

Foreword

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Many in the transfusion world in the UK have been involved, over the last few years, giving evidence to the Infected Blood Inquiry. This Inquiry is now concluded, and its chair, Sir Brian Langstaff, is preparing his final report. The Inquiry has been hugely important, first, because it gives an opportunity for those tragically infected or affected, at last to receive explanations, compensation and closure. But it is also particularly important because it lifts the lid on historic, but widespread cultural problems in the way that health services are delivered and gives us an opportunity to learn from those mistakes. Although concentrating on transmissible infection, the lessons learned are much more widely generalisable to other transfusion harms and to healthcare-associated injury more widely.

While giving evidence to the Inquiry, I felt reassured that many of the lessons had already been learned, and that, already, we were moving on. Within weeks, my complacency has been seriously undermined. Many of the reassurances I gave the Inquiry, based on historical data, have now been questioned by the data presented and analysed in this year's Annual SHOT Report.

While some of the alarming upward trend in errors and harms may reflect better reporting, there is undoubtedly a very strong underlying signal that all is not well. In particular, after several years of improvement and sustained safety in key areas, such as ABO-incompatibility, this year we saw 2 deaths and 1 case of major morbidity.

The key issues across these cases related to portering and collection errors, stressed situations, leading to shortcuts, over-ridden procedures, and an absence of final pre-administration checks. In each case, a series of errors lined up to contribute to the harm. Key, however, in this seems to be a willingness to disregard formalised procedures and safety checks in pressured situations. One might surmise that this is related to staff training, staff numbers and availability.

A similar story is told in many other chapters of this year's Annual SHOT Report. Laboratory errors this year numbered 431, an increase of 11% on 2021. The chapter authors commented in the key messages that 'a mismatch in workload and staffing levels had some impact upon over half of all laboratory incidents. When staffing levels are unsafe, this must be escalated'. In their recommendations they observe that 'many errors occur due to established procedures not being followed. It is important that laboratory staff understand the 'why' of an action before they move onto the 'how'.

Transfusion-associated circulatory overload (TACO) continues to be the major cause of harm. As with other categories of harm, the number of cases reported in the 2022 Annual SHOT Report is the highest to date, at 160, a 22% increase on the previous year.

Included in these were 8 deaths and 25 cases of major morbidity. SHOT has maintained for several years that 'a formal pre-transfusion risk assessment for TACO should be undertaken'. By and large, this is still not happening, and therefore, the final safety-net, again, is missing.

Across the board, there are common themes. Many of these relate to departure from established procedure particularly under stressed situations, communication, and staff training. We in the transfusion world are not alone in this. A recent Air Accident Investigation Branch report described the fatal crash of a light aircraft, in some part, due to weather, piloting experience, and training, but in large part to the way that air traffic control handled the situation. Distraction was a major element. Communication at all levels was poor; and the established procedures for dealing with the emergency were completely disregarded. The similarities between the human factors elements and root causes leading to the final poor outcome are strikingly similar to those we have seen in this year's Annual SHOT Report. The major

difference is the very small number of incidents in the aviation industry resulting in a fatal outcome or significant harm, compared with the very large numbers in healthcare.

After years of sustained improvement, there is a real risk that this is faltering, and could be lost. To prevent this, it is crucial that we adhere to good human factors, training, good communication, high levels of staff training, and no matter how stressed or busy the situation, that we do not set aside correct procedure in the heat of the moment. Workarounds are simply not acceptable. Escalation of these situations, and of resource and staffing levels to senior management is also important, even if painful, and even if the chances of this leading to a resolution seem slim. If we have learned only one thing from the Infected Blood Inquiry, it is that our patients have a right to expect this.



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References

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