Incident Investigation

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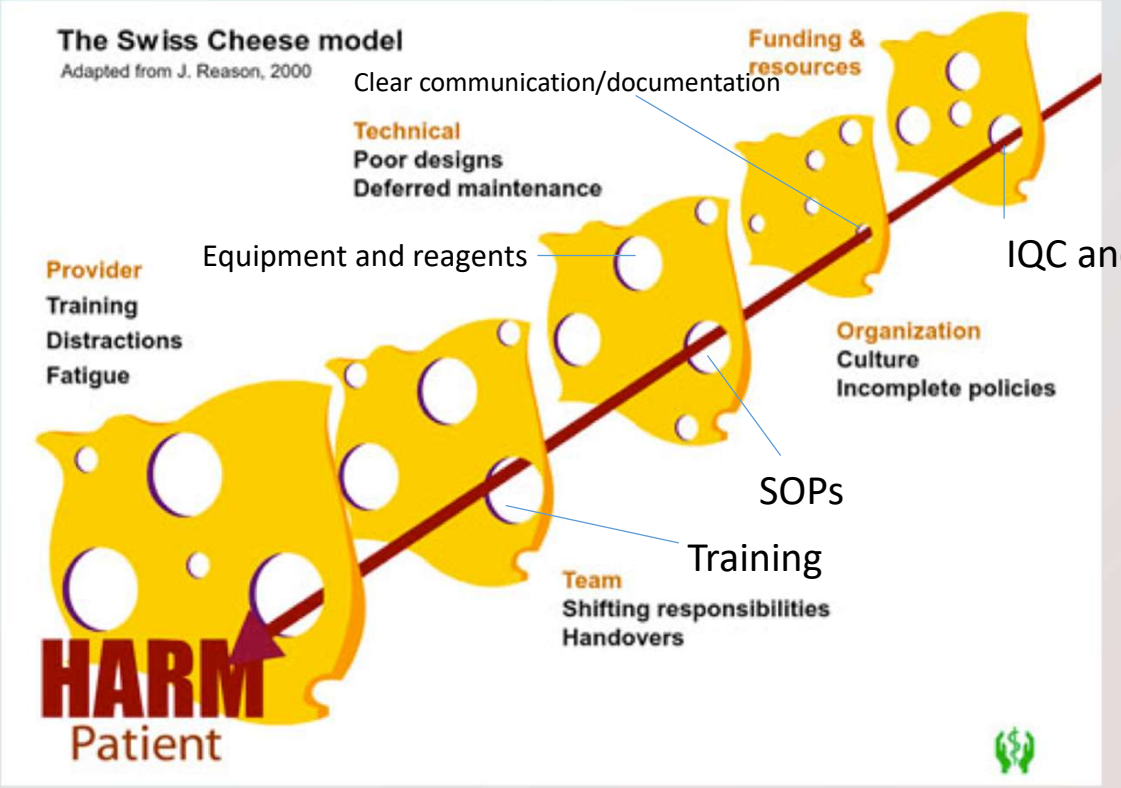
What is an incident?

- Dictionary definition: An event that is either unpleasant or unusual
- MHRA definition: An event that causes, or has the potential to cause, unexpected or unwanted effects involving the safety of service users, e.g. patients
- Local definition: Any adverse event affecting patients, staff, visitors, property, etc

Degrees of harm

- A scale: None → Low → Moderate → Severe → Death
- Near Miss → Never Event
- Transfusion example:
  - Near Miss – a wrong blood in tube (WBIT) that is identified by the checks in the process
  - Never Event – a WBIT that is not identified and results in an ABO incompatible transfusion

Swiss Cheese Model



Investigating an incident

- Be open minded
  - No preconceptions
  - Don’t be defensive or accusatory
- Get all the facts
- Documentary evidence from electronic systems
- Get witness accounts as soon as possible
  - Fresh in everyone’s minds
  - Approach with sensitivity
- Be fair to all parties
  - The majority of incidents are systemic failures and not due to an individual
- No gossiping!

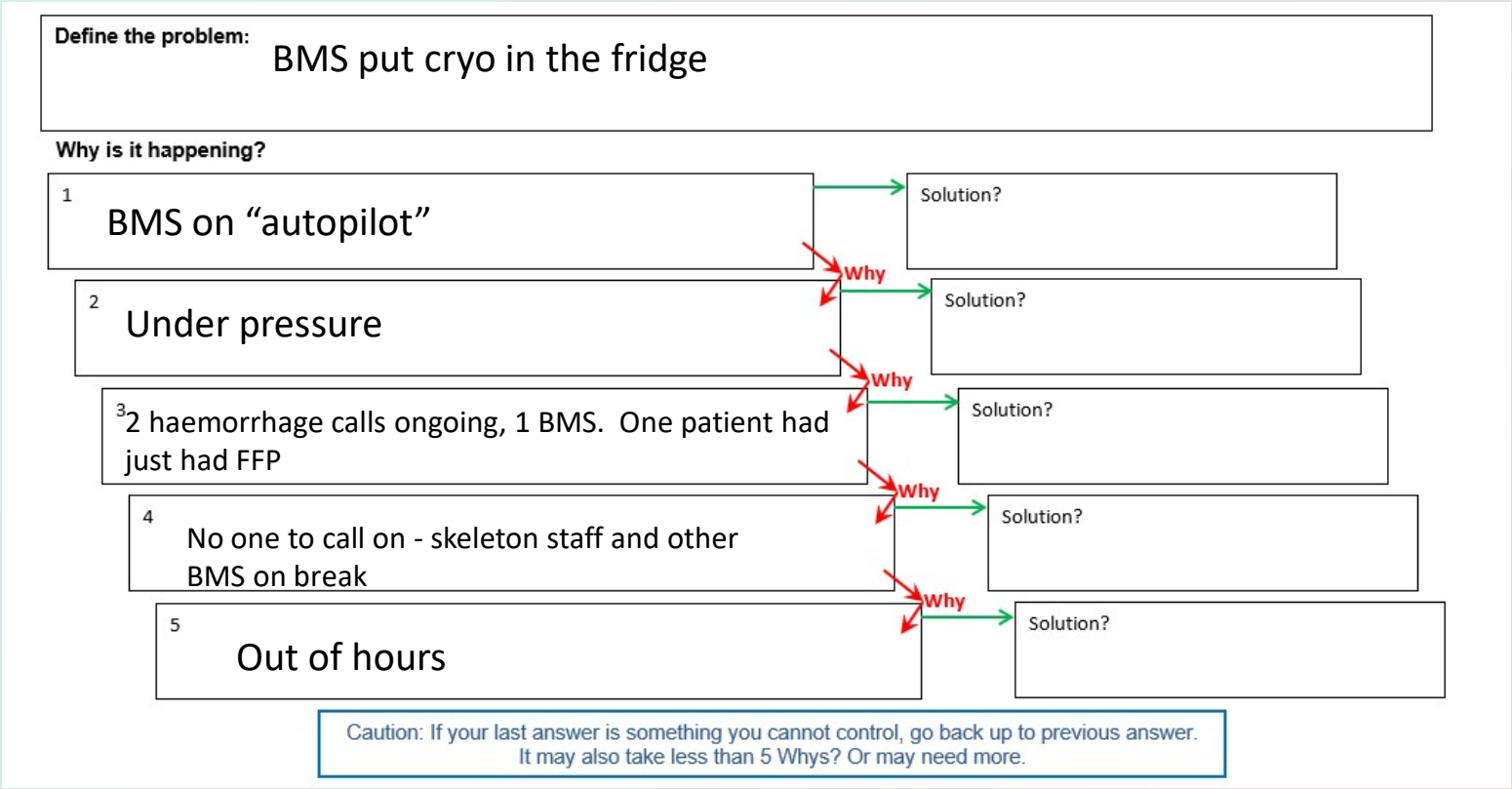
How to investigate

- The purpose of investigation
  - To learn how and why something happened
  - To establish ways of preventing re-occurrence – corrective or preventative action
  - Not to lay blame
- The time used to investigate should be proportional to the severity of the incident
  - Not always the case!
    - A WBIT that is identified by the checking process is a near miss, but requires investigation and root cause analysis

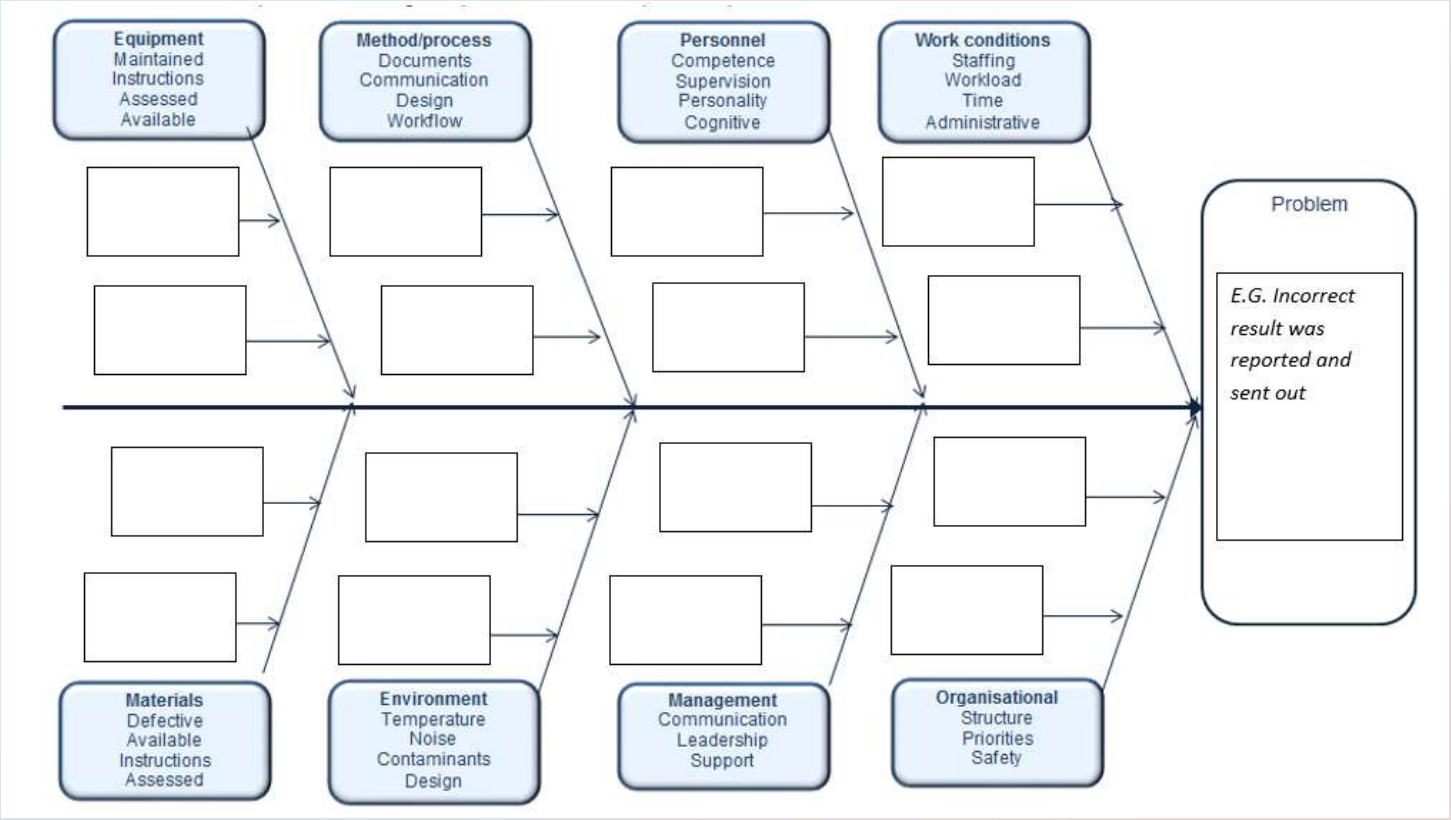
Root Cause Analysis

- Structured investigation
- Aim to identify the true cause(s) of a problem
- Information gathering
- Not always 1 root cause – could be multiple
- Methods:
  - 5 whys
  - Fishbone

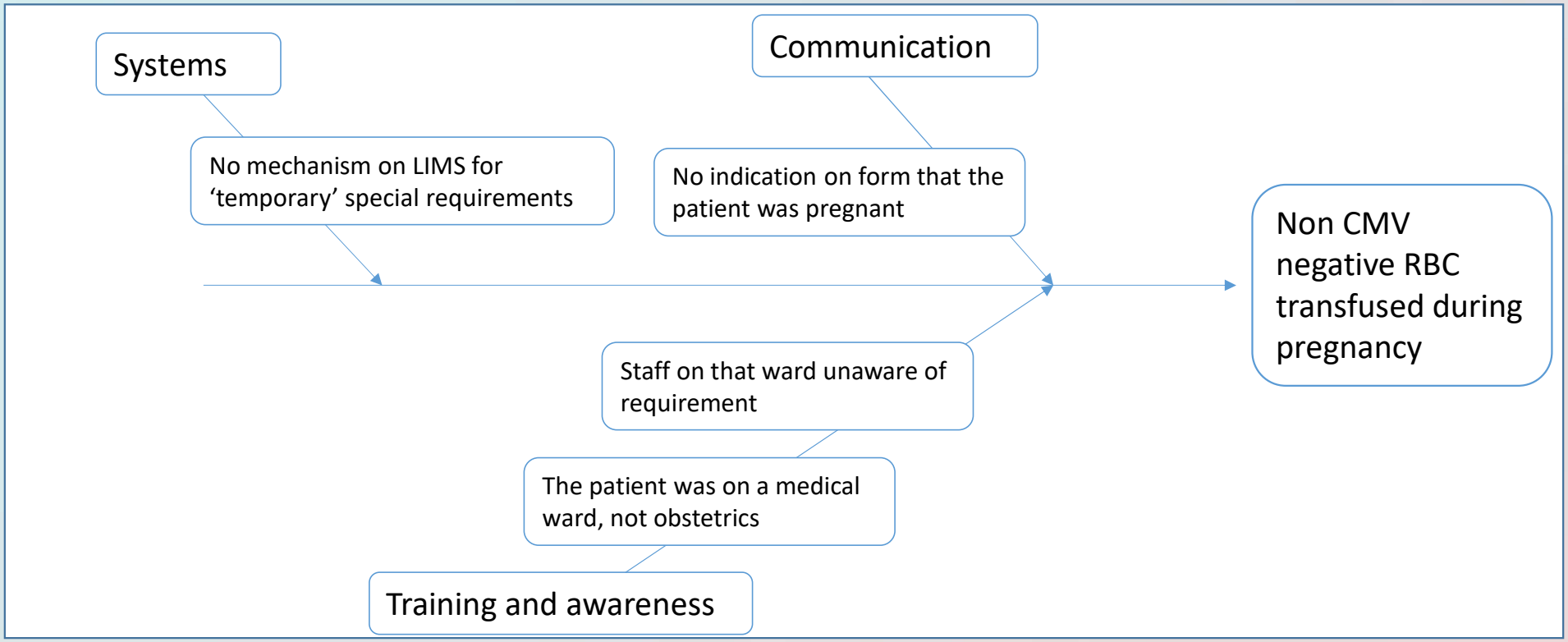
5 Whys


Define the problem:
BMS put cryo in the fridge
Why is it happening?
1
BMS on "autopilot"
Solution?
Why
2
Under pressure
Solution?
Why
3
2 haemorrhage calls ongoing, 1 BMS. One patient had just had FFP
Solution?
Why
4
No one to call on - skeleton staff and other BMS on break
Solution?
Why
5
Out of hours
Solution?
Caution: If your last answer is something you cannot control, go back up to previous answer.
It may also take less than 5 Whys? Or may need more.

Fishbone

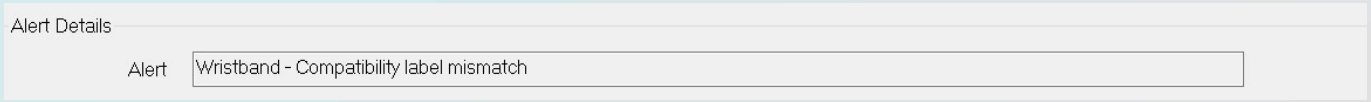

Equipment
Maintained
Instructions
Assessed
Available
Method/process
Documents
Communication
Design
Workflow
Personnel
Competence
Supervision
Personality
Cognitive
Work conditions
Staffing
Workload
Time
Administrative
Problem
E.G. Incorrect result was reported and sent out
Materials
Defective
Available
Instructions
Assessed
Environment
Temperature
Noise
Contaminants
Design
Management
Communication
Leadership
Support
Organisational
Structure
Priorities
Safety

Fishbone example



Example

- BloodTrack Alert



- Contact the ward
  - Stop what they are doing
  - Get unit back in the fridge if safe to do so
- Check that there are safe and appropriate units available
- Refer to the most relevant person to investigate
  - Transfusion Practitioner

Investigation

- First steps
  - Speak to the staff on the ward
  - Ask them to describe the checks they made
  - Physically check the unit
- Other staff in the process
  - Porters
  - Lab
- Documentary evidence
  - Electronic systems
  - Notes

Investigation

- Correct unit and correctly labelled at lab
  - Physically checked and electronic record of verification
- Electronic request for porter to collect unit
  - Shows correct patient was requested
  - Unit for correct patient was removed from fridge
  - Trained and competency assessed porter
- **But**
  - A unit for another patient was requested by another ward at the same time
  - Both jobs were given to the same porter

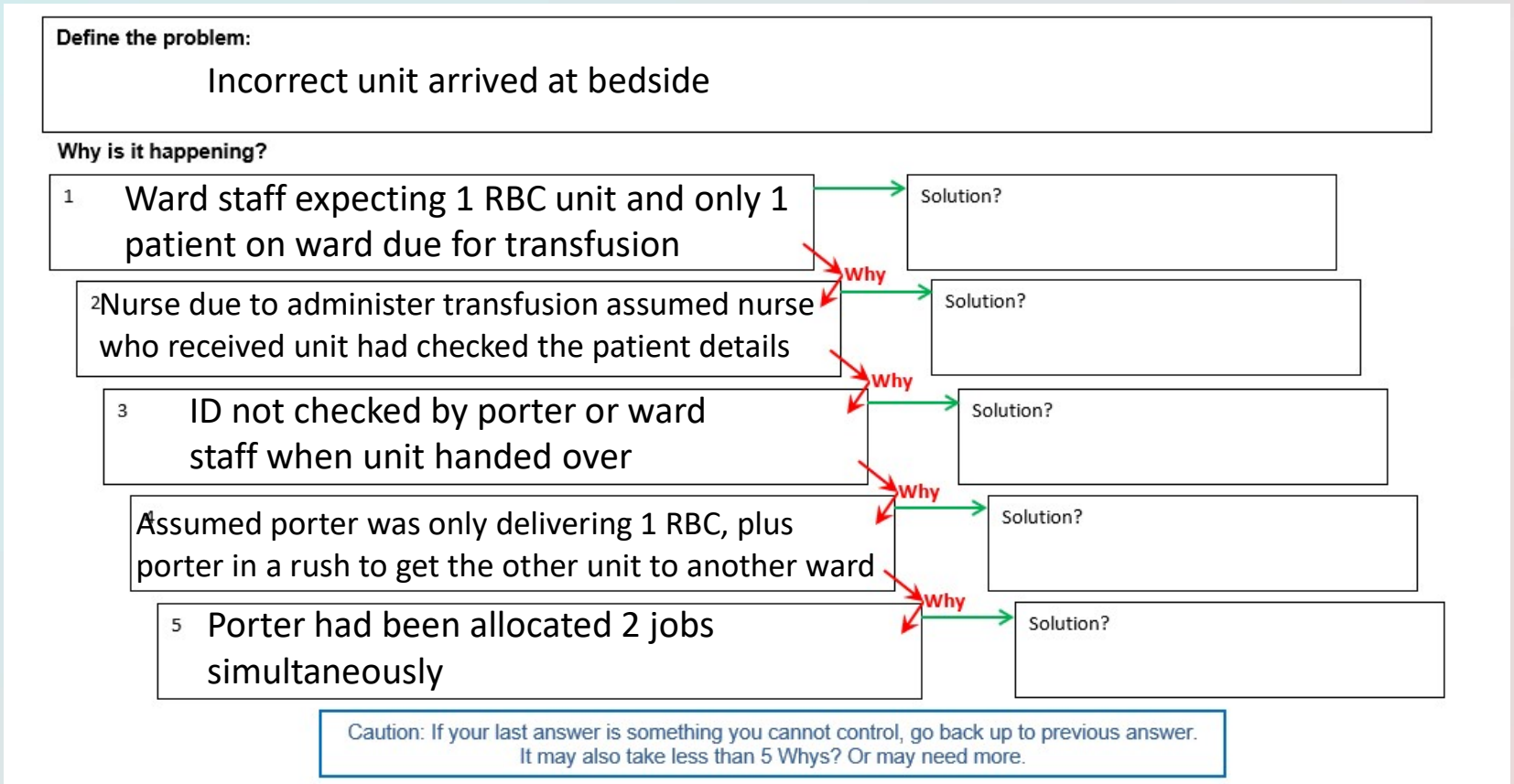
Investigation

- The porter collected both units
  - Distracted between the fridge and the wards
  - Handed unit over to a member of staff on the ward
    - Signed for it
- Unit handed to nurse looking after the patient
  - Expecting a unit of red cells
  - Didn’t check patient ID at this point
  - Didn’t check the patient ID until BloodTrack alerted!

Category of error

- Near miss
  - IBCT – WCT
  - Incorrect Blood Component Transfused – Wrong Component Transfused
- Report through SABRE portal
  - Also needs local incident report
- Root cause analysis

Root Cause Analysis



What is the root cause?

- Factors
  - Porter had been allocated 2 jobs and was distracted whilst doing them
  - Assumptions made about checks carried out by other staff
- Root cause – insufficient checking at all steps
- Changed documentation to better record these steps

Questions?

Transfusion STILL MATTERS

Thank you for listening