SHOT Acknowledging Continuing Excellence (ACE) Examples

Acknowledging Continuing Excellence (ACE) was first introduced in the 2019 Annual SHOT Report and has been introduced as a reporting category for the year 2021.

ACE reports are defined as “Exceptional transfusion practice by a team or department, that was above and beyond routine practice and has widespread learning opportunities.” All reports should have been discussed and agreed at the Hospital Transfusion Team/Committee (HTT/HTC) level before submitting to SHOT.

Please find full ACE definition here: https://www.shotuk.org/reporting/sabre/

The SHOT team have created two hypothetical ACE reports which can be used as a guide for reporters completing ACE reports. An example is given for ACE in Clinical and Laboratory practice. Screenshots of how the report will appear on the SHOT reporting system, dendrite, are found on page 4.

If you would have any further queries regarding ACE reports, please contact the SHOT Team via email shot@nhsbt.nhs.uk

Example 1: ACE for Clinical Practice

Give a detailed description of the adverse event or reaction

A patient with a GI bleed was on a general surgical ward when they suddenly deteriorated. The ward staff were unfamiliar with the Major Haemorrhage Protocol (MHP) having rarely used it, so this caused some nervousness and anxiety at the time. The MHP was activated but there was a breakdown in communication between the clinical team and the laboratory team. It appears that they did not have a member of staff identified as the 'co-ordinator' (to be the one point of contact from the clinical area to the lab) when such emergencies occurred. This led to delays in obtaining blood products for this patient.

In which area or category would you like to report continuing excellence

Transfusion Practice – Clinical

Please briefly describe what was excellent

The TP, Lab managers and clinical training lead (assisted by the IT dept) devised a training video to highlight the importance of identifying individual staff roles when the MHP is activated. Followed by a 'quiz' to test knowledge of those watching the video.

How was this different from routine practice

Normal practice has been to teach about staff roles on training days by reading through the actual MHP.

How was this shared locally

Initially the video was shown to medical students and it showed an increase in knowledge, measured by a quiz before and after watching the video. It is now used during blood transfusion training days for doctors, nurses, lab staff, switchboard staff and porters. The video is also available on the hospital intranet.

What one learning point would you like to share with the transfusion community

When a patient meets the criteria for activation of the MHP, one person in the clinical area should take responsibility for communication between the transfusion laboratory and the clinical area. This person should act as the "coordinator" to avoid miscommunication and facilitate the speedy delivery of blood components.

Example 2: ACE for Transfusion Laboratory Practice

Give a detailed description of the adverse event or reaction

When reviewing lab SHOT reports at the HTT, we noticed that 7 this year involved incorrect information noted following a telephone request or forgetting to pass on telephone messages. The TP's and Lab manager worked together to introduce a standardised telephone request form.

For the next 6 months after introduction of this form we had only 1 error concerning telephone requests (involving a locum member of staff unfamiliar with the process)

In which area or category would you like to report continuing excellence

Transfusion Practice – Laboratory

Please briefly describe what was excellent

Introduction of standardised telephone form leading to a reduction in errors from 7 over the past year, to 1 in the past 6 months. Communication with the clinical teams has also improved as they now know what to expect to be asked when they ring the lab and have the information to hand more often.

How was this different to routine pratice

Previous practice was a log of calls with a small space per phone call. It was often cramped and hard to include all relevant details. It was also hard for those who were working on the next shift to tell what had been discussed and agreed.

How was this shared locally

We did lots of training with lab staff (including a new SOP) and clinical department training leads before we introduced the form. We have presented the results in error reduction at the HTC, at our hospital audit day and at the regional transfusion committee. We will also submit a poster to BBTS next year.

What one learning point would you like to share with the transfusion community

Good clear communication improves safety. When everyone is clear on what to ask and what they are going to be asked everything is a lot smoother and safer!

ACE Questionnaire in Dendrite

Give a detailed description of the adverse event or reaction	When reviewing lab SHOT reports at the HTT, we noticed that 7 this year involved incorrect information noted following a telephone request or forgetting to pass on telephone messages. The TP's and Lab manager worked together to introduce a standardised telephone request form (one per phone call). For the next 6 months after introduction of this form we had only 1 error concerning telephone requests (involving a locum member of staff unfamiliar with the process).
Is this event related to	○ Labile component ○ Anti-D Ig administration ○ Cell salvage ○ Anti-D immunisation ◉ Acknowledging Continuing Excellence

Details of Continuing Excellence

In which area or category would you like to report continuing excellence	Transfusion practice - laboratory
Please briefly describe what was excellent	Introduction of standardised telephone form leading to a reduction in errors from 7 over the past year, to 1 in the past 6 months. Communication with the clinical teams has improved also as they now know what to expect to be asked when they ring the lab and have the information to hand more often.
How was this different from routine practice	Previous practice was a log of calls with a small space per phone call. It was often cramped and hard to include all relevant details. It was also hard for those who were working on the next shift to tell what had been discussed and agreed.

Sharing Good Practice

How was this shared locally	We did lots of training with lab staff (including a new SOP) and clinical department training leads before we introduced the form. We have presented the results of error reduction at the HTC, at our hospital audit day and at the regional transfusion committee. We will also submit a poster to BBTS next year.
What one learning point would you like to share with the transfusion community	Good clear communication improves safety. When everyone is clear on what to ask and what they are going to be asked everything is a lot smoother and safer!
Please add any further details	This did take a lot of time and enthusiasm from lab seniors and TP's, I would like to thank them for their efforts!
Please upload any relevant documents	
Is the questionnaire complete? Click 'Yes' to close the report	○ No ◉ Yes