Acknowledging Continuing Excellence in Transfusion (ACE) 6

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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	**NM**	Near miss
AI	Appreciative inquiry	**SAE**	Serious adverse event
NHS	National Health Service	**SAR**	Serious adverse reaction

Introduction

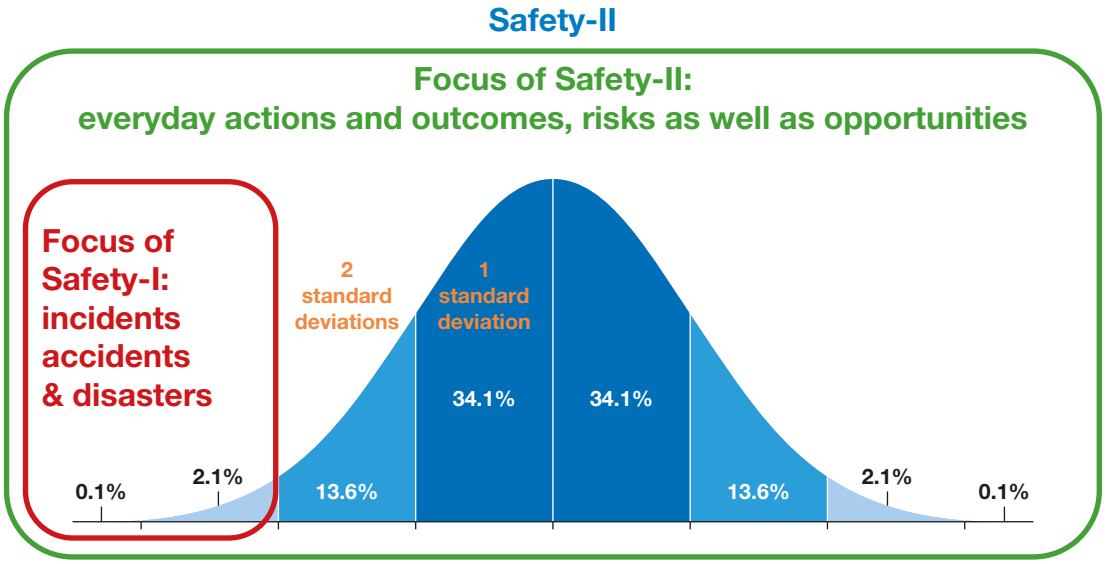
ACE was introduced in the 2019 Annual SHOT Report with a dual aim of recognising exceptional practice by teams or departments above and beyond routine practice and recognising innovative solutions to previous adverse events. Whilst SHOT continues to report on adverse transfusion incidents and reactions, it has always been acknowledged that excellence is highly prevalent and identifying this in the report will provide new opportunities for local learning and improving resilience and staff morale, contributing to a holistic approach to patient safety.

Incident investigations may recognise aspects of good practice or praise individuals for their actions but is mainly focussed on the errors and interventions for prevention of recurrence. This is the traditional Safety-I, or risk management, approach. Safety-II is a proactive approach looking at safe episodes of care to inform improvement in healthcare systems. Safety-II approach helps understand how things go right to explain how occasionally things go wrong and continuously aim to anticipate developments and events. This reframing of safety has major implications for the way we design our systems and the role of people within them. These affect everything, from our approaches to incidents, to quality improvement, to the way we train and lead teams. 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 (Figure 6.1, Hollnagel 2015). Learning how staff provide good care under difficult circumstances means we can ensure it happens more often.

We hope to promote a safer culture by looking at both instances of ‘what went wrong’ and ‘what went right’. It is clear that there is a place for both Safety-I and Safety-II approaches. Safety-II does not replace Safety-I, they complement each other and provide a different and valuable perspective.

Appreciative inquiry (AI) is an effective tool to help reframe safety issues and improve patient care. It is an engaging, inclusive, and collaborative way of exploring issues in healthcare, especially because it aligns neatly with the Safety-II paradigm. AI focuses on acknowledging strengths and values of individuals and organisations while understanding, accepting, and searching for positive meanings. It is effective at improving teamwork and helps improve team performance. This tool can be used as a framework for improvement projects or system-wide change (Bushe 2011, Trajkovski 2013).

Figure 6.1: From Safety-I to Safety-II



Note: this figure is from James Christie's Blog, adapted from the Safety-I and Safety-II diagrams from the document 'From Safety-I to Safety-II: A White Paper (EUROCONTROL, 2013) and 'A White Paper on Resilience Engineering for ATM (EUROCONTROL, 2009)

Recommendation

- All National Health Service (NHS) organisations should provide education and resources to support an effective safety culture based on a proactive approach to patient safety

Action: All NHS Trusts/Health Boards

Safety culture

SHOT has repeatedly promoted the importance of a 'just and learning culture' in healthcare, a culture in which individuals are not held accountable for systems failures over which they have no control and a culture in which learning from experiences is encouraged. By supporting staff to be open about mistakes, feel confident to speak up about potential risks and not fear blame, the organisation can learn valuable lessons and use this knowledge to ensure that errors are not repeated. We have provided the human factors toolkit (see Chapter 8, Human Factors in SHOT Error Incidents) within the SHOT incident reporting platform enabling reporters to incorporate a systems-based approach into their investigations and avoid placing blame on individuals.

Fostering a strong and effective safety culture is also vital to reduce transfusion incidents thus directly improving patient safety. This environment promotes effective leadership and teamwork, a feeling of psychological safety for the staff, inclusivity, trust and respect, a shared vision and above all, an openness and support for learning.

The Health Foundation developed a framework for measuring and monitoring safety. This sought to shift an organisation's thinking from reliance on regulatory compliance as a guarantor of safety (a mindset of assurance) to a proactive approach of measurement and monitoring (a mindset of enquiry) (Chatburn et al. 2018). This framework encompasses five core dimensions of safety as shown below in Figure 6.2.

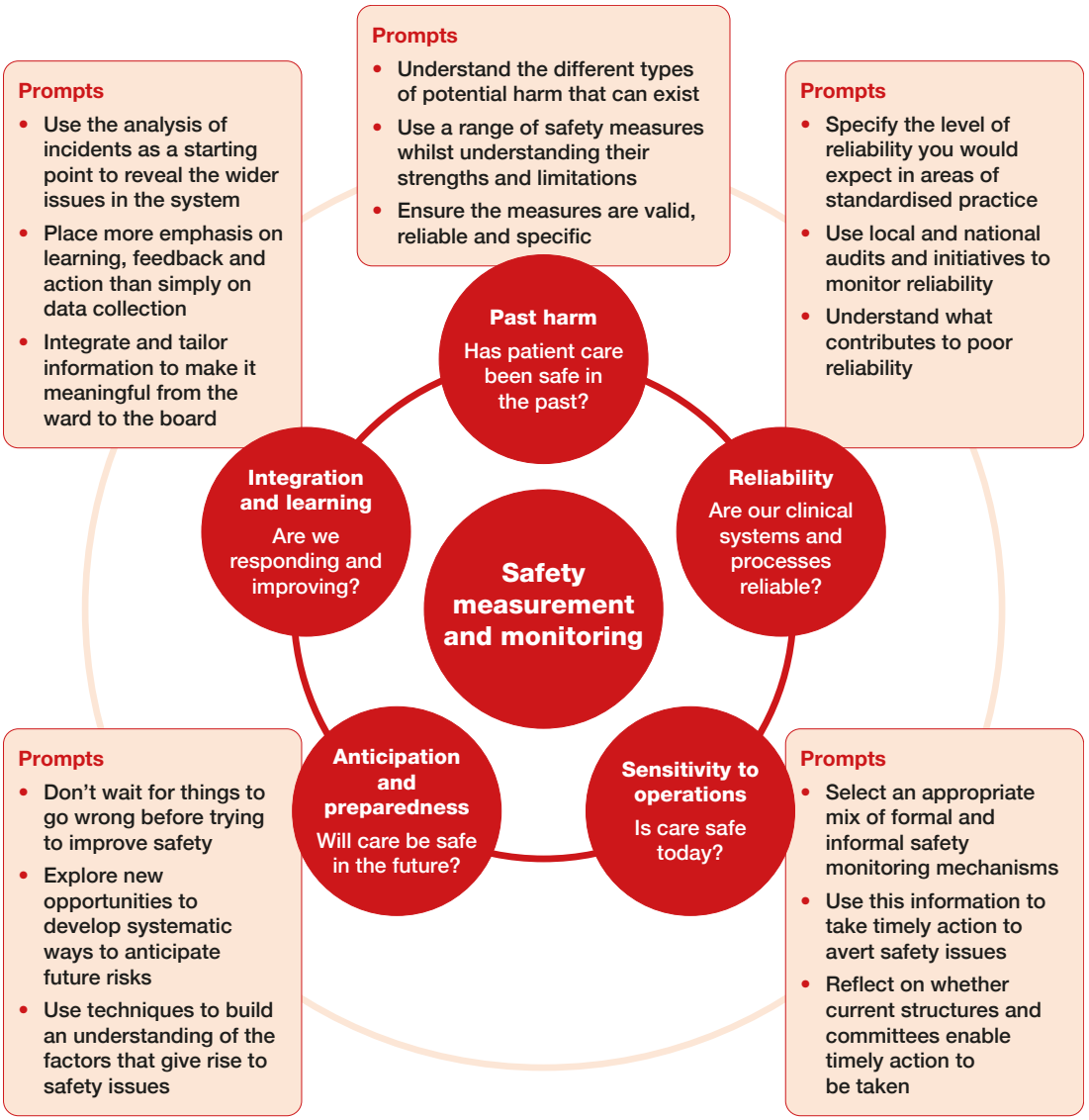


Figure 6.2: The framework for measuring and monitoring safety – and useful prompts for using it in practice (from the Health Foundation, 2018)

Using these core dimensions in their entirety can encourage organisations to take a holistic and proactive view of patient safety and support a cultural shift from the traditional risk management viewpoint. For a framework such as the one above to be effective it needs committed leadership from individuals that understand the concepts of Safety-I and Safety-II (Hollnagel et al. 2015), sufficient resources to implement and sustain this approach and a process for translating this for front line staff. The NHS Improvement's 'A Just Culture guide' also provides a powerful tool to help promote cultural change in organisations or teams where a blame culture is still prevalent (NHSI 2018).

Serial Annual SHOT Reports have shown a good, strong reporting culture in the UK. The participation data is reassuring and reports, including near miss events, continue to be submitted to SHOT year on year, even during the pandemic year 2020. Proactive, preventative, and predictive measures that provide information about the performance of healthcare activities are vital and help prevent incidents and improve safety. NM have potentially predictive qualities because they can help uncover hazards, risks, process weaknesses and patterns that can be addressed to avoid future incidents. Near miss reporting should be encouraged and reporting must be made as easy as possible. NM year on year constitute the biggest reporting category in SHOT and these have been picked up by vigilant staff (see Chapter 13, Near Miss (NM) Reporting). Learning from NM and improving systems will help reduce actual events and improve safety. As noted in Chapter 2, Participation in UK Haemovigilance, areas of underreporting have been recognised, possibly due to staff shortages and inadequate resources which need to be addressed and investigated further. One of the key 2019 SHOT recommendations was that all National Health Service (NHS) organisations should embrace Safety-II approach as a complement

to Safety-I, should analyse where and when things go wrong, proactively seek to prevent, eliminate risks and promote compliance with Safety-II by developing ways to support, augment and encourage these (Narayan et al. 2020).

ACE reports

A new reporting category was introduced by SHOT in January 2021 – reporters can submit instances of exceptional transfusion practice by a team or department, that was above and beyond routine practice and has widespread learning opportunities. Reporting in this category is not included in the participation data for SAE and SAR. Further information about this category and illustrative cases can be accessed from the SHOT website. It is hoped that this will encourage local processes to be put in place to recognise excellent contributions by individuals or teams and promote sharing best practices between teams.

SHOT have convened an ACE working group, the aim of this group is to promote reporting in this category, to review reports submitted to other categories, and withdrawn SHOT reports, for ACE aspects that can be shared as good practice. Some reported cases are withdrawn each year, as upon expert review, it is agreed that the clinical/laboratory teams have consciously made transfusion decisions taking into account the overall clinical picture of the patient and assessing risks and benefits. In such cases, individuals or teams may have identified learning that can be shared with the wider transfusion community to avoid similar scenarios, outside the confines of expected contingency planning. An example of such a report submitted included one that related to a full power outage which disconnected analysers, blood component storage devices, computer systems and telephone lines in a hospital transfusion laboratory. This report demonstrated the power of individuals working together to ensure that patient care was not adversely affected during this challenging time. SHOT was able to share the learning from this event, and the importance of robust contingency plans, via a national patient safety notice (available on the SHOT website https://www.shotuk.org/resources/current-resources/).

It is important to recognise that transfusion support is an essential element of modern healthcare and therefore should be considered in disaster preparedness. In addition, many national civil contingency arrangements require healthcare providers to demonstrate that they can deal with emergencies while maintaining critical services. Emergency preparedness is essential to provide a co-ordinated response to the event, maintain business continuity and guide recovery to ‘business as usual’. Any response should be flexible and scalable to deal with a variety of emergency incidences including combinations of escalating and unexpected events. The emergency response involves a mixture of plans, procedures, and improvisation (Alexander 2015). All give the opportunity to demonstrate excellence. Lessons identified should be captured during post event reviews as soon as practicable after the incident. Debriefing should be used to thank staff and recognise achievements. The principles of joint organisational learning should then be used across the global transfusion community to share excellence and continually improve the dynamic process of transfusion disaster preparedness.

Patient perspective

Author: Charlotte Silver (Lay Member)

Having received blood components throughout my life due to a rare and chronic blood condition, I welcome the addition of the ACE chapter. Learning from excellence is important in all areas of life but in a clinical setting it is nothing short of essential in order to enable more lives like mine to be saved and improved.

As an experienced patient I am reassured by comprehensive, timely, bedside checks and recognise their vital importance. I have the confidence to speak up if checks are not done in part or in full and have raised this as a concern in the past, however many patients may not recognise that a check has not been completed in full or they may not feel comfortable to speak up. As a patient you feel vulnerable, with little control over your treatment, you are reliant on excellent communication with medical staff and the lack of free movement due to being hooked up to machines can compound the feeling of being vulnerable.

Untimely and unclear communication between clinical teams makes me extremely nervous and adds extra anxiety to my appointments. I would rather my treatment was delayed whilst the hospital team check and recheck my treatment plan and/or bloods and this be communicated to me honestly, promoting respect and trust between patient and clinician.

I recognise just how hectic and stressful hospitals are and I am forever grateful and in awe of those who provide patient care. Behaviour change, such as taking time to acknowledge and learn from continuing excellence is a slow process made harder in busy and challenging circumstances. However, the COVID-19 pandemic has shown that it is possible to still create a nurturing culture of learning from excellence. As a patient I am reassured to know that there are steps being taken to acknowledge and learn from excellence and hope that this initiative will be taken up by all clinicians as it will be beneficial to not only clinicians but also patients.

Conclusions

There are several instances in reports submitted to SHOT where staff have demonstrated excellence in communication and collaboration to ensure safe transfusions. We encourage reporting all these instances where staff have taken proactive measures to improve communication, reduce delays and ensure safe bedside checks. If your team or organisation has made an extraordinary response in the face of adversity, or the unprecedented challenges of the pandemic, please share this via an ACE submission. If you have implemented an improvement action or identified a further measure for safety in a risk assessment, that has worked well, is sustainable and transferrable to other organisations this should be reported.

Learning from excellence has a valuable role to play in haemovigilance schemes and SHOT strongly encourages submissions to ACE. Learning from excellence and sharing good practice acts as a proactive safety measure in the absence of patient harm. As the number of SHOT-ACE reports increase, a repository of good practice will be developed and shared on the SHOT website. Sharing a single organisation's learning or good practice on a national repository can translate into avoidance of patient harm across a multitude of other organisations.

Combining Safety-I and Safety-II approaches will help provide a more holistic understanding of the underlying reasons for errors and procedural violations. This will help identify aspects of practice that could benefit from targeted interventions to help support staff in providing safe patient care. Reporting and studying success augments learning, enhances patient outcomes and experience through quality improvement work and positively impacts resilience and culture in the workplace.

Recommended resources

SHOT Safety Notice 01: Emergency preparedness in the transfusion laboratory in case of total power outage
https://www.shotuk.org/resources/current-resources/

ACE reporting - ACE definitions
https://www.shotuk.org/resources/current-resources/

ACE reporting – illustrative examples
https://www.shotuk.org/resources/current-resources/

SHOT
Serious Hazards of Transfusion

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