5 Acknowledging Continuing Excellence in Transfusion (ACE) n=5

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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.

Introduction

The cases submitted to SHOT under ACE are still low in numbers highlighting the need to improve awareness and engagement including ease of reporting. 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 capturing everyday excellence. This includes examples of good communication, collaboration, and innovation to address patient-care issues or a human approach resulting in a positive outcome. These often occur in difficult circumstances amidst staff shortages, high workload, and suboptimal 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 current challenges. This chapter is a celebration of these efforts.

A total of 12 cases were submitted, 5 met the criteria for SHOT ACE and 7 were learning from everyday events and are summarised in the supplementary information on the SHOT website. (https://www.shotuk.org/shot-reports/annual-shot-report-2024/).

ACE cases 2024

Table 5.1 summarises 5 ACE cases from 2024, all demonstrating key safety aspects such as communication, patient-centred approach, collaboration and team-working.

Supporting and encouraging excellence reporting within organisations

It is encouraging to see the steady number of reports of excellence being submitted. Learning from excellence still needs to be embedded in day-to-day practice widely. The following aspects need to be considered to facilitate improved reporting of excellence within organisations:

- Making reporting simple and accessible – ensuring reporting is quick and easy, using digital forms and easy to use templates minimising the need for lengthy narratives
- Using real-time recognition with immediate appreciation of staff involved and monthly excellence shout-outs
- Demonstrating the value of reporting excellence – sharing meaningful outcomes from reports to encourage future reporting; using team briefings or newsletters to show how reports led to improved processes, recognition of outstanding staff and patient safety enhancements
- Incentivising and normalising reporting with active participation from leaders; include a 'What went well today?' at the end of shift huddles
- Creating campaigns to improve staff awareness for example, a 'What's working well' campaign that would help promote positive event reporting including potential impact and testimonials from staff who have received positive feedback through excellence reporting

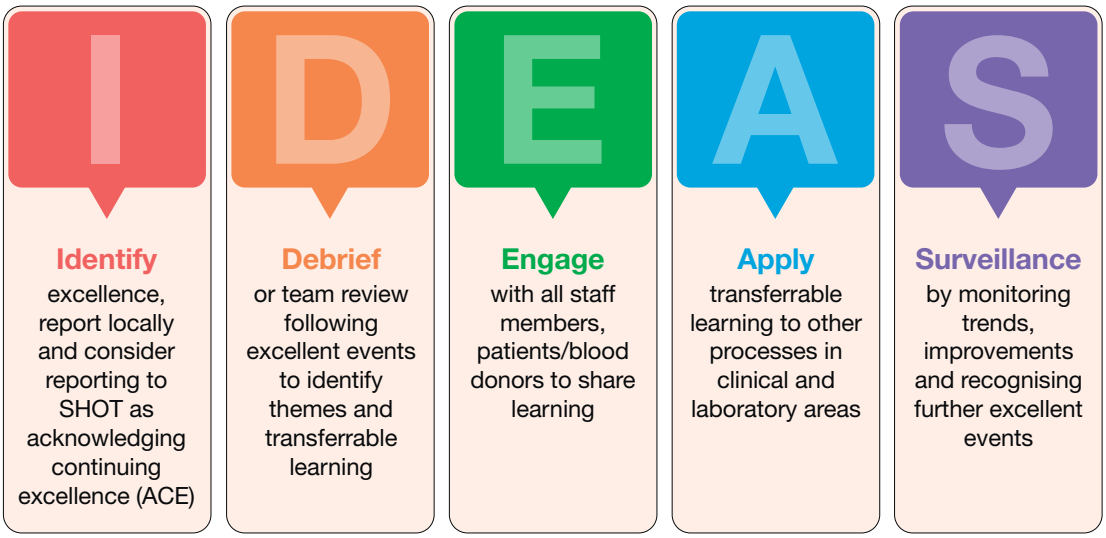
Table 5.1: Acknowledging continuing excellence (ACE) case summaries 2024

Case number	Summary	ACE themes
	Transfusion practice - clinical	
5.1	A staff nurse queried an inappropriate authorisation of two units of red cells and rapid rate, in a patient who had not had their haemoglobin checked for 3 weeks. They escalated concerns to the transfusion practitioners who discussed the patient with the haematology registrar. This facilitated identification of iron and folate deficiencies, and appropriate treatment was initiated. **Reporters' key learning point: 'If not sure, escalate'**	Patient focus Communication
	Teamwork and collaboration	
5.2	Good collaboration between the transfusion laboratory, surgical team, clinical haematology, and reference laboratory to provide blood components for a patient with a complex transfusion history. The laboratory team joined the surgical and anaesthetic teams to complete the pre-procedure World Health Organisation (WHO) surgical checklist. This helped timely provision of transfusion support and reassurance to the treating teams. **Reporters' key learning point: 'The communication with the entire theatre team via the WHO meeting was invaluable'**	Communication Collaboration Patient focus
5.3	Neonatal sample labels were redesigned to reduce the rejection rate. The new design allowed all core identifiers to be captured. A re-audit found the rejection rate had reduced to zero. This has prevented unnecessary re-bleeds for neonatal patients. **Reporters' key learning point: 'Work collaboratively with clinical areas and a systems-based solution will appear.'**	Collaboration Patient focus
5.4	Excellent teamwork and collaboration facilitated provision of 49 blood components over a 6-hour period for a patient with major obstetric haemorrhage, requiring emergency caesarean section. This occurred in a hospital which does not routinely deal with this clinical situation. **Reporters' key learning point: '… Our patient blood management (PBM) lead/transfusion practitioner was on-site and helping at the bedside which was invaluable… I think we are lucky to have a PBM team so involved as I don't believe this is the case in all organisations.'**	Communication Collaboration Patient focus
5.5	Outstanding care ensured good outcomes for mother and baby, both requiring resuscitations following an urgent caesarean section. The mother went into cardiac arrest due to a suspected amniotic embolism and required subsequent exploratory surgery for massive blood loss. Furthermore, the baby required transfer to neonatal intensive care after being born unresponsive. Multiple specialties collaborated on the care of these patients ensuring both survived. A significant number of blood components (n=20) were transfused in addition to salvaged red cells, fibrinogen, and tranexamic acid. This complex and hyperdynamic situation was managed with timely provision of transfusion support and surgical intervention. The case required input from multiple specialities (obstetrician, haematologist, surgeon, laboratory staff, cardiologist). This emergency occurred out-of-hours, overnight, where a limited number of staff and services would be routinely available. Staff were called in from home or from another site to assist and without question, contributed to the positive outcome for this patient. Clear communication and collaboration facilitated appropriate management for mother and baby. **Reporters' key learning point: 'Working together in effective teams to achieve common goals was vital…every member of staff involved stepped up to achieve the positive outcome for mother and baby.'**	Communication Collaboration Patient focus

Full case descriptions of the other ACE cases can be found in the supplementary information on the SHOT website.

Creating a sustainable learning culture by starting small, promoting useful tools that best fit with team's workflow, celebrating and learning from progress made, keeping it simple ensuring feedback loops in place and involving patients to reinforce learning is vital. An example framework for embedding learning from excellence into everyday practice is provided in Figure 5.1.

Figure 5.1: Framework to transfer IDEAS of excellence into practice

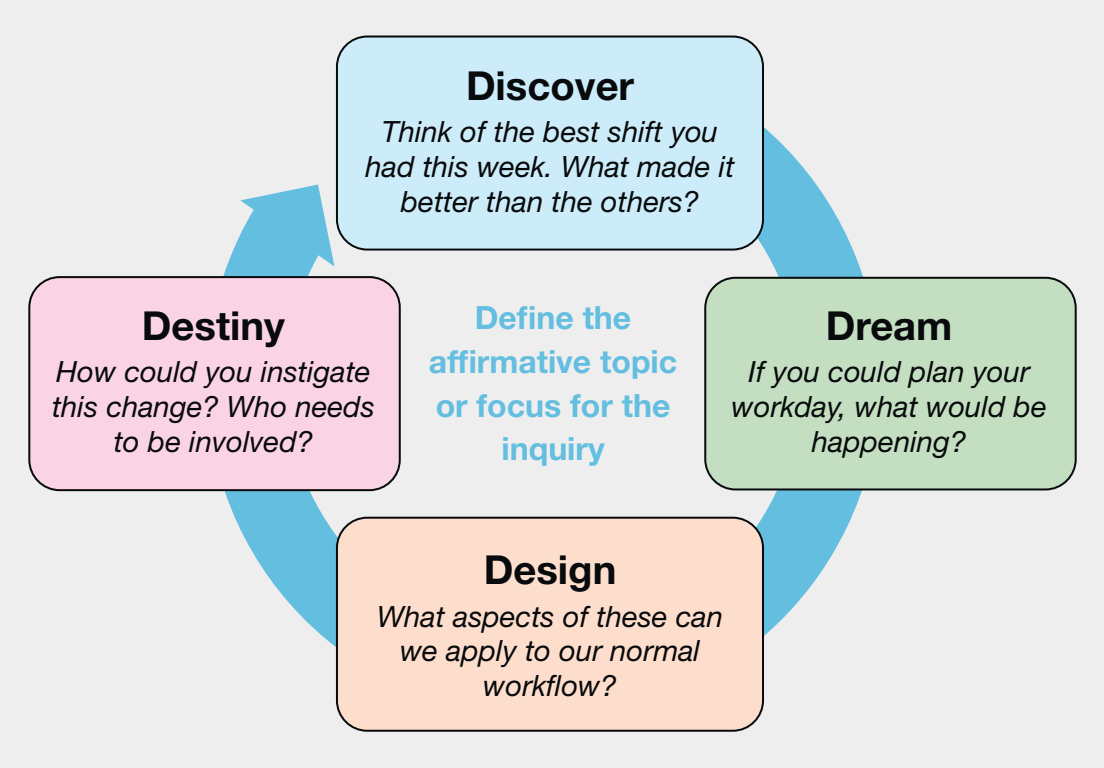


Tools to promote learning from excellence and everyday events

There are several tools and frameworks available to promote learning from excellence and everyday events, a few of which have been covered in previous Annual SHOT Reports.

Appreciative Inquiry is a strengths-based change approach used to bring about positive change in the system. It 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. 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 organisation (Cooperrider & Whitney, 2005). Appreciative Inquiry 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 & Fry, 2008). It can be used in team debriefs, meetings or feedback sessions. Figure 5.2 shows an example of the Appreciative Inquiry process and some example questions. NHS Health Education England provide further example questions in their module 'Start with what's working - An introduction to appreciative inquiry' (Russo, 2022).

Figure 5.2: Appreciative Inquiry process with example questions



This figure shows the '4D cycle' for appreciative inquiry on a mutually agreed affirmative topic (Cooperrider & Whitney, 2005) with questions from the NHS England introductory module on appreciative inquiry (Russo, 2022)

There are several ways in which learning from day-to-day events can be optimised. Event debriefs should include discussions about what went well and what can be improved. Additionally, team safety huddles; daily or shift-based quick meetings (5-10 minutes) facilitating structured approach, brainstorming solutions, and quality walkarounds offer opportunities to recognise and learn from excellence. A multidisciplinary, proactive approach ensures input from all staff groups to identify strengths, weaknesses, and measures to address them to optimise safety.

Neutral language matters for safety

Using a neutral taxonomy is essential for promoting objectivity, fairness, and learning. It reduces bias and blame, helps ensure clear communication and fosters a more constructive, just safety culture promoting staff engagement. This promotes a culture of learning and improvement.

The following changes are needed to adopt neutral language in safety matters:

- Review and standardise existing terminology: identify and remove emotionally charged, punitive or biased language; replace terms such as 'failure' with process-based descriptors 'unintended deviation'
- Ensure consistency in event categorisation across departments

- Train staff on the use of neutral language with focus on learning; provide examples of neutral versus biased terminology to promote consistency
- Update reporting systems to use neutral system-focused language
- Align policies and communications to reflect neutral, non-judgemental language avoiding implied blame

The language and terms used currently in healthcare focus on shortcomings or problems which can unintentionally reinforce negative stereotypes or low expectations, thus missing opportunities to learn from strengths or successes. Steven Shorrock (2023) has further elaborated on how such language can become weapons that can harm people and organisations, albeit to improve safety. Moving to a strengths-based approach will help identify what is working and build on those positives.

Some examples of language shift in safety taxonomy are listed below:

Traditional (blame-oriented)	Neutral (system-focused)
Nurse failed to verify identity	Identity verification process incomplete
Human error caused the event	Contributing human factors identified
Doctor's prescribing error	Medication order discrepancy

This is explored further in Chapter 7, Human Factors and Ergonomics in SHOT error incidents.

Neutral language helps avoid unwarranted and harmful blaming language, bias, and counterfactual reasoning to encourage learning and healing following events (Shorrock, 2023).

Compassionate governance

Compassionate governance is vital to enhance safety, and it ensures that policies, leadership, and safety practices prioritise patient care and wellbeing of healthcare workers. This integrates empathy, ethics and accountability into leadership and decision-making.

The following are key aspects of compassionate governance:

- Psychological safety: fostering an environment where staff feel safe to speak up about concerns, mistakes, and improvements without fear of punishment
- Just restorative culture: balancing accountability with learning ensuring fair responses to events, focusing on repair, reconciliation, and rebuilding trust rather than punitive measures
- Empathetic leadership where leaders actively listen, engage with staff, make decisions that reflect both operational needs and human impact. Compassionate leadership involves four behaviours attending, understanding, empathising, and helping (Atkins & Parker, 2012)
- Strengthening patient-centred care: involving patients and families in care decisions, policy developments and addressing health disparities through equitable access to care
- System accountability: recognising that most incidents are system-based failures rather than individual-based and addressing these factors to improve safety
- Transparent communication: encouraging open, honest, timely discussions about safety issues while avoiding blame-focused language
- Focus on wellbeing: prioritising the mental, emotional, and physical wellbeing of individuals within the system, recognising that stress and burnout impact safety and performance
- Ethical decision-making: ensuring policies and actions align with core ethical principles such as fairness, integrity, and respect for dignity
- Inclusivity and equity: actively considering diverse perspectives and ensuring governance structures support fairness and equal opportunities for all

- Continuous learning and improvement: creating mechanisms to learn from all events, fostering a culture of growth and innovation

Compassionate governance leads to safer systems, better patient outcomes and healthier, more engaged staff (West & Dawson, 2012; West, 2021).

Conclusion

By balancing error-focused learning with excellence-focused learning, transfusion teams can enhance safety, patient outcomes, staff morale and wellbeing. Implementing learning from excellence and day-to-day events requires practical tools and frameworks that encourage a positive safety culture, continuous learning, and system-wide improvements.

There are several instances in transfusion events submitted to SHOT where staff have demonstrated excellence in communication and collaboration to ensure safe transfusions. Reporting of all these instances where staff have taken proactive measures to improve communication, reduce delays, mitigate risks, and ensure safe pre-administration checks is encouraged. If your team or organisation has made an extraordinary response in the face of adversity, 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. Sharing learning from these cases nationally can help promote safety across a multitude of other organisations.

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. Clinical and laboratory transfusion staff are encouraged to use resources available to promote learning from excellence and embed civility in day-to-day practices (see 'Recommended resources' from SHOT at the end of this chapter and other sources such as https://learningfromexcellence.com/ and https://www.civilitysaveslives.com/).

While the term 'investigation' remains in use throughout this Annual SHOT Report, we are beginning a thoughtful shift toward more neutral safety language—such as 'learning review'—to better reflect our commitment to psychological safety and continuous improvement. This transition, designed to be compassionate and meaningful, will be phased in over the coming years. It signals a broader cultural change in how we approach safety, responsibility, and shared learning across the system. Alongside this, we continue to promote constructive attitudes and a learning-focused mindset to enhance safety practices.

Recommended resources

ACE reporting – SHOT Definitions and ACE Examples
https://www.shotuk.org/reporting/acknowledging-continuing-excellence/

SHOT video: Learning from excellence in transfusion
https://www.shotuk.org/resources/learning-from-excellence-in-transfusion/

SHOT video: Learning from day-to-day events
https://www.shotuk.org/resources/learning-from-day-to-day-events/

SHOT
Serious Hazards of Transfusion