

## 2017 SHOT Key Recommendations survey

The purpose of this survey was to understand progress with implementing key recommendations six months following their publication in the 2017 SHOT Annual Report (Published July 2018).

A link to the online survey was sent to all reporters and one response was requested from each Trust/Health board. Reporters were given three weeks to respond. The survey was estimated to take <15 minutes to complete. A short extension was provided to increase the response rate.

### KEY MESSAGE

There has been good progress made with implementing the 2017 SHOT key recommendations despite challenges and barriers to implementation. These were cited as, competing priorities, paucity of financial resources and lack of staff engagement.

### RESPONSE RATE

**126/222 (57%) compared to 160/222 (72%) preceding year**

Multiple factors were thought to be contributory to a lower response rate, including several ongoing surveys and short staffing

### Response rate by reporting country

England (99) Scotland (12) Wales (8) Northern Ireland (7)

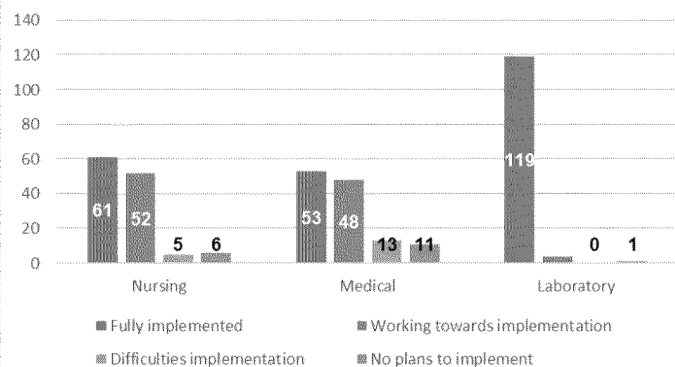
Trusts/Healthboards that covers paediatric transfusion (108)

Trusts/Healthboards that do not cover paediatric transfusion (18)

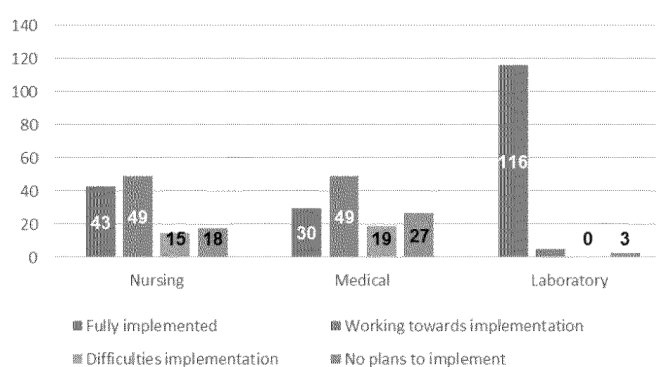
### Progress with implementing Key Recommendation 1

Training in ABO and D group principles is essential for all laboratory and clinical staff with any responsibility from the transfusion process. This should form part of the competency assessment.

Training in ABO and D group principles by staff group



Included in competencies - progress by staff group



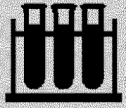
NB: Respondents answered all that applied



## Any difficulties/barriers and timescales to completion of key recommendation 1 (text responses)



30 responses demonstrated success with implementation



5 responses believed it was the responsibility of the transfusion laboratory



12 responses didn't recognise the need for this recommendation



12 responses explained how difficult it was to implement training



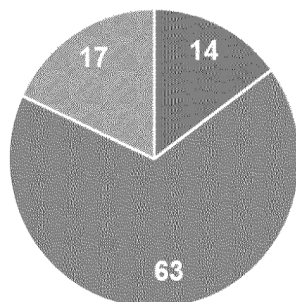
8 responses explained there were competing priorities and no current capacity to implement

## Progress with implementing key recommendation 2

All available information technology (IT) systems to support transfusion practice should be considered and these systems implemented to their full functionality

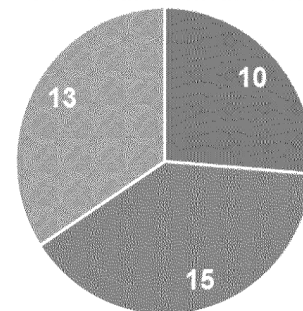
Electronic blood management systems should be considered in all clinical settings where transfusion takes place. This is no longer an innovative approach to safe transfusion practice, it is the standard for all

In place and to full functionality in all relevant clinical areas



■ Sampling ■ Collection ■ Administration

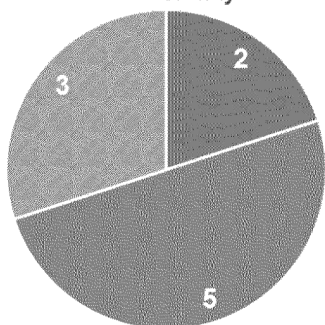
In place but working towards full functionality in all relevant clinical areas



■ Sampling ■ Collection ■ Administration

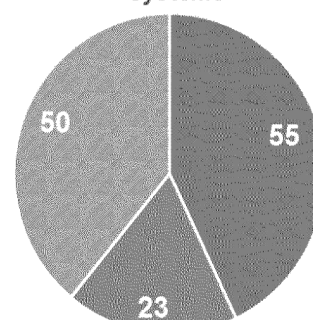


In place but no plans to progress to full functionality



■ Sampling ■ Collection ■ Administration

No plan to progress with clinical electronic systems

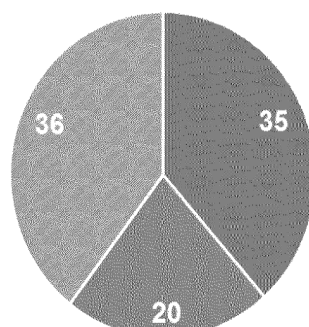


■ Sampling ■ Collection ■ Administration

*"Patient ID IT systems have been explored and quotes obtained from suppliers"*

*"Finance continues in all areas of transfusion to be a barrier"*

Business case submitted



■ Sampling ■ Collection ■ Administration

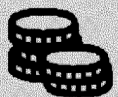
*"Priority is to have an improved LIMS"*

*"Go live 4<sup>th</sup> Feb for the whole hospital, sampling and bedside will be implemented as part of LIMS update next year"*

### Any difficulties/barriers and timescales to completion of key recommendation 2 (text responses)



9 responses explained that 'time' was a constraint to implementation



24 responses placed cost as the main barrier to implementation



27 responses demonstrated their success with progress with implementing this recommendation



18 responses detailed how they had future plans to implement this recommendation



2 responses said competing priorities as a barrier to implementation

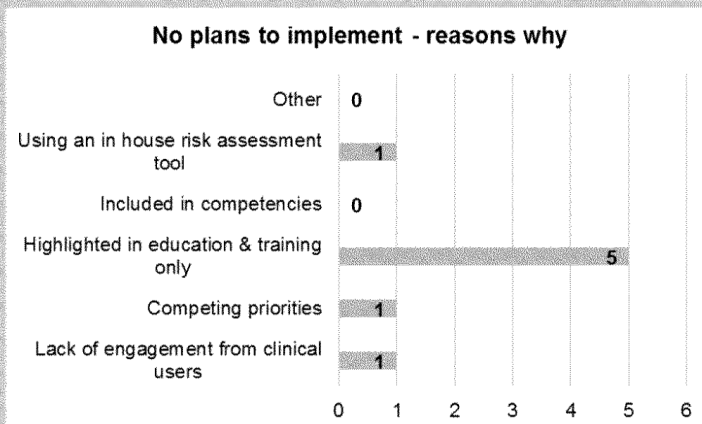
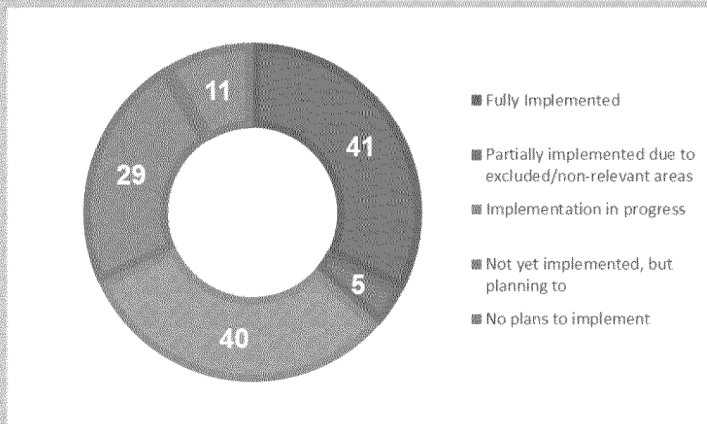


2 responses said they had risk assessed their process so not considering implementation



## Progress with implementing key recommendation 3

A formal pre-transfusion risk assessment for TACO should be undertaken wherever possible, as TACO is the most commonly reported cause of transfusion related mortality and major morbidity



## Any difficulties/barriers and timescales to completion of key recommendation 3 (text responses)



**11** responses demonstrated success with implementing this recommendation



**7** responses cited competing priorities as a barrier to implementing a TACO checklist



**13** responses explained where and how they include the TACO checklist in the patient assessment



**4** responses didn't recognise the need for a TACO checklist



**4** responses cited lack of staff engagement as a barrier to implementation



**15** responses explained future plans for implementation



*"We are just beginning to look of possible ways to implement"*

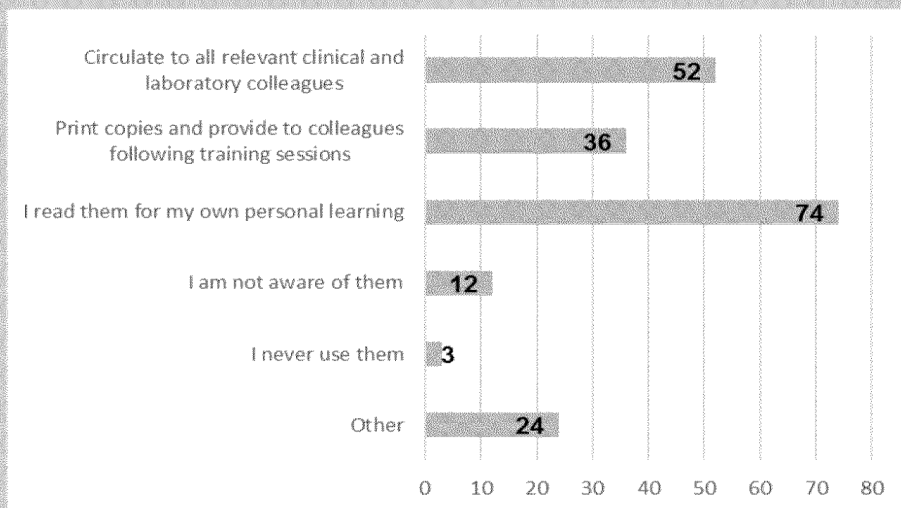
*"Engagement with medical staff is challenging"*

*"Lack of concrete evidence and guide of TACO"*

*"TACO checklist included on blood authorisation form"*

*"We are competing with other checklists"*

## How do you use the 'SHOT Bites' resources?



We are asked for further suggestions for future 'SHOT Bites' and you provided us with many potential topics. These will be considered at the next SHOT steering group meeting.

## Further comments received

*"It should be highlighted that the SHOT recommendations are just that - the actions for each recommendation should highlight that they are for consideration."*

*"SHOT Reports are useful tools for training"*

*"Make people more aware of things like SHOT bites and other resources"*

*"Not sure I support recommendations based on one incident"*

**Thank you for your participation in this survey**