

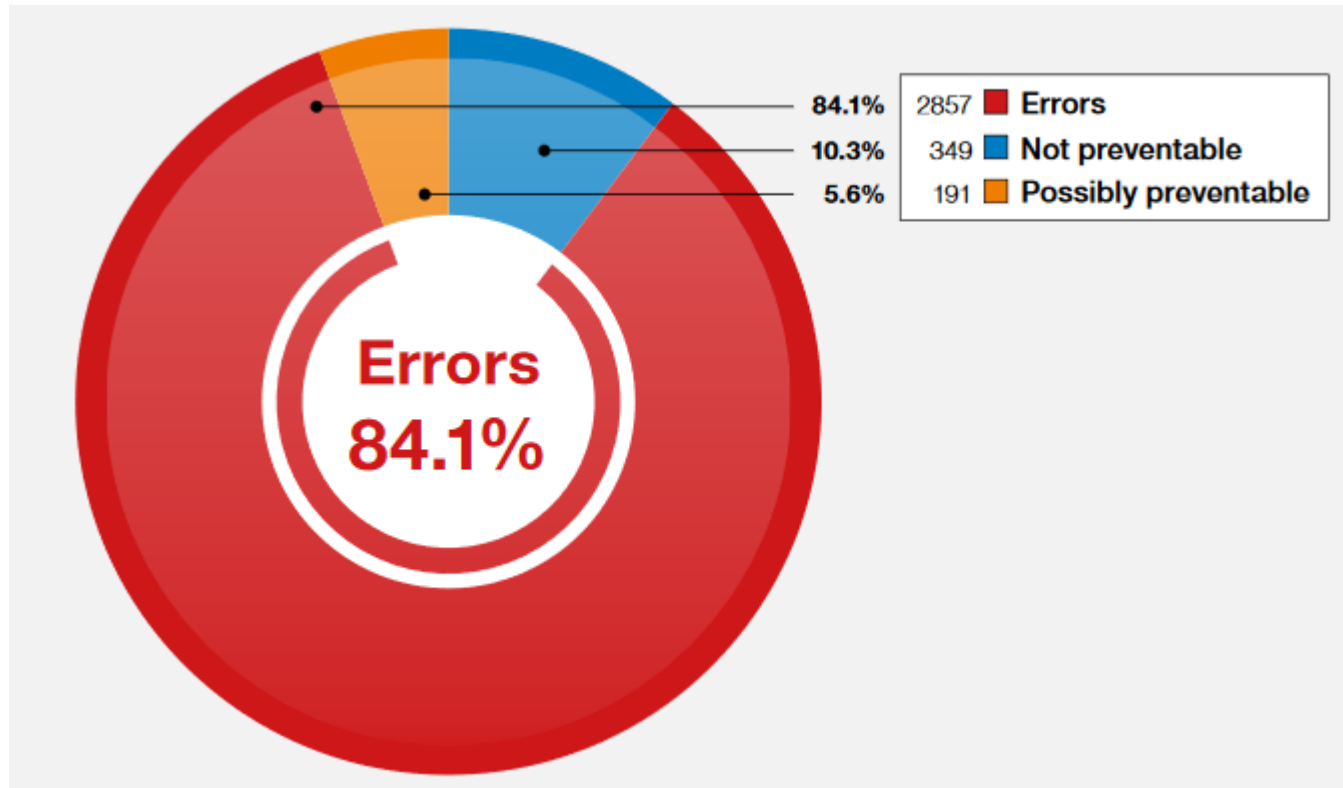
South East Coast  
Regional Transfusion Committee & Education Symposium

Blood administration training:  
Facilitating positive change to enhance patient safety.

Tuesday 9<sup>th</sup> March 2021

# Outline

- Background
  - SHOT (2019) data
  - SHOT (2019) recommendations
  - National recommendations
- BSUH training overhaul
  - Outlining the problem
  - Change & resistance theories used
  - Outcomes
- Acknowledgements



***“Inadequate staffing, lack of adequate training, poor supervision and poor safety culture have been identified as contributory to numerous incidents reported to SHOT. These need to be addressed urgently to reduce the risk to patient safety” SHOT (2019)***

# SHOT (2019) recommendations:

*“Staff should only take part in the transfusion process if they have been deemed competent to do so. Competency is best gained by training all staff....”*

*“All staff involved in transfusion must have mandatory transfusion training which should include identification of all blood components, and instruction about appropriate dosing particularly in paediatrics”.*

*“Ensure staff are identified for training, that training material is thorough and that staff competencies are assessed and updated frequently”.*



# ***“Why do I have to be assessed....”***

## **The National Blood Transfusion Committee (2016)**

“All staff involved in the transfusion process should receive training no less frequently than 3 yearly”

“Knowledge and understanding assessment should be performed at least every 3 years”

## **British Committee for Standards in Haematology (BCSH) (2012)**

“The NPSA Safer Practice Notice 14 (2006) ‘Right patient, right blood’ stipulates three yearly competency assessments for all staff involved in the blood transfusion process in the clinical area”

## **NHSBT – Transfusion Matters (2010)**

“The Health Service Circular HSC 2007/001 states that all relevant staff are assessed at least every three years for their competency in safe transfusion practice according to their role and responsibilities in line with the NPSA recommendations”

## **The department of health – Better Blood Transfusion (2007), outlines recommendations by the Safe Practice Notice (Right patient-right blood)**

“SPN emphasises the importance of the final pre-transfusion bedside check, and the need for NHS Trusts to consider the use of information technology to improve transfusion safety and ensure that all relevant staff are trained and undergo regular competency assessment.”

## **The Medicines and Healthcare products Regulatory Authority (MHRA) state**

“Assessments should be undertaken in a manner that are commensurate with the level of risk associated with the process but should be at least every two years”

# BSUH

## Blood administration training overhaul.



*“It is crucial that all staff involved in transfusion are trained in relevant transfusion policies and procedures....” SHOT (2019)*

# The problem



**Commencement  
to TP post in  
October 2019.**

**In excess of 1000  
clinicians had  
expired in their  
mandatory training  
at this point.**

**Up-to-date  
internal training  
records not  
maintained.**

# Key observations

**Poor compliance for mandatory reassessments as per national guidance.**

**Training had been previously allocated to clinicians who were not part of the transfusion team.**

**Poor uptake in staff theory training compliance.**  
**-Cancelled sessions**  
**-Only one accessible means of training available**

**Resistance to change unacceptable and outdated practices and attitudes in clinical areas.**

**A disconnect of understanding and awareness between the clinical wards and transfusion laboratory.**

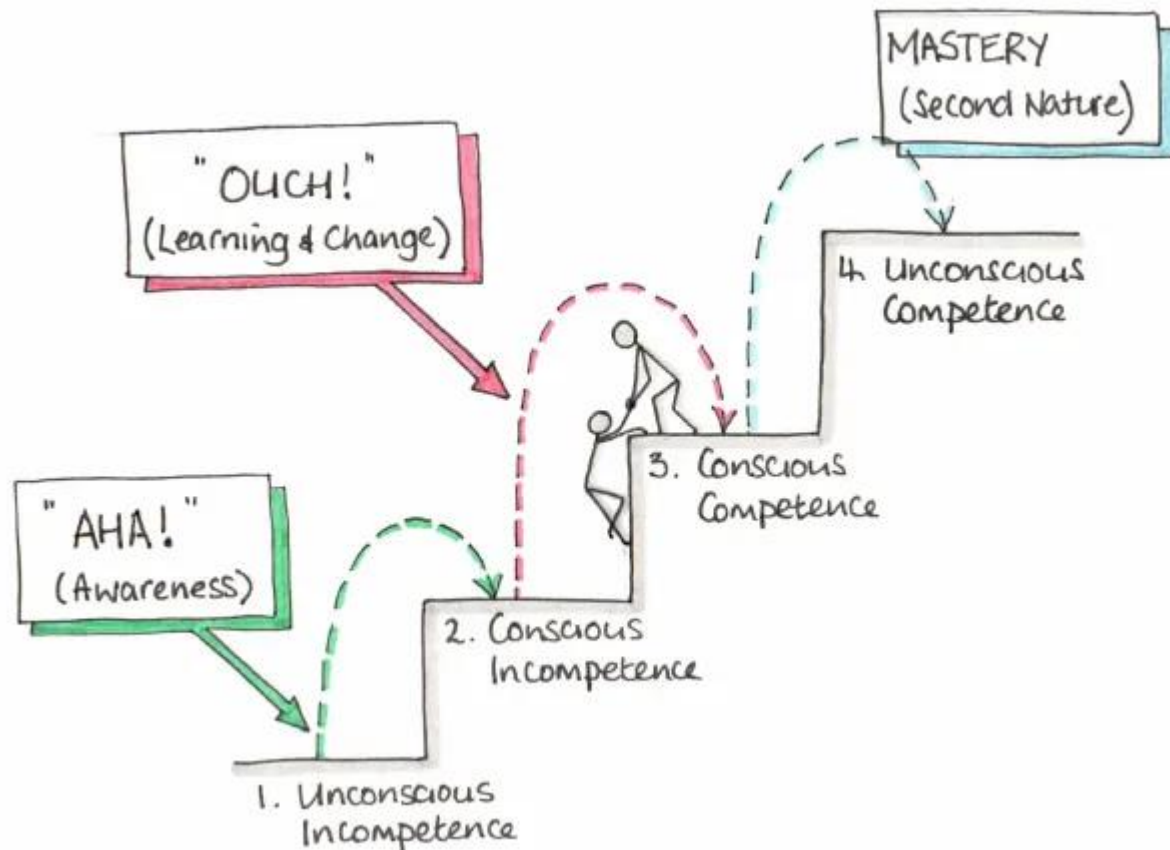
**Unnecessary clinical incidents relating to near misses , WBITs and wastage.**



Evolve positive change  
How is it done?

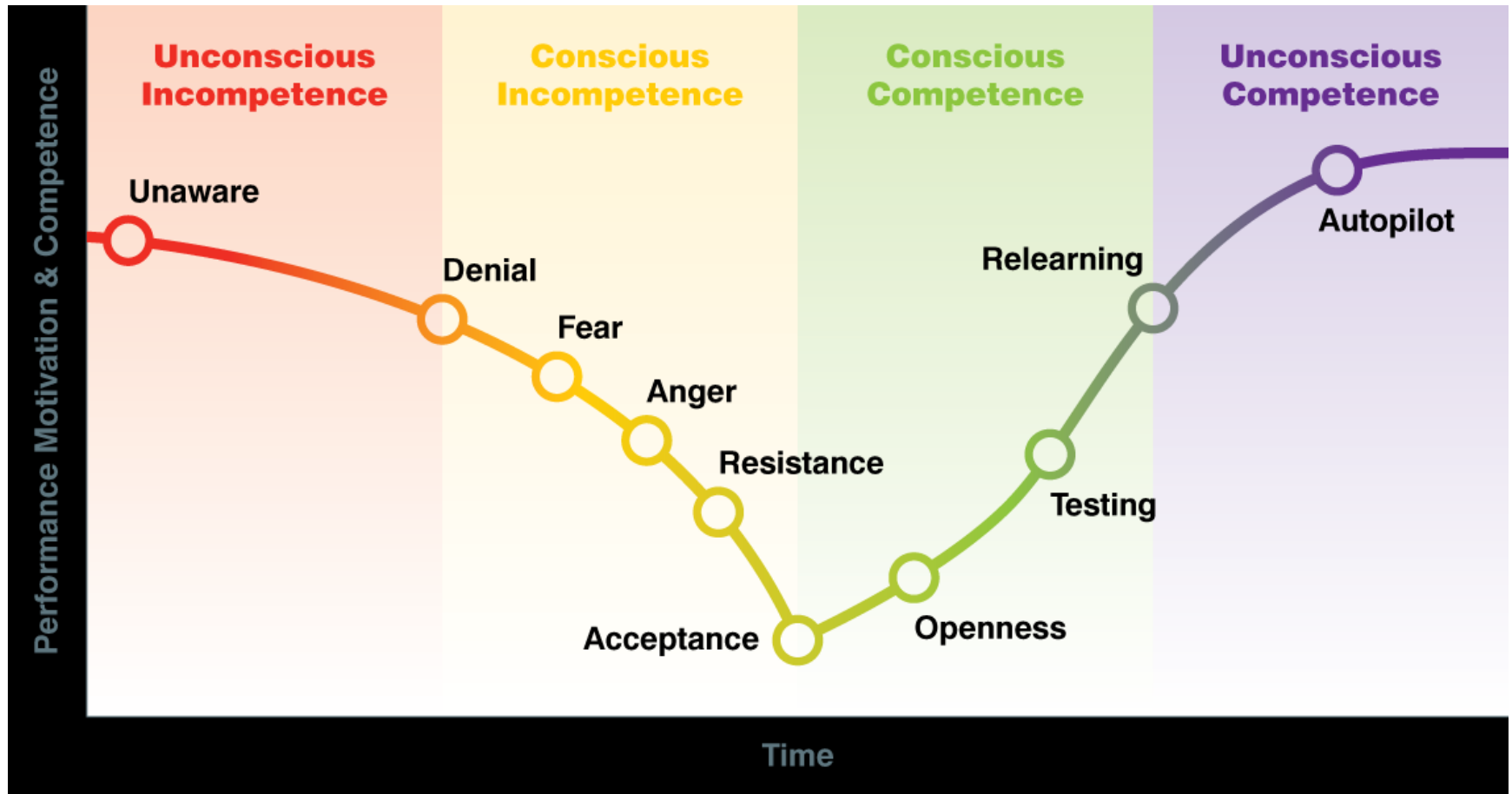


# Understanding how change works



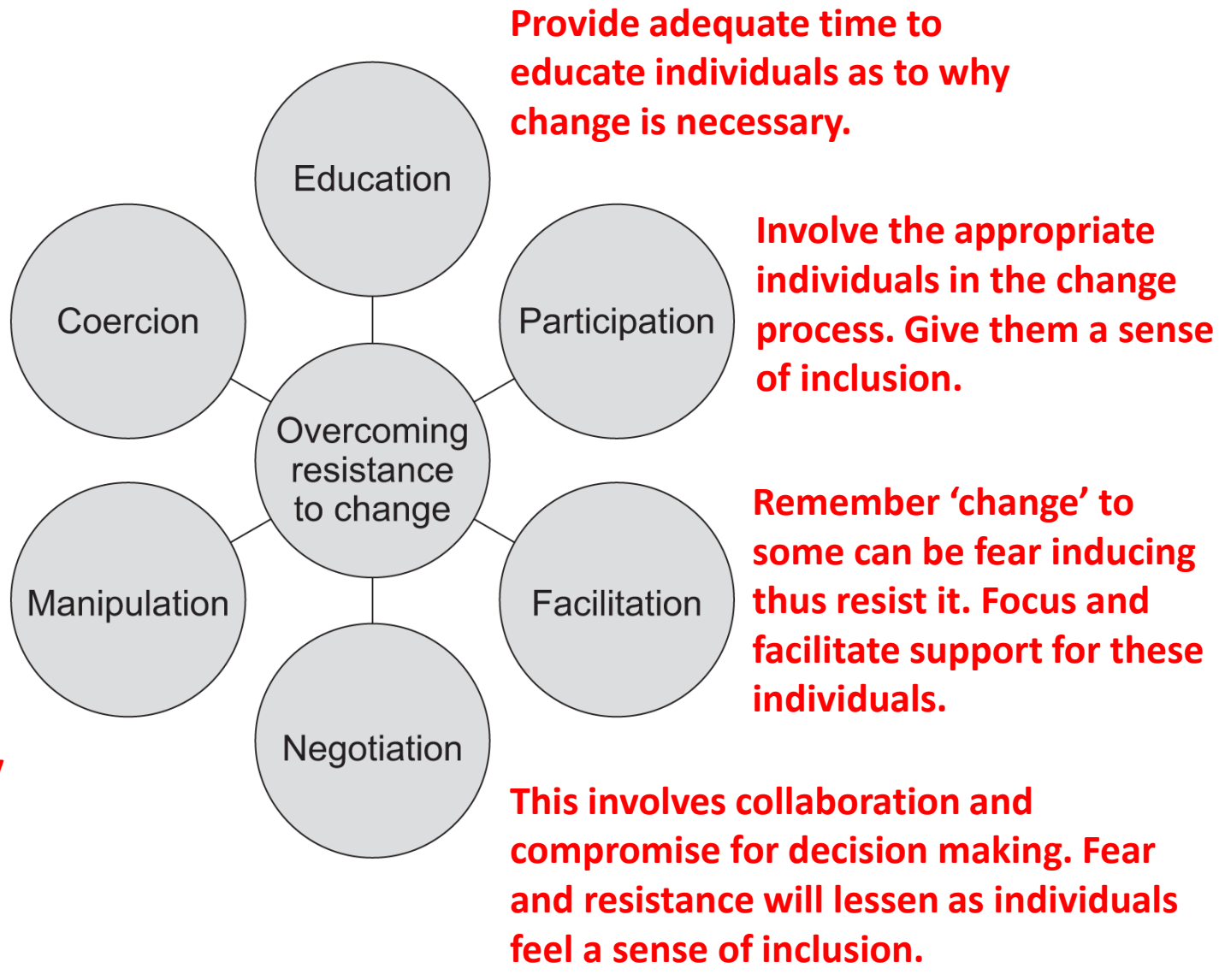
Conscious Competence ladder

# Understanding the emotional connection to change



# Understand how to overcome the resistance

If change proves successful, individuals can be 'won' over. Take the time to 'win' individuals over.

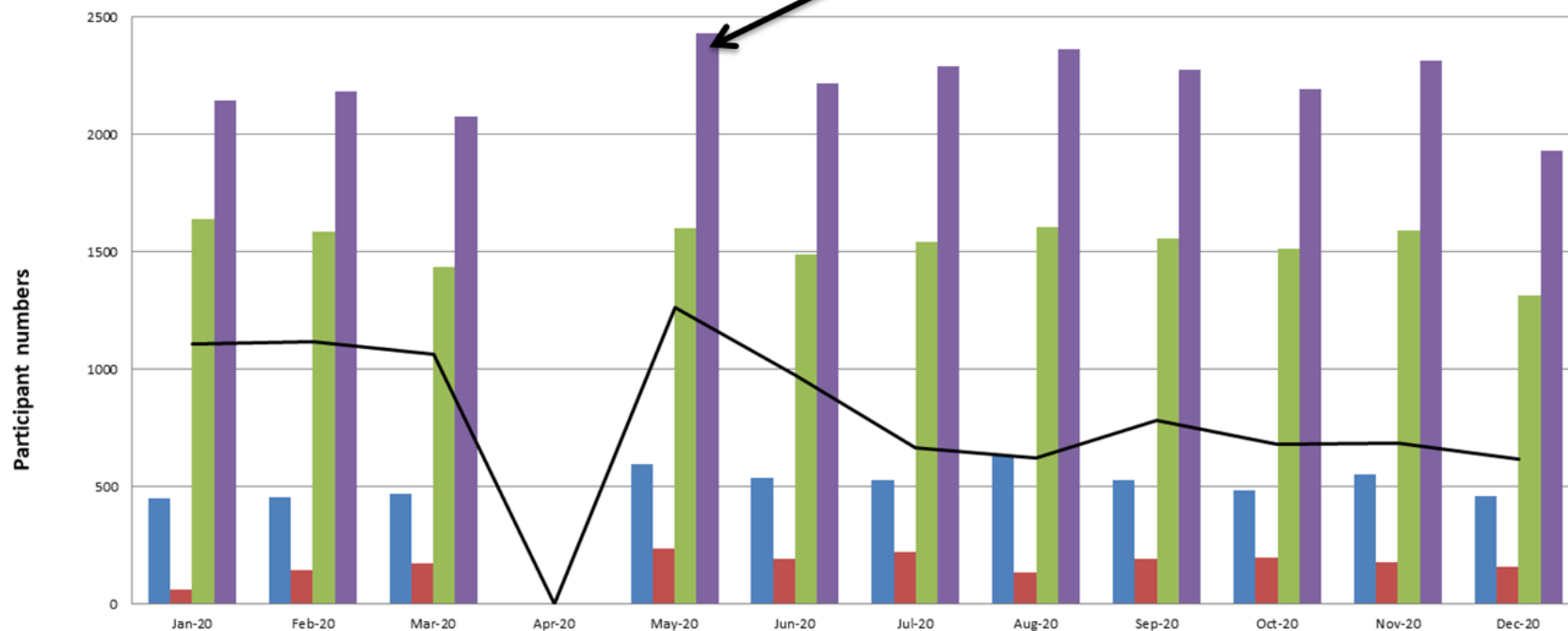


# The approach

- Know the scope: what's the problem?
- Research the problem: be prepared!
- Ask the 'tough questions'....whose responsible then and now? Why has this happened? How are we going to solve this?
- Have clear outlines for change.
- Engage with others in positions of change.
- Formulate key objectives.
- Know the timeline.
- Present the plan for change.
- Share the change.

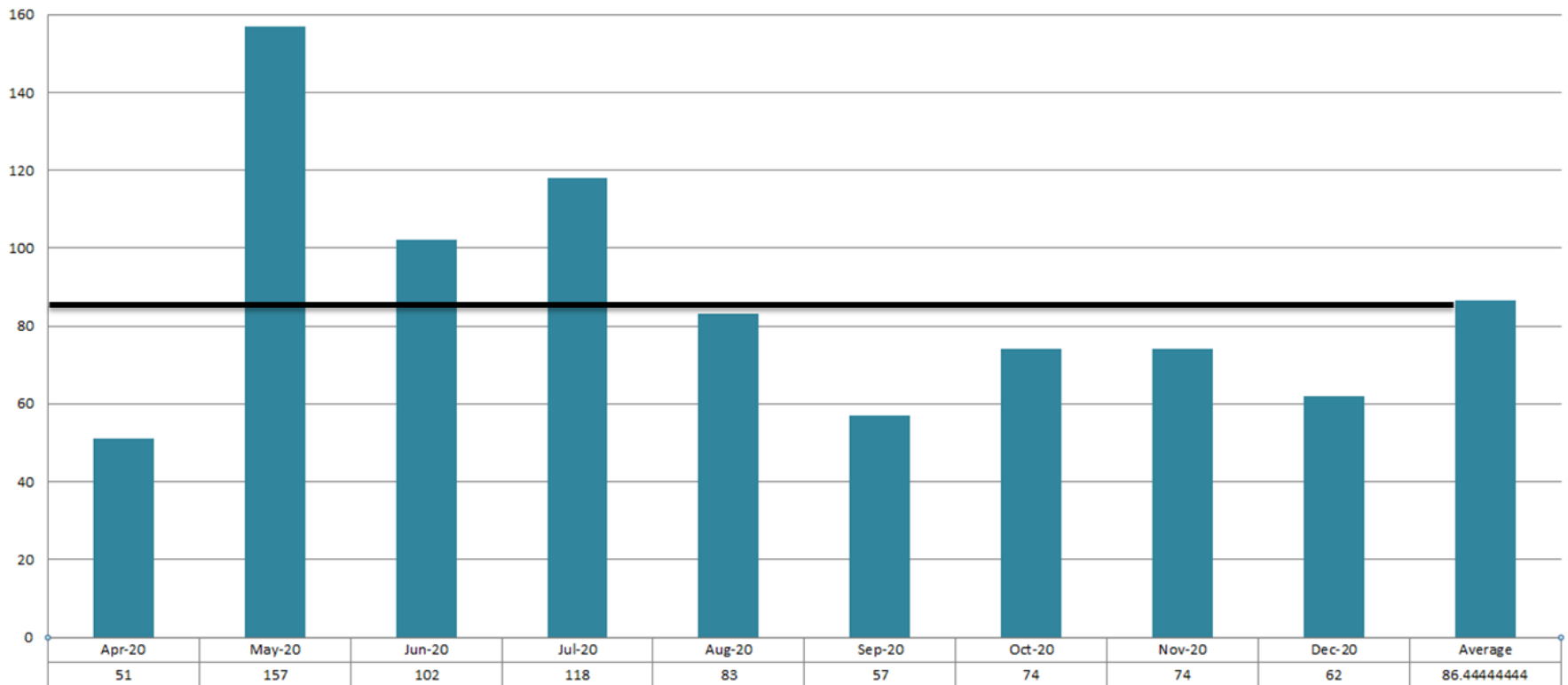
# The Outcome

During the roll out of the e-learning package on the 21<sup>st</sup> April 2020, participant enrolment increased via e-learning by 14.6% 😊

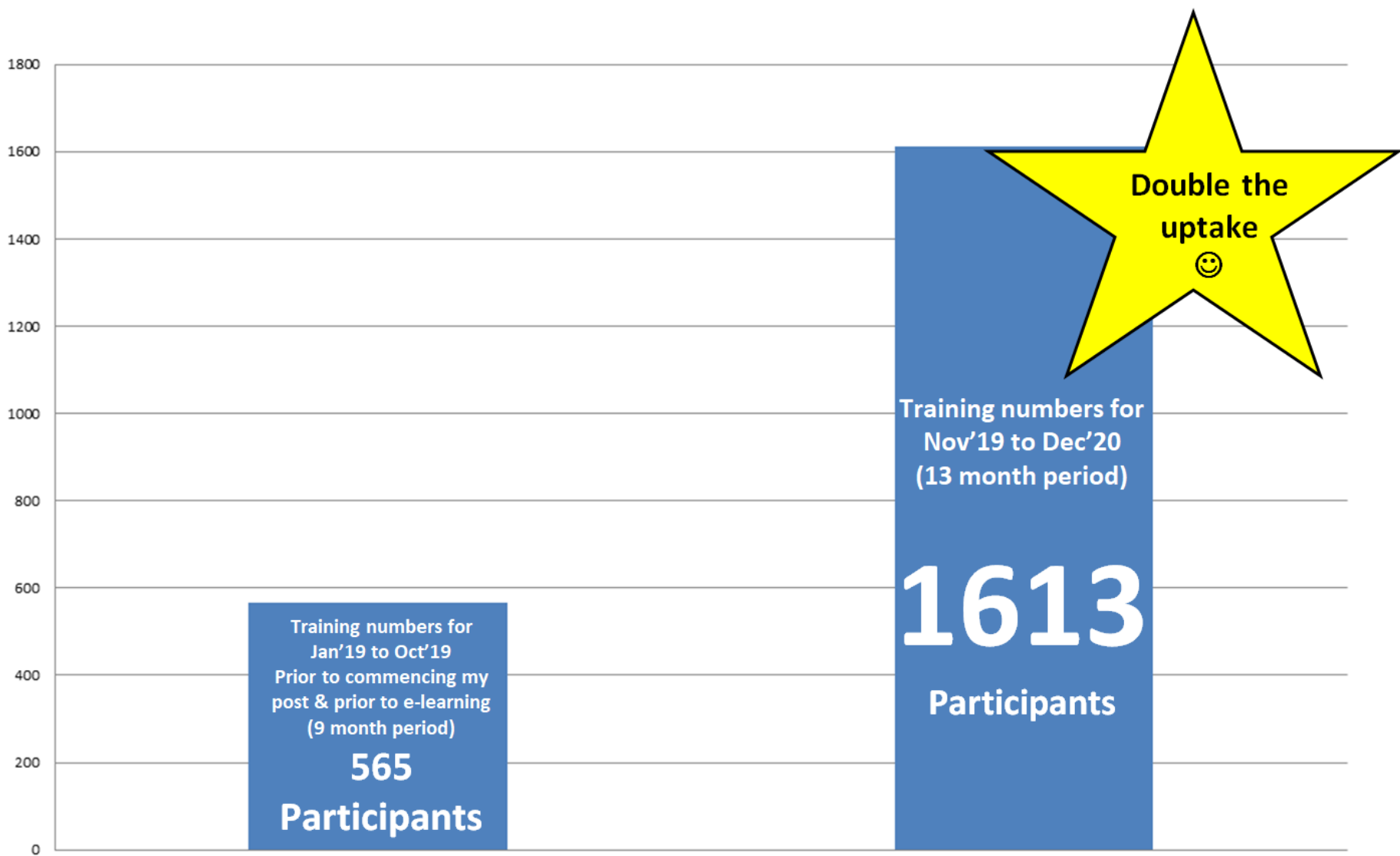


55.8% reduction in staff left to train by the end of 2020

### E-learning participants April 2020 to December 2020



Total participants: 778





**An abstract of this project was submitted to the Florence Nightingale Foundation.**

**The abstract won their quality improvement project for the South East Nurses & Midwives Leadership Programme which I completed in 2020.**

**I would like to take this opportunity to thank the Florence Nightingale Foundation and Brighton and Sussex University Hospitals NHS Trust for the support I received completing this course.  
In addition, I'd like to thank the South East Coast Transfusion Committee for providing me with the opportunity to present my accomplishment.**



AN INVESTMENT IN

**KNOWLEDGE**

— *pays the best* —

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**INTEREST.**

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-Ben Franklin-

Conscious Competence ladder:

<https://ukcpd.net/collegemembers/conscious-competence-ladder-developing-new-skills/>

Emotional Change Cycle:

<https://www.lovebusinesseastmidlands.com/love-business-news/2020/03/25/understanding-the-psychological-impact-of-covid-19/>

Kotter and Schlesinger's model for overcoming resistance to change:

<https://www.aqa.org.uk/resources/business/as-and-a-level/business-7131-7132/teach/teaching-guide-kotter-and-schlesingers-model-for-overcoming-resistance-to-change>

SHOT: <https://www.shotuk.org/wp-content/uploads/myimages/SHOT-REPORT-2019-Final-Bookmarked-v2.pdf>