E7. INCIDENTS POSSIBLE IN BLOOD BANKACTIVITY.

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Blood Bank Ploiesti

Introduction: Romanian word: "He who does not work any wrong" is quite true nowadays. It is widely recognized that in everyday life, man is fallible. The desire for self-improvement of any organization makes any implemented quality management system, to be inserted into a general procedure for registration and resolution of errors / nonconformity, a general procedure for undertaking preventive and corrective actions.

Observation and analysis of systematic errors / nonconformities in an organization, awareness of all activities sensitive critical points in the process, awareness of errors that can occur during activities of daily medical attention, executive staff on errors that may occur in a work, determine significantly reduce the number of errors / nonconformities.

Material and Methods: Full transfusion center staff has a responsibility to report and record incidents occurring in daily activities. Prevention of unwanted incidents as preventing their recurrence in CTS work, recording and analyzing their periodical meetings is a way of improving operational work a transfusion center, with the ultimate goal of increasing the safety of transfusion. Have been recorded since 2012, all incidents occurring in the transfusion chain, which were observed by staff or executive staff. These were analyzed and remedied quickly, at the time of or reviewed periodically, depending on their impact on business, to avoid repeating them.

Minor incidents can occur without impact on transfusion safety but major incidents can occur that affect the quality of blood products and transfusion safety so. After notaries systematic incidents occurring in everyday life, and after examining the processes in the blood Ploiesti, observing all the critical points, we made a schedule unwanted incidents that if we study and acknowledge them as possible to occur in some ways, we have a good chance to avoid them, to proceed in such a manner as not to produce, and to assure the quality of blood products.

Results: We identified 97 possible incidents that may affect the quality of blood products center. We classified the business sectors and we discussed with staff to try to work in such a way as to avoid them.

Conclusions: Awareness that can go wrong, identification of critical points in the system do to work responsibly, taking all measures to avoid mistakes that can affect quality of care.