Acknowledging Continuing Excellence in Transfusion (ACE) n=8

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Definition:

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

Abbreviations used in this chapter

ACE	Acknowledging continuing excellence in transfusion	**HCA**	Healthcare assistant
BMS	Biomedical scientist	**HTL**	Hospital transfusion laboratory
ED	Emergency department	**MHP**	Major haemorrhage protocol
FMH	Fetomaternal haemorrhage	**PACE**	Probe, alert, challenge, and escalate
		RTC	Regional transfusion committee

Key SHOT messages

- Learning from ACE is equally as valuable as learning from errors
- There are many ways to identify and recognise excellence which can be embedded within existing processes and day-to-day practice
- Excellence occurs within everyday practice and in response to unforeseen events

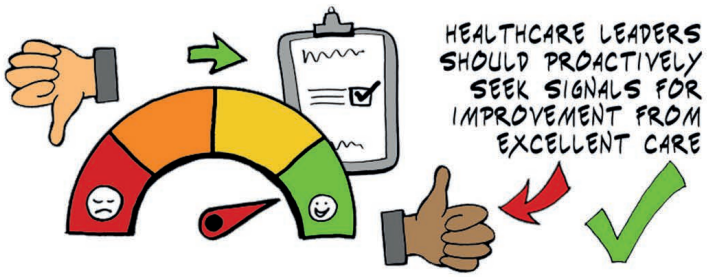
Recommendations

- Formal systems to recognise excellence should be implemented and engaged with wherever possible

Action: All hospital staff

- The light of excellence dims when it is not shared. Where excellent practice is identified this should be shared locally and within regional/national networks so that widest possible group of staff and patients can benefit

Action: All management levels, department and national



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Introduction

This is the 3rd year of including the ACE chapter within the Annual SHOT Report, and the 2nd year of data collection. In 2022, 8 reports were accepted under a wide range of ACE sub-categories and it has been encouraging to receive reports of the innovative work taking place within the transfusion community. Taking inspiration from these submitted reports, this year's ACE chapter takes a practical focus and explores how the transfusion community can continue to acknowledge and celebrate excellence.

The theories of Safety-I and Safety-II (Hollnagel et al. 2015), civility in the workplace (Johnson and Indvik 2001 and Porath and Pearson 2013), appreciative inquiry (Cooperrider and Whitney 2000 and Ludema et al. 2021) and psychological safety (Edmonson 2002 and Lagace 2018) remain extremely pertinent to the purpose of ACE. These theories have been well detailed in the 2020 and 2021 Annual SHOT Reports (Narayan et al. 2021 and Narayan et al. 2022). Resources related to these are available in the recommended resources and references for this chapter.

ACE cases 2022

Table 5.1 shows a summary of cases accepted under the ACE category in 2022, and the key themes identified. Two cases are discussed in detail in this chapter, and full case descriptions for the remaining cases can be found in the supplementary information on the SHOT website (https://www.shotuk.org/report-summary-and-supplement-2022/).

Table 5.1: Acknowledging continuing excellence (ACE) case summaries 2022

ACE category	Case number	Summary	ACE themes
Transfusion practice - laboratory	**1**	Introduction of 'improvement and development lead' role. Expedited many of the service improvements and transformational needs of the service	Innovation Positive change
Transfusion practice - laboratory	**2***	BMS recognised potential FMH in mixed field result of maternal sample. Initiated prompt detection and treatment of large volume foetal bleed	Collaboration Communication Patient focus
Teamwork and collaboration	**3**	Major haemorrhage at a district general hospital. Excellent multidisciplinary communication, rapid issue of fibrinogen concentrate, and cold chain maintained despite blood refrigerator difficulties	Collaboration Communication Patient focus
Teamwork and collaboration	**4**	Large scale cold storage failure. Excellent communication between all teams to rectify issue within time constraints	Collaboration Communication
Transfusion practice - clinical	**5**	Excellent teamwork and communication between clinical area and laboratory during MHP activation. All cold chain maintained and MHP stood down	Collaboration Communication Patient focus
Transfusion practice - clinical	**6**	A healthcare assistant questioned a nurse not following the 2-sample policy correctly and corrected the situation. This case has been included in the organisation's training	Patient focus Education
Patient or public engagement	**7****	An innovative project to rectify incidents of transfusion >5 hours was undertaken. This resulted in successful development and trial of 'transfusion take down tag' which has been shared regionally	Innovation Collaboration Communication Patient focus Positive change
Education and research	**8**	An innovative e-learning module was developed which has been used as the basis for other organisation's training	Innovation Collaboration Education

**This case is described in Case 14.3 in Chapter 14, Laboratory Errors*

***This case is described in Case 10.2 in Chapter 10, Handling and Storage Errors (HSE)*

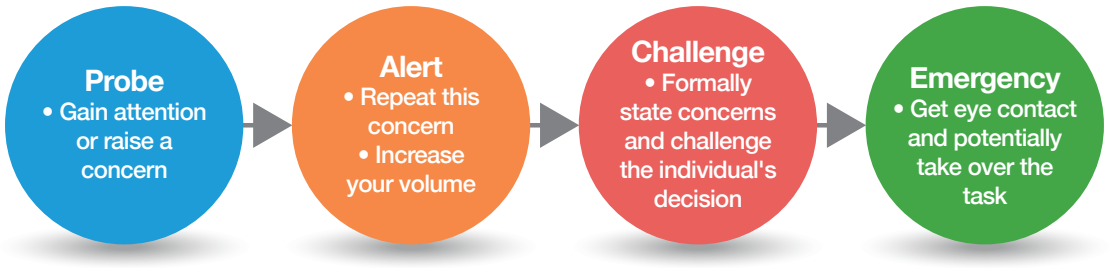
Case 5.1: Speaking up for patient safety despite hierarchical barriers

A HCA noticed a registered agency nurse taking two samples for a group and screen at the same time. The HCA challenged the process as this was against the organisations policy, however the nurse stated that they were going to put a different time on one sample. The HCA reiterated safe practice and local policy (that samples must be taken at different times by different people), removed and disposed of duplicate sample, and raised a near miss incident on the local reporting system. A repeat sample was taken and sent to the laboratory. The patient in question had no previous blood group on the system. The transfusion practitioner provided positive feedback to the HCA and escalated the incident to the organisation's central safety team. They have also incorporated this scenario into mandatory transfusion training.

This case demonstrates excellent patient care from an unregistered member of staff who felt empowered to challenge unsafe practice by a registered nurse. They were not swayed by hierarchical influence when an incorrect justification for the unsafe practice was given.

The probe, alert, challenge and escalate (PACE) model to improve patient safety, or 'graded assertiveness' describes the ability to speak up as a key safety behaviour, and integration of this model in healthcare culture can allow 'any health or care professional of any type or seniority to use graded assertiveness to challenge any action or behaviour they may feel is inappropriate or unsafe' (Royal College of Obstetricians and Gynaecologists n.d.).

Figure 5.1: PACE model



Case 5.2: Excellent teamwork and communication during a MHP activation

The MHP was activated for a patient in the ED of a medium sized hospital. The clinical staff on duty followed all procedures correctly, and the communication between the clinical area and laboratory was excellent. The BMS on duty was informed when the patient was expected, a single person for communication was established and all components taken out of the refrigerator or requested from the HTL were communicated clearly in a timely manner. The MHP was stood down at the end of incident.

Good communication between the clinical area and the HTL allowed for a very smooth running of the MHP with one person allocated to form that line of communication. Learning from this event was shared via email with the matron in the ED for them to disseminate to members of the team.

Learning from everyday events may be incorporated into incident trend and analysis to recognise areas where processes are working well and how similar workflows can be adapted in other areas of concern.

The benefits of learning from everyday work have been described as (Sharrock 2020):

- **Learning from everyday work helps to improve all aspects of performance and well-being –** this helps to improve all aspects of working and learning from one area can be applied to many without additional resource

- **Learning from everyday work does not require unwanted events –** when ordinary work is focused upon, it does not require adverse events and patient harm to occur to drive improvement
- **Learning from everyday work helps to see and build on what's strong -** looking at everyday work can recognise areas of strength and use these to build on elsewhere
- **Learning from everyday work helps to see slow changes –** the process of 'practical drift' explains how work can slowly move away from the expected, this can occur in both positive and negative ways and if day-to-day practice is examined this drift can be identified
- **Learning from everyday work can involve everyone –** by learning from everyday work, those involved in routine practices must be involved and can therefore have more ownership and engagement with any change necessary

Safety-II and ACE in practice

Safety-II in practice

Safety-II is learning from situations where safety is present. There is a challenge to implementing this in practice. The benefits have been discussed earlier, but how can this be achieved or operationalised? Suggested approaches could be (Verhagen et al. 2022):

- Using a Safety-II mind-set when looking at a problem area identified by Safety-I. If the whole process is examined there will be certain aspects which are functioning well
- Looking at Safety-I events and asking 'what was so ordinary' not just 'what went wrong' during incident investigation
- Areas where staff have raised conflicting priorities, work can be examined to determine how the people are maintaining a balance and still delivering safe care despite these conflicts
- Reframing certain tasks can alter the outlook of those undertaking them and encourage active engagement (e.g., using a checklist isn't just to prevent errors but to recognise what has been achieved and how to further improve care for the patient)
- Discussing and reviewing unusual events and not just adverse events allows learning from success in situations with additional risks and challenges

ACE in practice

ACE can take many forms and does not necessarily mean additional activities or time/resource. Occurrences that are excellent within healthcare often occur during everyday activities and may only improve care for a single individual or within a single area. However, the power of identifying these events and sharing learning can have a widespread impact. On the opposite end of the spectrum, ACE can influence regional and national practice and can cause a huge wave of change when they are shared on a larger scale. Figure 5.2 shows the range of interventions.

Figure 5.2: Range of ways to acknowledge continuing excellence (ACE) and potential impact

ACE=acknowledging continuing excellence; RTC=Regional transfusion committee

The following are examples of how ACE can take place and have been inspired by the cases submitted to SHOT in 2022.

- **Individual feedback**: In 3 cases excellent communication was identified within the ACE event itself. Learning from, and gratitude, about these events was fed-back to those involved as well as line management. Feedback can be as simple as an email following an event, a team debrief, communication in person or submitting local good practice reports. One case acknowledged excellent communication within major haemorrhage despite unexpected circumstances at a site that rarely encountered major bleeds. Learning from this case was shared by email, and at anaesthetic team meetings, hospital transfusion team and hospital transfusion committee meetings
- **Departmental action and influence**: In 2 cases feedback resulted in departmental change. Feedback can be discussed at departmental meetings and initiate changes to policies and procedures, trigger reviews of contingency plans, and evaluate whether the area would benefit from additional resources (e.g., implementing a quality improvement lead)
- **Hospital-wide action and influence:** In 2 cases ACE contributed to hospital-wide change which mainly centred around transfusion training. Learning from ACE can be used to influence the content of transfusion training, make updates to transfusion policy and involve teams outside of transfusion. This can lead to positive impact in other areas of patient care. In 1 case an event where an individual challenged dangerous practice has been included as a case study in local transfusion training.

Interaction and collaboration between departments can impact upon culture. This cooperation has been seen within several ACE cases and one study has shown the use of transfusion practitioners during large scale emergencies to improve sample labelling (Chowdry et al. 2021)

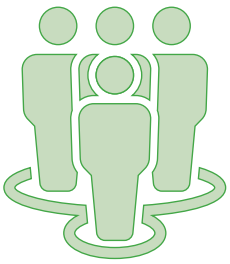
- **Regional/network action and influence:** In 2 cases ACE contributed to positive patient outcomes throughout a region or network. Presenting particular cases or projects of merit outside of individual hospitals stops innovative practice being limited and allows others to benefit. In 1 case (Case 7 in Table 5.1), an increase in error reports led to an intervention and improvement project within the organisation. The hugely positive outcome from this project was shared within the RTC and the organisations are now collaborating to implement the intervention regionally
- **National/international action and influence:** In 1 case a newly developed e-learning module has been used as a basis for other organisations. This illustrates the collective power of sharing good ideas and resources, which improve the care of patients. By submitting ACE reports to SHOT, learning can be captured and considered nationally and internationally

ACE tools

The following are suggested tools hospitals may wish to consider, to assist in the practice of ACE. Some of these are easily implemented and some may be longer term aspirational goals.

'Quick wins'

- ✓ Consistent positive feedback to staff within day-to-day communication style and debriefs
- ✓ Raising positive 'compliments' or reports of excellent practice
- ✓ Reporting to SHOT ACE



Medium term departmental actions

- ✓ Sharing of positive events as well as incidents at departmental meetings
- ✓ Using change request tools to record excellent innovations or solutions to problems, allowing these to be incorporated into future document versions
- ✓ Allocation of time for ACE or improvement projects within job descriptions and capacity planning
- ✓ Audit and audit tools such as the NCA vein-to-vein (see 'Recommended resources')
- ✓ Extracting the learning from ACE reports to enhance safety

Longer term goals

- ✓ Presentations to RTC or other regional network meetings
- ✓ Submitting abstracts to national meetings
- ✓ Submitting research papers
- ✓ Sharing resources

Conclusion

There is room for more than one viewpoint and approach to improving patient safety and by embracing all angles patients can only benefit. ACE data collection within SHOT allows organisations to share learning on a national and international basis. Recognising that persistent challenges exist in healthcare, it is the people within the systems who can be innovative, resilient and achieve excellence in the face of increasing pressures. People should be celebrated regularly for the difference they make within their everyday work as the excellence that occurs during routine work is often unacknowledged. This should be commended as well as the standout events. By sharing these experiences of ACE, it is hoped that these will inspire further improvements for patient and staff benefit.

Focus on ACE in emergencies

Just under half of all ACE reports received in 2022 involved excellent work during emergencies, 2/8 in MHP activation and 1/8 in a widespread cold storage failure. This illustrates the human resilience to pull together and make real-time beneficial decisions in face of the unexpected.

ACE has considerable value in emergency planning where learning from incidents provides a valuable opportunity to use many of the approaches above. Disaster may be rare or recurrent, depending on where you work in the world. Each event provides an opportunity to learn and improve. Lessons identified should be captured during 'hot debriefs' as soon as practical after the incident. Formal debrief may be held later using additional material. Methodology varies between organisations but may include one-to-one interviews, questionnaires, and responses to 'hot debrief postcards.' Debriefing should be used to thank staff and recognise achievements (Doughty et al. 2022).

Recommended resources

ACE reporting – SHOT Definitions and ACE Examples
https://www.shotuk.org/reporting/ace-reporting/

Civility saves lives (2022)
https://www.civilitysaveslives.com/

Learning from Excellence
https://learningfromexcellence.com/

National Comparative Audit – Vein to Vein audit - contact details
https://hospital.blood.co.uk/audits/national-comparative-audit/

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