Acknowledging Continuing Excellence in Transfusion (ACE)

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Definition:

Exceptional transfusion practice by a team or department, that was above and beyond routine practice and effective interventions that have widespread learning opportunities.

Abbreviations used in this chapter

ACE	Acknowledging continuing excellence in transfusion
AI	Appreciative inquiry
BMS	Biomedical scientist
FBC	Full blood count
GMP	Good manufacturing practices
NHS	National Health Service
SABRE	Serious adverse blood reactions and events
SOP	Standard operating procedure
TALK	Target, analysis, learning points, key actions
UK	United Kingdom
WBIT	Wrong blood in tube

Introduction

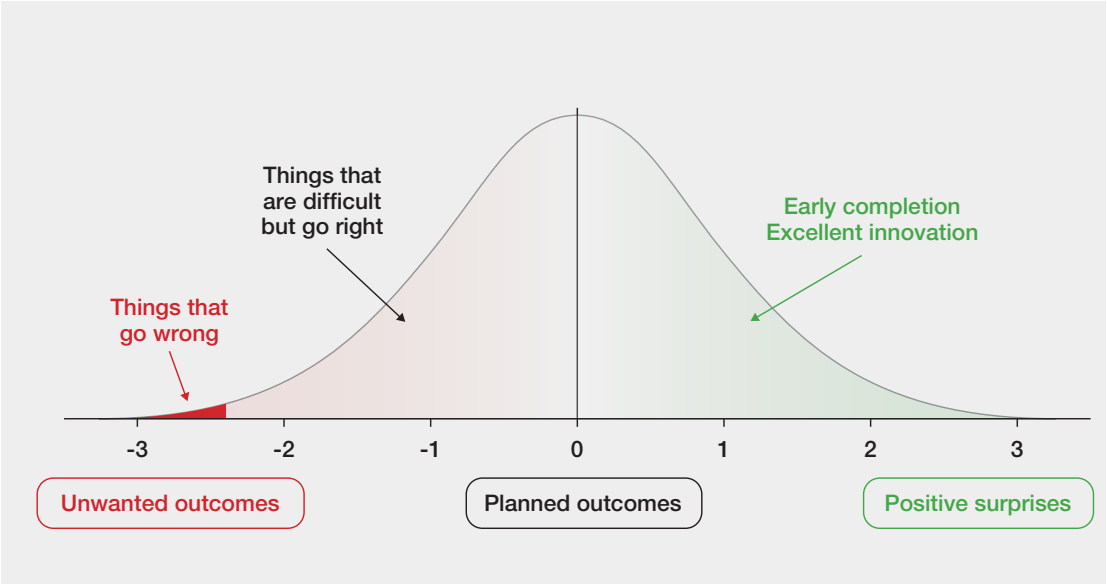
Recognising that studying excellence in healthcare can create new opportunities for learning, help improve resilience and staff morale, SHOT has recently introduced Acknowledging Continuing Excellence in Transfusion (ACE). ACE reports recognise the excellence and outstanding practices of teams or departments and effective interventions that have promoted transfusion safety and are submitted to SHOT, via SABRE, through a questionnaire on the SHOT database (Dendrite). ACE provides a platform to share learning opportunities from these examples of excellence. High quality care becomes the norm by embedding the learning from good practice into the system (Hollnagel et al. 2015). A reporting guide is available on the SHOT website (see 'Recommended resources' at the end of this chapter) to help staff submit reports in this category. This hopefully will encourage transfusion teams to identify excellent practice locally and report it to SHOT so that learning from excellence is embedded widely across the NHS.

Recognising errors and identifying improvement actions to prevent recurrence is the primary focus when incidents are investigated, which is typical of a Safety-I approach. While incident investigation templates may include recognition of notable practice, investigating a good practice event to see if there is any learning is often lacking. The linear approach of Safety-I, which involves tracing causes of events and mapping out steps in procedures, does not truly reflect the complexity and adaptability of healthcare which is constantly changing.

The Safety-II approach seeks to understand the ability of healthcare staff to adapt to problems and pressures and considers how resilient an organisation is. It has a focus on productivity and ensuring the best possible outcomes. Safety-II is a proactive approach that seeks to strengthen the ability of staff to prevent problems before they occur and ensure high quality care even when there are pressures and competing demands. Learning from how things go right, rather than wrong, is an important element of

Safety-II and is especially powerful since things go right much more often than they go wrong. Learning how staff provide good care under difficult circumstances helps ensure it happens more often. A Safety-II approach facilitates learning from excellence and provides a positive learning model which can be utilised alongside a Safety-I approach (Figure 5.1).

Figure 5.1: Event probability and safety focus (Hollnagel et al. 2015)



ACE – a form of learning from excellence

The prevailing approach to patient safety mainly considers safety from a deficit-based perspective. Efforts to reduce errors in healthcare may result in the creation of more complex systems. Reframing allows safety to be considered from a strengths-based perspective and allows alternative methods and tools to be used to improve safety. Strengths-based approaches, such as learning from excellence can be used to unmask the positive characteristics of safety, many of which are behavioural, cultural, and relational. Learning from excellence is being increasingly introduced across teams within healthcare, but still needs to be embedded fully into practice. Often staff are unaware of the various reporting systems and don't capture the excellent information (Preckel et al. 2020).

Learning from excellence has been promoted by SHOT to support the development of a just, learning and questioning culture within the transfusion community. Studying excellence creates opportunities for shared learning experiences and improves staff resilience and staff morale (Magwenzi 2021).

Opportunities to discuss examples of good practice and excellence can also be captured in event debriefs, including major haemorrhage activations. Debriefing is a prime opportunity to reflect on events, thank staff and acknowledge success. Debriefings should be learning orientated, a sharing of experiences in a supportive environment which will in turn lead to the improvements in patient care. A debriefing tool such as TALK (target, analysis, learning points, key actions) can assist teams to develop a shared learning culture and improve patient safety. The TALK tool supports the Safety-II principles, promoting reflectivity in the team, looking at what went well and endorsing collaborative change (Kolbe et al. 2021). Making changes that are effective and sustainable and can be built into the system to enable consistent good practice is vital to improve patient safety. While often things went well because of good communications and good teamwork, the challenge is ensuring this happens every time regardless of the individuals involved. Tangible actions are needed from these excellence reports that do not just include reminders, staff training and shared learning. System changes that support good practice every time are essential.

ACE reports

In January 2021 SHOT introduced a new category for reporting exceptional transfusion practice for teams or departments that go above and beyond the routine practices and effective interventions that have widespread learning opportunities. This process was created with the Safety-II approach in mind,

encouraging the reporting of excellence and using these reports to optimise learning. It also provides a platform to share the learning from these events. The SHOT ACE working group aims to promote reporting in this category but also pick out instances of good practice in error reports and highlight such examples.

An example of such a report being submitted related to a WBIT incident where the patient was transfused platelets based on incorrect FBC results. This incident has been described in detail in the supplementary information for Chapter 11b, Avoidable Transfusions on the SHOT website (https://www.shotuk.org/shot-reports/report-summary-and-supplement-2021/). The incident investigation was comprehensive and corrective/preventative actions included staff education and improvements in systems. The education team worked together to raise awareness about WBIT and sent out hospital wide alerts, undertook training sessions and encouraged a challenge culture if the sample tubes were not being labelled at the bedside. Effectiveness of these interventions will only be evident with time and all staff involved should be informed of the improvements made with these interventions.

Another example of a report submitted in the ACE category related to a critical incident outside the hospital grounds which required a police officer to collect blood components from the hospital transfusion laboratory and transport them to the scene. Police officers are not GMP trained and there was no SOP in place for such events. Laboratory staff provided clear instructions which the police officer followed, including not to open the box and delivered the blood components to the clinician in charge at the scene of the critical incident. All blood components were accounted for, and traceability was provided. Following this incident an SOP was created and training initiated for outside agencies to safely transport blood components. Prompt actions by staff in this case ensured safe and timely provision of blood components during an emergency without compromising safety. This was recognised as an example of excellence. Such an SOP to cover outside agencies to safely transport blood components in emergencies is recommended and could help avoid delays.

Although the COVID-19 pandemic has created a lot of challenges in the NHS, it has also created opportunities for novel ways to provide transfusion training. One report submitted to ACE highlighted that staff training in their hospital for competencies relating to transfusion practice pre-pandemic was at 50% compliance using face-to-face educational sessions. Since the pandemic, the hospital has used virtual training sessions enabling staff to access training more flexibly which has increased the compliance of blood training to 75%. This innovative practice ensured continuity of training through challenging times. All healthcare organisations had to adapt quickly to the evolving challenges posed by the pandemic, switching to virtual platforms and exploring innovative methods of continuing staff training and competency-assessments. This was utilised effectively by many organisations.

Civility in the workplace

Excellent practice and patient safety in the NHS are reliant on teams or departments engaging together to promote a positive culture of civility and kindness. Civility is behaviour that helps to preserve mutual respect at work; it comprises behaviours that are fundamental to positively relating with one another, building relationships and empathy.

It is now recognised that individual team members interactions with each other can impact on patient safety. Civility is often regarded as kindness and a sense of security. When this is lacking, safety may be compromised resulting in a negative clinical impact for patients (Porath and Pearson 2013). Incivility in healthcare can cause breakdowns in communication and does not foster good team working

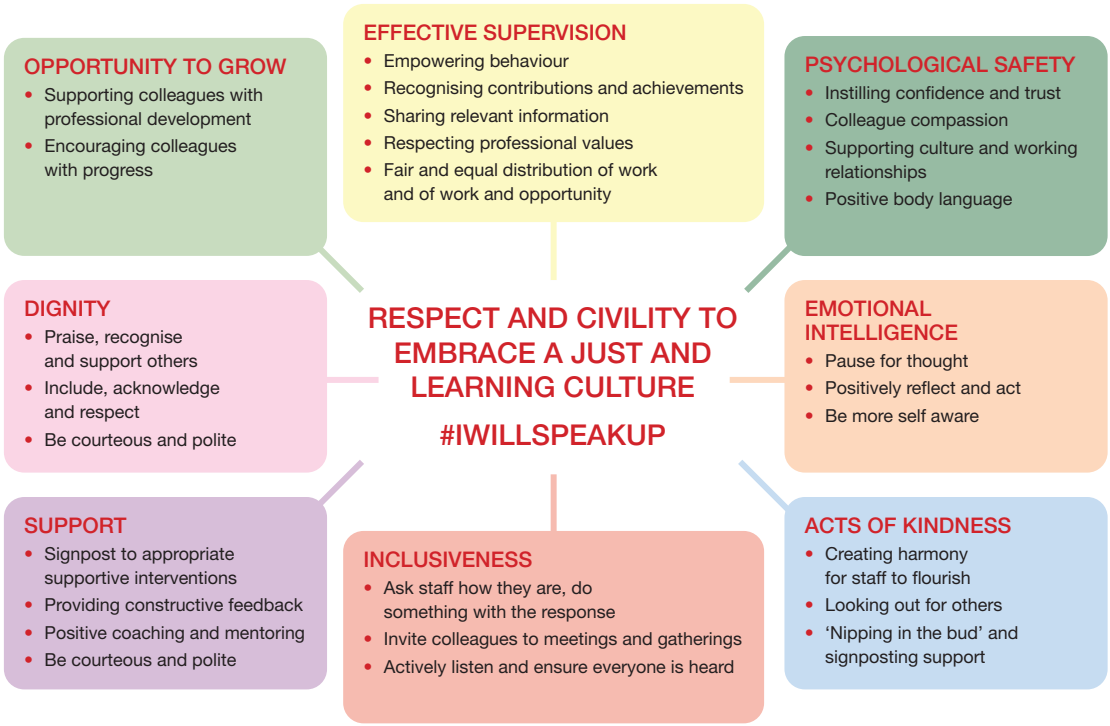
relationships, endangering patient safety. Good teamworking skills and good team relationships will achieve the best outcome for patients. Civility in the healthcare setting is crucial to reduce errors, reduce stress and encourage excellence (Civility saves lives 2022).

Johnson and Indvik (2001) identified 11 common uncivil behaviours:

1. Condescending and demeaning comments
2. Overruling decisions without giving a reason
3. Being disruptive in meetings
4. Giving public reprimands
5. Talking about someone behind their back
6. Giving others the silent treatment
7. Ignoring people
8. Not giving credit where credit is due
9. Sexually harassing employees
10. Giving dirty looks or negative eye contact
11. Insulting and yelling at others

Patient care is adversely impacted, and healthcare organisations suffer where there is not a culture of civility. There is also an impact on managers' time as they are required to deal with the grievance or investigation that can be associated with uncivil to disrespectful behaviour. NHS leaders and managers can make a difference in creating a culture based on civility where both the patient and staff experience are enhanced.

Figure 5.2: Respect and civility



Based on the infographic from Cheshire & Merseyside Health and Care Partnership https://www.cheshireandmerseysidepartnership.co.uk/civility-respect-and-the-importance-of-bystander-accountability/

Appreciative inquiry (AI)

AI is a collaborative, strengths-based, positive approach to change in organisations. The term 'appreciative inquiry' refers to both the principles and theory behind a strengths-based change approach as well as all the specific techniques used to bring about the positive change in the system. AI asks people to explore strengths and successes that already exist to facilitate change. This leads to extraordinary performance by reinforcing relationships and culture, creating common vision and direction, promoting learning and innovation, and energising collective action.

AI helps create an atmosphere of possibility, bringing enthusiasm and excitement back into teams and organisations. AI methods focus on the entire system, ensuring leaders, managers, employees, customers, and stakeholders all feel heard and acknowledged. The result is happier, more engaged employees with lower turnover, higher-performing employees, more collaboration, more creativity, and stronger teams and organisations (Cooperrider and Whitney 2000). AI is essentially a set of core principles that can potentially change existing patterns of conversation and ways of relating and give voice to new and diverse perspectives to expand what can be possible (Ludema et al. 2001). AI is usually described as using a four-stage version of the action research cycle, known as the '4D cycle' shown in the figure below and premised on the definition of a mutually agreed affirmative topic (Cooperrider and Whitney 2000).

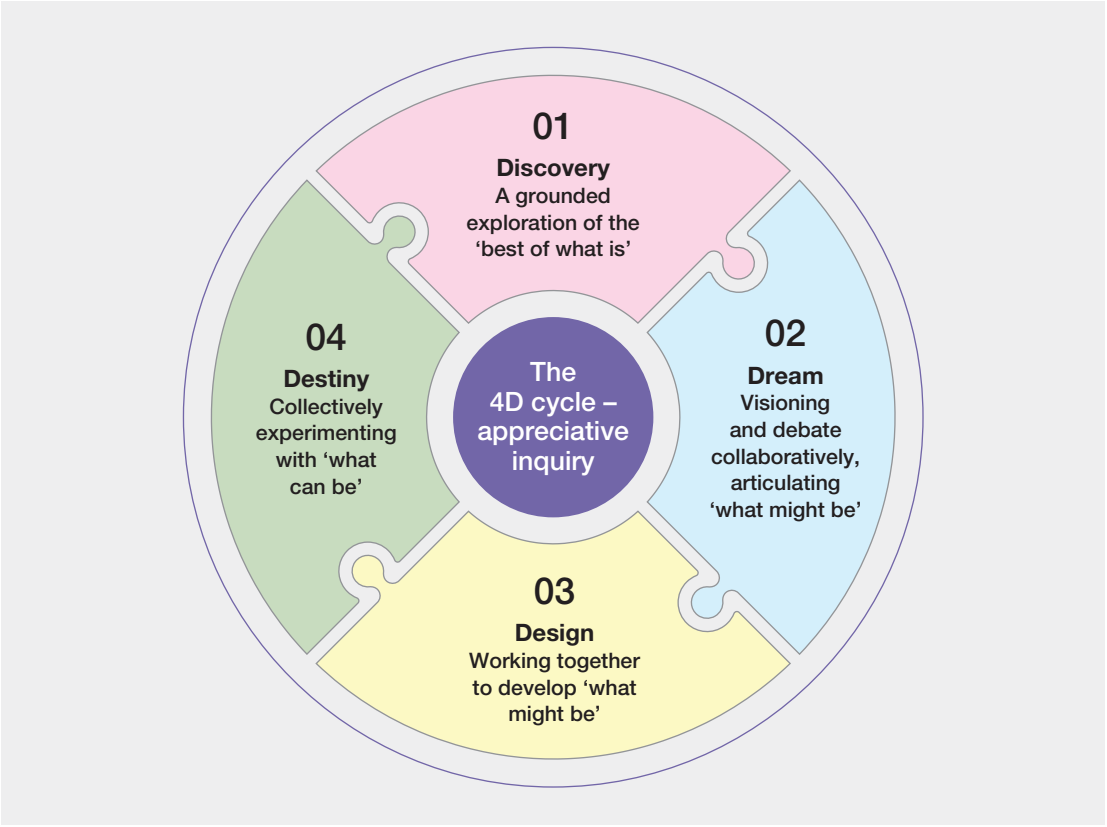


Figure 5.3: The 4D cycle for appreciative inquiry

AI provides a unique and valuable approach to making positive change in transfusion practices. It can help us look at established practices through a new lens and can help disrupt longstanding patterns of thinking and interaction and move them in a positive direction. AI can be used at individual, team, organisational and system levels. Such an approach can be applied in practice development, change management, incident investigations, workforce development, service redesign and delivery, thus potentially influencing transfusion practices in multiple ways. Using more established tools and approaches in healthcare and the assets-based approaches that AI provides will help build safer systems.

Psychological safety

Psychological safety in the workplace is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes (Edmondson 2002). In a psychologically safe work environment, people accept the fact that they do not need to be the 'expert in the room'. People are willing to learn, to connect, and are not concerned with looking good (Lagace 2018). Healthcare leaders can build psychological safety in their organisations by creating the right climate, mindsets, and behaviours within their teams. Those who do this best act as catalysts, empowering and enabling other leaders on the team, even those with no formal authority, to help cultivate psychological safety by role modelling and reinforcing the behaviours they expect from the rest of the team (McKinsey and Company 2021). Positive team climate in which team members value one another's contributions, care about one another's well-being, and have input into how the team carries out its work is the most important driver

of psychological safety and most likely to occur when leaders demonstrate supportive, consultative behaviours, then begin to challenge their teams (Frazier et al. 2017). A systematic review of psychological safety literature published in 2020 identifies a list of enablers of psychological safety within healthcare teams (O'donovan and Mcauliffe 2020). This list can be used as a first step in developing observational measures and interventions to improve psychological safety in healthcare teams.

When staff feel psychologically safe, they perform better at work, co-operate better in teams, boost creativity, learning and quality of work relationships and hence safer patient care. A good reporting and learning culture results when staff feel psychologically safe. It is vital that this is embedded in clinical and laboratory transfusion teams to improve transfusion safety.

Conclusion

ACE reporting promotes learning from excellence. This enables transfusion teams and healthcare organisations to identify when things work well so that this is embedded in practice. Excellence can often be difficult to define. Staff work extraordinarily hard every day facing several challenges and there can be a tendency to think that 'they are just doing their job' or 'they should do that anyway'. But it is this 'ordinary excellence' that needs recognising so that gratitude can be shown, and shared learning can take place. It may be an individual member of staff who performs a task exceptionally well, goes above and beyond their usual role or does something in an innovative way. It may be an excellent episode of communication with a patient, relative or colleague or an exceptional teaching session. It could be an example of excellent team working which might be in an emergency or it could be an instance where teams have come together and improved systems when things have gone wrong. Learning from excellence can also be used as a quality improvement tool.

Civility and psychological safety in workplaces foster a great safety culture within teams, providing a safe environment for staff to raise concerns, challenge norms, report incidents and near miss events thus optimising learning and building safer systems. ACE reports submitted to SHOT have shown how staff have used clear communication, seamless collaboration and co-ordination, and supportive team working to ensure safe transfusions. Learning from such events will help embed good practices and improve patient safety. SHOT advocate incorporating such learning from excellence in all transfusion teams, such a culture of positive reinforcement, appreciative inquiry and learning from these reports should be shared widely within organisations to help improve patient safety in all areas.

ACE reporting reflects a proactive approach to patient safety and focuses on capturing and learning from episodes of excellence in transfusion to further improve the quality and safety of care provided. It also provides an opportunity to thank and recognise staff for excellence, which may improve resilience, culture, and morale.

SHOT
Serious Hazards of Transfusion

Recommended resources

ACE reporting – SHOT Definitions
ACE reporting – ACE Examples
https://www.shotuk.org/resources/current-resources/

TALK
https://www.talkdebrief.org/talkhome

Learning from Excellence
https://learningfromexcellence.com/

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