Supplementary File 27: Themes related to fidelity of receipt and enactment from process evaluation interviews in Trial 2

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| **Themes related to fidelity of receipt (trial 2)** |
| **Theme** | **Sub-theme** | **Supporting quote** | **Source** |
| Understanding of feedback  | Perceived clarity of the feedback | *“I thought the format was quite good really. For our hospital, for clinical staff making the decisions, what they should be looking at, and then how to manage that. I thought it was quite… yeah, fairly straight forward really.”* | H23 P02, Non-Transfusion practitioner |
| Visual representations of hospital performance facilitated comprehension  | *“He [TP] had a projector with the graph that you guys used. They’re very comprehensive actually those graphs because you can see where you are.”* | H23 P01, Non-Transfusion practitioner |
| The feedback had clear details on how to improve practice | Identifying key information for hospitals and how to move forward | They were very well laid out. They were to the standards. There was summaries in the front of them. The main points were well highlighted. As I said, there was a very concrete action plan, then which I used. So they were quite good, and the presentation was good as well. | H25 P01 |
| Perceived appropriateness of the recommendations | The recommendations were appropriate I think because obviously that’s what you want to do ultimately, and as long as it’s clear within the recommendations that you can transfuse outside of that standard if there’s a clinical reason I don’t… I think there’s nothing… the recommendations were fine. | H19 P01 |
| **Themes related to fidelity of enactment – Trial 2** |
| **Theme** | **Sub-theme** | **Enhanced Content + Enhanced Follow-On** | **Enhanced Content+ Standard Follow-on** | **Standard Content + Enhanced Follow-on** | **Standard Content + Standard Follow-on** |
| **Sharing feedback with relevant staff** | Presenting to the HTC | “[I received the feedback] via email from [TP at H23]… And he, he verbally fed back at one of our HTC meetings as well.”H23 P02 Consultant Haematologist | Well, I was emailed by your team, well, from the NCA. I got all the findings through and that was discussed through our HTC and then it transcribed down then to the heads of departments for escalation, or information to the relevant teams.H26 P02 | the vascular surgeon was there, obstetrics was there, ED was there and haematology was represented because our HTC chair is a haematologist. H20 P01 | *Did not mention HTC, but all discussed sharing it with the HTT.*  |
| Sharing feedback beyond the HTC | It was out of my scope to get the actions implemented. All I could do was pass onto the people that needed to do that **H24 P03** | I mean the haematology multidisciplinary team, the immediate team, the clinical team and haematology that it went there, we had a meeting basically to discuss the outcomes of the audit and what we were going to do in terms of moving forward.H19 P01 | We did the data gathering together, and shared it out across the trust. H28 P01 | All the consultants got a copy of the audit report, and I think I sent the audit report round to everybody else, but all my consultants on this site got a copy of the audit report as well. I know that the lead biomedical scientist in transfusion, as well, had copies of this.H30 P01 |
|  | Conducting a gap analysis  | my transfusion matron has also been… well she’s the one who developed the gap analysis in the first place. H22 P01 | (no evidence of conducting a gap analysis) | (no evidence of conducting a gap analysis) | (no evidence of conducting a gap analysis) |
| **Responding to the feedback** | Formulating an action plan | I did create an action plan which I have then shared with all necessary parties **H24 P03** | we had a big action plan and we decided we would make a specific transfusion plan that the person- the haematology patients, either red cells or platelets, their whole plan for transfusion would be documented and all that stuff. H25 P01 | For both the themes around formulating an action plan and making changes – the hospitals all answered no to the question have you set any goals, or developed plans. No elaboration of why.  | So, it was just the one plan and one goal that’s been delivered, and it was just getting the local policy ratified, where we dropped the Hb trigger. I just took it to the haematology consultants’ management meeting, and just got their agreement and then we changed the local policy.H31 P01 |
|  | Changes to practice were not always a result of feedback (across the trial arms, there were more reports of changing practice in standard feedback reports in response to feedback in comparison to enhanced feedback).  | *“W*e will come up with some guidance, but it won’t necessarily always be followed, that’s kind of, that’s what’s happened in the past with various other issues.H23 p02 | The data collector, as he fed back, there was just one person who was picked up in the audit who actually brought the results down. So, what we did instead then, was specifically target that person, rather than implementing a change in the service. H25 P01 | Most said they did not make changes due to not agreeing with audit standards.  | We’re now advocating the single unit transfusion, which we didn’t do before, and we’re also advocating that for in-patients single unit transfusions and also that they have the haemoglobin checked after each unit. The transfusion consultant is also talking to the haematologist about platelet transfusion because if they were below ten before we would give platelet prophylactically, which now she’s saying if they’re not bleeding then we don’t do them. The practice is changing there as well and we’re using more tranexamic acid than we used to.H29 p01 |
| **Monitoring practice**  | General monitoring of use of blood products in haematology  | Yeah, the nurses police us very well. So yeah, they do, they keep an eye… and you know, we don’t… we are endeavouring to… the workload’s ever increasing so we really don’t want to transfuse people unless it’s absolutely necessary. H23 P02  | We had the feedback, we met with multidisciplinary team and haematology probably a couple of weeks after that, the audit started probably a couple of weeks after that. So they only audited sort of for eight weeks I think, so it did show some improvement. H19 P01 | (No evidence of on-going monitoring blood use in practice).  | I haven’t done a formal audit, but I have moans from the lab about the one unit transfusion numbers, because they say it is upping their cross matching work, and I have repeated phone calls from clinical areas, from nurses, saying, “[H31\_P01], is it really 70 now?” “Yes, it is”. So, I know that people are following the guidelines, and the lab actually, haematology is along at [hospital in H31], and the lab at [hospital in H31] actually review all the patients’ Hbs every day and they won’t provide blood now unless it has dropped to 70. H31 P01 |