

# **REFLECTIVE LEARNING and SHOT**

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DID YOU  
KNOW  
THAT  
YOU'RE  
VERY  
GOOD  
LOOKING?



UPON  
REFLECTION  
I THINK  
YOU'RE  
RIGHT.





# HISTORY



- Educational philosopher John Dewey
- Born 1859 Vermont
- Professor of Philosophy
- Challenged the accepted means of educating
- Promoted reflective actions
- Learning by doing

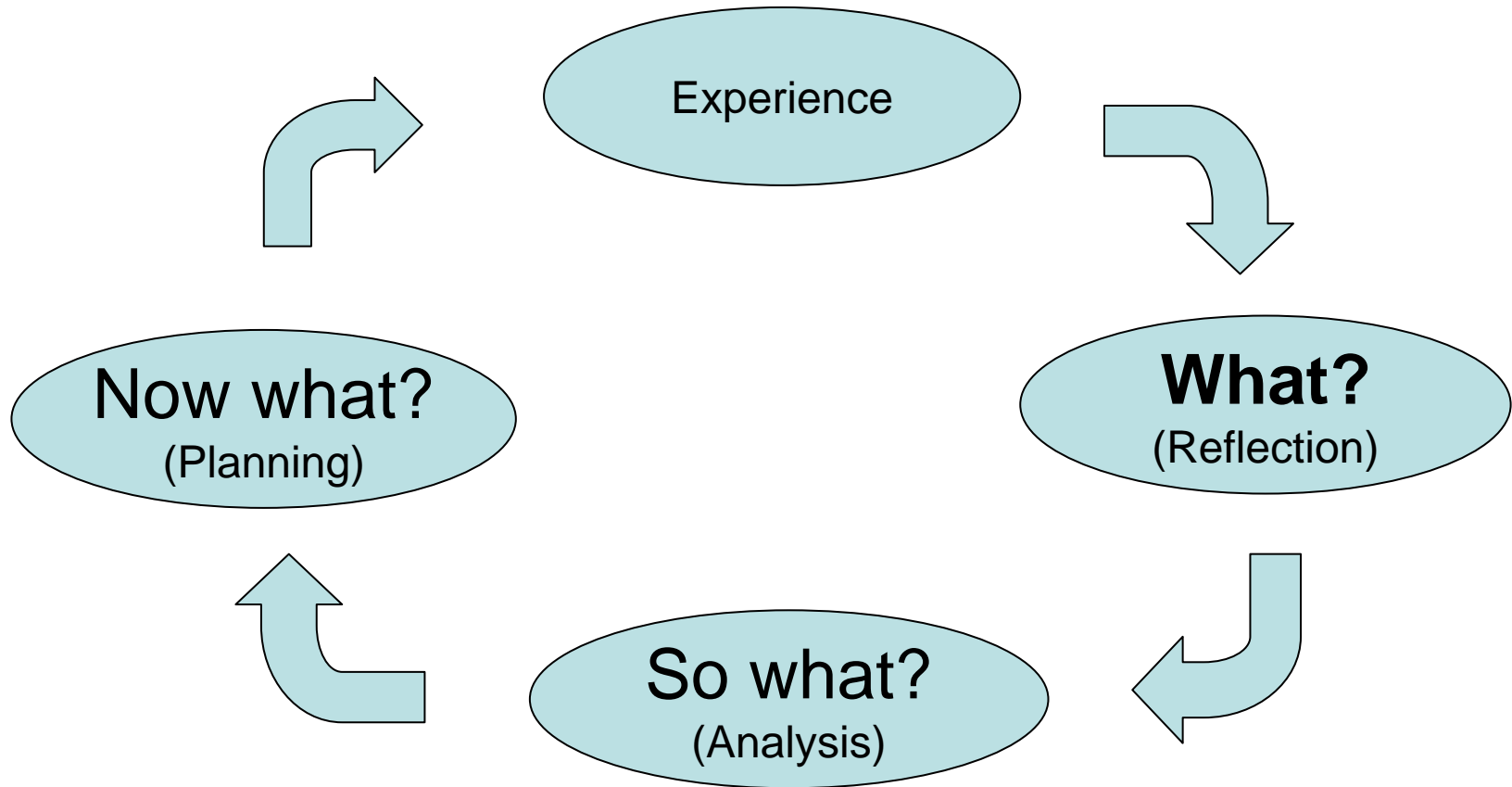
# DEFINITION

- Requires the student to reflect on the actions they have taken against the outcome
- Compare to procedures/policies in place
- Knowledge learnt can be incorporated into the action next time
- View problematic situations and convert them to potential learning opportunities
- Alternatively – learn from mistakes

# WHY SHOULD WE DO IT?

- Reflective learning or reflective practice preferred as evidencing CPD as it avoids the “went to that meeting” (but slept through half of it) route
- Helps to meet future mandatory CPD requirement
- Can be achieved within the workplace
- Facilitates a skilful, appropriate and effective response to situations

# KOLB LEARNING CYCLE



# HOW CAN IT BE ACHIEVED?

- Quietly reflecting on events
- Problem based learning
- Writing out a sequence of events
- Reflect critically but constructively
- Self assessment / Peer assessment
- Undertake reflection with a tutor / mentor to facilitate learning

# Continued.....

## WHEN?

- ASAP
- Review 1-2 wks later

## HOW?

- Must be reflective NOT descriptive
- Write in first person
- Include thoughts and feelings
- Analyse own role
- What effect does event have on others?
- Show learning

# WHAT'S IN IT FOR THE INDIVIDUAL?

## Advantages

- Improve confidence and competence
- Improves practice
- Learn new information
- Learn from others
- Increases knowledge of the organisation
- Become more aware of strengths and limitations
- Can set new developmental goals

## Disadvantages

- May become more introspective and anxious
- Time consuming
- Lack of experience can affect reflection
- Need to recognise when you need help and how to get it

# ISSUES

- Requires honesty
- Requires a strong sense of vision
- Requires good judgement
- Needs an ability to grasp and interpret changing situations
- May be some reluctance when it involves reflecting on errors in the workplace
- Takes time to complete
- Scientists tend not to be good at the emotional aspects
- Flow charts may help
- Senior staff need to encourage

# HOW CAN WE USE SHOT?

- Annual report
- Summary of main findings
- General recommendations
- Specific recommendations
- Category specific analysis
- Case vignettes
- Learning points

**Surely it can't happen here**



# Example 1

## IBCT – Case study (2003)

- Young female with Fe Def anaemia
- 4 unit transfusion prescribed
- Request made ‘out of hours’
- Policy to make K- units available
- On call BMS selected a K+ unit
- 1 year later patient pregnant
- Anti-K detected at booking


# Apply Kolb learning cycle



**What?**  
(Reflection)

- **Take a look at your own laboratory / clinical practices and ask questions**
- How do we deal with cases like this?
- What is our policy on 'out of hours' transfusions?
- What is our policy for transfusing patients with Fe Def anaemia?
- Is everyone aware of need to give K-blood to females under 60yrs?
- Could we have selected a K+ unit in error
- What role does our IT system play?
- What do we do about KK females – should they really receive kk blood?
- Do we involve the clinicians?

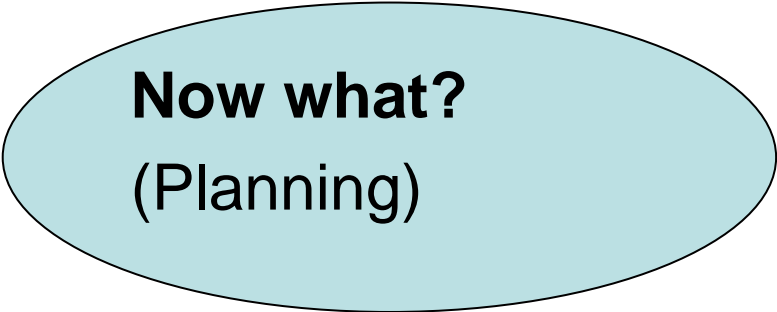
# Continued.....



**So what?**  
(Analysis)

- **This is about making sense of what is happening – comparing your own organisation with the happenings of the case study.**
- Could a similar incident happen in your organisation?
- What are the good points in our organisation?
- What are the bad points in our organisation?

# Continued.....



**Now what?**  
(Planning)

- **This is about putting into practice what has been learnt from the incident under consideration**
- Move towards minimising non essential transfusions occurring 'out of hours'
- Refer requests for blood in Fe Def cases to Haem Consultant
- Separate stock of K- units for female patients
- Appropriate warning flags on blood bank IT system
- Education of staff

# Example 2

## Delayed Haemolytic Transfusion Reactions (2004 report)



**What happened?**  
Experience

- Due to non detection of an antibody caused by previous immunisation
- 43 reports
- No deaths but indication of morbidity and increased bed stay
- Of these 25(60%) had Kidd antibodies
- Difference in detection by common techniques in use

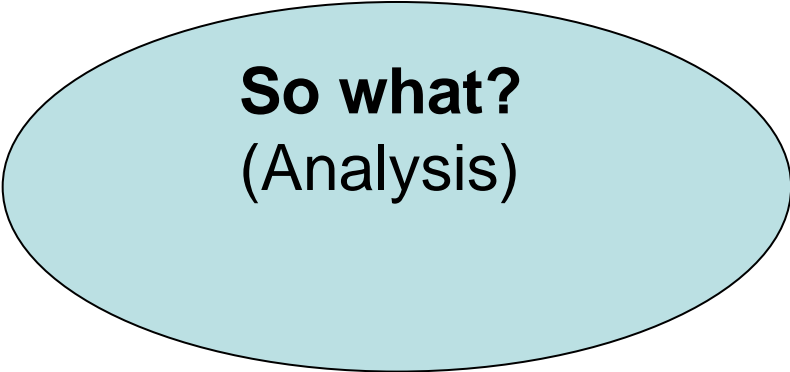
# Apply Kolb learning cycle



**What?**  
(Reflection)

- **Take a look at your own laboratory / clinical practices and ask questions**
- Nobody has died – we're ok?
- Have we had cases where Hb failed to increment as expected?
- Do we detect Kidd abs?
- Incidence of DHTR in our lab?
- How do we investigate suspected DHTR?
- Is our technology good enough?
- What evidence is 'out there'?

# Continued.....



**So what?**  
(Analysis)

- **This is about making sense of what is happening – comparing your own organisation with the happenings of the case study.**
- 1 similar case – what action did we take?
- Plasma or serum samples for investigation?
- Follow-up

# Continued.....

**Now what?**  
(Planning)

- **This is about putting into practice what has been learnt from the incident under consideration**
- Storage of samples post crossmatch
- Samples needed for DHTR investigations
- Competence required in new techniques?
- Review of technologies, practical and theoretical
- Maybe think about a change in laboratory technology

# Reflective benefits

## Advantages

- Improve confidence and competence
- Improves practice
- Learn new information
- Learn from others
- Increases knowledge of the organisation
- Become more aware of strengths and limitations
- Can set new developmental goals

## Disadvantages

- May become more introspective and anxious
- Time consuming
- Lack of experience can affect reflection
- Need to recognise when you need help and how to get it

**I can see you're all flagging**



# Have a safe journey home

