Just Culture and Process Improvement in Transfusion Medicine

Vein to Vein 2016

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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

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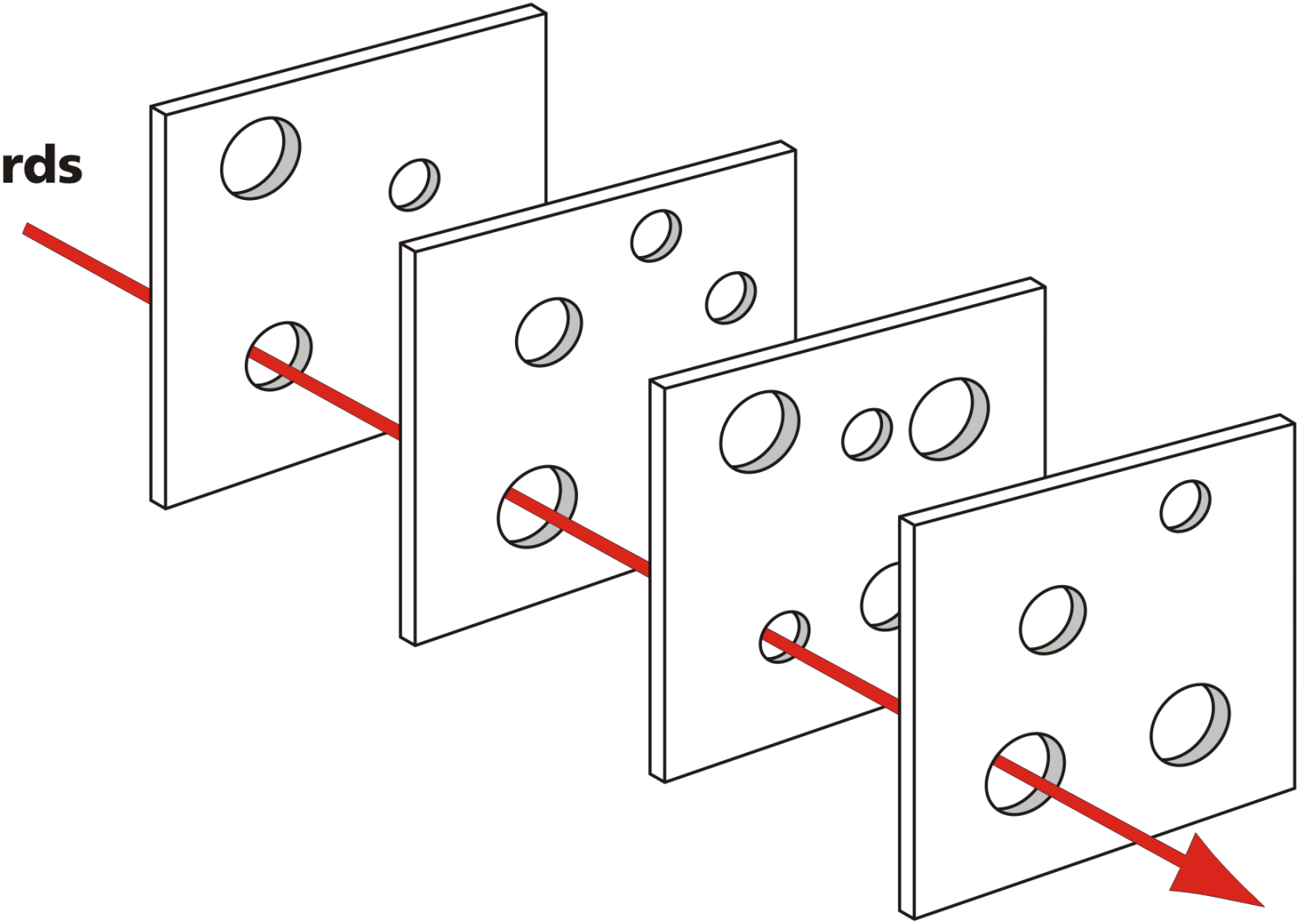
In a Just Culture

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

Hazards

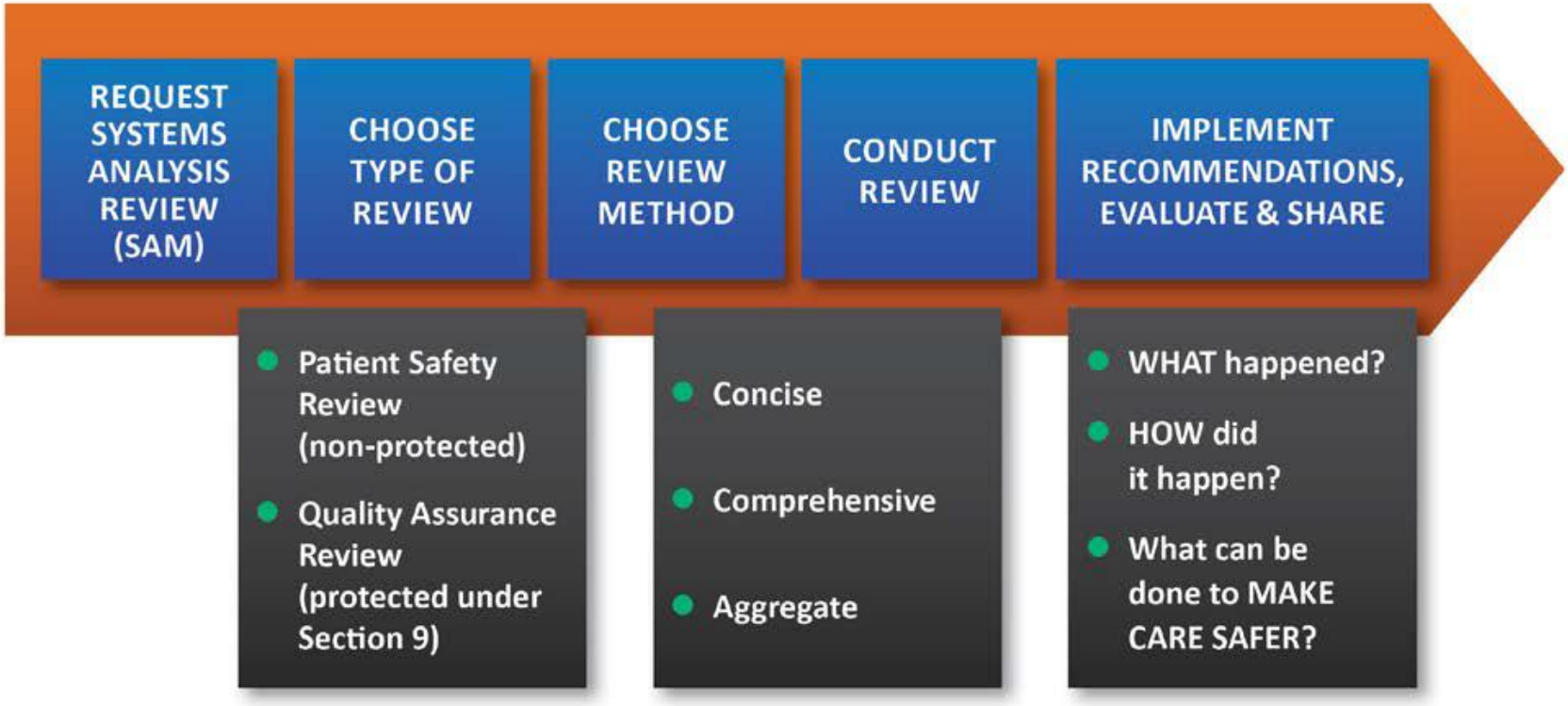


Patient Harm

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



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.


VALTER:O

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

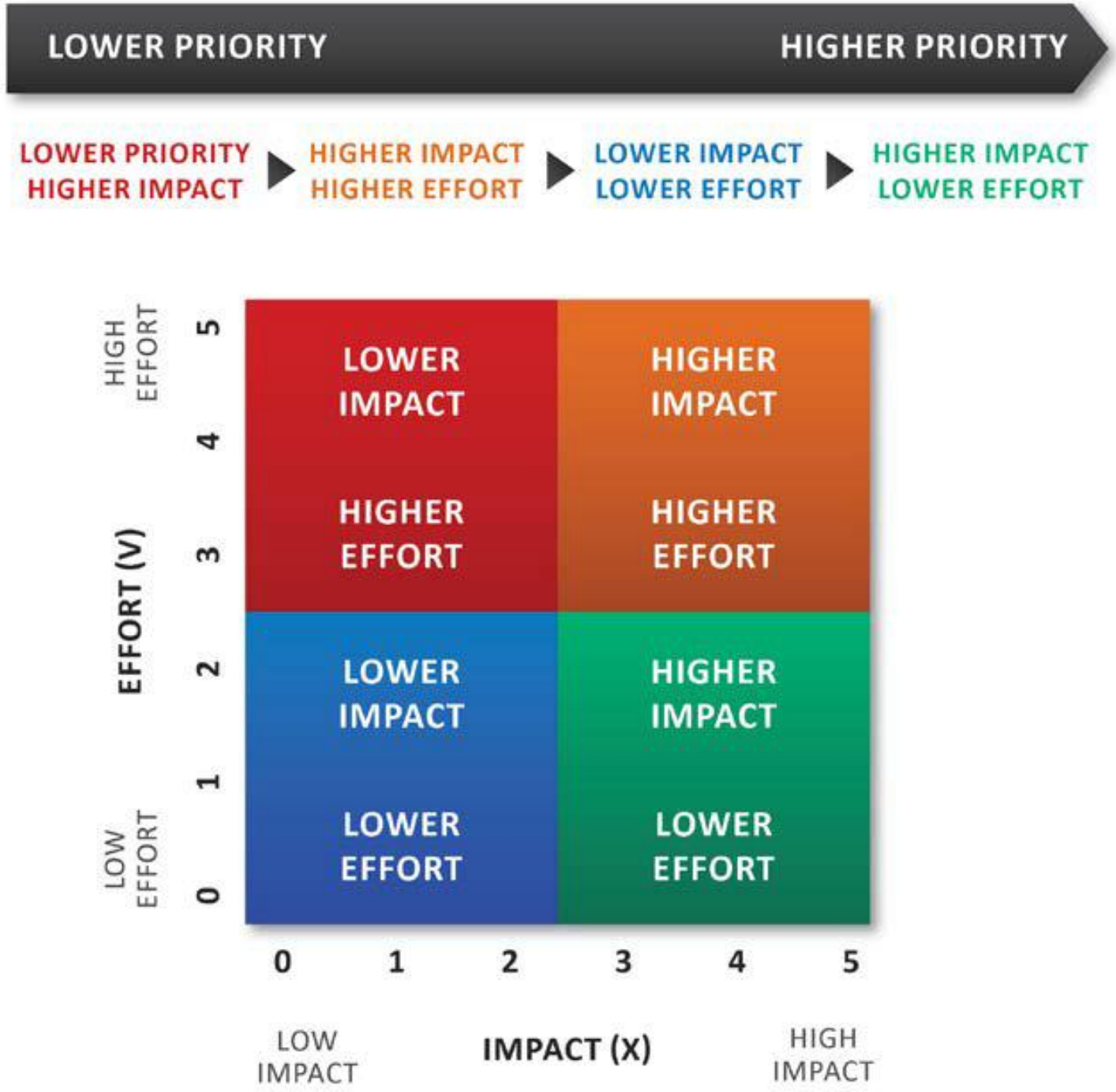
Understanding Why it Happened

- 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


LOWER PRIORITY
HIGHER PRIORITY
LOWER PRIORITY
HIGHER IMPACT
HIGHER IMPACT
HIGHER EFFORT
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HIGH EFFORT
LOW EFFORT
EFFORT (V)
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HIGHER EFFORT
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HIGHER IMPACT
LOWER EFFORT
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5
LOW IMPACT
IMPACT (X)
HIGH IMPACT

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

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- 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