

Staff fatigue and transfusion safety: A hidden risk

Introduction: Staff fatigue is a critical but under-recognised threat to transfusion safety. Fatigue has been defined in several ways and in essence, refers to a feeling of lack of energy, exhaustion, or a feeling of 'running on empty' and could be due to several causes ([Tiredness/fatigue in adults | Health topics A to Z | CKS | NICE](#)). While clinical and laboratory staff/management may recognise fatigue as a personal challenge, it is rarely acknowledged as a system-level safety hazard that requires organisational risk mitigation. Despite fatigue being well-established as a contributory factor in other safety critical industries including patient safety healthcare incidents (see HSSIB report), it remains overlooked in transfusion event investigations.

Why is fatigue missed so often?



Cultural norms, peer pressure and presenteeism: Heroism, "getting on with it" and pressure to keep pace with colleagues creates reluctance to acknowledge fatigue as affecting performance, particularly when speaking up is seen as letting others down.



Blame and shame: Staff fear disciplinary action if fatigue is mentioned as a contributory factor in incidents.



Lack of awareness: Sub-optimal training together with a lack of frameworks to identify and measure fatigue-related risks within organisations.



Systemic invisibility: Unlike technical failures, fatigue is treated as a personal responsibility rather than an organisational hazard.



Inconsistent definitions: There is no standardised, agreed definition of fatigue across healthcare, making systematic identification difficult.

[The Healthcare Services Safety Investigations Body \(HSSIB\) investigation \(2025\)](#) concluded: "Staff fatigue is beginning to be recognised as a risk, but understanding remains inconsistent and fragmented".

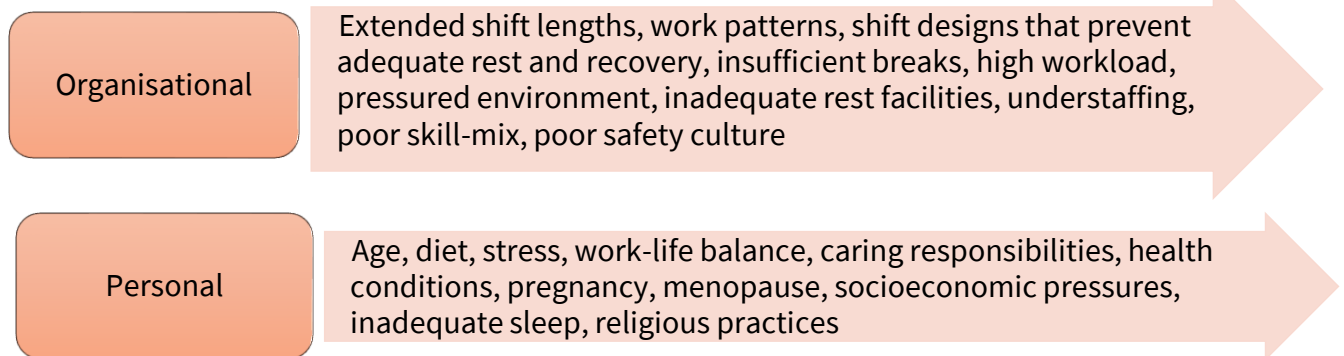
How can fatigue contribute to transfusion safety incidents?

Fatigue impairs the cognitive functions essential to ensure transfusion safety.

Cognitive impact	Transfusion safety risk examples (I don't think we can cover everything here)
Reduced attention	Errors in identifying correct patient/component compatibility/ antibody identification etc.
Slower task completion	Delays in urgent transfusions; rushed safety checks
Impaired decision-making	Not recognising contraindications; overlooking vital signs
Diminished situational awareness	Missed adverse reaction symptoms; ineffective communication
Emotional dysregulation	Team tensions; reduced compassion and incivility affecting patient interactions and care
Poor memory	Incomplete documentation; forgotten steps in transfusion protocols and processes

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Organisational and personal contributors to fatigue risk



Organisational risk mitigation: A system-level approach (Useful reference: [Fatigue risk management for health and social care](#) published in 2024 from Chartered Institute of Ergonomics and Human Factors (CIEHF))

Shift 1: From personal to organisational responsibility

Here are some recommended organisational actions:

Assess and measure: Establish baseline data on shift patterns, break compliance, and workload in transfusion areas (clinical and laboratory)

Design safer rotas: Limit shift length, provide regular adequate breaks, avoid consecutive long shifts, align with circadian physiology (HSE guidance available)

Provide environmental support: Accessible rest facilities, nutritious food, hydration, adequate lighting, ergonomic workspace design (such as blue tone lighting 5000K for areas where attention required)

Staffing and skill-mix: Ensure adequate staffing ratios to manage workload and enable meaningful breaks

Create psychological safety: Establish a safety culture where discussing fatigue is encouraged and free from punishment

Incorporate **wellbeing checks** as part of team meetings, safety huddles and annual PDPR processes

Shift 2: Policy and procedural integration

Organisations should embed fatigue risk management into existing frameworks:

Fatigue policy: Develop a formal fatigue risk management policy aligned with CIEHF and HSSIB guidance

Transfusion-specific protocols: Include staff fatigue screening in pre-transfusion checklists; recognise high-risk periods (e.g., mid-afternoon, end of shift)

Organisational reporting system and escalation pathways: reporting systems to include fatigue and relevant signposting to support no blame culture. Enable staff to flag fatigue concerns without fear; provide clear escalation routes

Incident investigation framework: Standardise fatigue within contributory factor analysis. Consider use of fatigue trigger tool to explore work patterns as a contributory factor

Framing for staff: Present fatigue investigation as shared learning, not blame

Conclusion: Staff fatigue is not a personal weakness; it requires an individual and organisational approach to address the associated risks relative to the work context. By treating fatigue as a formal risk, with formal risk assessment, effective management plan, consideration within incident investigations, and implementing evidence-based mitigations, transfusion services can protect both staff wellbeing, patient safety and organisational performance. The evidence is clear: fatigue contributes to serious incidents. The time to act is now.