REFLECTIVE LEARNING and SHOT

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DID YOU KNOW THAT YOU'RE VERY GOOD LOOKING?

UPON REFLECTION I THINK YOU'RE RIGHT.
HISTORY

- Educational philosopher John Dewey
- Born 1859 Vermont
- Professor of Philosophy
- Challenged the accepted means of educating
- Promoted reflective actions
- Learning by doing
DEFINITION

• Requires the student to reflect on the actions they have taken against the outcome
• Compare to procedures/policies in place
• Knowledge learnt can be incorporated into the action next time
• View problematic situations and convert them to potential learning opportunities
• Alternatively – learn from mistakes
WHY SHOULD WE DO IT?

• Reflective learning or reflective practice preferred as evidencing CPD as it avoids the “went to that meeting” (but slept through half of it) route
• Helps to meet future mandatory CPD requirement
• Can be achieved within the workplace
• Facilitates a skilful, appropriate and effective response to situations
KOLB LEARNING CYCLE

Experience

Now what?
(Planning)

So what?
(Analysis)

What?
(Reflection)

So what?
(Planning)
HOW CAN IT BE ACHIEVED?

• Quietly reflecting on events
• Problem based learning
• Writing out a sequence of events
• Reflect critically but constructively
• Self assessment / Peer assessment
• Undertake reflection with a tutor / mentor to facilitate learning
Continued……

WHEN?
• ASAP
• Review 1-2 wks later

HOW?
• Must be reflective NOT descriptive
• Write in first person
• Include thoughts and feelings
• Analyse own role
• What effect does event have on others?
• Show learning
WHAT’S IN IT FOR THE INDIVIDUAL?

**Advantages**
- Improve confidence and competence
- Improves practice
- Learn new information
- Learn from others
- Increases knowledge of the organisation
- Become more aware of strengths and limitations
- Can set new developmental goals

**Disadvantages**
- May become more introspective and anxious
- Time consuming
- Lack of experience can affect reflection
- Need to recognise when you need help and how to get it
ISSUES

• Requires honesty
• Requires a strong sense of vision
• Requires good judgement
• Needs an ability to grasp and interpret changing situations
• May be some reluctance when it involves reflecting on errors in the workplace
• Takes time to complete
• Scientists tend not to be good at the emotional aspects
• Flow charts may help
• Senior staff need to encourage
HOW CAN WE USE SHOT?

- Annual report
- Summary of main findings
- General recommendations
- Specific recommendations
- Category specific analysis
- Case vignettes
- Learning points
Surely it can’t happen here
Example 1
IBCT – Case study (2003)

- Young female with Fe Def anaemia
- 4 unit transfusion prescribed
- Request made ‘out of hours’
- Policy to make K- units available
- On call BMS selected a K+ unit
- 1 year later patient pregnant
- Anti-K detected at booking
Apply Kolb learning cycle

• Take a look at your own laboratory / clinical practices and ask questions
• How do we deal with cases like this?
• What is our policy on ‘out of hours’ transfusions?
• What is our policy for transfusing patients with Fe Def anaemia?
• Is everyone aware of need to give K- blood to females under 60yrs?
• Could we have selected a K+ unit in error
• What role does our IT system play?
• What do we do about KK females – should they really receive kk blood?
• Do we involve the clinicians?
Continued......

- This is about making sense of what is happening – comparing your own organisation with the happenings of the case study.
- Could a similar incident happen in your organisation?
- What are the good points in our organisation?
- What are the bad points in our organisation?
This is about putting into practice what has been learnt from the incident under consideration

- Move towards minimising non essential transfusions occurring ‘out of hours’
- Refer requests for blood in Fe Def cases to Haem Consultant
- Separate stock of K- units for female patients
- Appropriate warning flags on blood bank IT system
- Education of staff

Now what? (Planning)
Example 2
Delayed Haemolytic Transfusion Reactions
(2004 report)

• Due to non detection of an antibody caused by previous immunisation
• 43 reports
• No deaths but indication of morbidity and increased bed stay
• Of these 25(60%) had Kidd antibodies
• Difference in detection by common techniques in use
Apply Kolb learning cycle

What? (Reflection)

- Take a look at your own laboratory / clinical practices and ask questions
- Nobody has died – we’re ok?
- Have we had cases where Hb failed to increment as expected?
- Do we detect Kidd abs?
- Incidence of DHTR in our lab?
- How do we investigate suspected DHTR?
- Is our technology good enough?
- What evidence is ‘out there?’
This is about making sense of what is happening – comparing your own organisation with the happenings of the case study.

- 1 similar case – what action did we take?
- Plasma or serum samples for investigation?
- Follow-up
Continued......

- This is about putting into practice what has been learnt from the incident under consideration
- Storage of samples post crossmatch
- Samples needed for DHTR investigations
- Competence required in new techniques?
- Review of technologies, practical and theoretical
- Maybe think about a change in laboratory technology
Reflective benefits

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- Need to recognise when you need help and how to get it
I can see you’re all flagging
Have a safe journey home