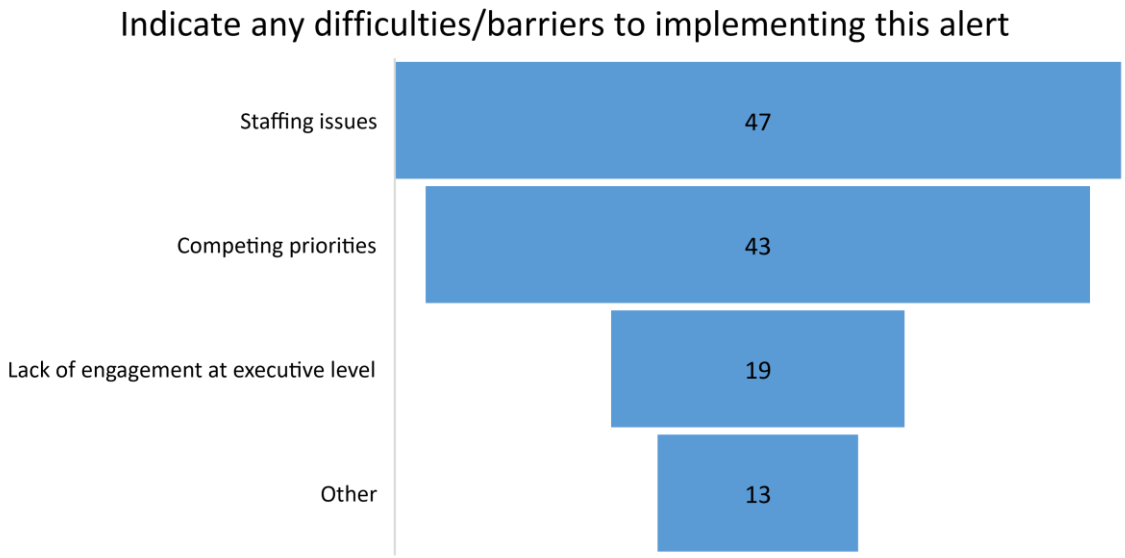


Most organisations that responded to the survey were compliant with these national recommendations or stated that compliance was in progress.

The survey asked if adequate support and allocation of resources had been provided for the alert and what the main difficulties/barriers to implementation were



Twenty-eight organisations felt that adequate support and allocation of resources had not been provided for the alert compared to 25/66 that responded yes.



For difficulties and barriers to implementing the alert respondents were asked to select all factors that applied. The majority selected staffing issues and competing priorities as the main barriers. Themes included

- Unavailability of adequate resources to deliver training/ MHP drills
- Lack of engagement from Training and Development departments.
- Staffing levels, constraints, and recruitment within the TP teams
- Lack of support at executive level to implement the CAS alert actions
- Financial constraints – clashing priorities/cost pressures including the implementation of IT systems
- Staffing levels in clinical areas and workload pressures
- TP teams were given responsibility for the implementation of CAS alert actions

The final survey question asked for further comments to support responses, successes along the way, or timescales for completion for the purpose of shared learning.

There were 31 responses provided to this question in the survey. The overall response was positive from those who made comments and are in the process of implementing many of the recommendations from the alert. Some themes that emerged are detailed below

There were some very good comments made about Transfusion Practitioners and Hospital transfusion teams (HTT) having good relationships with the clinical teams.

Some comments that transfusion teams are being asked to implement the alert but not necessarily receiving appropriate support from the wider clinical team and most responses from the survey came across as though the sole responsibility for this alert was with the transfusion team and not the rest of the hospital.

There were a few comments that teams were willing and enthusiastic about that changes but there was a lack of resources, staff and time to support the changes specifically regarding simulation training.

There were several comments regarding lack of support and time to be able action the alert.

We would like to thank all participating organisations for your valuable input

The majority of responses to the survey and implementation were positive

Responses received have helped understanding of the challenges faced

Survey responses will help to inform future transfusion safety alerts

National Blood Transfusion Committee (NBTC) and Serious Hazards Of Transfusion (SHOT) would like to acknowledge and thank colleagues from the United Kingdom and Ireland Blood Transfusion Network (UKIBTN) for their assistance with the survey.

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