Encouraging laboratories to improve practice
UK initiatives

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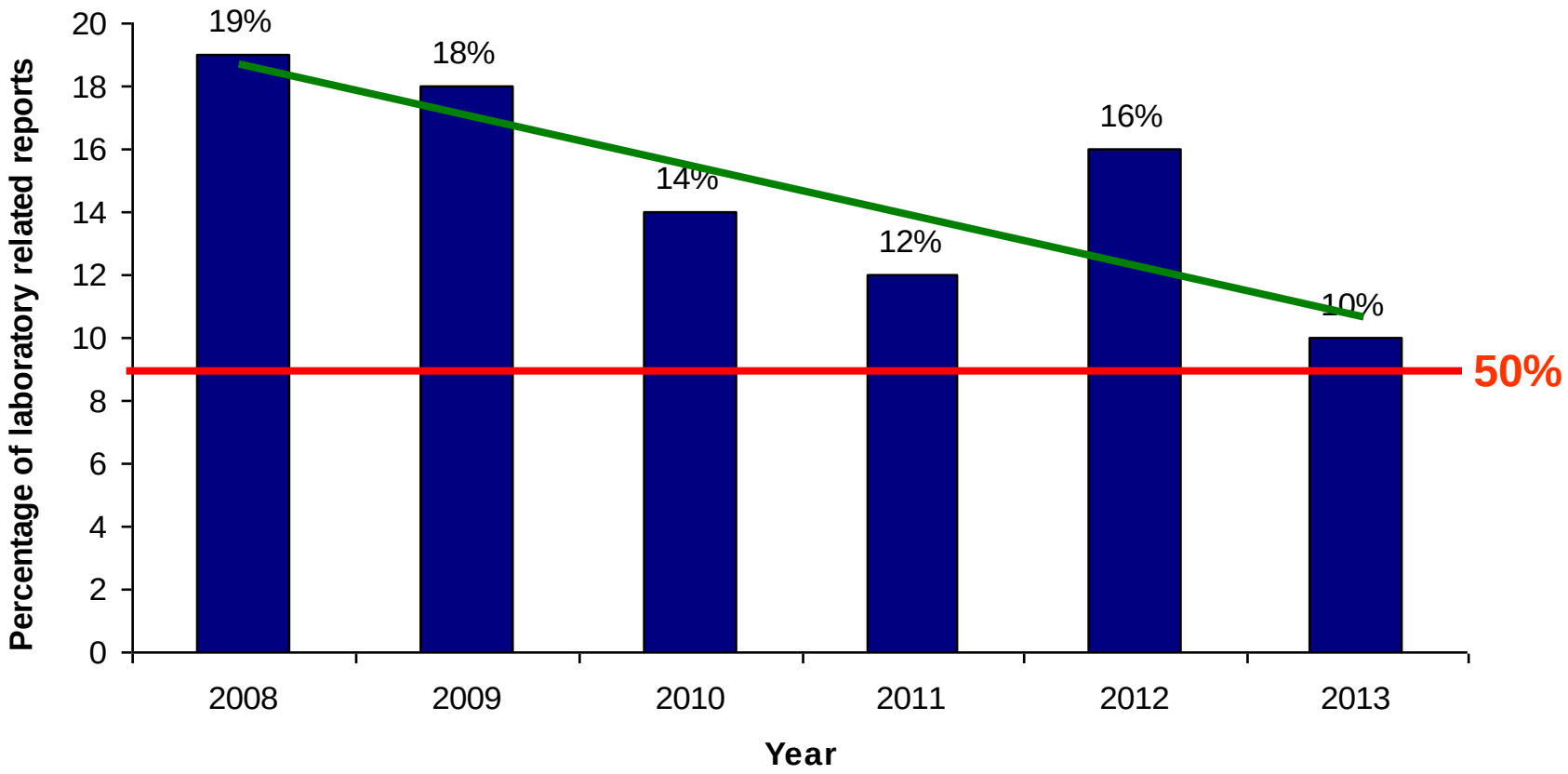
Background – UK Transfusion Laboratory Collaborative

- **UKTLC was established in 2006 in response to wrong blood events reported to SHOT**
- **UKTLC is an IBMS-led initiative involving all major transfusion organisations within the UK**
- ***Recommended minimum standards for hospital transfusion laboratories*:**
  - **Published in 2009 following two national surveys**
  - **Staffing, Technology & Knowledge and Skills**
  - **Aim to facilitate a drop in the number of errors originating in the laboratory that are reported to SHOT (by 50% by 2012)**

Has 50% reduction in errors been achieved?



Year	2008	2009	2010	2011	2012
Total Number of reports analysed	1040	1279	1464	1799	1516
Number of Lab errors	200	230	205	217	247

Two further national surveys to assess recommendations

- Surveys were distributed to:
  - 322 laboratories in 2011
  - 304 laboratories in 2013
- The response rate for each survey was:
  - 162/322 (50%) in 2011
  - 188/304 (62%) in 2013
- Factors possibly impacting the responses on both surveys:
  - Staff being on holidays
  - Staff being on call
  - Other activities occurring within the Hospitals *i.e. mergers/partnerships*

Staffing

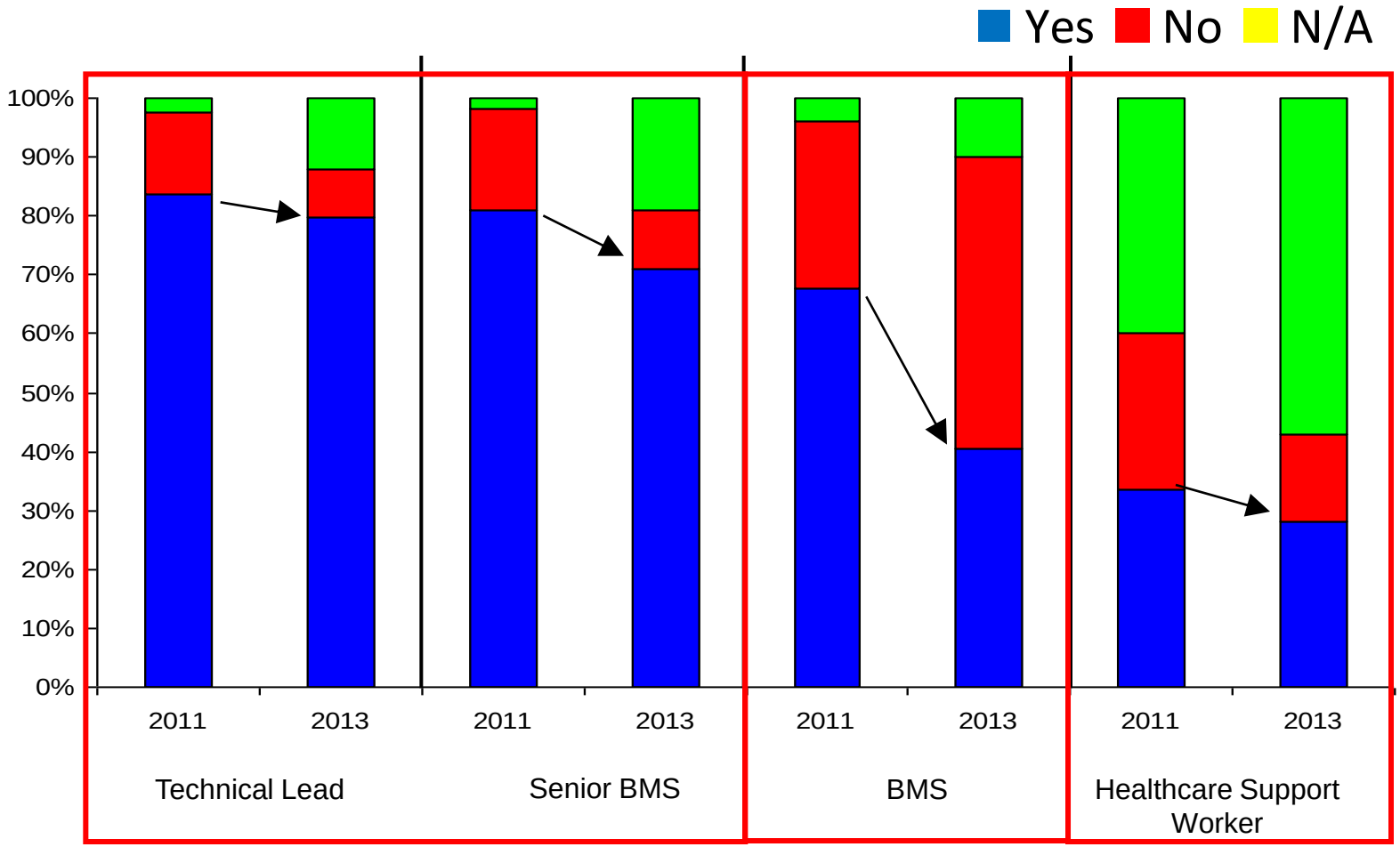
	2011	2013
Lead scientist completed survey	89% (144/162)	80% (151/188)
Not a lead scientist	10% (16/162)	16% (30/188)
Did not answer	1% (3/162)	4% (6/188)

Almost half of those completing the survey as lead scientists did NOT meet the level of qualifications recommended by the UKTLC

44% (63/144)	47% (71/151)

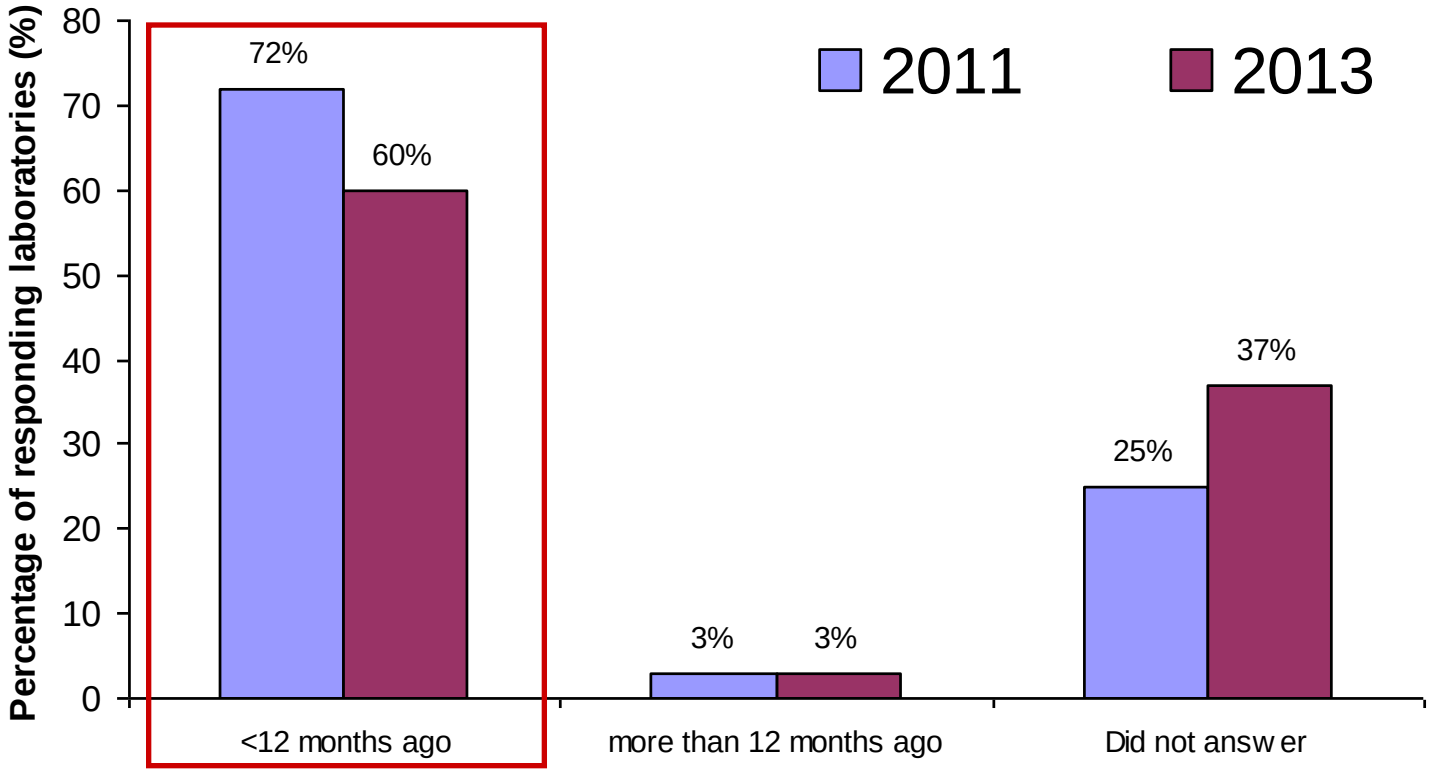
Staffing

Proportion of staff that are based for at least 75% of their time in blood transfusion



Knowledge and Skills

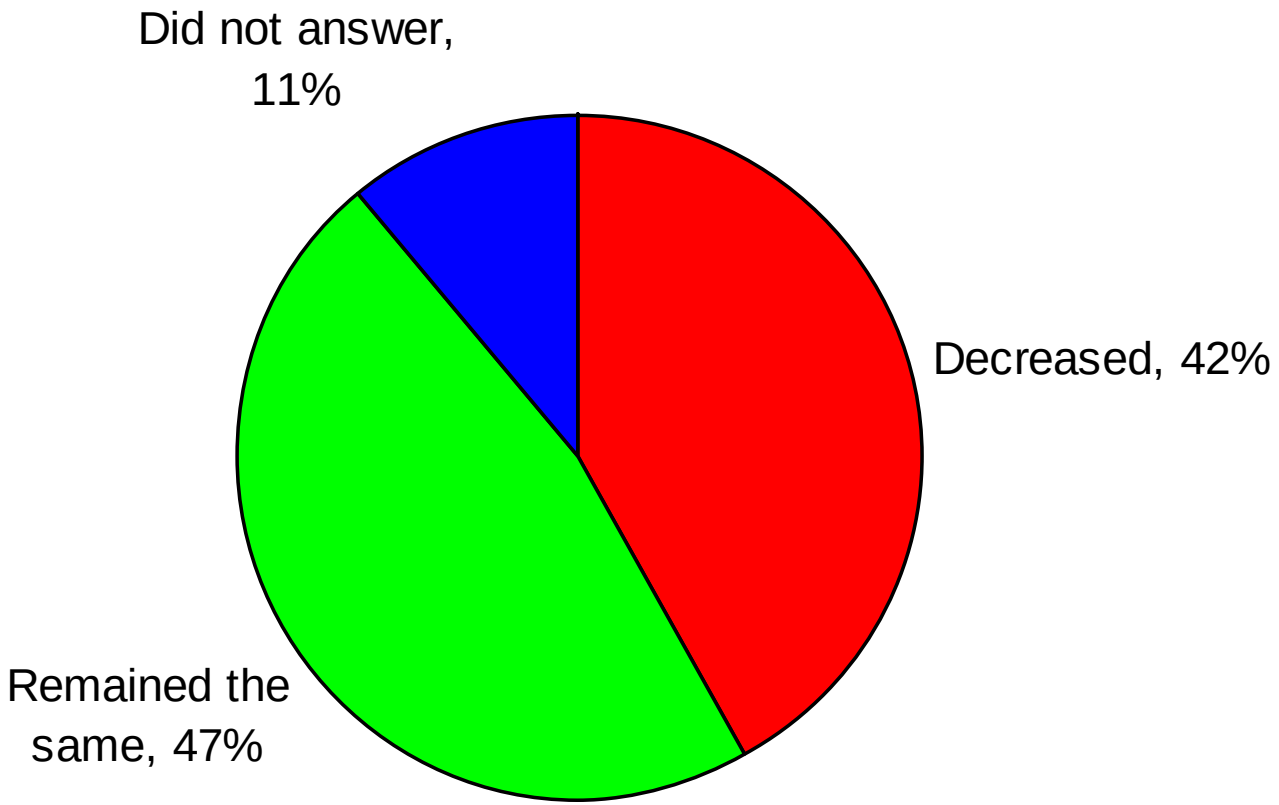
Numbers of staff with training updates completed within the last 12 months fell from 72% in 2011 to 60% in 2013



Knowledge and Skills

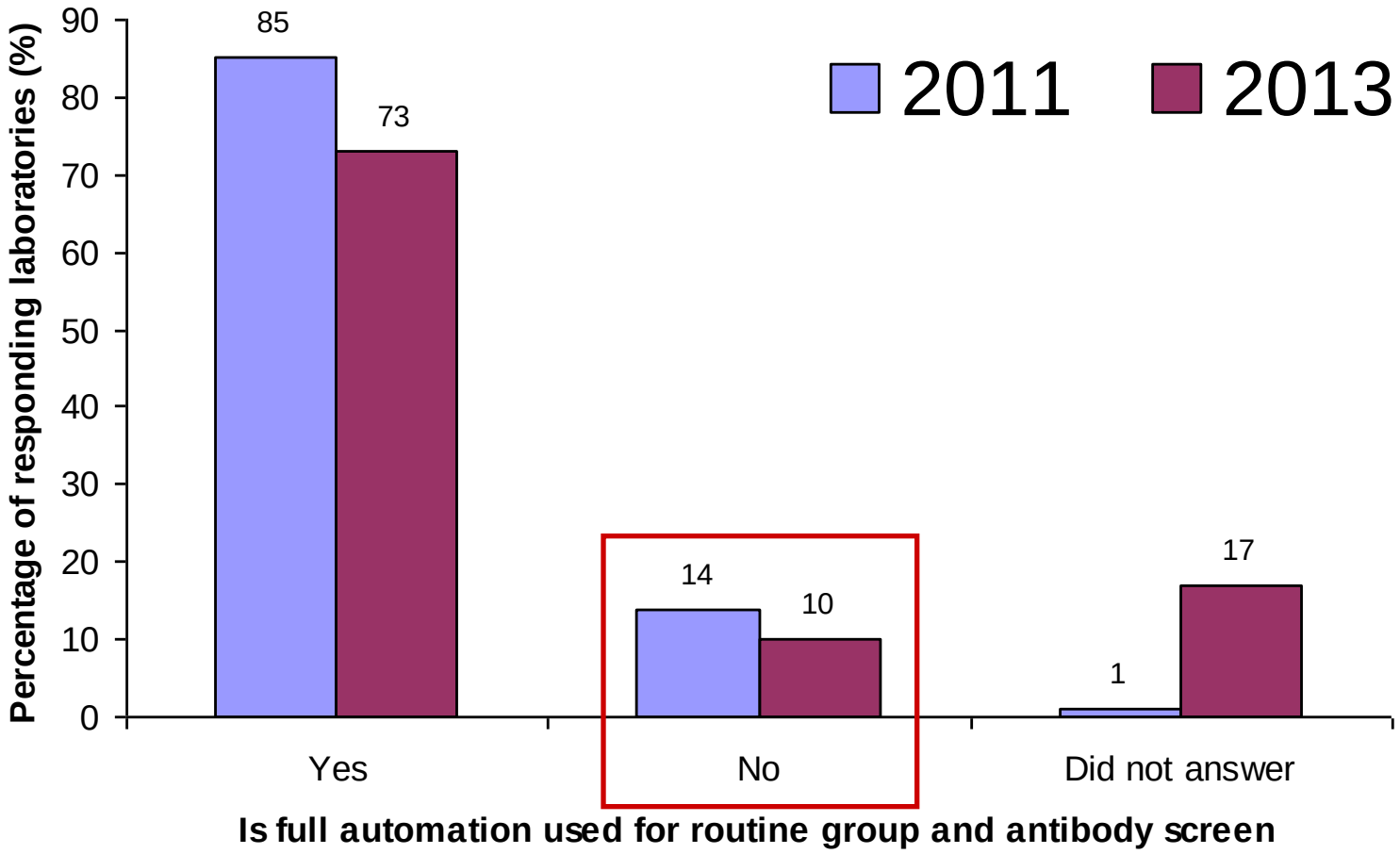
No respondents reported an increase in funding for education in 2013 and 42% reported a reduction

Changes to the financial resources available to support staff education between 2011 & 2013



Technology

Is full automation used for routine group & antibody screen during core hours?



Summary

Staffing:

- There are fewer lead scientists with appropriate transfusion qualifications

Finance:

- Fewer resources available for training and education
- Full implementation of 24/7 automation is not yet achieved

Conclusion

- **50% target for reduction in laboratory errors not achieved**
- **Survey results showed that implementation of the UKTLC recommendations was incomplete**
- **The UKTLC has revised its recommendations into ‘standards’ to be published in 2014**
- **All UK laboratories are encouraged to comply with these standards to improve patient safety**

Acknowledgements

- UKTLC

  (collaborators include: BBTS,IBMS, UK NEQAS, RC Path, NHSE/CMO's NBT and equivalents in Scotland, Wales and Northern Ireland)

- Blood transfusion laboratories in the UK

- SHOT Team & Steering Group

- SHOT Operations Manager - Alison Watt


SHOT Symposium 2014
The Lowry Theatre, Salford Quays
Manchester, UK
Wednesday 9th July - £75
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