Survey of Staff Feedback following Transfusion Serious Untoward Incident Investigation

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Introduction
From June 2013 there has been an increase (from zero to four) in the number of incidents where patients received a blood component labelled for another patient. These Serious Untoward Incidents (SUI) were investigated by the Hospital Transfusion Team (HTT), local and senior nursing managers. The HTT sought to obtain feedback following these investigations from the staff involved in the incident.

Objectives
To determine any lessons to learn from staff experiences and any subsequent feelings following SUI investigation.

Methods/Study Design
A retrospective mixed-method approach using exploratory qualitative and quantitative postal questionnaire was used. The questionnaire was sent to known staff involved in the SUI events. The returned quantitative data was entered onto and analysed using Excel, the qualitative data was analysed using a thematic approach.

Results
Four out of seven (57%) responses were received. All respondents cited stress, overwork, busy ward and/or fatigue as contributory factors to the SUI.

Emergent Themes: The ‘human factors’ below were described across all survey participants in both their immediate response and in the ensuing time after the incident:

<table>
<thead>
<tr>
<th>Emotional</th>
<th>Cognitive</th>
<th>Work/Systems</th>
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<tbody>
<tr>
<td>Stress</td>
<td>Fatigue</td>
<td>Busy ward</td>
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<td>Fear</td>
<td>Distracted</td>
<td>Overworked</td>
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<tr>
<td>Devastation</td>
<td>Failure to follow policy</td>
<td>Poor nurse - patient ratio</td>
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<td>Feel inadequate</td>
<td>Rushed</td>
<td>Night shift</td>
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<tr>
<td>Feel a poor role model</td>
<td>Panicked</td>
<td>Urgent Transfusion</td>
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<td>Loss of confidence</td>
<td></td>
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<td>Tremendous guilt</td>
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<td>Self critical: ‘worst nurse’</td>
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<tr>
<td>Panicked</td>
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<tr>
<td>Remorse</td>
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</tbody>
</table>

Respondents also displayed ‘second victim phenomenon’ first described by Wu in 2000: “Healthcare workers are often impacted by medical errors as ‘second victims’, and experience many of the same emotions and/or feelings as the ‘first victims’ - the patient and family members.”

In the LHHT survey, respondents described feelings of...

What went well? Respondents state they felt:
- Supported by the HTT
- The HTT ensured investigation process was open and transparent
- The HTT investigators were approachable

Lessons Learned: Respondents thought the investigation process should be quicker to alleviate further stress and suggested keeping staff involved and updated with progress. Support and the help from someone who has experience of SUI investigations would also be helpful.

What’s New?
- The transfusion authorisation chart adapted to be a ‘pre-administration checklist’
- 7 point de-brief proforma developed to guide discussion including where to find support e.g. a SUI ‘buddy’

Conclusions & Recommendations
- Staff feelings need to be equally considered alongside and beyond the day of the SUI investigation
- Support is crucial e.g. from HTT, colleagues and independent staff
- Incident investigations should be conducted in an environment of openness and honesty
- Use open questions to ascertain how staff feel following the SUI: advise how these feelings may continue
- Ensure investigation is conducted as quickly as possible - keeping staff informed and included throughout
- Ensure staff feel supported in ways desired by the individual e.g. 1:1, telephone, on-line, group discussion, SUI buddy
- Advise staff where they can access additional support: SUI Buddy/Occupational Health/Peers/Counsellors

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References:
Wu A.W., Medical error: the second victim, the doctor who makes the mistake needs help too. BMJ. 2000 Mar 18; 320(7237): 726–727.

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