

Investigating & Reporting Errors from a Hospital Perspective

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Barriers to Investigation & Reporting



The Problems

1. The Report Forms
2. Logistical / Local Difficulties
3. Cultural Difficulties

Report Forms

- Report forms generic - difficult to design -not good at capturing all the data required
- Vital Information can be omitted by the hospital as the relevant fields are not on form
- Misinterpretation of data on forms
- No such thing as a '1 size fits all' form

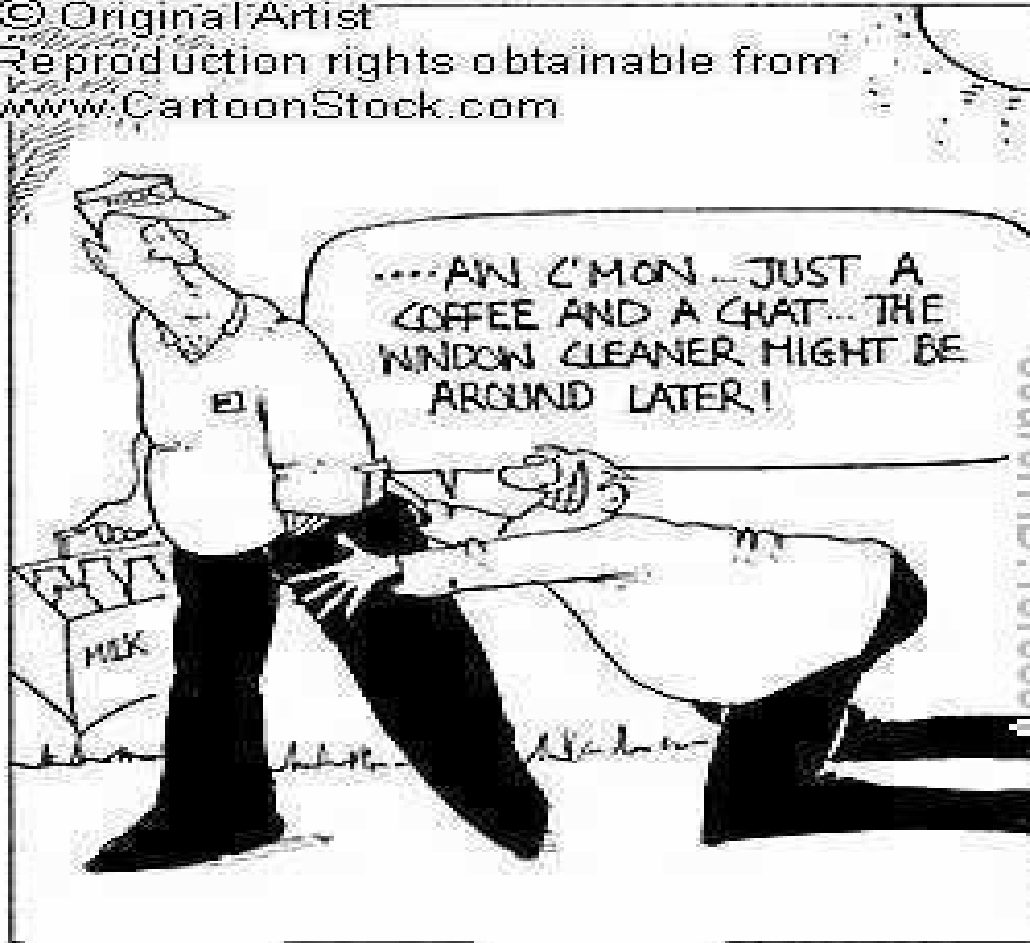


Who should be contacted in case of an accident?
" Why 999 of course, and these people are going to
be teaching my children"

Logistical / Local Difficulties

- Staff involved on nights off / annual leave-Time from event to completion of forms – can be days / weeks in some cases –months- staff forget what happened / why they did things a certain way
- Case notes missing / difficult to find
- Poor / Lack of Communication
- Poor documentation relating to the event
- Lack of support from senior management &/or Consultant Haematologist

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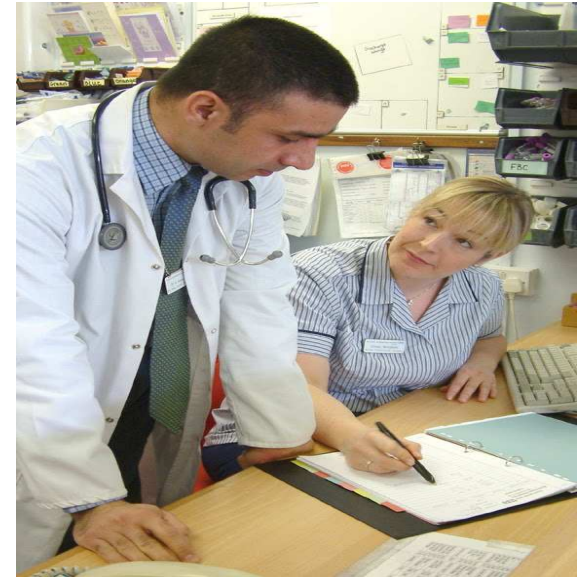
As a Haemovigilance Officer, Colin struggled with feelings of Isolation

Cultural Difficulties

- Fear of reporting – is there a good culture for enabling reporting /dealing with error ?
- Staff un-cooperative/ not willing to accept their mistakes or see reporting as reflecting badly on their practice

Ways to Overcome Barriers

- Try and initiate investigation ASAP
- Consistent approach to each investigation
- Use tools available – devise own tool
- *Never assume anything* -always establish the facts
- Speak to all staff involved (including medical staff)
- Set up meeting with all staff involved in the error to get accurate timelines, establish facts etc
- Devise your own forms for collecting data you think you will need- This can be later transferred onto the NHO forms
- Write up summary of each event including results of RCA
- Use errors to teach – staff more interested in errors that have occurred in their own hospitals
- Build good relationship with all grades of staff – trust & good communication are key
- If documentation is poor -bring this up as an issue that needs to be addressed



The Investigation Process

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Establish the *FACTS*

1. What happened
2. How it happened
3. Who was involved
4. Where it occurred
5. When it occurred
6. Any relevant contributory factors
7. Outcomes for patient
8. Corrective actions taken
9. Preventative actions taken

Internal Documentation

- UPMC Beacon hospital have developed a range of forms to assist the HVO in systematic event investigation , documentation and external reporting
- All steps of the event / reaction investigation & reporting are documented - from initial event / reaction investigation to close-out
- These forms ensure that all investigation and reporting steps are carried out consistently & ensures that no steps are omitted.
- The data on the internal forms can be used to assist in the completion of NHO report forms – eliminating the need to go back to the medical / nursing notes for data

Event Summary / RCA

- Once internal investigation is complete – Event Summary +/- RCA of event can be carried out
- The event summary documents all facts surrounding the error / reaction using a systematic approach

The Event Summary Template

- Background
- Event Occurrence
- First Site of Error
- Error Discovery
- Treatment Given (SAR)
- Outcome for Patient
- Error Causes / Contributory Factors
- Corrective / Preventative Actions

Case History

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Background

Date /Time:

- This young male required a day case procedure for investigation into PR bleeding & associated anaemia
- He had a past medical history of CVA and was on warfarin
- He had been off his warfarin prior to this admission due to the planned invasive procedure
- His INR on admission to the day unit was elevated at 1.7
- This result was available at 1030am

Error Occurrence

Date/Time:

- The consultant was informed of the INR result & prescribed 1 unit Solvent Detergent Plasma (Octaplas) to reverse the warfarin pre procedure (1st site of error)
- The laboratory staff informed the clinical staff that PCC (Octaplex) - the product of choice in this setting , was available in the lab
- The consultant confirmed that plasma (Octaplas) was to be issued & transfused
- 1 unit plasma was transfused and the patient was taken for their procedure at 1400

Error Discovery

Date/Time:

- The following day laboratory staff informed the Haemovigilance Officer that 1 unit of Octaplas had been issued to a patient with an elevated INR
- The Haemovigilance Officer investigated the details surrounding the transfusion (including clinical indication for transfusion) and discovered that the wrong component / product had been prescribed & transfused to reverse the effects of warfarin.

Causes of Error / Contributory Factors

- Failure to adhere to the current guidelines on the management of warfarin reversal

(This consultant had been made aware of the correct management of warfarin reversal as a letter from the consultant haematologist had previously been sent - outlining the current guidelines)

Corrective / Preventative Actions

- The event was discussed at the next hospital HTC and a plan of action agreed
- The Haemovigilance Officer contacted the patients primary consultant and spoke with them regarding the hospital policy on the appropriate management of warfarin reversal
- It was agreed that in addition to the current protocol (which was available on the hospital intranet) pocket sized protocols would be printed and made available to all medical staff & be placed in all clinical areas
- A presentation to medical staff focusing on coagulation issues & management of warfarin reversal was organised by the HVO and given by the consultant haematologist at grand rounds

Reporting Externally

- Completed Internal investigation /event summaries / RCAs can be edited & sent to NHO , in addition to the NHO forms
- Additional vital information relating to an event / reaction that is not captured on the NHO forms can be communicated to the NHO this way
- Reduces the requirement for further data being requested from the NHO at a later date

Summary

- Document consistently
- Develop internal documentation to assist in the recording / reporting of events
- Speak to *all staff involved* to gather facts- effective communication is key to error prevention
- Don't work in Isolation - Work together with other grades of staff to analyse & prevent errors



Together Everyone Achieves More

As each goose flaps its wings,
it creates an uplift for the birds that follow



By flying in a V-formation, the whole flock
adds 71% greater flying range than if each flew alone

"Communication + Co-Operation = Success"