National Blood Transfusion Committee

National Blood Transfusion Committee

Recommendations for Training and Assessment in Blood Transfusion

Background

In 2006 the NPSA, in conjunction with the NBTC and SHOT, issued a Safer Practice Notice, [SPN], *Right Patient Right Blood.* This document detailed actions to be taken by all NHS and independent sector organisations to improve the safety of blood transfusions. Actions required were to implement a programme of training and observational competency assessment for all staff involved in the transfusion process,

The NPSA was disbanded in 2012 and a working group of the NBTC was formed to review the competencies and recommend a way forward. Following this review, this document gives recommendations for training and assessment for all staff involved in the transfusion process.

These recommendations have been developed by an NBTC working group, in collaboration with Transfusion Practitioners from across the country and are supported by NHS England. This document is not intended to be prescriptive or indeed mandatory but rather it is intended that there will be flexibility at trust level in how these guidelines are implemented.

Recommendations

General

- Trusts must have in place a system of training, knowledge assessment and practical competency assessment for all staff involved in the transfusion process.
- Staff must be trained and assessed prior to taking part in the transfusion process.
- Individual healthcare professionals are responsible for their own practice and ensuring that their training and assessments are up to date and valid, and that they are practicing in compliance with local policy.
- It is accepted that it is not possible for 100% of all staff to be compliant at any one time. Ward or departmental managers must establish the number of staff that need to be trained and assessed to ensure the safe and effective delivery of transfusion in their area. Therefore, 100% of staff currently participating in transfusion activities must be trained and assessed.
- Local policies should include guidance on actions to be taken in exceptional situations when there are no trained and assessed staff available in the clinical area to administer a transfusion.
- A risk based approach should be adopted when deciding on training and testing intervals based on the number and nature of incidents and the frequency that staff are carrying out procedures. The intervals may be different for different staff groups.

Core Standards

- Training, Knowledge testing and assessment packages should reference National Standards (Appendix 1) to facilitate transferability between trusts. The Standards have been developed from the BCSH Guideline on Administration of Blood Components 2009 and have been agreed through a sounding board of Transfusion Practitioners and the relevant stakeholders in the National Blood Transfusion Committee
- Training, testing and assessment packages must be developed from National Standards to ensure an in depth understanding of the rationale for the processes and the dangers in not following the processes, as well as the processes themselves
- Standards relating to local processes should be added as appropriate.

Training

- All staff involved in the transfusion process must receive training as a minimum of every 3 years
- Training should involve the delivery of information/knowledge/rationale that the staff require in order to conduct the relevant tasks within the transfusion process
- Training may take the form of face to face training, E learning or local workbook
- It is recommended that the training covers the key learning outcomes, based on National Standards (Appendix 1).

Knowledge and understanding tests

- Knowledge and understanding assessment must be performed at least every 3 years
- Knowledge tests may be performed face to face, as a paper based exercise, or via E learning
- Knowledge tests must be performed against National Standards (Appendix 1) and local specific processes.

Practical assessment

- The practical competency assessment must cover the performance criteria detailed in the National Standards
- Following an individual's initial training, a one off practical competency assessment must be undertaken
- This need not be repeated provided on-going satisfactory performance
- How the practical assessment is completed can be locally determined, and may be completed through observed practice in the clinical area or through simulation

Transferability of training, knowledge tests and practical assessments

- Training, testing and assessment that has been undertaken against National Standards (Appendix 1) and referenced these, will be transferable between trusts.
- The use of training and assessment 'passports' is recommended
- The need for further training, knowledge testing and practical assessment against either the core standards or specific local processes, will be at the discretion of the individual trust or staff member.
- The outcome of training, knowledge tests and practical assessment should be recorded through the ESR system.

Management of incidents and poor performance

- Individuals who are involved in transfusion related incidents, or who fail knowledge tests or practical assessments, should be managed in a consistent way across trusts.
- Individuals should be given two attempts to pass the knowledge test and practical competency test, after which retraining must be undertaken.
- Individuals failing knowledge tests or practical assessments must not continue to practice until satisfactory performance has been demonstrated.
- The Hospital Transfusion Team must be involved in the investigation of all transfusion related incidents.
- Hospital Transfusion Teams must ensure that incident reports and investigations are available to the line managers and educational supervisors of all individuals involved in transfusion incidents.
- Individuals involved in incidents may be asked to include details of the incident, and any reflection undertaken, for discussion in their annual/educational appraisal
- Individuals involved in incidents may undertake retraining and / or repeat assessments at the discretion of the hospital transfusion team and/or line manager.
- Individuals involved in incidents must not continue to practice until the investigation is completed and any necessary remedial actions have been undertaken.

Version 1 of this document has been produced by – NPSA SPN14 review group – a working group of the NBTC and approved by NBTC September 2014

Version 2 was produced to incorporate the draft NBTC Standards as shown in Appendix 1 for consultation and final approval at the NBTC in September 2015