

National Blood Transfusion Committee

Requirements for Training and Assessment in Blood Transfusion

Summary

- This document and the National Standards (Appendix 1) set out what the National Blood Transfusion Committee (NBTC) consider to be necessary requirements for transfusion training.
- For all staff involved in the transfusion process Trusts must have in place a system for training, knowledge and understanding assessments to be undertaken a minimum of every 3 years (2 years for blood collection) and more frequently if deemed necessary at a local level.
- Training may take the form of face to face training, E learning or local workbook.
- Following an individual's initial training, a one off practical competency assessment must be undertaken. This practical assessment need not be repeated if there is on-going satisfactory performance but should be repeated if there is a period of greater than one year out of a workplace where transfusion routinely takes place.
- Individuals who are involved in transfusion related incidents, or who fail knowledge tests or practical assessments, should be managed in a consistent way as set out in locally defined policies.

Background

In 2006 the NPSA, in conjunction with the NBTC and SHOT, issued a Safer Practice Notice, [SPN14], *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 abolished in 2012 so a NBTC working group was formed to review the competencies and develop guidance to replace the former NPSA document. The working group's guidance was produced in collaboration with Transfusion Practitioners across the country and supported by NHS England. The guidance encompassed how staff involved in the transfusion process should be trained and assessed. It is for individual Trusts to make their own arrangements for implementing the guidance.

This document sets out what the NBTC consider to be necessary requirements for training; it is not intended to be prescriptive about implementation at a local level.

The term 'must' is used where there is an absolute requirement for a framework to implement the guidance. The word 'should' is used where a certain course is strongly advised but local policies or extenuating circumstances may allow variation with documented rationale. The word 'may' is used where an action is suggested as best or acceptable practice/but amenable to local interpretation.

Requirements

General

- Staff must be trained and assessed as competent prior to taking part in the transfusion process.
- Individual healthcare professionals are responsible for their own practice and ensuring that their knowledge and assessments are up to date and valid and that they are practicing in compliance with local policy.
- 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. All staff participating in the transfusion process must be trained and have demonstrated competency in the parts of the process they are involved in.
- Local policies should include guidance on actions to be taken in exceptional situations when there are no competent staff available in the clinical area to administer a transfusion.
- A risk based approach may be adopted when deciding on staff assessment intervals based on the number and nature of untoward incidents and the frequency of procedures carried out by individual staff.

Core Standards

- 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 collaboration with a sounding board of Transfusion Practitioners and the relevant stakeholders in the NBTC.
- Training, testing and assessment packages should be developed from these National Standards. They are intended to ensure a knowledge of practical procedural details and an in depth understanding of the rationale for the processes and the dangers in not following these.
- Standards relating to local practice may be added as appropriate.

Training

- All staff involved in the transfusion process should receive training no less frequently than 3 yearly (2 yearly for blood collection).
- 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.
- Training should cover the key learning outcomes, based on National Standards (Appendix 1).

Knowledge and understanding tests

- Knowledge and understanding assessment should be performed at least every 3 years (2 years for blood collection).
- This may be undertaken in a variety of formats e.g. 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

- Following an individual's initial training, a one off practical competency assessment must be undertaken.
- The practical competency assessment must cover the performance criteria detailed in the National Standards.
- The form of practical assessment should be determined locally. E.g. it may be completed through observed practice in the clinical area or through simulation or through some other means.
- This practical assessment need not be repeated if there is on-going satisfactory performance but should be repeated if there is a period of greater than one year out of a workplace where regular transfusion is taking place.

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 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 Electronic staff record (ESR) or equivalent 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 within a Trust as outlined below: this should be agreed by the Hospital Transfusion Committee.
- 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 should be involved in the investigation of all transfusion related incidents.
- Hospital Transfusion Teams should 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 serious and/or repetitive incidents should undertake retraining and / or repeat assessments on the direction of the hospital transfusion team and/or line manager.
- A risk assessment should be undertaken by a senior member of the team to decide whether individuals involved in transfusion incidents are allowed to continue to be involved in the transfusion process pending full investigation.

Reference

BCSH Guideline for Administration of Blood Components

http://www.bcsghguidelines.com/documents/Admin_blood_components_bcsgh_05012010.pdf

Glossary

BCSH	British Committee for Standards in Haematology
NBTC	National Blood Transfusion Committee
NPSA	National Patient Safety Agency
SHOT	Serious Hazards of Transfusion