6 Acknowledging Continuing Excellence in Transfusion (ACE) n=15

Author: Simon Carter-Graham

With contributions from: Members of the SHOT team and ACE WEG

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
BMS	Biomedical scientist
CT	Computed tomography
DAT	Direct antiglobulin test
ED	Emergency department
GI	Gastrointestinal
GP	General practitioner
G&S	Group and screen
Hb	Haemoglobin
HCA	Healthcare assistant
Ig	Immunoglobulin
MDT	Multi-disciplinary team
MH	Major haemorrhage
MOH	Major obstetric haemorrhage
OSHA	Occupational Safety and Health Administration
PCC	Prothrombin complex concentrates
TACO	Transfusion-associated circulatory overload
WBIT	Wrong blood in tube

Key SHOT messages

- It is encouraging to see an increase in the number of reports where organisations have shared excellent practice and learning
- Key themes include positive process change, collaboration, and excellent communication between teams

Recommendations

- All healthcare organisations should embrace a Safety-II approach (learning from excellence and day-to-day events) as a complement to Safety-I. It is necessary to analyse where and when things go wrong, whilst proactively seeking to promote good practice by celebrating when things go right and developing ways to support, augment and encourage this
- All healthcare organisations should regularly measure safety culture in clinical and laboratory teams with appropriate improvement actions, provide education and resources to support an effective safety culture based on a proactive approach to patient safety

Action: Senior management and leadership teams in all healthcare organisations

Introduction

SHOT ACE is an example of learning from excellence, emphasising studying successful outcomes or practices to improve safety. It is about shifting the focus from solely analysing failures to understanding what works well and replicating those strengths and behaviours. This approach promotes a more positive and proactive learning culture. It is encouraging to see a steady increase in the number of reports submitted to SHOT in this category.

In 2023 there were 15 reports accepted under a wide range of ACE sub-categories. As with previous years, the cases reported reflect the continued commitment of healthcare staff who work tirelessly to deliver safe and appropriate transfusions despite the challenges faced within healthcare settings.

This year's ACE chapter captures the importance of acknowledging and celebrating excellence, with the aim to encourage organisations to focus on the things that are going well rather than when things go wrong. This approach offers an opportunity to learn from good transfusion practice and ultimately improve patient care. Furthermore, it aims to highlight the importance of incorporating civility and safety indicators in workplace processes as well as fostering and embedding a safety culture in everyday practice.

ACE cases 2023

Table 6.1 shows a summary of cases accepted under ACE in 2023 and the themes identified which make the events noteworthy. Full case descriptions can be found in the supplementary information on the SHOT website (https://www.shotuk.org/shot-reports/report-summary-and-supplement-2023/).

While the name of the category SHOT ACE suggests that it tends to identify extremely good (i.e., excellent) examples of work/practices, submitted reports are actually capturing everyday excellence; examples of good communication, collaboration, and innovation to address patient-care issues or a human approach resulting in a positive outcome, occurring in often difficult circumstances amidst staff shortages, high workload and poor IT. The SHOT team would like to acknowledge the hard work, dedication, and teamwork that transfusion staff in both clinical and laboratory areas demonstrate whilst caring for patients despite all the challenges. This chapter is a celebration of these efforts.

Table 6.1: Acknowledging continuing excellence (ACE) case summaries 2023 (n=15)

Case number	Summary	ACE themes
	Transfusion practice - clinical	
1*	Major haemorrhage in ED. Excellent multidisciplinary communication. Rapid issue of PCC.	Collaboration Communication Patient focus
2	Major haemorrhage in theatres. Excellent multidisciplinary communication. Porter supervisor and recovery nurse went above and beyond duty.	Collaboration Communication Patient focus
3	Nurse and HCA challenged a doctor who had not correctly identified a patient when taking a pre-transfusion blood sample and had left the patient's side with the unlabelled sample.	Patient focus Relatable education
4	Major haemorrhage patient dealt with by a team unfamiliar with this situation. Rapid action was taken on the low Hb result (41g/L). Whole team including porters and transfusion laboratory staff acted coherently and efficiently.	Collaboration Communication Patient focus
5	Doctor completed a prompt review of a patient with TACO. Always provides very detailed clinical reviews and has an excellent awareness of transfusion adverse events thus ensuring prompt reporting to SHOT.	Collaboration Communication Patient focus
	Transfusion practice - laboratory	
6*	Excellent communication and collaboration during two extremely challenging major trauma cases. Anaesthetists and surgeons made sure all involved staff were thanked for the fantastic job they did.	Communication Collaboration Patient focus
7	The clinical team stated the biomedical staff did exceptionally well and assisted with great communication throughout a MOH and issued blood products in a timely manner under difficult circumstances.	Communication Collaboration Patient focus
8	Fetal bleed detected in patient's G&S sample as part of a pre-delivery screen. BMS showed superior knowledge in advising clinicians. Mother was given the appropriate dose of anti-D Ig.	Communication Collaboration Patient focus
9	BMS identified WBIT based on the patient's haematocrit for a patient who had not previously had a G&S sample sent. This prevented the incorrect samples from being processed and an incorrect blood group being recorded in the patient's file.	Communication Collaboration Patient focus
	Teamwork and collaboration	
10*	New process in place to ensure patients have their transfusion specific requirements assessed and managed with any requirements being communicated to the MDT, the patient, and their GP being informed and involved in the process.	Innovation Collaboration Positive change Patient focus
11	BMS staff suggested and designed a form to aid carrying out the process of phenotyping for multiple red cell antigens involving the use of multiple anti-sera reagents with different techniques and incubation requirements. Previously only detailed individually by referral to the manufacturer's product information sheet for each anti-sera.	Innovation Collaboration Positive change Patient focus
12	MDT work within the hospital and Blood Service to crossmatch for a patient experiencing a haemorrhage. The antibody screen had proved positive and the group was inconclusive and DAT positive. Due to the complex result a total of 28 units were crossmatched in order to obtain compatible units.	Collaboration Patient focus Communication
13	Two MH occurred around 19:30. On top of these two further code reds were called in shortly afterwards. The laboratory team worked extremely well together demonstrating exceptional practice and excellent communication skills. Two members of staff went above and beyond by staying an extra 2 hours after a 12-hour shift to help their colleagues.	Collaboration Patient focus Communication
14	Pregnant patient with pancytopenia (36^{+4}/40). The patient had markedly low B12 and folate levels and required an emergency caesarean section overnight and multiple blood components. The BMS was lone working at the time of delivery. It was an exceptional example of truly multidisciplinary teamwork.	Collaboration Patient focus Communication
15*	A specific protocol was developed for authorisation of PCC where intracranial haemorrhage has been confirmed on CT or life-threatening GI bleed has been identified and 1000IU of PCC can be administered immediately allowing time to discuss further PCC requirement with the consultant haematologist. Audit results identified that 67% patients now receive PCC within 1 hour of the decision being made.	Innovation Collaboration Positive change Patient focus Relatable education

**Please see the supplementary information on the SHOT website for a detailed discussion of these cases (https://www.shotuk.org/shot-reports/report-summary-and-supplement-2023/)*

Communication and civility

Excellent communication was noted between the clinical area and the transfusion laboratory in several of the ACE cases, especially in MH situations where effective communication is vital to ensure co-ordinated care for transfusion safety. In several incidents the staff involved were commended for their skills and commitment to patient safety. In these incidents it is clear that civility played a part. In very stressful situations, the language and tone of what is said between colleagues is very important as incivility can adversely impact patient care and 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 & Pearson, 2013). In 1 case, a healthcare professional challenged the unsafe practice of a colleague, preventing a potential error. This shows that difficult conversations can be had with positive outcomes.

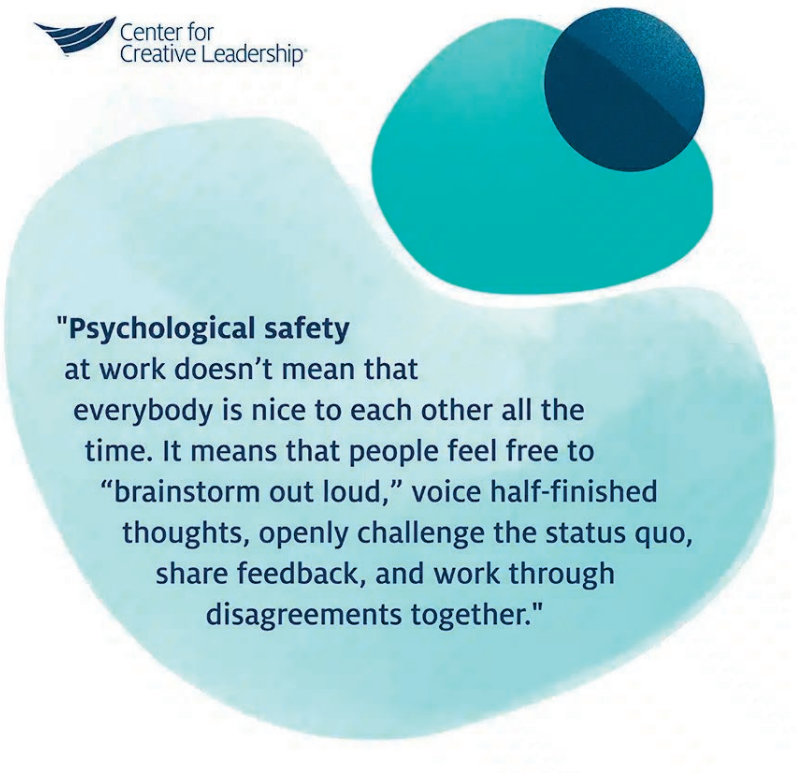

Figure 6.1: What is psychological safety at work? How leaders can build psychologically safe workplaces

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To ensure psychological safety for all staff, leaders need to show compassionate leadership and understand the experiences and needs of their workforce. There is clear evidence that compassionate leadership results in more engaged and motivated staff with high levels of wellbeing, which in turn results in high quality care (West, 2021). Civility in the workplace and psychological safety is discussed in more detail in the ACE chapter of the 2021 Annual SHOT Report (Narayan, et al., 2022).

Positive procedural changes

In 3 cases, changes were made to recognised protocols such as the way PCC use was standardised and made more efficient.

In 1 case, the process for ensuring patient's specific transfusion requirements were met was improved. Updates were made to ensure the appropriate training was given to the relevant staff.

Safety indicators in healthcare: leading/lagging indicators

Safety indicators in healthcare encompass a wide range of measures that assess various aspects of patient care, organisation processes and factors impacting safety. Leading indicators are proactive,

preventative, and predictive measures that provide clues to future incidents. They also offer evidence on the effectiveness of a safety management system. Preventative actions can then be undertaken before an error or incident occurs. According to OSHA (2019) '*Whilst lagging indicators can alert you to an error or to the existence of a hazard, leading indicators are important because they can tell you whether activities are effective at preventing incidents'*. Some examples of leading indicators include near miss reporting rates, safety culture surveys, equipment maintenance schedules, while incident rates and patient outcomes are lagging indicators. By utilising both leading and lagging indicators, healthcare organisations can implement a balanced approach to safety management focusing on both proactive prevention and reactive response to optimise patient care and staff wellbeing. Figures 6.2 and 6.3 show the key differences between the lagging and leading indicators for safety.

Figure 6.2: Lagging versus leading indicators

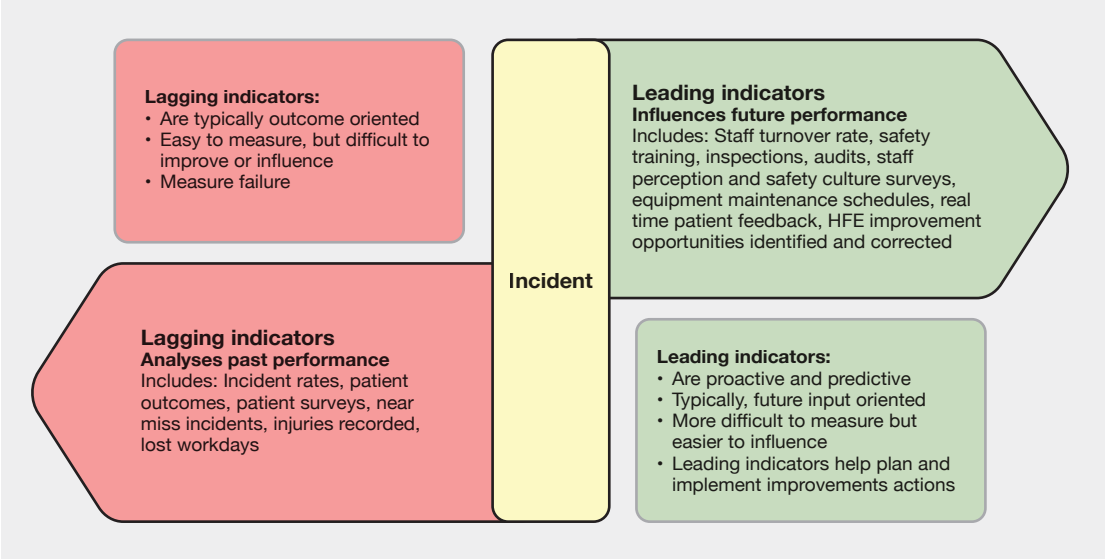
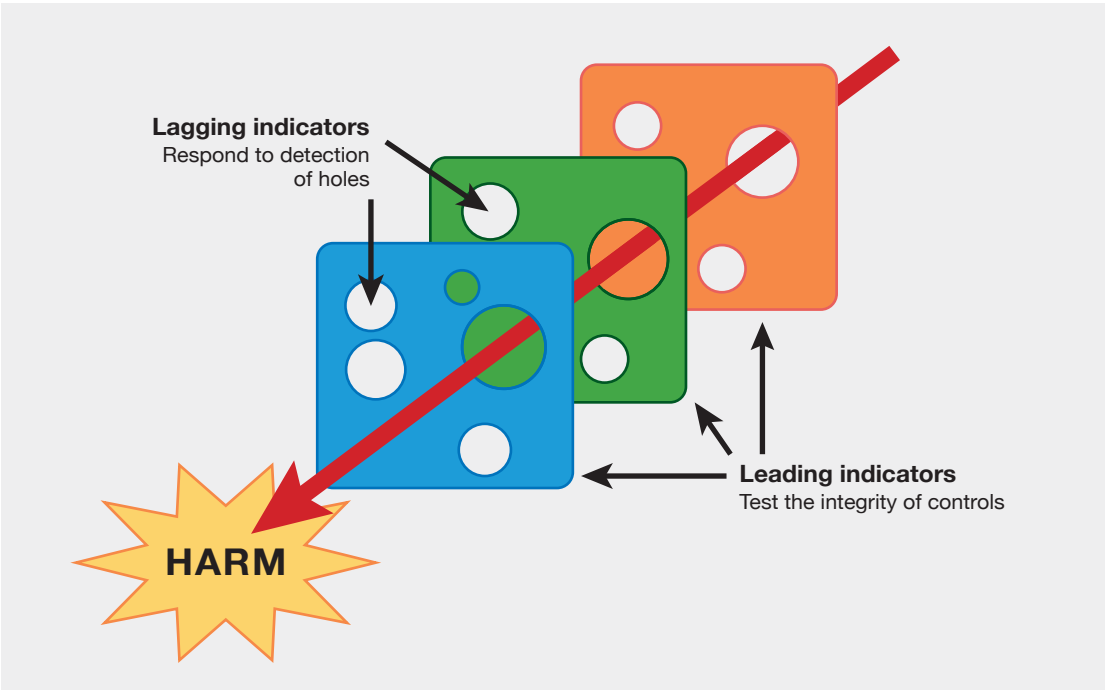


Figure 6.3: Safety performance indicators and the Swiss cheese model



Source: https://risktec.tuv.com/knowledge-bank/measuring-safety-safety-related-key-performance-indicators/, The 'Swiss cheese model' of accident causation was originally proposed by James Reason focussing on the systemic failures of safeguard and barriers that can result in patient harm

Further information on this can be found in the supplementary information on the SHOT website (https://www.shotuk.org/shot-reports/report-summary-and-supplement-2023/).

Safety culture

Building a strong safety culture is essential in reducing transfusion errors, improving patient outcomes, and promoting a positive work environment for healthcare professionals. Regular measurement of safety culture in healthcare is essential for fostering a culture of continuous improvement, enhancing patient safety, and maintaining organisational effectiveness. Any concerning signals from safety culture surveys (SHOT, 2024) require prompt urgent, proactive action to address identified issues, prevent harm, engage stakeholders, and enhance safety for all patients, blood donors and staff.

A strong, just, no-blame, learning safety culture promotes open communication, teamwork, continuous improvement, and a focus on learning from experiences to enhance patient care and outcomes (See 'Recommended resources' at the end of the chapter). Figure 6.4 outlines tangible ideas to improve safety culture.

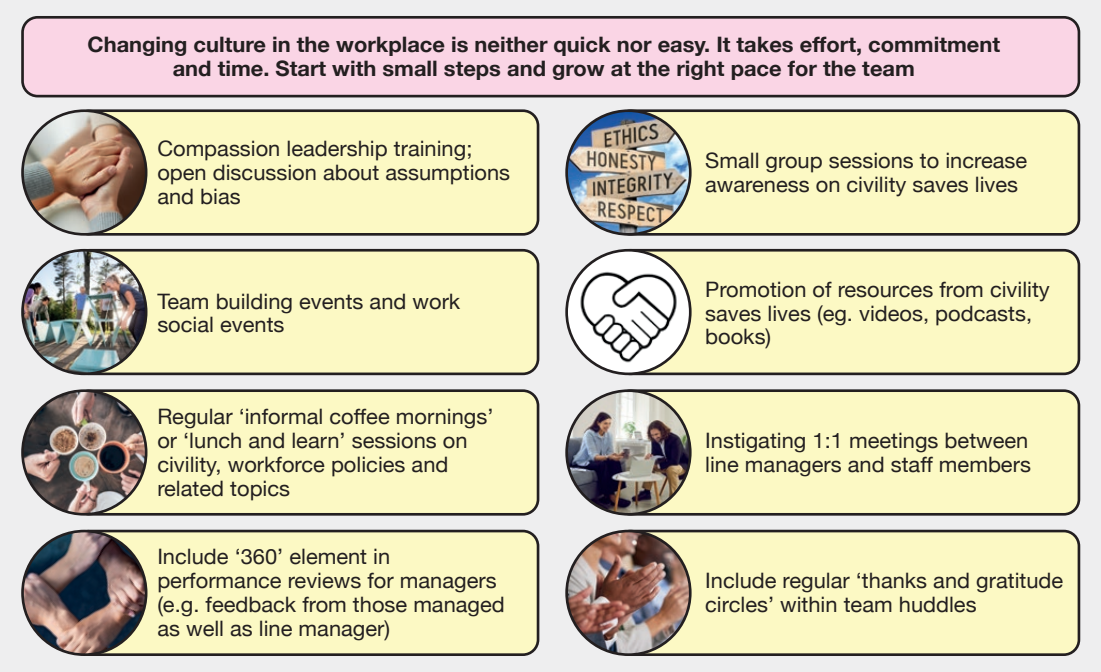


Figure 6.4: How changing safety culture in the workplace can improve transfusion safety

For information about the 2023 UK-wide transfusion laboratories safety culture survey please see 'Recommended resources'.

Conclusion

Widespread learning from excellence is important for all organisations as it allows individuals and teams to understand what works well and replicate those successes. By analysing and recognising excellence, we can identify best practices, develop strategies for improvement and foster a culture of continuous learning and growth. This approach helps to reinforce positive behaviours and achievements, leading to greater staff engagement, efficiency, innovation, and overall success. Additionally, celebrating excellence can boost morale and motivation within teams, creating a supportive and positive work environment. Promoting a learning culture where staff learn from day-to-day events enhances resilience, provides valuable insights, allows adaptation, and supports a growth mindset. Staff should receive training to be able to use tools to support learning from day-to-day events and excellence, thereby paving the way for a holistic approach to safety.

While more teams and organisations are adopting learning from excellence, it is important to recognise the impact of system changes on patients and staff involved. Feedback loops must be in place to ensure the impact of these changes are captured and acted upon promptly.

Recommended resources

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

SHOT Bite No. 23: Civility in Healthcare (2023)
SHOT Bite No. 24: Speaking up for safety (2023)
SHOT Bite No. 26: Acknowledging Continuing Excellence (ACE) (2023)
https://www.shotuk.org/resources/current-resources/shot-bites/

Learning from Excellence
https://learningfromexcellence.com/

NHS Innovation Service
https://innovation.nhs.uk/innovation-guides/

Life Sciences Hub, Wales
https://lshubwales.com/

InnoScot health
https://innoscot.com/

Civility in the workplace
https://www.civilitysaveslives.com/

References

Narayan, S. et al., 2022. *The 2021 Annual SHOT Report,* Manchester: Serious Hazards of Transfusion (SHOT) Steering Group. doi: https://doi.org/10.57911/QZF9-XE84.

Occupational Safety and Health Administration (OSHA), 2019. *Using Leading Indicators to Improve Safety and Health Outcomes* [Online], s.l.: OSHA. Available at: https://www.osha.gov/sites/default/files/publications/OSHA_Leading_Indicators.pdf (Accessed 11 April 2024).

Porath, C. & Pearson, C., 2013. The price of incivility. *Harvard Business Review*, 91(1-2), pp. 114-121. Available at: https://hbr.org/2013/01/the-price-of-incivility (Accessed 16 May 2024).

Serious Hazards of Transfusion (SHOT), 2024. *UKTLC.* [Online] Available at: https://www.shotuk.org/resources/current-resources/uktlc/ (Accessed 02 May 2024).

West, M., 2021. *Compassionate Leadership: Sustaining Wisdom, Humanity and Presence in Health and Social Care*. s.l.:The Swirling Leaf Press. Available at: https://swirlingleafpress.com/compassionate-leadership/ (Accessed 08 May 2024).