UK Transfusion Laboratories Culture Survey Report 2019 - Summary

Anecdotal reports were received from 33 different sites and include but are not limited to:

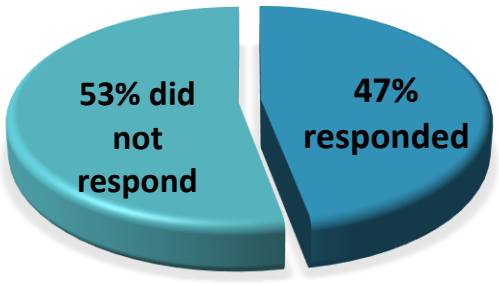
- Disciplinary action taken against an individual as the result of a SHOT/SABRE reportable incident without a full route cause analysis being conducted
- Audit or change data that have been manipulated
- Staff being verbally criticised for actions that they have taken or have suggested, in front of colleagues, that has left them distressed and upset

Survey aims

Is learning culture being eroded where the focus is on individuals instead of investigating the processes and environment?	Is data being manipulated inappropriately to create a positive picture of quality management system (QMS) function?	Do pathology staff feel adequately supported or empowered to voice their concerns to senior managers about shortfalls within their QMS?
Do staff feel there are insufficient resources available for them to allow effective management and development of a safe transfusion service and QMS?	Is difficulty in retention and recruitment of appropriately qualified and experienced staff a direct result of the culture employed by a site?	

Response Rate

The electronic survey (Surveymonkey®) was emailed to 202 SABRE reporters via the registered reporters email in early 2019. The overall response rate to the survey was **47% (94/202)**



Results

Full results can be found in complete report and accessed at:
https://www.shotuk.org/uk-transfusion-laboratories-culture-survey-report-2019/
A selection of which are shown below:

6 Respondents

Were aware of themselves or a colleague being disciplined as a direct result of a single quality incident such as a SABRE/SHOT event

20 Respondents

Have felt under pressure from line managers, or those more senior, to present an unrealistic impression of the laboratory's compliance with the good practice guide (e.g. state of audits, training and BCR submission)

Were aware of themselves or a colleague being affected by behaviour changes from either Pathology or Trust management towards you following an adverse external inspection?

37 Respondents

Replied that staff are reluctant to work in the transfusion laboratory, citing additional pressure over and above that of haematology

35 Respondents

Were aware of staff leaving or taking early retirement, who cited the pressure in delivering both a safe transfusion service and fulfilling regulatory requirements.

Recommendations

The findings of this survey strongly suggest a need for further investigation. This could be a larger project, either by site visits of Pathology laboratories commissioned by a nominated independent body, and/or each laboratory carrying out a more detailed internal investigation. The focus of the recommendations, which are listed in full in the report, are around engagement from senior management, and additional education in the scope and importance of human factors.

Blame culture throughout healthcare

NHS Staff survey

In England, similar patterns to those seem in the culture survey are reflected throughout the NHS workforce. Results in 2019 show that whilst blame culture is improving, 40.3% of those surveyed felt their organisation did not treat those involved in an error or near miss fairly. Over half of all staff continue to work additional unpaid, showing a lack of staffing capacity. Pathology mangers should use the results of the staff survey as valuable resource to highlight areas for improvement, and gauge the culture experienced by staff working in their department.

UKTLC survey 2019

The 2019 UKTLC survey results showed a decrease in staffing levels, increased vacancies and a higher demand on staff time for training newcomers. These factors stretch the available resource for maintaining safe quality systems, and for the appropriate and proportionate investigation of incidents. Where staff feel stretched, errors are likely to increase, and easy and immediate 'quick fix' outcomes of ingestion are often found. These frequently attribute the cause to the individual and can contribute to a pressured and demoralised workforce.

Institute of Biomedical Science

In a 2019 statement in response to the NHSI consultation on patient safety, the IBMS echoed that the blame culture is the product of a pressured and overloaded system. Staff are committed to improving the culture, but training, resources and examples of best practice are required to achieve this.

Health and care professions council

HCPC standard 7.2 states "You must support and encourage others to report concerns and not prevent anyone from raising concerns." Furthermore, in response to the Professional Standards Authority's report 'Telling patients the truth when something goes wrong' (2019), the HCPC has stated an intention to commission research to help address some of the issues that create environments which do not promote candour and learning.

Discussion

Disciplinary action must be the very last option and only undertaken when investigations prove unequivocally that the individual is to blame and not the processes and the environment that they work within. Taken outside of best practice advice and the regulatory framework, disciplinary action is:

A barrier to incident reporting and transparency
A negative influence on staff confidence
A barrier to effective management and morale
A detrimental effect on recruitment and retention

Recording the cause as human error means that the site has missed the opportunity to improve operations and genuinely reduce the risk of reoccurrence

The UKTLC survey (2019) also reported 47.8% laboratories had vacancies, suggesting that **laboratories are having their available resource seriously stretched** affecting their ability to deliver a safe an effective transfusion service

The NHS and other health governance organisations and commissions have highlighted the importance of an open reporting culture in creating and maintaining patient safety

Managers must take a strong supportive lead in all aspects of securing data, making these transparent and a true reflection of the issues that a site is facing. Risks can only be mitigated if they are identified and accepted and organisations can only do that by being open and honest.

Pressure to falsify data, either by fear of reprisal after failing to meet expectations or giving 'bad news' or rewarding failure, will only exacerbate a culture of poor performance. This is likely to create an environment which discourages reporting from staff.

Poor data integrity is an indicative sign of a poor-quality culture

Staff are leaving - increasing capacity pressures and knowledge loss. It is important to identify the exact triggers for these retirements/ resignations to understand what organisations can do to **support, and retain staff within the workplace**. These measures could include introduction of new technologies and or employment of additional personnel to avoid the loss of such experienced and valued individuals. Organisations must also ensure that when staff take retirement that they have an **effective succession and business continuity plan in place**

Empowerment of staff has been shown to improve the quality of work, employee satisfaction, and collaboration throughout the whole organisation. In addition, employee productivity increases, and organisational costs decrease (The Kings Fund 2014)