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Using incident reporting to improve your QMS

South Central Regional Meeting

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Background

MHRA, SHOT, UKTLC, NBTLM, RCPath and others recognise the pressures in Transfusion laboratories

- Resource
- Vacancies
- Skills
- Education
- Workload

- Incident reporting – another challenge or a tool?

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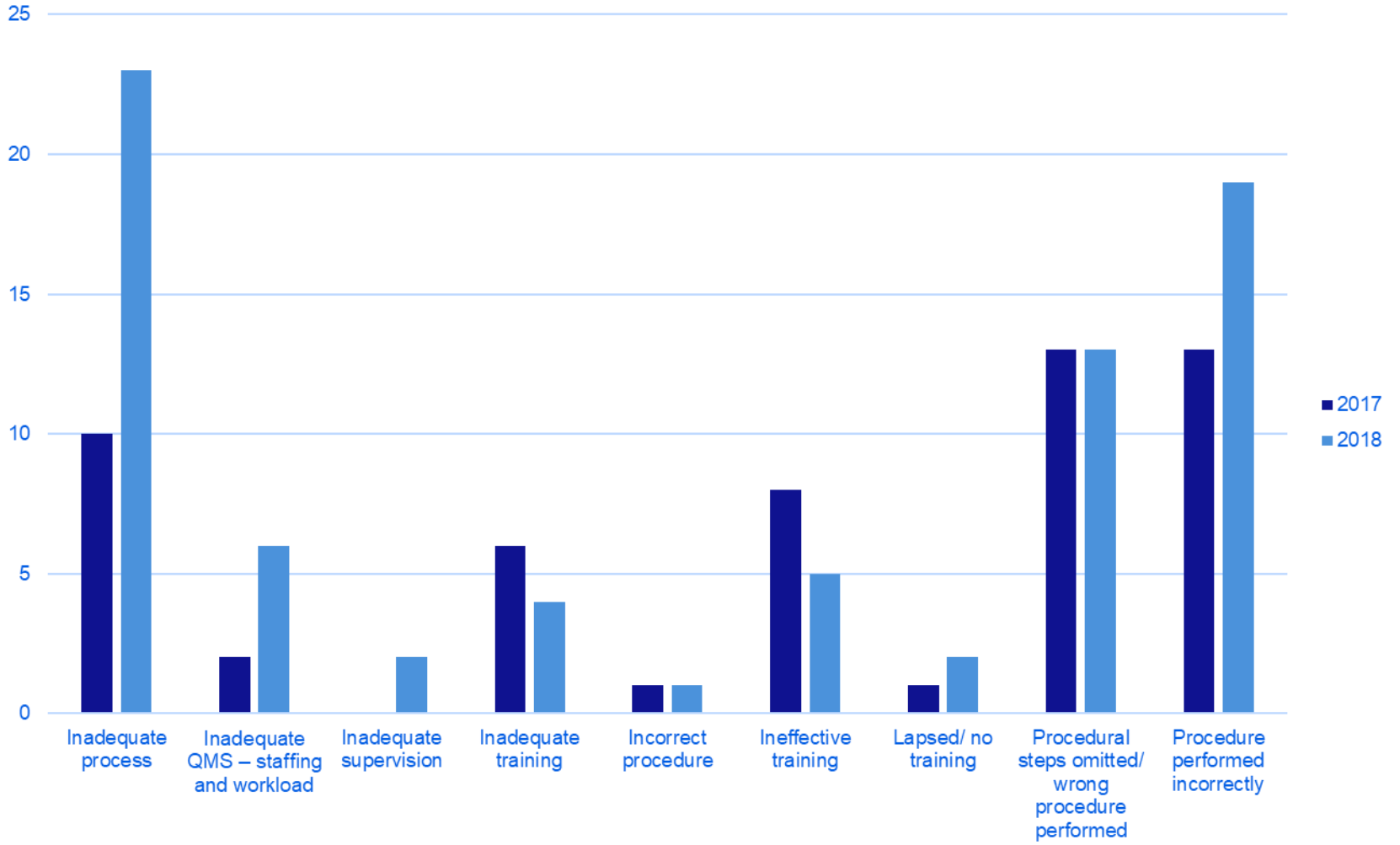
Root causes

- 54 Human error (2017) c/w 75 (2018)
- Increase in number of reports linked to Inadequate process and staffing and workload



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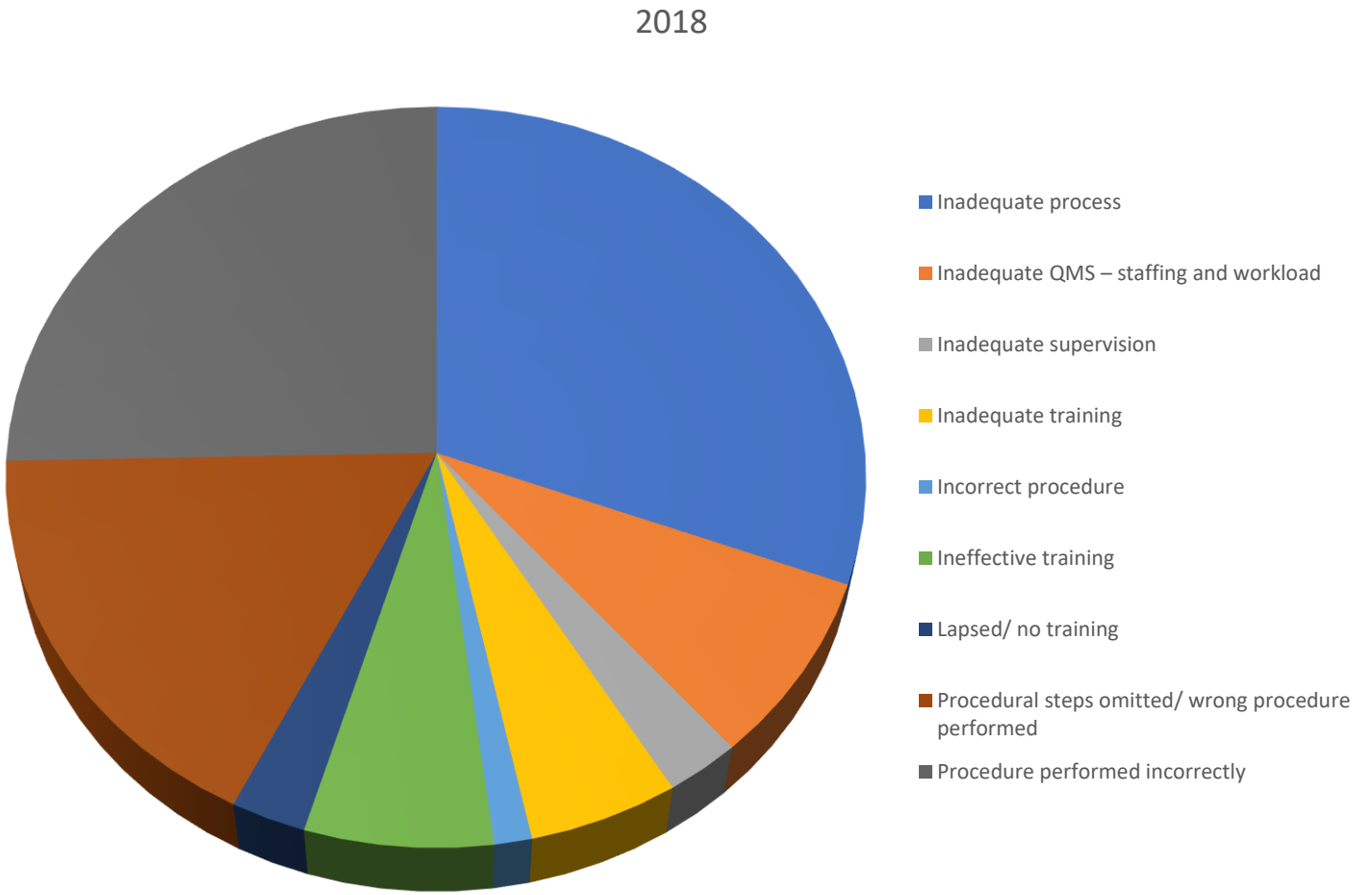
Root causes

- However, still 42% of all reports are procedural errors i.e. assessed to be entirely the responsibility of the individual
- Only 8% staffing and workload



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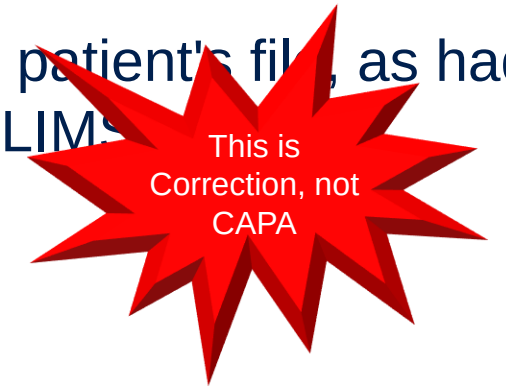
Typical SABRE report

2 units of red cells to patient that were not irradiated. Message on the patient's notes stating they needed Irradiated units. There was no flag on the patient's record. No BMS had added the flag stating irradiated was required.

BMS did not follow the instruction on the critical n

Irradiated flag added to the patient's file, as had not been updated since migrated over to Labcentre from old LIMS



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Further info

The BMS is unable to confirm why he missed the critical notes on the patients file stating that irradiated units were required. However, the critical notes should still have been acted upon.

The number of staff in the lab having reduced does contribute to the number of different jobs BMSs are doing at one time. Therefore concentration is not always easy.

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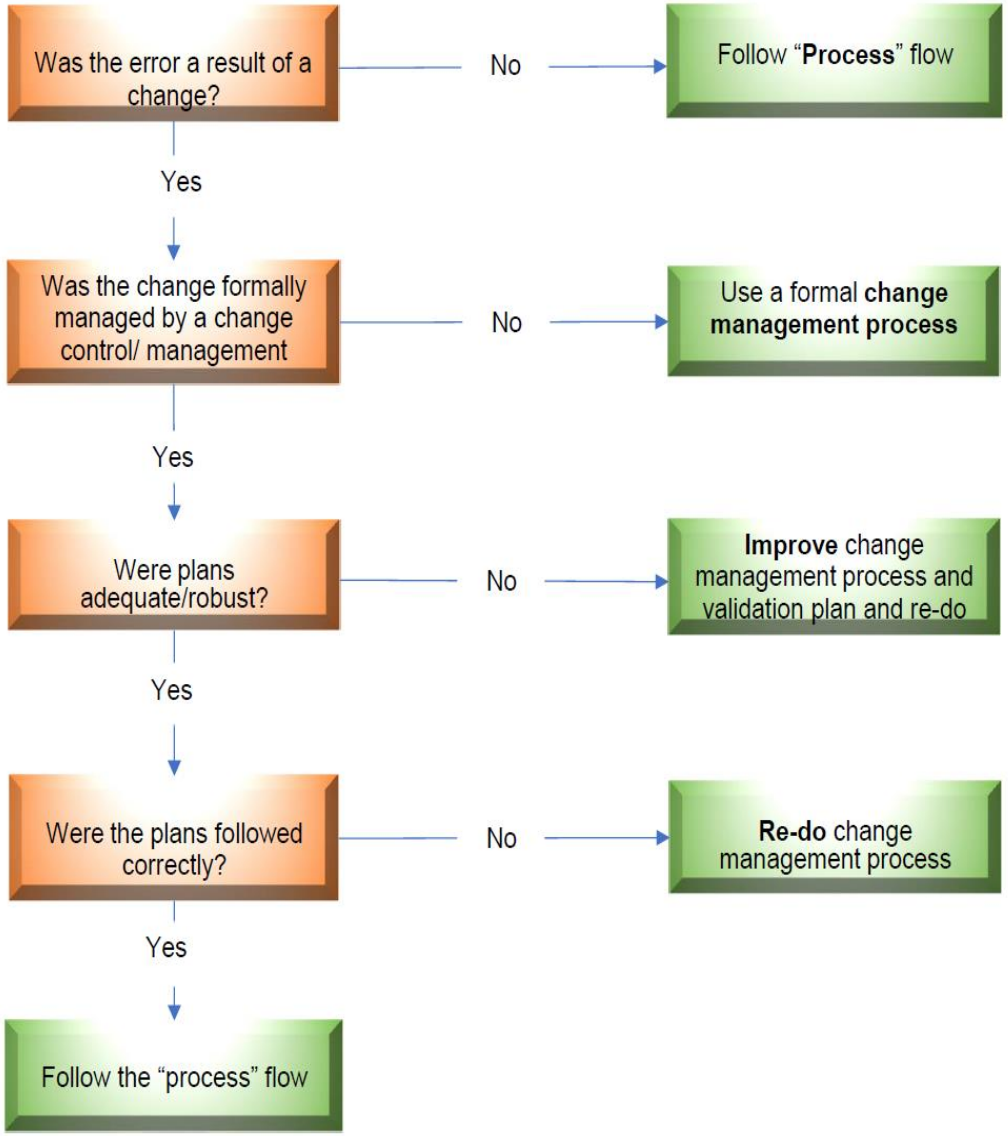
Managing change



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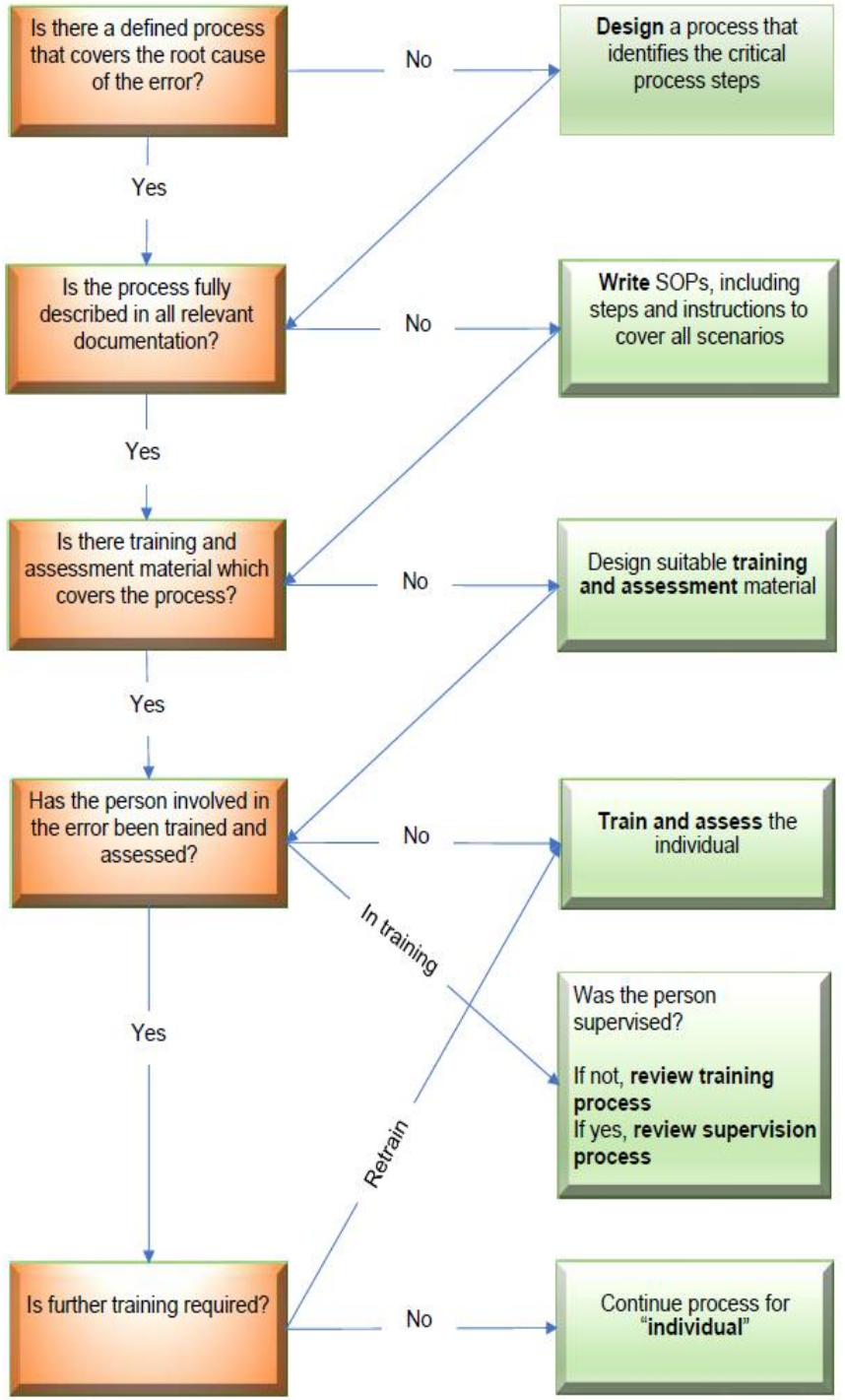
Process



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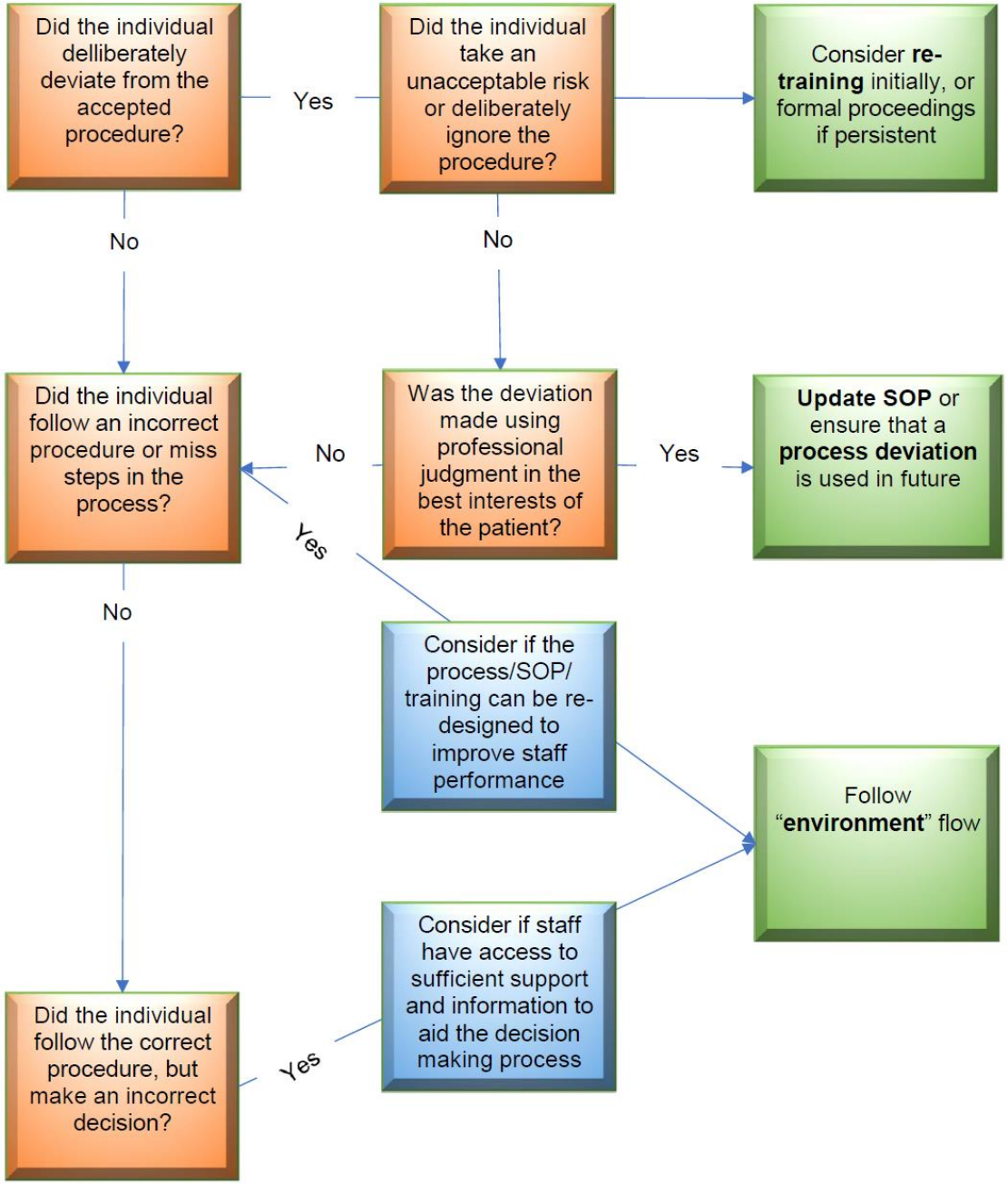
Individual



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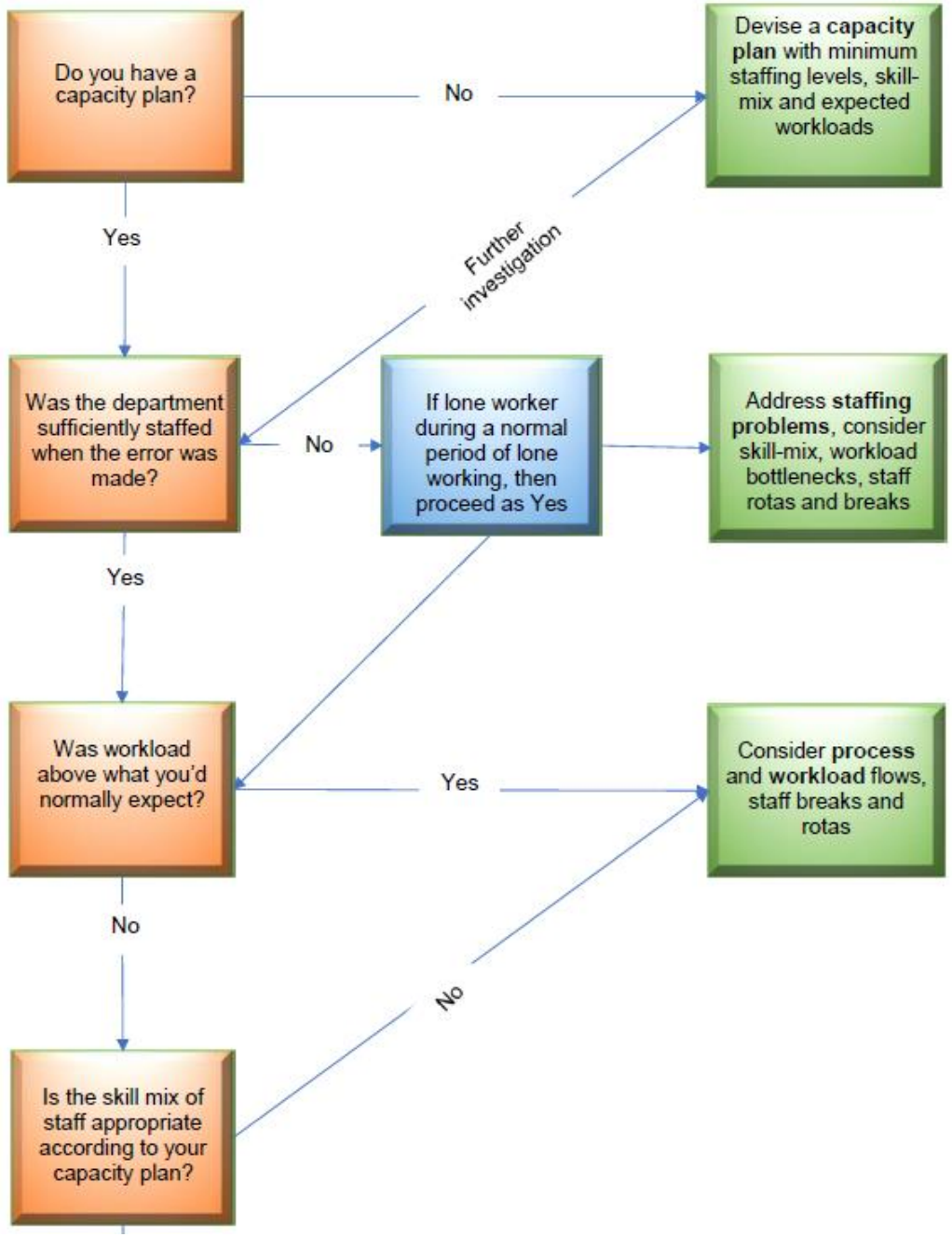
Environment



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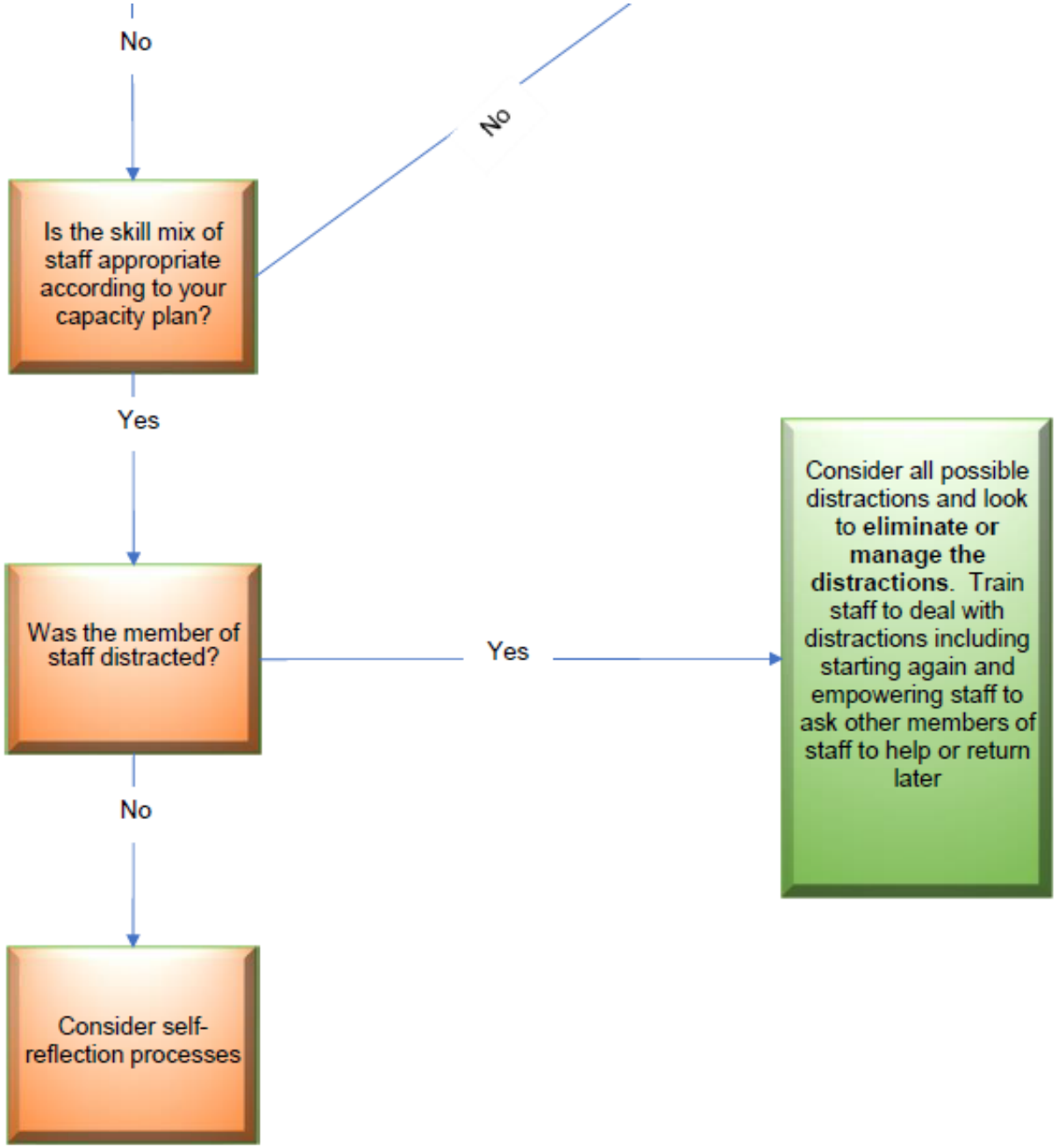

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Case study

Rh + K phenotype not performed for Sickle patient. Diagnosis missed on a number of occasions

Two units cross-matched, issued and transfused

Patient developed Anti-C and anti e

Conclusion

BMS did not follow guidelines and SOP already in place

Assumes that full responsibility lies with BMS i.e victimised and no improvement to QMS initiated

Further info

Short staffed on that particular night

Existing vacancies

Although BMS has responsibility for their actions, opportunities to recognise deficient QMS should be taken and acted upon and escalated if necessary

Improvements cannot be made if you don’t document this