RCA – Pleasure or Pain

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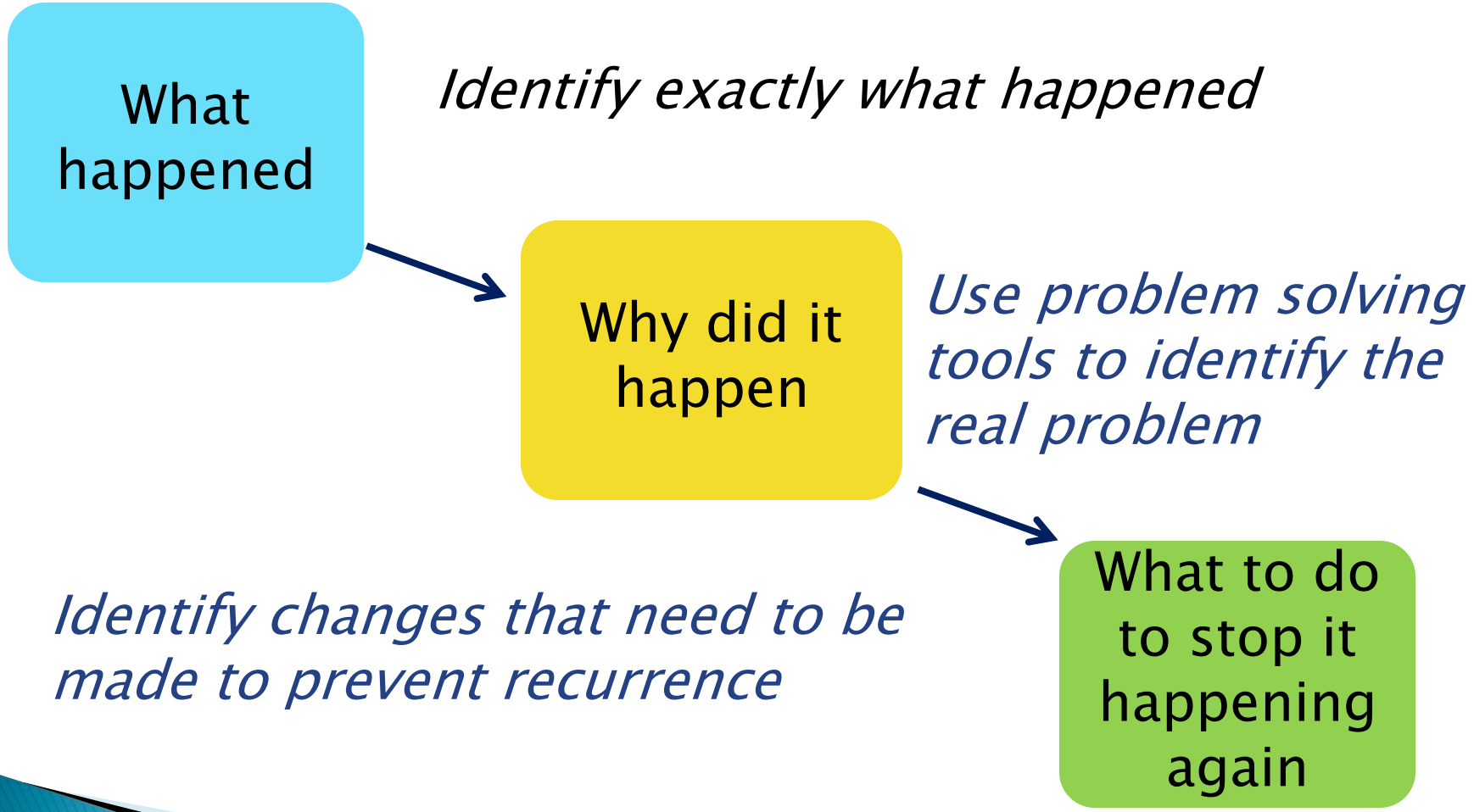
What is Root Cause Analysis?



Why do we do it?

- Identify **system/process** errors
- Needed to identify appropriate preventive actions
- Human error (unless lack of training) more difficult to put right and can be considered as a **weak** preventive action

Roles- what is your main job role?

30%	1.	BMS working in the lab
36%	2.	Transfusion Lab Manager
1%	3.	TP (BMS background)
0%	4.	TP (Nursing background)
14%	5.	Quality
18%	6.	Other

How many of you have been involved in undertaking a full RCA?

37%	1.	No
63%	2.	Yes

What tools are you most familiar with and use most?

46%	1.	5 whys
25%	2.	Tabular time line
18%	3.	Fishbone
0%	4.	Change analysis
10%	5.	None of the above

Are the majority of your incidents due to:~

26%	1.	Process error
63%	2.	Human error
11%	3.	Don't know

Case 1:
Paediatric patient has serious reaction to platelets would you investigate?

90%	1.	Yes
10%	2.	No just report to SABRE/SHOT

On writing the report from the case notes you identify a discrepancy in platelet counts pre platelet transfusion from previous results. What would you do?

Accept that platelet counts around 10 are notoriously unreliable

95%

1. Look at other parameters

5%

2. Continue with the report as this is a “red herring”

An F2 doctor was asked to review the patient history and use this case to present at the grand round. He noted that the ward had electronic mobile workstations for sample labelling linked to 2D patient wristbands. He noted in his presentation that it could not be a wrong blood in tube. Is this true?

0%	1.	Yes
66%	2.	No
34%	3.	More information needed

Case 1 – answers

- Wrong FBC result associated with patient and patient had an unnecessary platelet transfusion
- Sample incorrectly labelled (WBIT)
- Nurse labelled sample away from the patient's bed side
- Mobile computers don't hold charge well
- Don't hold charge well because they are always plugged in
- The carts are difficult to fit into the single rooms

How would you report this to SHOT?

40%	1.	SAR noting an unnecessary tx as well
44%	2.	Unnecessary tx noting a SAR as well
17%	3.	Don't know

Case 2:
Patient 7 days old neonate on SCBU
Rep*ort mismatch on patient ID during bedside checks*

- Would you investigate?

96%	1. Yes
4%	2. No

Upon investigation it is noted that there are multiple alarms on the electronic blood transfusion system showing a patient mismatch
What are your next steps?

0%	1. Nothing
32%	2. Use the 5 whys tool to help determine the cause of the issue
68%	3. Start a timeline to determine the timing of events

Further investigation shows that the laboratory staff had failed to follow the SOP on request entry of patient information.
What are your next steps?

0%	1. Nothing – You have found the root cause
1%	2. Suspend the BMS until they are able to explain their actions
99%	3. Use the 5 whys tool to determine the reason for this failure to follow the SOP

Case 2: the answers

- The BMS was new to night shifts
- Failure to use the barcode scanner to input the patient information
- BMS used a lab PC which didn't have a barcode scanner attached
- Error compounded by BMS not asking for help when they couldn't resolve an earlier mistake

Case 3: 3 units of red cells packed in a box and taken to theatre (validated for 6 hours). Box was discovered, still sealed, 24 hours later.
Who would you report this to?

19%	1.	SABRE
29%	2.	SHOT
25%	3.	Both
27%	4.	Neither

What would be the corrective action?

2%	1.	Place units back into stock and mark as not used
0%	2.	Place units in an issue fridge case the patient needs blood in the next 24hrs
98%	3.	Discard all units

What could be the preventative action?

26%	1.	Tell theatre they can only have blood when they are ready to transfuse
10%	2.	Only send 1 unit to theatre packed in a box
4%	3.	Buy boxes that you can validate for longer than 6 hours
60%	4.	Get an issue fridge in theatre so this cant happen again

Case 4:

A unit of platelets is recalled by the Blood Service due to a bacterial positive result. You inform the service you have quarantined the unit but before you get the unit off the agitator an emergency request comes in for 10 units for a trauma patient. After finishing your shift and getting home (3 hrs later) you remember the recall and phone in to ask staff to quarantine. Unit transfused no reaction in patient. Do you report this to SABRE?

90%	1.	Yes
10%	2.	No

What is the immediate corrective action?

0%	1.	Nothing
35%	2.	Discuss with the Blood Service consultant
20%	3.	Discuss with the local haematologist
45%	4.	Tell the patients consultant that a bacterial positive platelet has been transfused to their patient

What is the preventative action?

3%	1.	Discuss with the staff and understand why it happened
3%	2.	Review the SOP
16%	3.	Ensure the platelet is quarantined prior/same time as responding to the BS
79%	4.	All of the above