Just Culture and Process Improvement in Transfusion Medicine

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Sometimes Bad Things Happen….

- Human error is inevitable.
- Human error can lead to patient harm.
- We cannot change the need for humans in health care.
- We CAN change the systems they work in.

- A Just Culture acknowledges that errors occur, and seeks to reduce the risk of error by process improvement.
Just Culture

- Recognizes that to err is human.
- Recognizes that the individual should not carry the burden for system deficiencies over which they have no control.
JUST CULTURE

SOMEONE REPORTED THIS WRONG!!

OH NO!
I HOPE THAT WASN'T ME!

BY KONRA MUELLER

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In a Just Culture

- We feel SAFE
- We are treated with care and compassion
- We are treated with respect and dignity
Hazards

Patient Harm
Systems Analysis Methodology

- A standardized analysis tool to review adverse events and close calls
- Used where an adverse event is suspected to be a result of a system deficiency
- Goal is to understand what happened, not whose fault it is.
- Extent of the review (concise, comprehensive, aggregate) depends on the severity and frequency of the event
The SAM Process

REQUEST SYSTEMS ANALYSIS REVIEW (SAM)
- Patient Safety Review (non-protected)
- Quality Assurance Review (protected under Section 9)

CHOOSE TYPE OF REVIEW
- Concise
- Comprehensive
- Aggregate

CHOOSE REVIEW METHOD

CONDUCT REVIEW
- WHAT happened?
- HOW did it happen?
- What can be done to MAKE CARE SAFER?

IMPLEMENT RECOMMENDATIONS, EVALUATE & SHARE
Steps to SAM

1. Initiate the Review
2. Understand What Happened
3. Understand How and Why it Happened
4. Develop Recommendations – What can be done to make care safer?
5. Produce a Report
An example

• Our lab received a phone call from CLS that a patient we had transfused may have suffered a delayed hemolytic transfusion reaction.
• The patient had a antibody history, and we had given her antigen positive units.
• The patient was now deceased.
FIRST – Support Our Staff

• Despite our best efforts, there is always the potential for something to go wrong.
• When it happens, staff must be supported with care, compassion, respect, and dignity.
• Employee and Family Assistance Program
Understanding What Happened

- Create a timeline of events
- Include *what* happened, not *who* did it
- Take the context and circumstances into account
- Gather information from all available sources, including other departments and patient/family if applicable.
- Other Tools:
  - SAFER matrix
Understanding Why it Happened

• Look for root causes
• 5 Why’s
• Tools:
  – Fishbone Diagram
  – Constellation Map
How Can We Prevent it From Happening Again?

• Create Recommendations
  – Front line staff are the experts
  – Evaluate effort and impact of recommendations
  – Use SMARTS criteria to choose recommendations
    Specific
    Measurable
    Attainable
    Realistic
    Timely
    Sharable
Our example...What Happened

• Patient had multiple antibodies and required an urgent transfusion.
• Transfusion instructions were to provide phenotype specific units if possible.
• Anti-S was neither confirmed nor ruled out in the antibody ID. Patient was S negative.
• Only one S negative RBC unit was available on site
• Patient was transfused with one S negative RBC and two S positive RBC (crossmatch compatible)
What Happened…cont’d

- Patient was transferred to Calgary
- Testing in Calgary identified positive DAT due to Anti-S
- Patient experience a Delayed Hemolytic Transfusion Reaction due to anti-S
- Patient eventually expired (DHTR not considered the cause)
- Discovered that the history of anti-S was available in Netcare prior to transfusion.
Why it Happened

• Staff are “supposed” to check Netcare for transfusion history, but the system is slow and each test result must be accessed individually (no consolidated place for antibodies).

• Staff have multiple places to check history (manual files, local LIS, Netcare)

• Unclear whose job it is to check history

• Documentation of history check not standardized

• Uncertainty of requirement for antigen negative units if an antibody is “not ruled out”
How Can We Prevent it From Happening Again?

- Improve Netcare so all antibody history from across the province is consolidated in a single field
- Develop a policy regarding “not ruled out” antibodies
- Define who is responsible for checking patient history and establish a standardized method of documenting that history has been checked
Some things are out of our control

• Improve Netcare so all antibody history from across the province is consolidated in a single field

• What may not meet SMARTS criteria for us, might be possible on a provincial level
• Report the event in RLS