Serious Hazards of Transfusion (SHOT) 2018 Key Recommendations Survey

Survey Aims and Response Rate

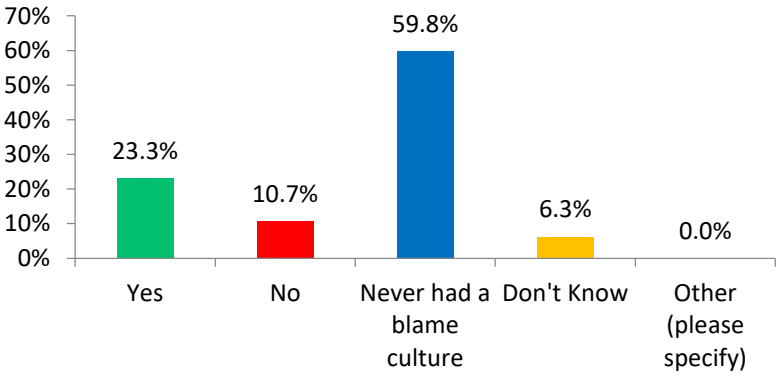
The Key Recommendations survey aims to understand progress with implementing Key SHOT Recommendations in NHS Trusts/Healthboards. This was circulated six months following the release of the 2018 Annual SHOT Report.

The electronic survey (Surveymonkey®) was emailed to all registered Serious Adverse Blood Reactions and Events reporters in January 2020 and was available for 4 weeks. Questions were either single or multi-choice (results indicated by percentage or absolute number respectively). One response was requested per Trust/Healthboard, however data received reflects that some Trusts/Healthboards responded more than once. A total of 128 responses were received in full, with representation from all countries of the United Kingdom.

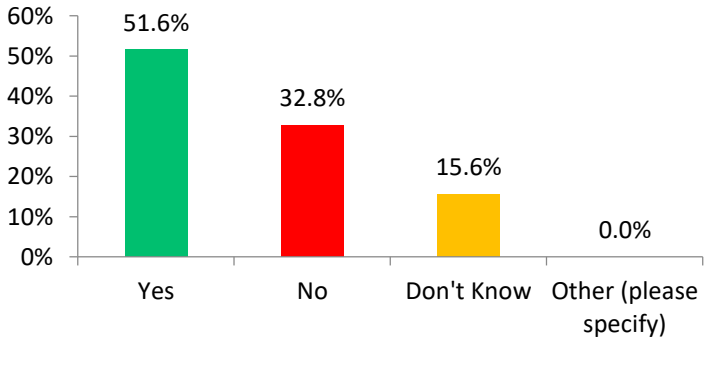
Key Recommendation 1

All NHS organisations must move away from a blame culture towards a just and learning culture

The Key SHOT Recommendations encourage moving away from a blame culture - has this influenced your practice?



The Key SHOT Recommendations encourage moving towards a just and learning culture - has this influenced your practice?



Responses indicate that:

- Human factors (HF) principles are being applied, and systemic factors are being evaluated
- Staff are being supported with re-training as needed

It appears that a just culture is already widespread and opportunities were identified for collaboration, sharing and learning.

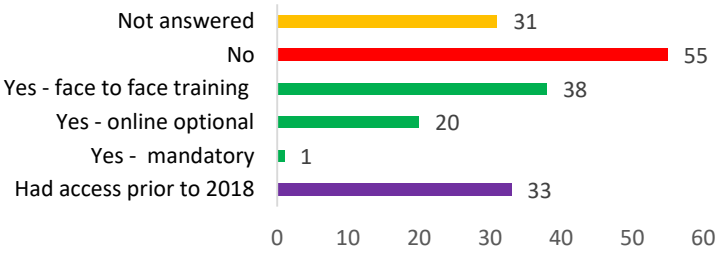
Supporting & encouraging staff to report incidents, finding where systems failed

Reinforced as opposed to influenced. We always try to have a just and learning culture within the department

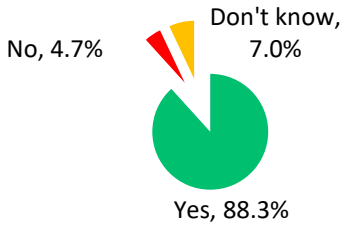
Key Recommendation 2

All clinical and laboratory staff should be encouraged to become familiar with human factors and ergonomics concepts

Have you had any provision of HF training to staff? (Please tick all that apply)



Do you use HF principles to identify systemic issues and agree appropriate corrective and preventative actions?



- HF training is available online and SHOT Recommendations have encouraged more take-up. It is available through many routes but is rarely mandatory with much variation in access, delivery and target-audience
- Transfusion incidents can often be multifactorial with the root cause difficult to identify. Laboratory staff are working hard to collaborate with clinical staff, difficulties with this can be encountered due to limited staffing resources and time
- 68% responses stated their local incident reporting system does not contain a tool to capture and score HF. This may indicate missed opportunities to learn

If the incident requires a root cause analysis then a section for human factors is included and this is attached to the final report

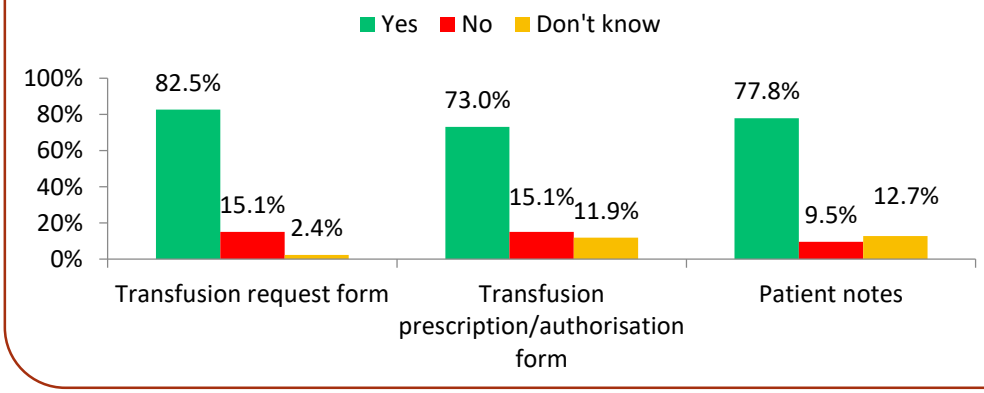
Our Trust takes little interest in investigating anything which doesn't result in patient harm

Near misses are almost universally used as learning opportunities and differences in approach to this are seen. Respondents stated competing pressures for time and resource are providing obstacles

Key Recommendation 3

All transfusion decisions must be made after carefully assessing the risks and benefits of transfusion therapy. Collaboration and co-ordination among staff is vital

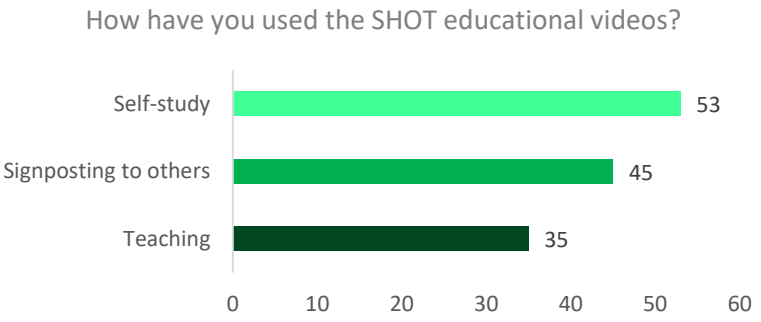
Is the rationale for transfusion decisions captured on any of the following?



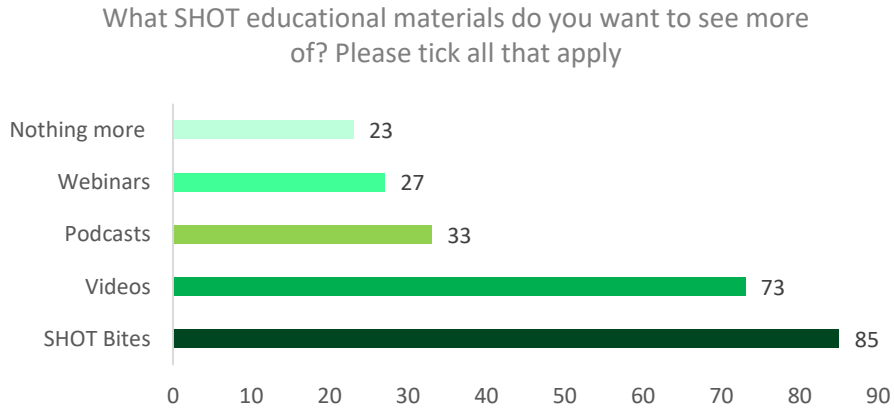
Documentation to capture transfusion decision rationale is widely available, but not standardised. Compliance was also highlighted as an issue. Comments showed the use of innovative solutions, electronic and otherwise.

In the policy and guidelines but not usually done in practice

SHOT resources – Availability and use



- 66% of respondents have seen the SHOT educational videos
- Trust/Healthboard IT issues and difficulties with media platforms have influenced accessibility



Further resource suggestions included PowerPoint presentations, screen savers, posters and web links

Other comments and SHOT actions

Whilst responses received regarding just culture and application of HF principles in investigating incidents are encouraging, this is not always reflected in the reports received. Organisations are encouraged to embed these principles in day to day practices and provide training to staff not only in technical skills but also non-technical skills.

SHOT report should have layered recommendations, those that are directly influenceable by transfusion and those that are more cultural. How about a chief exec summary?

- A number of reporters stated that the recommendations were too vague and not within the power of transfusion staff to achieve. SHOT recognises that organisational culture can be deeply embedded and difficult to change. We would like to encourage our reporters that small changes within our own control can radiate outwards, and represent a new way of doing things to our colleagues
- SHOT provide suggestions for key personnel to action relevant recommendations. We are aiming to contact chief executives and medical/nursing directors, to raise awareness about transfusion related issues and help make transfusion safety a priority

SHOT are developing more resources, including: SHOT Bites, webinars, videos, and podcasts. These resources will be on topics related to haemovigilance and can be used for education and training purposes.

The SHOT team would like to thank everyone who took the time to complete the survey. Your feedback is very useful and is sincerely appreciated. The full Annual SHOT Report 2018 is available at https://www.shotuk.org/shot-reports/report-summary-and-supplement-2018/