IIHMR UNIVERSITY

A retrospective study on Risk Assessment of Laboratory Complaints and Root Cause Analysis of High Risk Complaints

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INTRODUCTION

A risk assessment is simply a careful examination of what, in your work, could cause harm to people, so that you can weigh up whether you have taken enough precautions or should do more to prevent harm.

The law does not expect you to eliminate all risk, but you are required to protect people as far as 'reasonably practicable'

Conducting a Risk Assessment:

- Identify the hazards
- Decide who might be harmed and how
- Evaluate the risks and decide on the precautions that need to be taken to eliminate or reduce the risk
- Record your findings and implement them
- Review your assessment and update it if necessary

Rating a Risk:

- A Most Unlikely Event [1] x Trivial Injuries if event occurs [1] = Risk Rating of [1] Minimal Risk (1x1=1)
- A Likely Event [3] x Major Injuries if event occurs [4] = Risk Rating of [12] High Risk (3x4=12)

OBJECTIVE:

- **Broad objective:**
  To study the work flow of laboratory department
- **Specific Objective:**
  - ✧ To assess risk of the retrospective complaints of laboratory department
  - ✧ To conduct root cause analysis for high risk complaints

METHODOLOGY:

- **Study Type:**
  - ✧ The study is descriptive in nature. A comprehensive study has been conducted to measure the risk of complaints against laboratory department.
- **Sample Size:**
  - ✧ 178 complaints were assessed for risk
- **Sampling Technique:**
  - ✧ Non Probability convenience sampling technique

METHODS OF DATA COLLECTION:

- ✧ • **Quantitative data :**
- ✧ Negative feedbacks and complaints for laboratory department of last one year
- **Qualitative data:**
- ✧ Informal interviews for failure in process flow
- ✧ Focused group discussion
- ✧ Observation

FINDINGS OF THE STUDY:

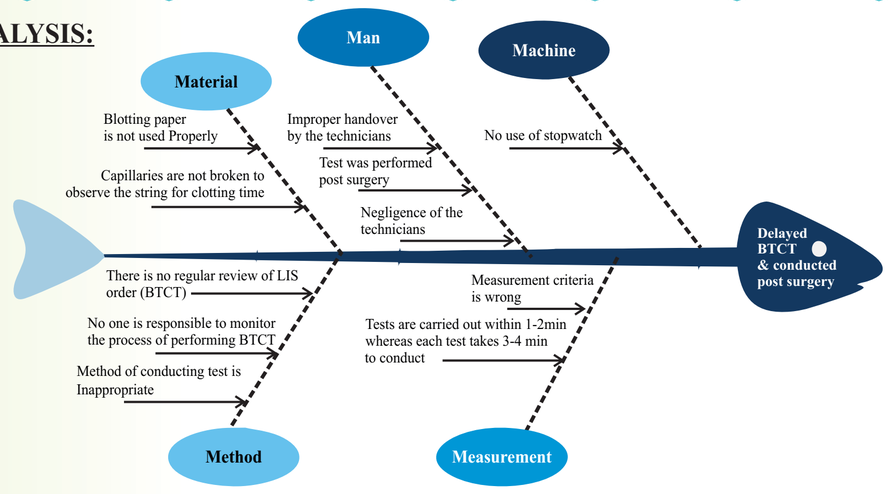
ROOT CAUSE ANALYSIS OF LABORATORY ERROR IN BTCT TEST

Description of the case : Patient ******, MRN: ****** admitted under Neurologist was advised to undergo Craniotomy. BTCT test was to be conducted as pre operative laboratory.

Action Plan/ Recommendations:

- Continuous monitoring of LIS to check pendency of BTCT
- Educate the involved personnel.
- Pre operative checklist should include BTCT findings

FISH BONE ANALYSIS:



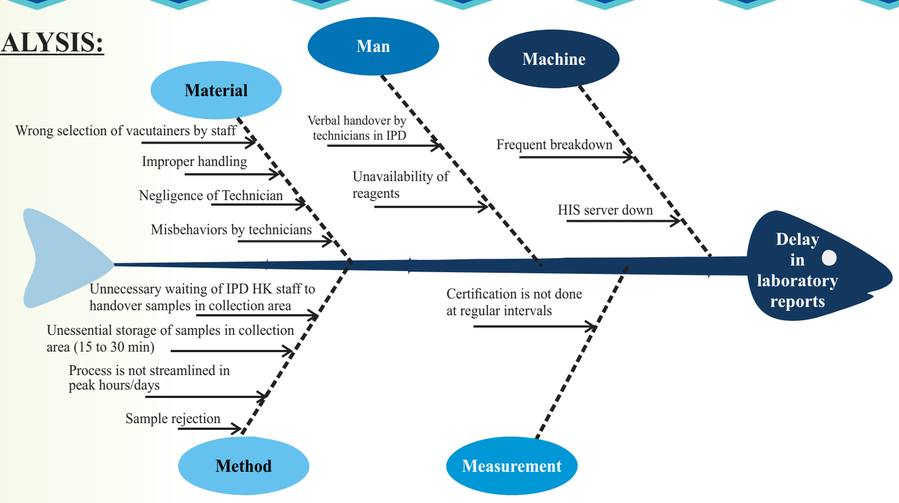
ROOT CAUSE ANALYSIS OF DELAY IN LABORATORY REPORTS

Description of case: Delay in dispatching reports from laboratory is very common leading to delay in consultation, patient dissatisfaction, increase in refunds etc.

Action Plan/ Recommendations:

- Stock monitoring process
- Equipment back up & Increase sample collection area
- Proper calibration & maintenance of equipments.

FISH BONE ANALYSIS:



ROOT CAUSE ANALYSIS OF NEAR – MISS : BLOOD GROUPING ERROR

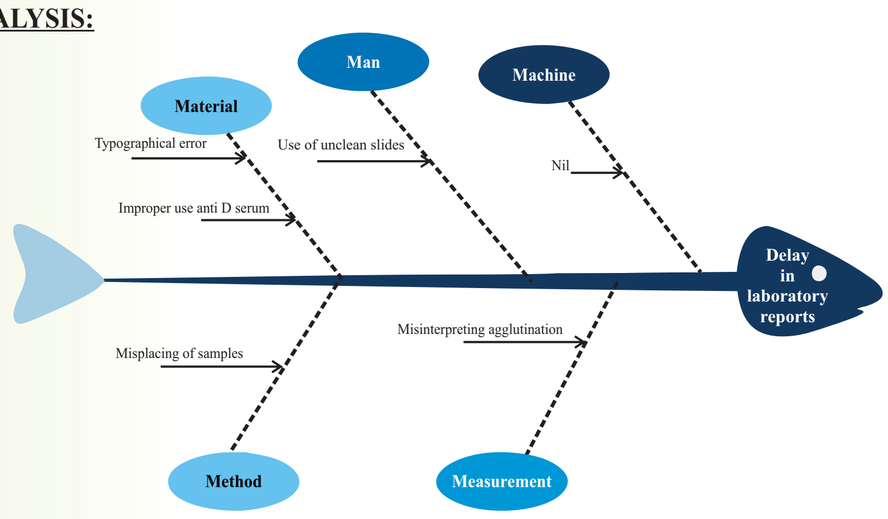
Description of the case :

Blood group reporting error. A patient with blood group B+ve was reported as A+ve.

Action Plan/ Recommendations:

- Proper tracking of samples (match with name & MRN)
- Cross checking of typed reports with the processed sample (Agglutination)
- Deploy trained staff for transcriptions(to avoid typographic error)

FISH BONE ANALYSIS:



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