Serious Hazards of Transfusion (SHOT) 2020 Key Recommendations Survey

Survey aims and response rate

The Key Recommendations Survey aims to understand progress made in implementing Key SHOT Recommendations in NHS Trusts/Health Boards. This survey was circulated 6 months following the release of the 2020 key recommendations.

The electronic survey (Online surveys) was sent to all registered Serious Adverse Blood Reactions and Events (SABRE) reporters in February 2022 and was available for 8 weeks. Questions were either single or multiple-choice. One response was requested per Trust/Health Board. A total of 84 responses were received in full, with representation from all countries of the United Kingdom.

Acknowledging Continuing Excellence in Transfusion (ACE)

It is encouraging that 86% of respondents were aware of the *Acknowledging Continuing Excellence in Transfusion (ACE)* chapter and 79% reported that their healthcare organisation has an option to submit excellence reports.
Some SHOT ACE resources can be found here: Current Resources (shotuk.org)

SHOT Resources – Availability and Use

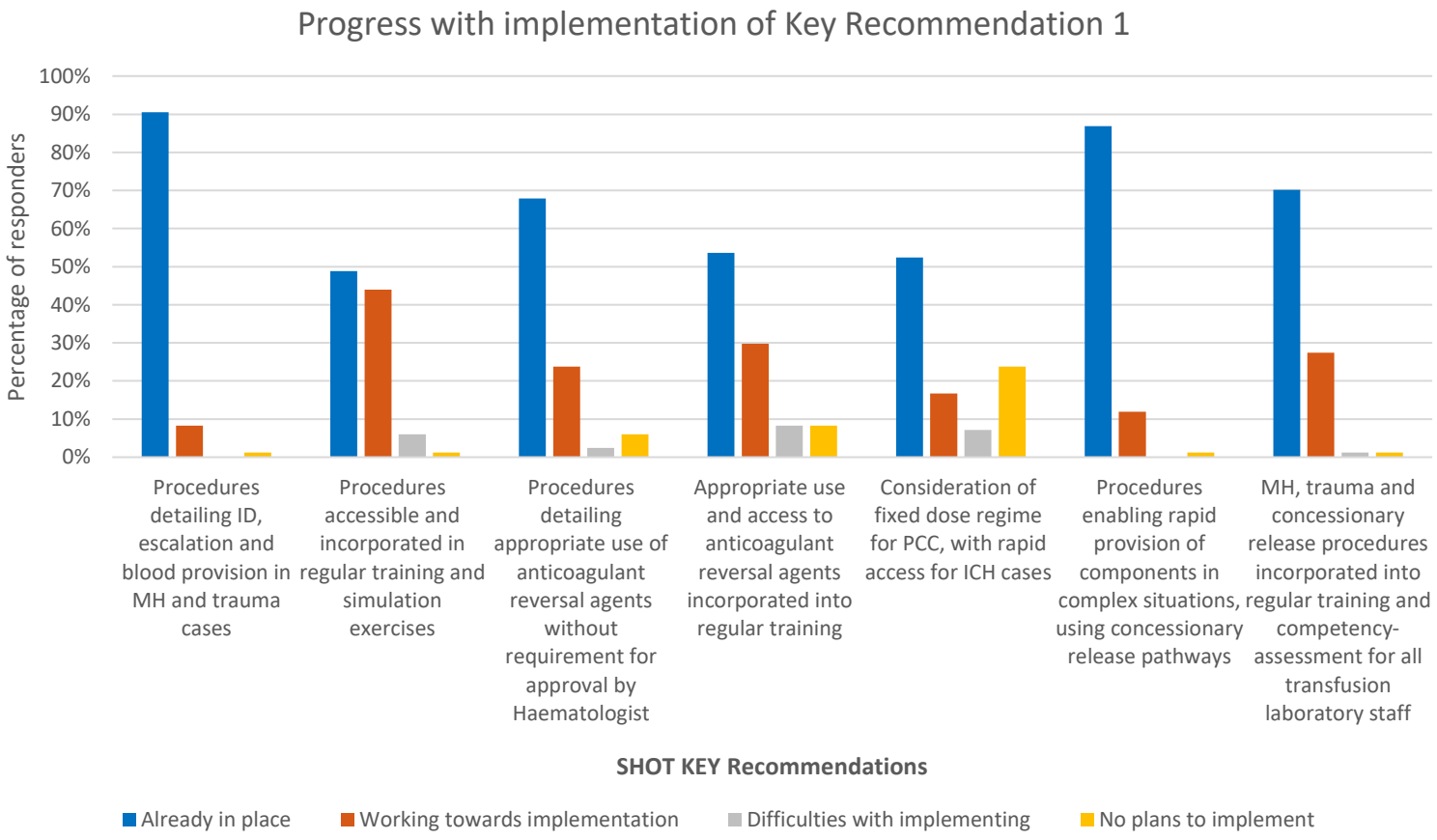
- Resources are used for self-learning, induction, and team-learning
- Webinars were viewed by 94% of respondents and SHOT Bites remain a well used resource
- SHOTcasts and participation bench-marking data continue to be the least used SHOT resources
- Time constraints, competing priorities and staffing pressures were cited as the major barriers to accessing SHOT resources

Suggestions for future training and topics included:

- More SHOT Human factors training and courses
- More templates for root cause analysis and for WBIT investigations
- How to undertake a good investigation and asking the right questions

Key Recommendation 1

Transfusion delays, particularly in major haemorrhage and major trauma situations, must be prevented. Delays in provision and administration of blood components including delays in anticoagulant reversal, particularly in patients with intracranial haemorrhage (ICH), can result in death, or serious sequelae. Every minute counts in these situations.



Responses indicate:

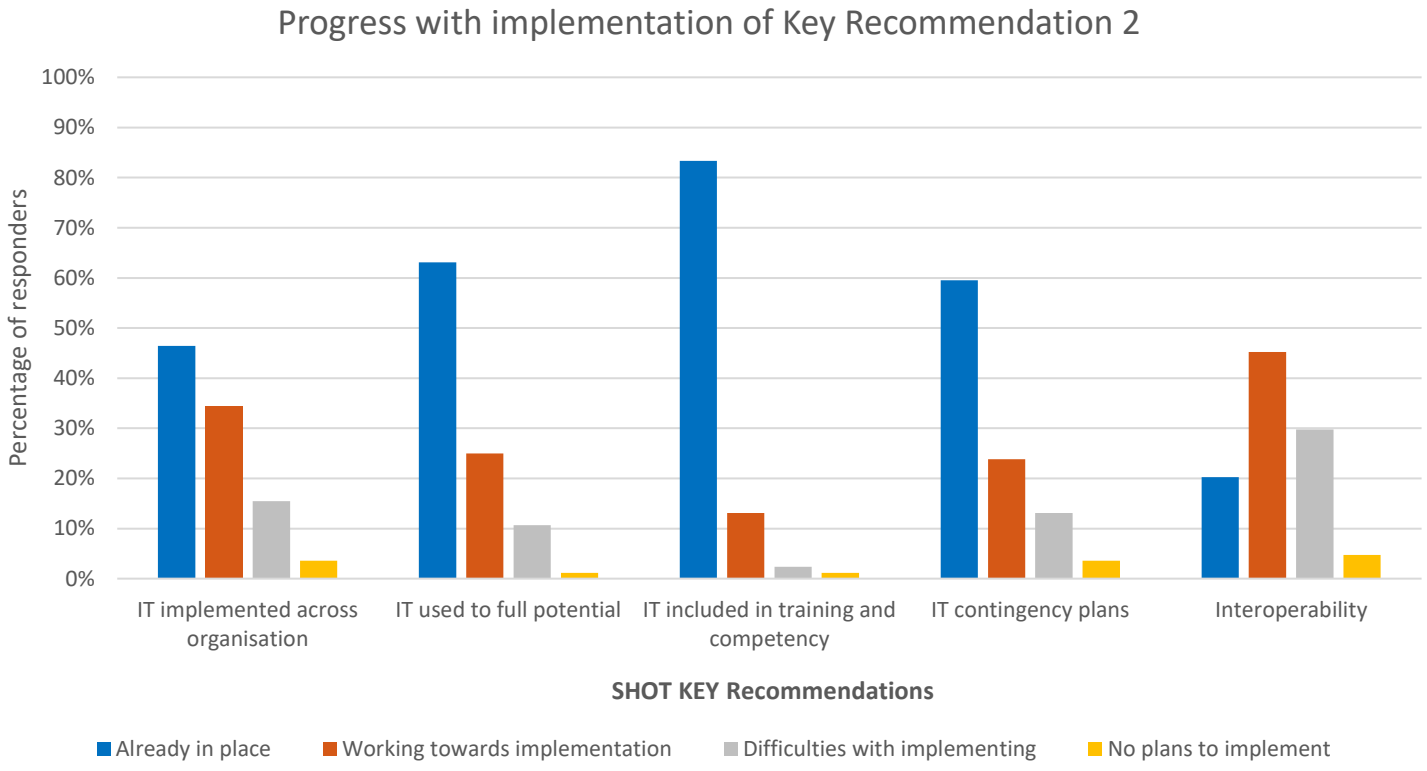
- Issues with lack of experienced clinical staff and senior BMS in the Transfusion Laboratories
- Procedures are in place for concessionary and rapid release of blood components and products in many organisations
- Staffing shortages reduce capacity for simulations and emergency drills

"We have a concessionary release document to cover all situations. This is incorporated into training"

Ongoing simulation exercises, but constant rotation of staff makes full confidence in appropriate training difficult

Key Recommendation 2

Effective and reliable transfusion information technology (IT) systems should be implemented to reduce the risk of errors at all steps in the transfusion pathway, provided they are configured and used correctly.



Key themes in barriers to implementation of effective and reliable IT systems: Moving towards a new electronic patient record (EPR) system, internal Trust IT, cost, problems with interfacing between IT systems.

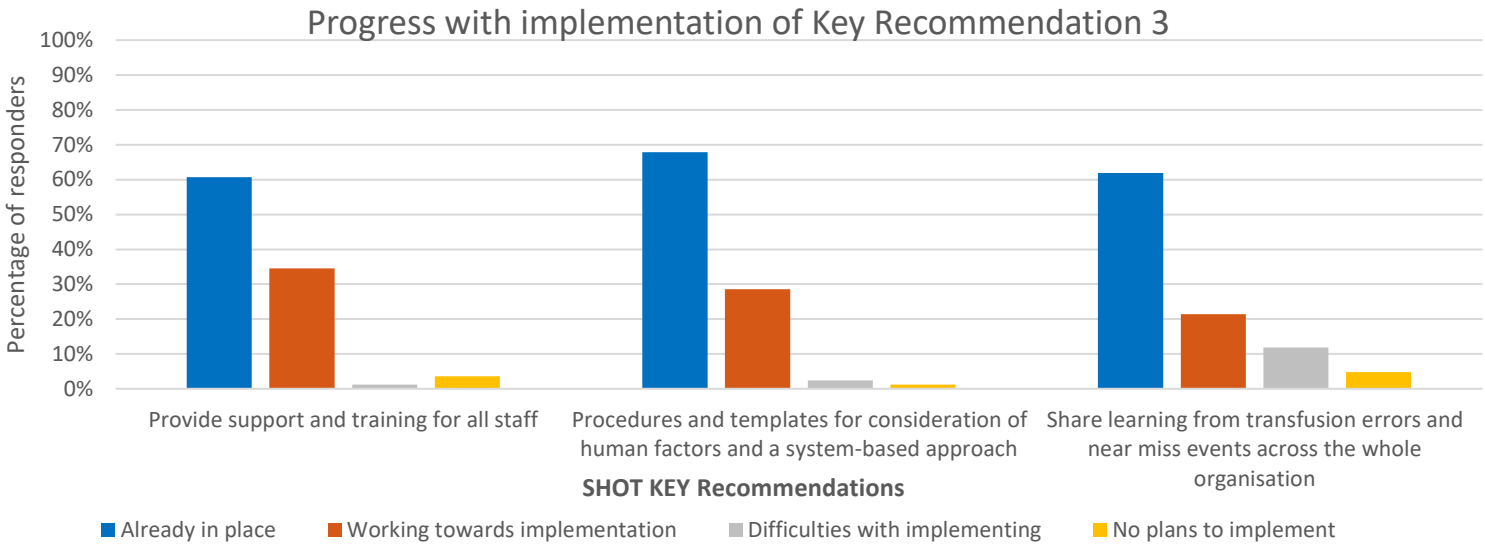
"Transfusion digital strategy continues to be raised by us at every opportunity, but we are still not high on IT agenda"

Full potential of IT systems are still limited due to interface issues.
The SHOT UK Collaborative Reviewing and reforming IT Processes in Transfusion (SCRIPT) group aims to improve transfusion safety through improved IT systems and practices. Find out more at: https://www.shotuk.org/resources/current-resources/script/

Working towards local blood tracking, but slow at implementation due to effect of covid pandemic. Region working toward integrated LIMS, tracking and electronic care record that can all be linked

Key Recommendation 3

Effective investigation of all incidents and near miss events, application of effective corrective and preventive actions, and closing the loop by measuring the effectiveness of interventions should be carried out to optimise learning from incidents.



"Human factors to be further incorporated into procedures and templates across the Trust."

Time scale factors, staff availability due to sickness, and environmental factors were key themes raised as a barrier to compliance with this recommendation.

How to engage the clinical area or hospital management!

- Respondents commented that SHOT should produce three or four achievable key recommendations
- SHOT has taken this on-board with the 2021 recommendations in the 2021 report by specifying key personnel to action relevant recommendations
- SHOT provides a gap analysis tool for the 2021 recommendations to support audit and senior management engagement

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 2020 is available at Report, Summary and Supplement 2020 (shotuk.org)