2023 SHOT and UKTLC Transfusion Laboratory Culture Survey (NHS, Independent hospitals and UK Blood Services) Summary

SHOT and UKTLC aimed to measure and understand the safety culture in laboratories in hospitals and Blood Services in the UK, with input from the MHRA haemovigilance team. In 2019, a survey found evidence of disciplinary action following single quality incidents and pressure from line management to present a false impression of safety within the laboratory. Further concerns have been raised regarding the safety culture within the laboratory and the SHOT and UKTLC laboratory culture survey 2023 was distributed to transfusion laboratory professionals to gain more information. A document with suggestions to improve safety culture has been created to support healthcare organisations: https://www.shotuk.org/resources/current-resources/uktlc/

Survey was live from 8th to 29th of November 2023

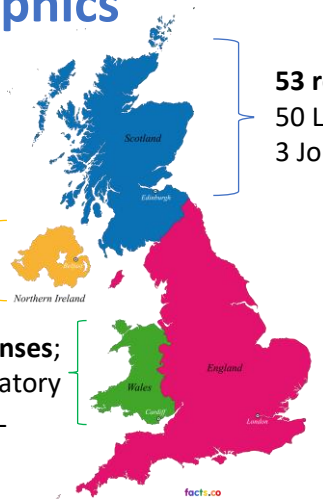
35 questions relating to psychological safety and civility

Completed by 543 individuals

479 responses from UK **laboratory** and joint clinical and laboratory roles (CL)

Laboratory staff included HCPC registered and non-registered staff

1. Demographics

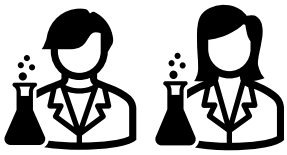


53 responses;
50 Laboratory
3 Joint CL

13 responses;
12 Laboratory
1 Joint CL

20 responses;
17 Laboratory
3 Joint CL

393 responses;
360 Laboratory
33 Joint CL



Staff grade or NHS Banding

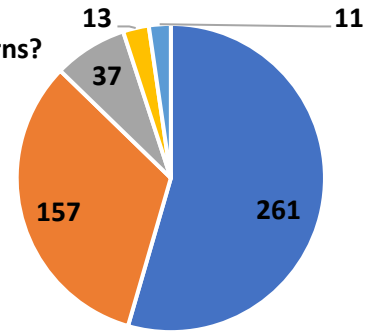
- 37 unregistered staff
- 185 registered staff
- 159 registered/supervisory staff
- 98 Management

2. Psychological Safety and Civility

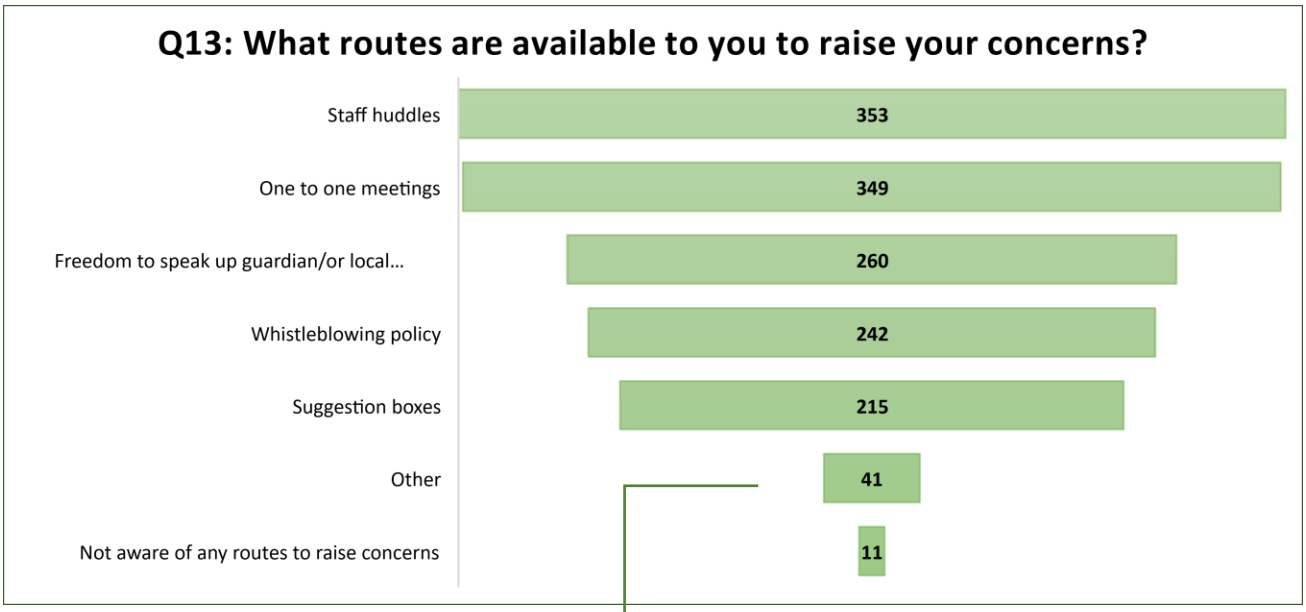
2a. Speaking up for safety

Q10: Do you feel empowered and safe to voice your concerns?

- a) Yes - I am listened to and change occurs if appropriate
- b) Yes - I can raise concerns but no action taken or feedback provided
- c) No
- d) Unable to comment, not faced this situation
- e) I am not comfortable expressing my response



Nearly 1 in 5 laboratory staff do not feel psychologically safe in their workplace.
Over 2 in 5 felt concerns raised are not acted upon or felt unsafe to raise safety concerns

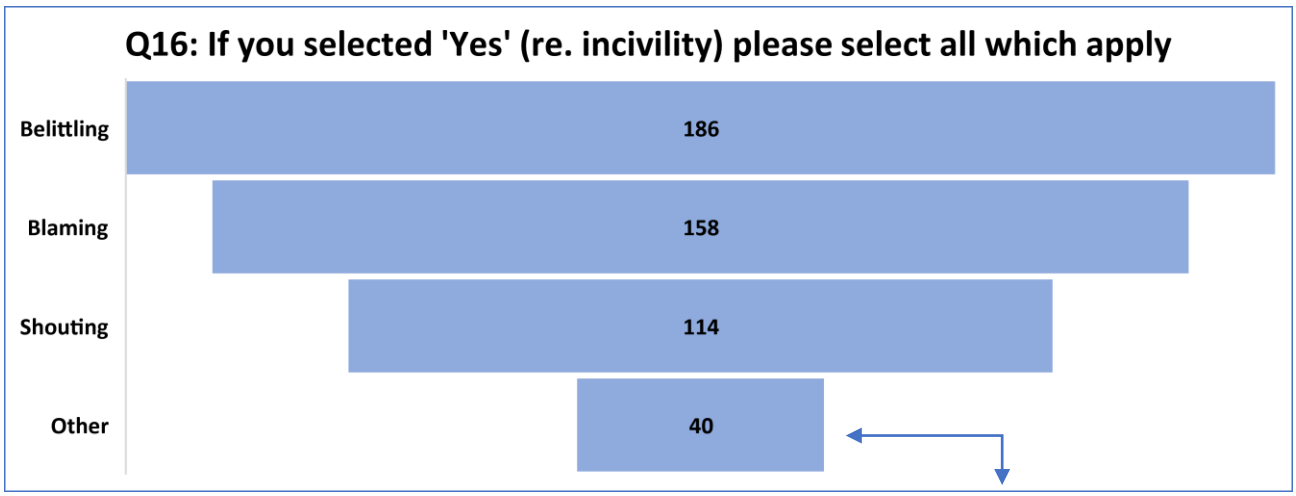


'Other' responses included:

Email or verbal communication to managers	Q-Pulse or equivalent
Discussion with band 7	Staff networks
Datix reporting or local equivalent	Governance
Discussion with Hospital Transfusion Team	Grievance
Union	Monthly staff meetings

2b. Incivility

Just under half of transfusion staff 228/479 (47.6%) had faced incivility in the workplace. These were mostly belittling, blaming, shouting and false accusations



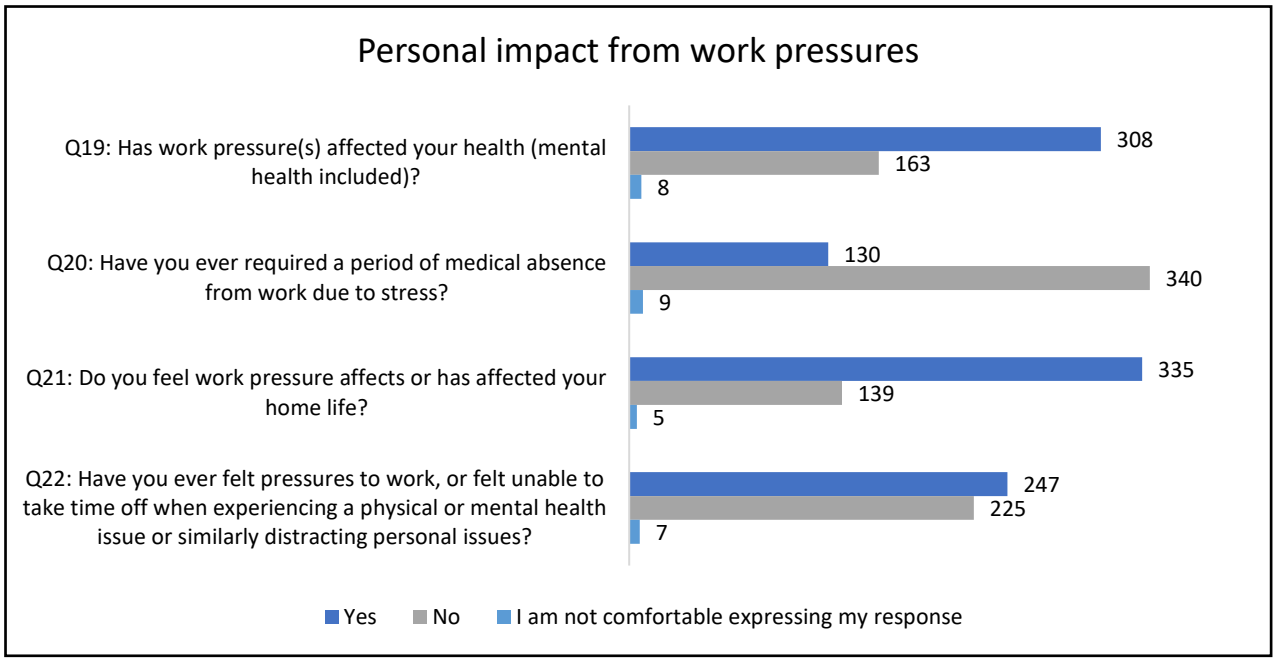
40 laboratory staff shared other experiences of incivility

- ⚠ 81.6% laboratory staff had been belittled
- ⚠ 69.3% laboratory staff had been blamed
- ⚠ 50% laboratory staff experienced shouting

- ⚠ False accusations
- ⚠ Rudeness
- ⚠ Aggression
- ⚠ Ignoring
- ⚠ Bullying

2c. Personal impact on health and home life

Almost half, 225/479 (47.0%), of laboratory staff had either considered or moved roles or organisations due to concerns regarding safety culture

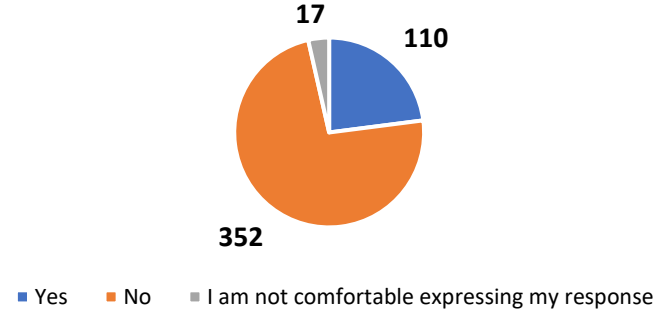


⚠ **64.3% laboratory staff's health including mental health had been affected by work pressures**
⚠ **70.0% laboratory staff feel that that work pressures had affected their home life**

27.1% laboratory staff had required a period of medical absence from work due to stress

47% laboratory staff had felt pressures to work or felt unable to take time off when experience a physical or mental health issue or similarly distracting personal issues

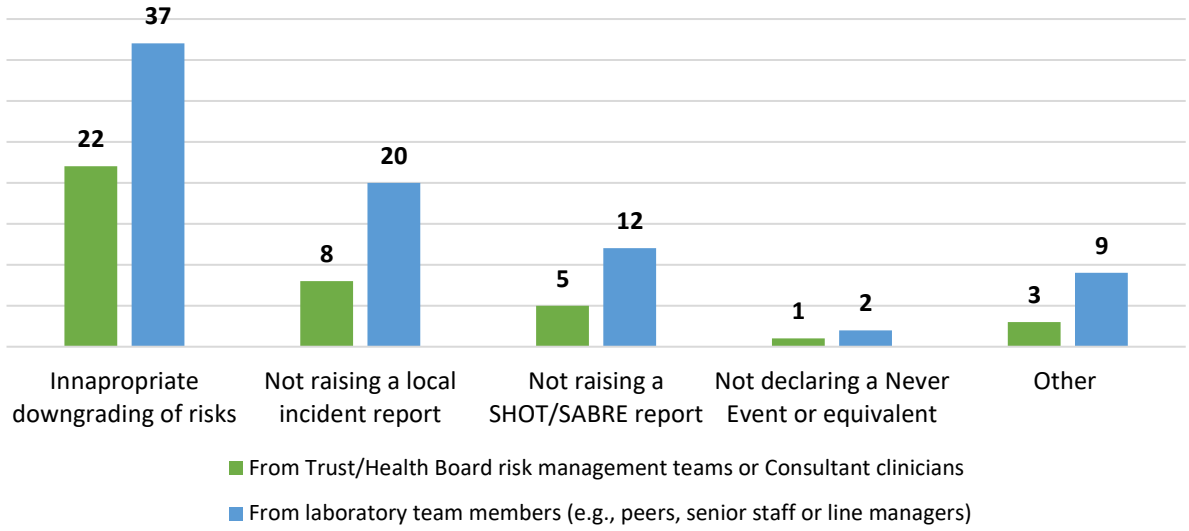
Q23: Does a poor safety culture affect your ability to do your day-to-day role competently and confidently?



23.0% laboratory staff answered 'Yes'
73.5% laboratory staff answered 'No'
3.5% laboratory staff were not comfortable expressing their response

2d. Incident Reporting

Pressures to present inaccurate assessment of the severity of an incident, or been discouraged from reporting to external bodies

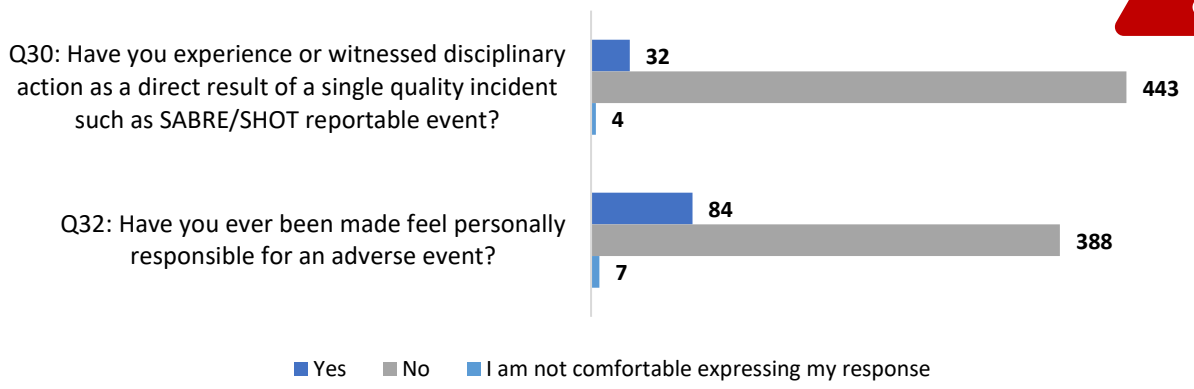


⚠ **Approximately 1 in 8 of laboratory staff had felt under pressure from laboratory team members to present an inaccurate assessment of the severity of an incident or been discouraged from reporting to external bodies**

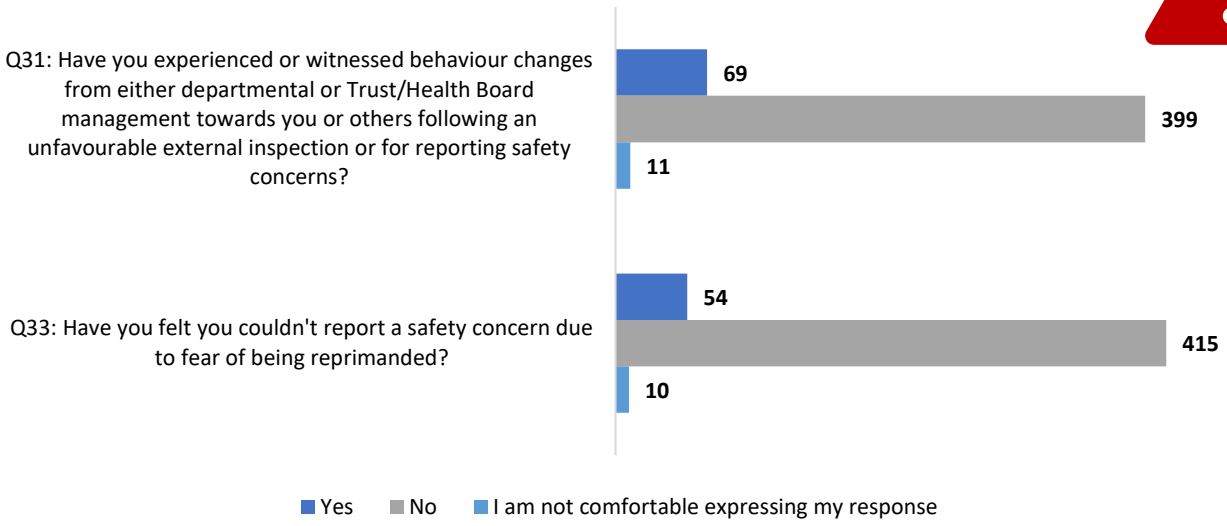
⚠ **Approximately 1 in 16 of all laboratory staff had felt under pressure from Trust/Health Board risk management teams or Consultant clinicians to present an inaccurate assessment of the severity of an incident, or been discouraged from reporting to external bodies**

Fear of being reprimanded prevented 54/479 (11.3%) laboratory staff from reporting safety concerns. Any number of staff feeling unable to report safety concerns is unacceptable

Disciplinary action and responsibility attributed to laboratory staff following adverse events



Behaviour changes following unfavourable external inspection and reporting safety concerns and fear of reprimand



Disciplinary Action

- 32 laboratory staff had experienced or witnessed disciplinary action as a direct result of a single quality incident

Personally responsible

- 84 laboratory staff had been made feel personally responsible for an adverse event

Behaviour changes

- 69 laboratory staff had experienced or witnessed behaviour changes following an unfavourable external inspection or for reporting safety concerns

2e. Improvements or changes to safety culture

- **There were 155/479 (32.4%) positive responses relating to improvements in safety culture, 275/479 (57.4%) negative responses and 49/479 (10.2%) laboratory staff not comfortable to express their response.**
- **It is important to note that according to more than half of the responses there hadn't been any improvements or changes to safety culture in the participants organisations**
- **These results are contradictory to those received in the UKTLC survey (2022) where most respondents (73/74, 98.6%) felt that there was a just culture in their laboratory where issues were freely raised, and concerns openly discussed**

3. Reflections and Recommendations

- These data provide a snapshot of attitudes and beliefs within UK transfusion laboratory staff
- There is vast scope for improvement in safety culture within transfusion laboratories in the UK
- Whilst the healthcare system faces increased challenges, stresses may be filtering down and having a very real impact on those working to provide a safe service for patients
- The quality of care provided may be suffering due to this poor safety culture
- A top-down approach is key to implementation of an effective safety culture that filters down to all levels within the organisation

Recommendations

RAISING CONCERNS

✓ Organisations must have clear and effective strategies to ensure that staff concerns are listened to, considered, and managed appropriately in a timely and equitable manner
→ To: Chief executive officers

✓ Organisations must have a mechanism in place to support staff who raise concerns and ensure that there is an open and appropriate feedback loop including protection for staff who do speak up about unsafe practice
→ To: Chief executive officers, Human Resources (HR) lead and Safety lead

IMPROVING SAFETY

✓ Incident investigation reports submitted to external organisations that require amendments should only be altered with an appropriate justification and based on risk. These changes must be auditable to protect the data integrity of the incident reported
→ To: Quality leads and Safety leads

✓ Leaders in organisations must empower a positive, learning, safety culture where staff feel confident and supported to speak up, report complaints or raise safety concerns. Responsibility for staff and patient safety needs to be driven from the chief executive level. Senior leaders must communicate issues to Executive Management in sufficient detail to allow adequate understanding of the issues raised
→ To: Chief executive officers

✓ Organisational policies must ensure that involvement in an adverse safety event should never result in disciplinary action unless malpractice or malicious intent is proven
→ To: Chief executive officers, HR lead and Safety lead

✓ Patient and donor safety incidents must be investigated thoroughly bearing in mind quality risk management principles and with the application of human factors principles and consideration of systemic factors contributing to the incident. Blame culture must be avoided. That means, instead of asking, "Who's at fault?" leaders must shift the focus to, "Where/why/how did the process or quality system break down?"
→ To: All staff with responsibility for incident investigation

✓ The content of this report should be discussed in all transfusion laboratories (hospital and blood services) with their representative pathology directors or equivalent
→ To: Laboratory managers, Pathology directors and Safety leads

SUPPORTING STAFF

- ✓ Laboratory managers and Pathology leads should implement a framework for regular 1:1 meetings or mentoring with their staff members to improve communication, culture, retention and create a route for concerns to be raised (to include health and wellbeing discussions)
  → To: Laboratory managers and Pathology leads

- ✓ Training must be in place for all staff that includes how to recognise, manage and mitigate incivility and the potential impact on patient safety. All staff must be made aware of their responsibilities and mechanisms for raising concerns.
  → To: Chief executive officers, HR leads and Safety leads

- ✓ Organisations must have a policy, with robust mechanisms for implementation and effectiveness to protect staff from bullying, undermining and harassment and promote a positive working environment in place which should be easily accessible at all times. Measures must be in place to ensure that the effectiveness of the policy is monitored, such as staff surveys or equivalent.
  → To: Chief executive officers, HR leads and Safety leads

- ✓ Training must be in place for all staff that includes how to recognise, manage and mitigate bullying and harassment, with appropriate support mechanisms in place. All staff must be made aware of their responsibilities and the importance of a zero-tolerance approach must be reinforced
  → To: Chief executive officers, HR leads and Safety leads

- ✓ Each laboratory should have an independent and objective culture survey performed at least on a biennial basis with an action plan as appropriate. It is important that the issues identified as part of the culture survey are addressed and actioned as soon as it is practically possible.
  → To: HR leads

- ✓ Staff with leadership responsibilities must act as role models following expected behaviours within the workplace. These leadership skills and behaviours must be assessed as part of their annual appraisals with appropriate key performance indicators.
  → To: HR leads

- ✓ Organisations should offer occupational health services and employee schemes such as employee assistance programmes to support staff health and wellbeing. Flexible working policies should also be available to support effective work-life balance
  → To: HR leads

If you require further support, please see SHOT Bite 24: Speaking up for patient safety
https://www.shotuk.org/resources/current-resources/shot-bites/

Recommended resources

- Civility saves lives: https://www.civilitysaveslives.com/
- Patient Safety Incident Response Framework: https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/
- Restorative Just Culture Checklist: https://www.safetydifferently.com/wp-content/uploads/2018/12/RestorativeJustCultureChecklist-1.pdf
- SHOT Bite No.23: Civility in Healthcare: https://www.shotuk.org/resources/current-resources/shot-bites/
- SHOT Bite No.24: Speaking up for safety: https://www.shotuk.org/resources/current-resources/shot-bites/
- Suggestions to improve safety culture: https://www.shotuk.org/resources/current-resources/uktlc/