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

|  |  |  |
| --- | --- | --- |
| 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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