

QA SysOp Practice Kit

Answer Key

Case 2



MERS-TM Event Discovery Report (worksheet) Transfusion Service

Instructions: Use this worksheet to collect event discovery/occurrence information, and then enter it into the online database.

Section A – Discovery Information

1. Report date: 12 mo./ 21 day/ 2001 year 2. Discovery date: 12 mo./ 21 day/ 2001 year 3. Day of discovery: Weekday Weekend/Holiday
4. Discovery time: 12-4 AM 4-8 AM 8-12 Noon 12-4 PM 4-8 PM 8-12 Mid.
5. Discoverer's job description: Clerk House staff MD/DO MLT MT RN LVN / LPN Other
 Supervisor QA/QC Discoverer's name: Elizabeth
6. Where in the institution was the event discovered:
 Trans. Serv. OR ER ICU L&D Clinic Hosp. Ward Other Location Code _____

7. Describe briefly the event you discovered.
Autologous unit of RBCs was left in the OR refrigerator for 24 hours following the patients surgery.

8. How did you discover this event?
During the OR refrigerator check by the transfusion service staff.

9. Where in the process was the event discovered?
- | | | | | |
|--|--|--|---|--|
| <input checked="" type="checkbox"/> Product Check-In | <input type="checkbox"/> Patient/Product Request | <input type="checkbox"/> Order Entry | <input type="checkbox"/> Sample Collection | <input type="checkbox"/> Sample Handling |
| <input type="checkbox"/> Sample Testing | <input type="checkbox"/> Product Storage | <input type="checkbox"/> Product Selection | <input type="checkbox"/> Product Manipulation | <input type="checkbox"/> Available for Issue |
| <input type="checkbox"/> Product Issue | <input type="checkbox"/> Product Administration | <input type="checkbox"/> Miscellaneous | | |
10. Product/Record Action: Product retrieved Product destroyed Record corrected Floor/Clinic notified
 Additional testing Pt. sample recollected Other

Section B – Occurrence Information

1. Date the initial antecedent event occurred: 12 mo./ 20 day/ 2001 year 2. Time initial antecedent occurred: 12-4 AM 4-8 AM 8-12 Noon 12-4 PM 4-8 PM 8-12 Mid. 3. Day initial antecedent occurred: Weekday Weekend/Holiday
4. Person involved: Clerk House staff MD/DO MLT MT RN LVN/LPN Other Supervisor QA/QC
Person involved: OR staff-unknown.
5. Where in the process did the initial antecedent (occurrence) event first occur?
- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> Product Check-In | <input type="checkbox"/> Patient/Product Request | <input type="checkbox"/> Order Entry | <input type="checkbox"/> Sample Collection | <input type="checkbox"/> Sample Handling |
| <input type="checkbox"/> Sample Testing | <input type="checkbox"/> Product Storage | <input type="checkbox"/> Product Selection | <input type="checkbox"/> Product Manipulation | <input type="checkbox"/> Available for Issue |
| <input type="checkbox"/> Product Issue | <input checked="" type="checkbox"/> Product Administration | <input type="checkbox"/> Miscellaneous | | |
6. Where in the institution did the initial antecedent (occurrence) event occur?
 Trans. Serv. OR ER ICU L&D Clinic Hosp. Ward Other Location Code _____
7. Product Issued? Yes No 8. Product Administered? Yes No

Report Accession Number 350 : Sub-site code (if applicable) _____

**QA SYS OP
INVESTIGATION
REPORT**

Report Accession Number:

350

Event Codes:

1. Consequent code

Event Type

2

This is a no-harm event because the patient did receive a homologous unit rather than the autologous, but no harm occurred as the homologous unit was compatible.

Process Code

UT

Subprocess Cod

010

NOTE: UT 010 tells us that products were infused in the wrong order.

2. Initial antecedent code

Process Code

UT

Subprocess Code

012

The OR staff did not check their refrigerator for unused products after the patient's surgery was completed.

3. Significant antecedent code

Process Code

PC

Subprocess Code

005

The purpose of the refrigerator check was to return unused products to inventory. The 'return to inventory' code is general and can cover both the omitted check (Nancy) and the delayed check (Elizabeth).

You, as QA Sys Op, feel that important lessons can be learned from both occurrences – but the potential for a concrete change comes from Nancy's omission and the sign-off sheet issue. You have not committed yourself to changing the sign-off sheets, but you are going to collect more information about the issue.

4. Additional description of the event:

All you feel you need to add at this point is:

Auto unit left in OR refrigerator due to two omitted checks and one delayed check. Resulted in patient getting one unit of

homologous RBCs instead. ICU notified.

You can always edit this description as needed in the database.

5. Risk Assessment:

QES: 0.1

There was not a significant increase in risk to the patient to get a compatible homologous unit of blood rather than the autologous unit.

QEP: 0.1

It was rare for someone to forget to check the OR refrigerator. The probability that all three checks of the OR refrigerators would fail is even smaller.

QES x QEP: 0.01 (initial RAI)

Event Type – this event was not a near miss with an unplanned recovery, so nothing is added to the initial RAI.

Was a product issued? Yes, a compatible homologous unit of red cells was issued instead of an autologous unit. However, there was no way for the issuing technologist to know that there was one remaining autologous unit. You add 0.2 to the initial RAI.

Final RAI: 0.21

A root cause analysis is recommended for events with a Final RAI of 0.5 or above. This event does not meet that criterion.

6. Organizational risk:

The answer is “high” for two reasons:

Because the patient received homologous blood instead of his autologous blood, there is the potential for the patient to get upset.

The transfusion service looks inefficient to other departments within the organization.

7. Follow-up:

Your follow-up action is based on the Final RAI value. At the bottom of the RAI sheet, you see that the recommended action for an RAI of 0.21 is to “Monitor only.”

However, due to the organizational risk, additional action is planned. You will also “consider change” when examining the sign-off sheet issue. Elizabeth notified the ICU about the auto and alerted them to the situation soon after discovery.

8. If appropriate, describe the long-term preventive action to be taken:

This event had been a learning experience for Elizabeth. She is a perfectionist and always tries to do too much. She now understands that this attitude has inherent risks. To be safe, she will need to learn to ask for help when needed.

However, Nancy's issue with the checklists was worth looking at, but you had not decided to actually make a change yet. You decide to put in a tentative long-term preventive action:

Look into combining the checklists.

9. What type of investigation will this event receive?

Based on organizational risk you mark "Expanded investigation."

Rough or Linked?/ Rough/Link Cause Codes 1-4 / Link to Accession Number:

Because you are performing an expanded investigation and will perform a root cause analysis to determine causes, you won't need to estimate causes or link the event to a previously expanded case. You leave this section blank.

Notes:

This is where extra notes about the event can be recorded such as unit numbers and patient information.

Patient information should never be entered into the MERS-TM database!



QA SysOp Investigation Report (worksheet)

Report Accession Number: 350

Event Codes:

1. Consequent (discovery) Code: 2 2. Initial antecedent (1st occurrence) Code: UT 012 3. Significant antecedent (occurrence) Code: PC 005
UT 010

*Enter 1-4 on the first line: 1=No recovery, harm 2=No recovery, no harm 3=Near miss, unplanned recovery 4=Near miss, planned recovery

4. Additional description of event (optional):

Auto unit left in OR refrigerator due to two omitted checks and one delayed check. Resulted in the patient receiving one unit of homologous RBCs. ICU notified

5. Risk Assessment:

Final RAI: 0.21

6. Organizational Risk:

QES: .99 .90 .75 .50 .25 .10
 QEP: .99 .90 .75 .50 .25 .10

High Low N/A

7. Follow up:

Propose action Consider action Monitor External report to other dept/org FDA Reportable

8. If appropriate, describe the long-term preventive action to be taken:

Look into combining checklists

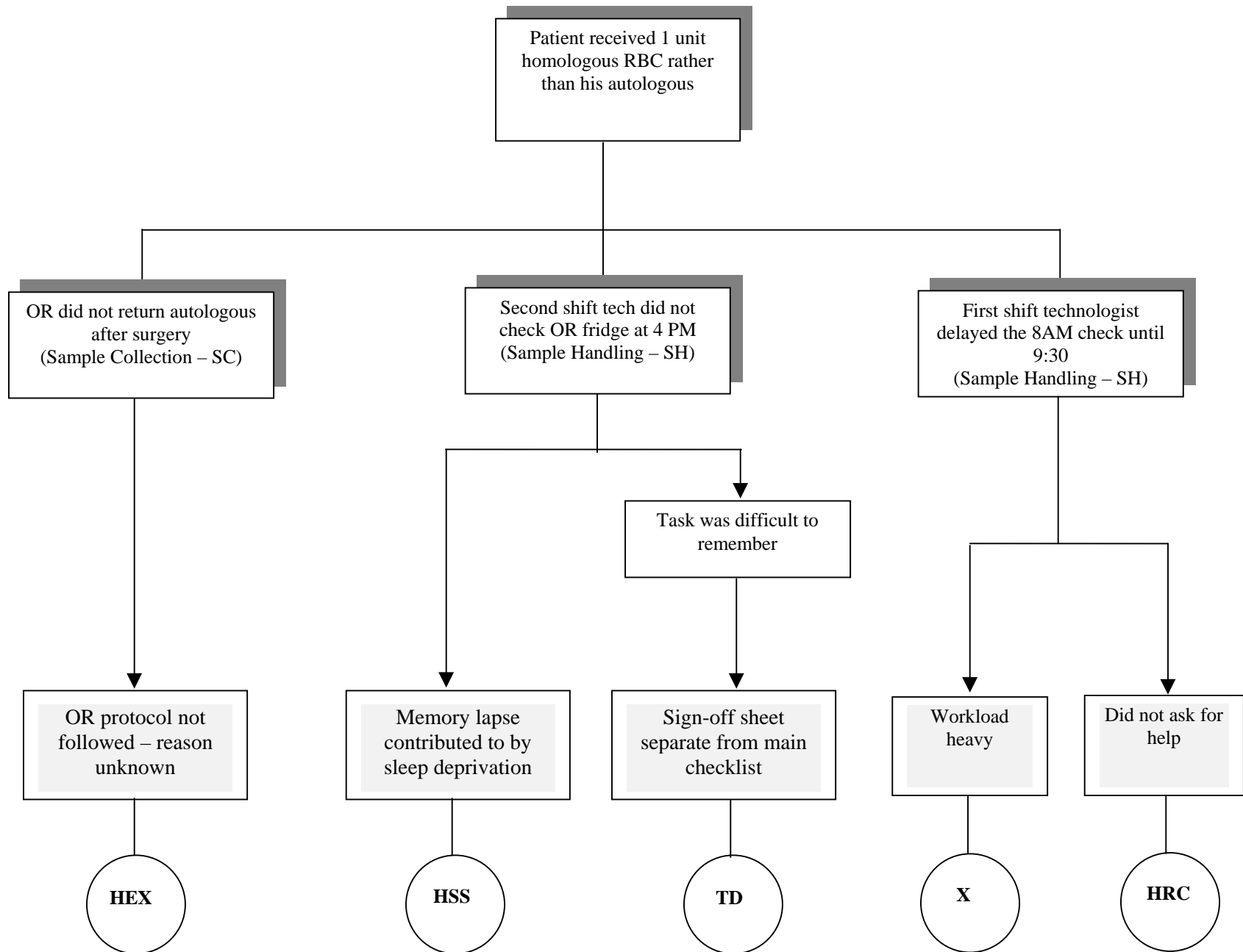
9. What type of investigation will this event receive? Routine Investigation Expanded Investigation

Complete this section only if this event is undergoing a routine investigation.

Rough or Linked?	Rough/Link Cause Code 1	Rough/Link Cause Code 2	Rough/Link Cause Code 3	Rough/Link Cause Code 4	Link to Accession Number
—	—	—	—	—	—

Notes:

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**ROOT CAUSE
ANALYSIS REPORT
WORKSHEET**

Report Accession Number

You use the accession number automatically generated by Database Functions when you entered your discovery report.

Consequent Event Code

You use the same code you created for the Consequent Event Code on the QA Sys Op Investigation Report form: 2 UT 010

Describe what happened:

The Consequent Event code tells you that there was no recovery, the event reached, or almost reached the patient (2 UT) and that products were administered in the wrong order (010). The description should go beyond this information, not duplicate it. You use the text from the consequent event at the top of the causal tree:

Patient received 1 unit of compatible homologous RBCs rather than his autologous unit.

Initial Antecedent Event Code 1

You use the same code you created for the Antecedent (1st Occurrence) code on the QA Sys Op Investigation Report form: UT 012.

Describe what happened:

Again this should expand upon the code. You write:
OR staff did not return the auto after surgery.

Cause Code 1a:

HEX

Describe what happened:

OR procedures not followed, reason unknown.

Antecedent Event Code 2

PC 005

Describe what happened:

Second shift technologist did not perform the 4 PM OR refrigerator check.

Cause Code 2a:

TD

Describe what happened:

Difficult to remember task, sign-off sheet separate from main sign-off sheet.

Cause Code 2b:

HSS

Describe what happened:

Technologist did not remember task, unavoidable sleep deprivation contributed.

Cause Code 2c:

N/A

Describe what happened:

N/A

Antecedent Event Code 3:

PC 005

Describe what happened:

One and a half-hour delay in the 8 AM refrigerator check.

Cause Code 3a:

HRC

Describe what happened:

Technologist did not ask for help when she became busy.

Cause Code 3b:

X

Describe what happened:

Workload was heavy, department was short staffed.

Cause Code 3c:

N/A

Describe what happened:

N/A

There are no additional antecedent events. You review the form to make sure it makes sense and that you did not use any non-standard abbreviations or hospital/patient identifying information. This form is now complete.



Root Cause Analysis Report (Worksheet)

Instructions: This form is to be filled out after a causal tree has been built and the root causes of the event identified. Space has been provided for the consequent event and four antecedent events as well as their descriptions. List the antecedent events in order of occurrence, beginning with the initial antecedent.

Within each antecedent event section, space is provided for up to three root cause codes plus their descriptions. If there are additional root cause codes within a section, indicate so at the end of the section.

Report Accession Number: 350

Consequent Event Code	Describe what happened.
<u>2 U T O 1 0</u>	<u>Patient received one unit homologous RBCs rather than his Autologous unit.</u>
Initial Antecedent Event Code 1	Describe what happened.
<u>U T O 1 2</u>	<u>OR staff did not return unused product as outlined in their protocol</u>
Cause Code 1a <u>H E X</u>	<u>Protocol not followed - reason unknown.</u>
Cause Code 1b <u>---</u>	_____
Cause Code 1c <u>---</u>	_____
Are there additional root cause codes for antecedent event 1? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Antecedent Event Code 2	Describe what happened.
<u>P C O O 5</u>	<u>Second shift did not check DR refrigerator to retrieve any unused products</u>
Cause Code 2a <u> T D</u>	<u>Difficult task to remember as check-off sheet is separate from main check-off sheet.</u>
Cause Code 2b <u> H S S</u>	<u>Forgot to check DR refrigerator. Sleep deprivation contributed.</u>
Cause Code 2c <u> ---</u>	_____
Are there additional root cause codes for antecedent event 2? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	



Antecedent Event Code 3 <u>P C 0 0 5</u>	Describe what happened. <u>Delay in first shift OR refrigerator check until 9:30 (Homologous unit issued 9 AM)</u>
Cause Code 3a <u>H R C</u> Cause Code 3b — — <u>X</u> Cause Code 3c — — —	<u>Technologist was busy, did not ask another tech to perform the check.</u> <u>Heavy workload</u>
Are there additional root cause codes for antecedent event 3? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Antecedent Event Code 4 — — — — —	Describe what happened. _____
Cause Code 4a — — — — — Cause Code 4b — — — — — Cause Code 4c — — — — —	_____ _____ _____
Are there additional root cause codes for antecedent event 4? <input type="checkbox"/> Yes <input type="checkbox"/> No	