QUALITY IMPROVEMENT MONITORING FORM (QIM)

PRIVILEGED & CONFIDENTIAL QUALITY ASSURANCE DOCUMENT, PROTECTED BY RCW 70.41.200

To be completed by staff person observing the QI opportunity

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| Reported by: Tech ID completing QIM form | Was product issued? Y / N *(circle one)* |
| Date and Time of Incident:  | Was the specimen redrawn or recollected? Y / N *(circle one)* |
| Patient Name: | Was there a delay in providing products? Y / N *(circle one)* |
| Patient MRN: | Accession Number | Were incorrect results reported? Y / N *(circle one)* |
| Unit Number:  | Component | Was the lab responsible for the error? Y / N *(circle one)* |
| Geographic Location:  | What was the actual effect on the patient?□ Unknown □ No Effect □ Minor □ Serious |
| Patient Location/Nursing Unit:  | Who has been notified of this incident? |
| Personnel involved :(Tech IDs) | Shift: | Other information: |

*(Check issue area in appropriate category (Pre-Analytic, Analytic, Post-Analytic, Administrative, Transfusion, Computer, Reference Lab)*

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| PRE-ANALYTIC |
| 🞏 Data Entry error or IT entry🞏 Order – Verbal Order not recorded🞏 Order – Test Missed🞏 Order – Ordered w wrong location🞏 Order – Ordered on wrong encounter🞏 Order – Wrong test ordered🞏 Order – Failed to order, Add on or modify test🞏 Order –Ordered on wrong patient🞏 Other  | 🞏 Patient ID – Ordered on wrong pt🞏 Patient ID – Wrong Pt Drawn 🞏 Patient ID – Wrong name on sample🞏 Patient ID – Wrong MRN on sample🞏 Patient ID – Wrong Pt registered 🞏 Patient ID – Wrong Pt. Label on Requisition🞏 Pre-Op req incomplete/inaccurate🞏 Requisition info incorrect🞏 Wrong product type ordered  | 🞏 Specimen Date/Time wrong/missing🞏 Specimen delayed or lost in lab🞏 Specimen delayed or lost in transport🞏 Specimen lost (reference lab)🞏 Specimen not collected/missed 🞏 Specimen suboptimal – IV contaminated🞏 Specimen suboptimal – handling/storage🞏 Specimen suboptimal – QNS🞏 Specimen suboptimal - hemolyzed🞏 Specimen suboptimal - clotted🞏 Other |
| ANALYTIC | POST- ANALYTIC | ADMINISTRATIVE |
| 🞏 Delay in Testing🞏 Clinical Instruments or Service delay/error🞏 Instrument error/downtime🞏 Reagent/Supply Issue🞏 Wrong sample used for testing🞏 QC or PM not performed🞏 Results not verified🞏 Pending List not printed or reviewed🞏 Other  | 🞏 CV not called or delayed call🞏 CV called but not verified🞏 Inappropriate sample storage post testing🞏 Incorrect results/comment reported🞏 Results delayed🞏 Results mailed or sent to wrong provider🞏 Results not reported or sent to wrong Dr🞏 Other | 🞏 Blood Product Inventory backordered🞏 Billing Error🞏 Daily Operations Reports not run🞏 Blood supplier Courier error🞏 Customer Complaint🞏 Environment of Care Issue🞏 Inventory or Supply issue🞏 Vendor supplier issue🞏 Recalled Product🞏 Cab/Delivery service error🞏 Other |

Brief Description of Problem/Issue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| TRANSFUSION SERVICE ISSUES | COMPUTER ISSUES | REFERENCE LAB ISSUES |
| 🞏 Transfusion Tag Info wrong or missing🞏 Massive Transfusion Protocol Issue🞏 CRYO ordered thawed but not given 🞏 FFP ordered thawed but not given🞏 Patient testing not performed/recorded🞏 Product not unpacked timely🞏 Product out of monitored storage>30min🞏 Product spiked, not given🞏 Product transport issue🞏 BAD file not updated🞏 Suspected TRRX workup issue 🞏 Transfusion Record not completed by Nurse🞏 Trauma Sample Issue🞏 Unit bag failure🞏 Unit failed inspection🞏 Unit hung without proper filter🞏 Unit issued w/o Dispense in Sunquest🞏 Unit not entered into LIS when returned🞏 Unit not released as required🞏 Unit testing not performed/recorded🞏 Wrong product ordered🞏 Other | 🞏 Epic Downtime/Issue🞏 Sunquest Lab Issue🞏 Hematrax Issue🞏 Instrument Interface Issue🞏 Printer issue🞏 Copier issue🞏 Other IT issue | 🞏 Results delayed🞏 Communication delay on sample issue🞏 Wrong Test done🞏 Report Issue🞏 Result incorrect or corrected🞏 Sample Lost 🞏 Other |
| PRODUCT/INVENTORY ISSUE |
| 🞏 UNIT OUTDATED ON SHELF🞏 UNIT OUTDATED/REC’D SHORT DATE |

FOR SUPERVISOR/MANAGER USE ONLY

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| CONTRIBUTING FACTOR | INVESTIGATION/CORRECTIVE ACTION TAKEN | PROCESS or PROCEDURE CHANGE |
| 🞏 Environmental Factor(s)🞏 New Employee <90 days🞏 Instrument malfunction/error🞏 SOP not followed🞏 SOP incomplete/in error🞏 SOP not created🞏 Staffing low/volume high/unusual situation🞏 Technique Problem🞏 Training Issue🞏 Other | 🞏 Cognitive (Misinterpretation, faulty decision)🞏 Non-Cognitive (Slip, lapse in attention)🞏 Patient Adverse event - PSN completed🞏 Sentinel Event – Root Cause Analysis 🞏 Root Cause Analysis scheduled🞏 Revise SOP🞏 Train Staff🞏 Employee follow up 🞏 Transfusion FDA reportable events  BPDR # \_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏 Other |  |

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| MANAGER REVIEW/DATE | INVESTIGATED BY | FOLLOW UP BY COMPLIANCE ANALYST |
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