

NPSA Safer Practice Notice 14 Review Group of the National Blood Transfusion Committee

Terms of Reference

1.0 Background

The National Patient Safety Agency (NPSA) co-authored with the National Blood Transfusion Committee (NBTC) and Serious Hazards of Transfusion (SHOT) recommendations to improve transfusion safety in 2006. The recommendations were issued in the format of a Safety Practice Notice titled 'Right patient, right blood'.

http://www.transfusionguidelines.org.uk/docs/pdfs/bbt-02_npsa-notice-14.pdf

The main recommendations were that all NHS and independent sector organisations administering blood in England and Wales should:

- 1.1 Implement an action plan for competency-based training and assessment for all staff involved in blood transfusion.
- 1.2 Ensure that the compatibility form and patient notes are not used as part of the final pre-transfusion bedside check.
- 1.3 Systematically examined their local transfusion procedures and appraised the feasibility of using electronic patient identification and tracking systems for transfusion procedures, photo identification cards for regularly transfused patients, and a labelling system for matching samples and blood for transfusion to the patient concerned.

The implementation dates were November 2009 for completion of all initial competency based training and assessments. This date was subsequently revised to November 2010.

In 2008 the NBTC formed a Task and Finish Workgroup to support clinical colleagues implement the recommendations. The main output from the group was the publication of a toolkit to assist hospitals with implementation of the competency based training and assessments which was posted on the Better Blood Transfusion Toolkit. Examples of good practice and guidance of how to comply with the requirements of the SPN were also included along with frequently asked questions.

Current situation

Many hospitals have experienced difficulties in fully implementing the competency-based training and assessments as set out in the Safer Practice Notice. Concerns have been repeatedly raised at the NBTC, RTC Chairs meetings and by Transfusion Practitioners.

In the survey of the implementation of Better Blood Transfusion at the end of 2010, only 22% of NHS Trusts have provided competency-based training and assessment for blood administration to >91% of relevant staff; 76% of Trusts have assessed 50% or more of their staff for competency in blood administration compared to 12% in 2008. 24/150 (16%) are using bar code or other electronic systems for patient identification for blood transfusion.

6 Trusts reported using bedside IT for >90% of their transfusions using bedside IT (13 in 2008). 9 Trusts use electronic patient identification systems to collect >10% of blood samples for transfusion (5 in 2008).

The National Survey of Transfusion Practitioners carried out in May 2010 noted that 'The increase in workload created by regulation and in particular by NPSA SPN 14 cannot be underestimated; it has caused a huge shift in emphasis away from appropriate use. Most Transfusion Practitioners feel they are now driven by regulation and compliance rather than governance in relation to blood safety and appropriate use'.

In light of the planned abolition of the NPSA in March 2012 and a lack of clarity regarding the likely role of any successor in this type of notification, the NBTC in collaboration with SHOT consider that the recommendations in the Safer Practice Notice should be reviewed.

A working group of the NBTC was established to review training and competency assessments set out in SPN 14 published in 2006 and the evidence for their effectiveness, difficulties encountered in implementation and suggest practical recommendations for the future.

The working group's key recommendation is that the competencies should remain as these are important to patient safety but the format and frequency of the assessments should be revised with a greater emphasis placed on knowledge and understanding. Other recommendations included:

- The SPN competency assessment frameworks need revising and updating in line with recent British Committee for Standards in Haematology guidance on the administration of blood components and BSQR regulations.
- There is a requirement for a national framework of standard knowledge tests transferable between Trusts and a proposal for an NBTC working group to review the current competence framework and theory based assessments.

2.0 Remit

2.1 To review the format and frequency of competency assessments with a greater emphasis placed on knowledge and understanding rather than observed assessment.

2.2 Revise and update the Safer Practice Notice competencies.

2.3 Develop a framework of standard knowledge tests transferable between trusts.

3.0 Expected Output

To provide an update to the NBTC meeting in September 2012 and a final report to the March 2013 meeting.

4.0 Key Stakeholders

Dr Craig Taylor, Consultant Haematologist and West Midlands RTC to Chair the working group.

Dr Paula Bolton-Maggs, Medical Director of SHOT. Representatives of MHRA, RTC Chairs, NHSBT, Transfusion Practitioners in England.

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