Incidents and Attitudes: tools to address learning

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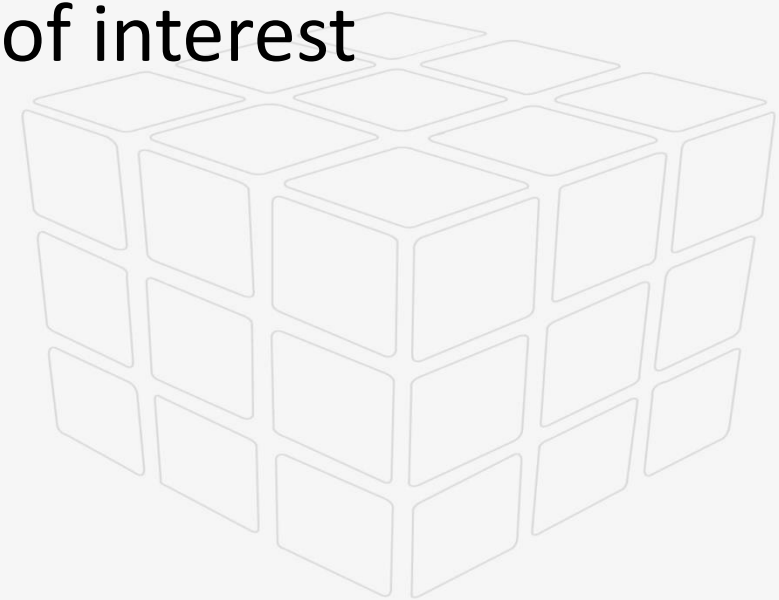
- Disclaimer: No conflicts of interest



Common WBIT interview responses

I cannot believe I did that, I am usually so careful

What about the other samples I took at the same time?

Have I done this before?

I knew what I should be doing but did it a different way

I heard Haemovigilance give examples in training and thought I wouldn't be so stupid

I was so sure it was the right patient, I knew him

I could have killed the patient


I cannot believe I did that, I am usually so careful
What about the other samples I took at the same time?
Have I done this before?
I will never ever ever EVER do this again
I could have killed the patient

Common Findings

Assessed as competent

Without prompt – could rhyme off the correct procedure for safely taking a transfusion sample

Root cause: conscious breach of protocol workload blaming interruption, shortcut introduction, attitude, complacency

If only others could feel your pain! …….and learn your lesson

- F1 sharing their WBIT experience with Trust workshadowing students – e.g. speak at induction

- Staff involved in WBIT becoming committed transfusion assessors

Get them early – Uni Pre placement

- Medical and Nursing – identification, communication and documentation
- Chatty session- emphasis on concept of patient ID in all sampling: Blood group/ Troponin/ Potassium/ Tumour markers
- Penny Allison or you-tube videos / Scenario act outs
- Demonstrate safe ID procedure to have as a core procedure – like putting on a seat belt!
- Is correct ID for a patient not as important as foreign travel and bank withdrawl ID

Trust Engagement

- Senior & Educational lead staff back up
- Junior Dr and Nurse champions – two way contact as back up
  - Send out anonymous incident feedback
  - Get Junior Doctor ideas for teaching sessions
  - Invitation for audit participation
  - Alert for changes, news, procedures
  - Have group forums- – representative on Blood Interest groups

Sharing Incident learning

- Broadly disseminate individual anonymous incidents
- Present a mixed incident presentation or newsletter
- ‘Idiot question’ session
- Work-shops based on scenarios/SHOT case studies
- Share Haemovigilance presentations –eg cases reported to SHOT by staff followed by Haemovigilance annual SHOT report summary

Audit and research

- Senior and Junior staff

- Assessing practice of peers and delivering feedback –
  eg appropriate use/ documentation

- NI START programme http://nitransfusion.com/audit/start%20initiative.html
  - – expertise and showcasing - our future HTC m

Drills

As many observers as possible

4 types

- Planned testing a new or amended protocol – does it work – staff all get familiar
- Testing staff's and departments ability to carry out protocol
- Experienced staff demonstrating how to do best
- Blood Bank/ Clinical/ Porters – observe each others situations


KEEP CALM
AND
FOCUS ON
TEACHING AND
LEARNING