Tracking Number: NCE-2016-219

Nonconforming Event (NCE) Report Form

☒ Existing nonconformity
❒ Potential nonconformity

DATE/TIME OF NONCONFORMITY: 29 June 2016 1030 **DATE/TIME OF REPORT:** 29 June 2016 1045

PERSONNEL REPORTING NONCONFORMITY: Hematologist Tech RR

PATIENT'S NAME: Adisu Modise (IF APPLICABLE) **PATIENT ID:** MR1998 (IF APPLICABLE)

PATIENT'S CLINICIAN: Dr. Waka (IF APPLICABLE)

LOCATION OF NONCONFORMITY: Hematology Section

BRIEF DESCRIPTION OF NONCONFORMITY: Dr. Waka called to inquire about the WBC and PLT counts he ordered on his patient. He explained that he received only a hemoglobin result instead of the FBC he ordered. He wants to know what is going on and why does laboratory not give results that he needs.

HOW WAS THE NONCONFORMITY DISCOVERED? Dr. Waka called, and I answered the phone.

REMEDIAL (IMMEDIATE) ACTION TAKEN: I explained the FBC analyzer was broken since yesterday, and we can only perform hemoglobin tests on our POC instrument. He wanted to know why he was not notified until he called the laboratory looking for missing results. He was angry because if he had known ahead of time, he would have made other arrangements. I explained that I will log his complaint and give it to the hematology section supervisor immediately.

Report provided to

Supervisor Name: Hematology Section Supervisor **Date/Time:** 29 June 2016 1055

Supervisor must obtain tracking number within 24 hours of receiving the occurrence; write number on top, right-hand corner.

Nonconforming Event (NCE) Investigation and Management Form

Instructions

Tracking Number: **NCE**-2016-219

- *Begin investigation as soon as possible. Determine what, who, when, how, and then why (cause analysis) things went wrong in the process that led to the nonconforming event.*
- *Classify the event.*
- *Propose action to correct the problem or mitigate the risks*

Supervisor/Manager Investigation (attach pertinent information if required):

I spoke to Dr. Waka to apologize for the inconvenience. I explained that because the FBC analyzer was broken we were not analyzing patients. We did not want to provide wrong results to him. He explained that he understood but would appreciate to be notified earlier. He stated that he is never sure what he should interpret when he sees no result next to the requested test.
Dr. Waka then asked about another patient where he ordered a FBC but did not even receive a hemoglobin result. I explained that we ran out of hemoglobin cartridges mid-morning. He noted that he does not have the time to call laboratory trying to guess what is happening with his patients. I explained that we have a *Delay Notification Procedure*, and a memo will be coming out shortly.

Name: Hematology Section Supervisor Date/Time: 29 June 2016 1055

Classification (check all that apply):							
Non-laboratory Error		Laboratory Error	X	Laboratory Section: Reception Hematology Section			
Pre-examination		LIS problem		Receiving/Delivery		Complaint	
Examination		Equipment		Waste Management		Safety/Injury	
Post-examination	X	Purchasing		Environmental Issue/Housekeeping		Reference Lab	

Proposed correction (attach action plan if approved): I will notify the Technical Supervisor earlier so that the memo can be sent out immediately. I will write the date/time in the section's communication book so that everyone knows in the section that the Technical Supervisor has been notified.

QA Officer Comments: Make sure the wards are notified in a timely manner

Risk Score: 2 Name: Quality Manager Date/Time: 29 June 2016 1300

NCE Management Database Entry:

NCE closed and entered into database Name: Quality Manager Date: 29 June 2016

Cape Clinic Hospital Laboratory
18 Cape Artemis Road
Providence X, Country X
Phone: +254 066-5555 Ext 204/205

Laboratory Hematological Request Form

Patient Name: Adisu Modise **Age:** 36 **Gender:** F

Ward: Women's Medical Ward **Lab No.:** **Specimen:** blood

Ordering Physician: Dr. Waka

Collector: YT **Collection Date:** 29 June 2016 **Collection Time:** 0745

Clinical history of the patient: **Routine / Urgent / Timed:**_________

possible idiopathic thrombocytopenic purpura (ITP); splenomegaly, corresponding FBC for scheduled bone marrow this afternoon

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Investigations Required:

	Result	Initials	Date/Time
1. Hb	10.1 g/dl	RR	29/6/2016 0830
2. FBC	(see stapled attachment)		
3. Differential Count			
4. ESR			
5. Malaria Smear			
6. Retic			
7. CD4			

Please note: All biological reference intervals are made available in the *Laboratory Handbook for Clients.*

Additional Comments and Interpretation

I/C Laboratory Reviewer SEW Date/Time 29/6/2016 0900