ACT Government Health

CANBERRA HOSPITAL AND HEALTH SERVICES

Self Reflection

A tool for Incident Management

Improving Healthcare International Convention
November 2015

We had a problem

- Blood specimen labelling errors by medical and nursing staff
  - Wrong Blood in Tube (WBIT) and
  - Major mislabelling
- These errors had the potential to result in catastrophic harm
- Staff were not complying with correct patient identification
- The risk was high

Understanding the causes

- Investigations of multiple incidents across multiple clinical areas
- Observational auditing
- Discussion with staff

What did we learn

- Non compliance with correct patient identification procedures
- Lack of understanding of types of harm and harm potential
- Over reliance on other people/processes
- Lack of understanding of the risks
- Lack of accountability

- Policy & procedure
- Completed e-learning & education
- Knew what they had done incorrectly
- Could articulate the correct process
- Lack of appreciation of the risk of harm
- Over reliance on others

Who are the people making these errors

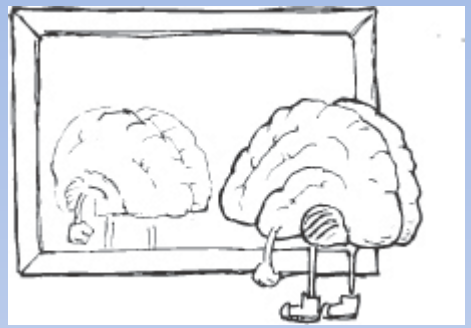
- ✓ They are Health Professionals
- ✓ They are educated
- ✓ They are trained
- ✓ They are trusted
- ✓ They are caring
- ✓ They do not intend to cause harm

HOWEVER

They are human and their errors do have the potential to cause harm

The Reflection Tool

Aim:



- Self review
- Understand the error
- Be accountable to learn and improve
- Learn from mistakes
- Leader engagement
- Identify areas for improvement
- Share your learning's
- Reflect on expected practice

WRONG BLOOD IN TUBE & MAJOR PATHOLOGY MISLABELLING & STAFF REFLECTION TOOL

Incidents related to pathology specimen labelling have been identified as a high risk requiring urgent action. The consequence of these incidents has the potential to significantly harm our patients. Many of the incidents relate to incorrect patient identification.

Health Professionals are accountable for ensuring the correct patient identification processes are followed.

You have been provided with this reflection tool to assist you and your manager with understanding the cause of these errors and to identify where practice in this area can be improved.

Please complete this reflection tool within 24 hours of becoming aware that you have been involved in a pathology specimen labelling incident.

It is expected that all staff involved in pathology specimen collection are familiar with and meet compliance with ACTH Standard Operating Procedure: Patient Identification: Pathology Specimen Labelling.

RISKMAN ID#: _____ CLINICAL AREA: _____

NAME: _____ DESIGNATION: _____

RETURN COMPLETED FORM to: _____

By:

Note: Any information used to assist with Quality Improvement will be de-identified.

Q!	REFLECTION QUESTIONS (most are a tick or circle response, some require a written response)
1!	How often do you perform pathology specimen collection? (circle) Daily Weekly Occasionally Rarely
2!	What was the specimen collection request?
3!	What was the incident? (circle) a) Wrong Blood in Tube (WBIT): patient identifiers on both request form and the specimen tube match exactly but there is another patient's blood in the tube. b) Major pathology mislabeling: patient identifiers on the request form and the specimen tube are from different patients.
4!	What was your role? (Circle) a) Specimen collector? b) Specimen collection witness? (Go to Q7) c) Other? (Describe)
5!	Did you have the completed and labelled request form with you at the time of collection? Yes or No / If 'No' why?
6!	Did you label the specimen tubes while still with the patient? Yes or No / If 'No' why & where did you label the tubes/container?
7!	Describe how you confirmed correct patient identification, including on the request form and the specimen tube/container?
8!	Describe the purpose of the witness (where relevant)?
9!	How should the witness confirm it is the correct patient's specimen in the tube?
10!	*Refer to the Standard Operating Procedure: Patient Identification: Pathology Specimen Labelling.* What step(s) in the procedure were not followed and why?

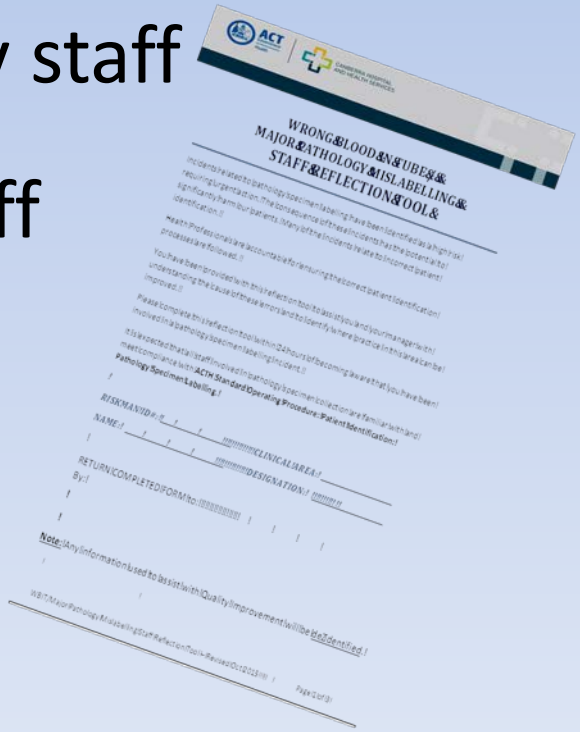
11!	What preventable harm did the patient experience as a result of this incident? (Circle)! a)! Another venepuncture/procedure for specimen recollection?! b)! Delay in results?! c)! Delay in treatment?! d)! Incorrect diagnosis?! e)! Other (describe):!!
12!	What did you say to the patient when you had to recollect the specimen?! !
13!	How was the error detected?! !
14!	Describe the possible outcome if the error had not been identified.! !
15!	Describe the barriers that prevented the correct procedure being followed in this case.! !
16!	What would you do differently in the future?! !
17!	Do you have any suggestions for how the system could be improved to help staff prevent these errors/incidents?! ! !
18!	Other comments:! ! !
!	Manager/CNC/Supervisor! Name_____ Designation_____! Comment:! ! ! Date:!!

Thank you for your cooperation!

Please arrange an appointment to discuss this reflection tool with your CNC/Manager!!

The Trial

- Trialed in high risk areas
- Engagement of leaders
- Engagement of Laboratory staff
- Engagement of clinical staff



Feedback

Leaders:

- Opportunity to discuss the incident & contributing factors related to:
  - the individuals practice &
  - the clinical unit
- Engage staff in problem solving
- Team approach to improvement & change

Staff:

- Very valuable
- Considered the impact of their practice

The Outcome

- Reduction in errors
- This may not be directly attributed to the reflection tool
- A catalyst for leader engagement & team approach to incident management & problem solving
- Quality improvement-team approach
- Taking responsibility and implementing solutions

Thank you