**Job Aid 2:** **NCE Training of All Staff 4-15**

**Purpose**: An effective NCE management program necessitates that staff at every level of the organization recognize NCEs and know how to report them, and that they feel comfortable doing so.

1. Explain the purpose and use of NCE information for your organization
   * Expand upon *Culture of Quality*
     + Consider reviewing the Quality Policy with staff and connect the following:
       - * How occurrence reporting reduces risk which improves quality;
         * How the organization’s culture welcomes these opportunities for quality improvement;
         * How problems occur when processes go wrong, not because people want to make mistakes.
     + Explain the importance of organizational knowledge of NCEs occurring.
       - Laboratory is a high-risk business, and wrong results may be catastrophic to the patients we serve.
       - A problem that goes unreported to those who can fix it (i.e. management) is a problem unresolved.
       - Unreported problems are highly likely to recur that through recurrence there is an increase of severity of consequences to the patient.
       - Quality is dependent on processes, and management is responsible for the design and implementation of those processes. Therefore, management recognizes that problems with quality at the bench level are primarily due to imperfect processes, rather than the fault of the staff.
       - Problems occur when processes go wrong, not because people want to make mistakes
2. Define *Just Culture* and how it applies at your site.
   * + Share your site’s *Just Culture Policy*
     + Ensure staff really understands what a nonpunitive reporting system means.
       - The goal is prevention not punishment
       - A culture in which we learn from our mistakes by making it safe to talk about them.
       - A way of thinking and documenting about how design has adversely affected staff performance. NCE reporting enables the redesign of a system or modification of the work environment to aid staff.
3. Review staff’s role and responsibilities within the organization’s NCE program
   * + Note that employees must be willing to report events in the interest of patient safety, even if the NCE involves their own inadvertent error.
     + Ensure staff understands NCEs will occur, and it is their responsibility to report NCEs to ensure appropriate follow-up is taken.
     + Alert staff that management will ask the involved employee as well as other staff if they have suggestions for system change.
     + Discuss issues that should not enter the NCE process, but instead should be brought to the supervisor’s attention and dealt with individually:
       - Accusations
       - Rumors or Gossip
       - Grievances
       - Personnel Issues (e.g. harassment, discrimination, substance abuse, or violence)
       - Compensation Issues
       - Disputes with organizational policies
4. Review the reporting process using the approved documents.
   * Discuss how to identify a NCE and take appropriate remedial action
     + - Types

Complaints

Sentinel Events

Amended reports

Concerns by staff regarding barriers to compliance with policies, processes, and procedures

Handling of examination nonconformities (e.g. IQC, EQA, calibration)

* + - * Remedial action is action taken to contain or remedy the problem (i.e. eliminate the symptoms of the problem)
  + Demonstrate how to report a nonconformity using the approved form
    - * Designate the person to whom the NCE occurrence reports are submitted. This is usually a supervisor
      * Address standardization of reporting, such as one NCE per report vs multiple similar NCEs per report
  + Address aspects of a good report vs a poor report
    - * A good report

Provides facts about the problem not emotions

Provides all relevant facts

Focuses on the problem and not the person

|  |  |  |
| --- | --- | --- |
| **Good** | **Poor** | **Comment** |
| Patient Reddy, Revina (ICU) MR 12345, had a FBC drawn at 1430. The results showed a decrease in wbc (2.1), rbc (3.33), hgb (9.1), and plt (2). The yesterday’s platelet count was 252. I rimmed the specimen, and there were no clots. I spoke with Kelly, the patient’s RN. She explained that to help the laboratory, she removed the clot before sending the specimen to the laboratory.  **Remedial Action**: Sent the phlebotomist to redraw patient. Redrawn specimen results corresponded with yesterday’s results with a plt of 241. Wrote *REJECT* on tube. Updated log books. Attached copies of the clotted FBC results and redrawn FBC results. Gave copy to reception to credit the request involving the clotted specimen. | Clotted specimen. Spoke with Kelly. Kelly got really angry and complained that laboratory does not do its job. I told Kelly that the patient must be redrawn and that I was sending our phlebotomist. Kelly slammed the phone down.  Remedial Action: Specimen redrawn by our phlebotomist and not Kelly.  Specimen is okay. | The good example focuses on the problem. The poor example focuses on the person. |

1. Target specific areas of concern about the reporting process, such as:

* Nothing ever changes;
* No feedback is received;
* Strong fear of retaliation;
* Lack of confidentiality to the entire process.