Forging Together Without Competition: Embedding Culture Principles using Cause Analysis

Friday, March 11th
1:00-2:00PM EST
Webinar Logistics

Getting on the Telephone:
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• Please remember to mute yourself

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Questions and Comments:
Should you have any questions and/or comments during the webinar, please enter them into the question box, and we will address them during the open discussion portion.
Webinar Speakers

Jeanette Teets, RN, MSN, CPNP
*Director of Patient Safety & SPS Culture Lead*
The Children’s Hospital of Philadelphia

Stephen Czekalinski, MBA, RN, BSN
*Patient Safety Manager*
UH Rainbow Babies & Children’s Hospital

Susan Teman, BSN, RN, CPPS
*Clinical Integration Specialist-Simulation*
Helen DeVos Children’s Hospital
# Webinar Agenda

<table>
<thead>
<tr>
<th>Topic</th>
<th>Facilitator</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome, Webinar Overview, &amp; Introductions</td>
<td>Laurie Stevens</td>
<td>3 min.</td>
</tr>
<tr>
<td>Cause Analysis 101 – Root Cause Analysis</td>
<td>Jeanette Teets</td>
<td>17 min.</td>
</tr>
<tr>
<td>Hospital Sharing</td>
<td></td>
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<tr>
<td>• UH Rainbow Babies &amp; Children’s Hospital</td>
<td>Stephen Czekalinski, Susan</td>
<td>30 min.</td>
</tr>
<tr>
<td>• Helen DeVos Children’s Hospital</td>
<td>Teman</td>
<td></td>
</tr>
<tr>
<td>Audience Q&amp;A &amp; Adjourn</td>
<td>Jeanette Teets</td>
<td>10 min.</td>
</tr>
</tbody>
</table>
Webinar Objectives

- Share how transitioning to a standardized Root Cause Analysis methodology can improve learning from safety events, develop mitigation strategies and prevent harm reoccurrence.

- Apply executive leadership and patient family engagement as key components in sustaining a standardized approach.

- Knowledge of how unit-based Root Cause Analysis and Apparent Cause Analysis are used to mitigate safety events and engage patient and families.
About SPS

Laurie Stevens
Project Specialist
OUR MISSION:

Working together to eliminate serious harm across all children’s hospitals
Children’s Hospitals’ Solutions for Patient Safety (SPS) Network Map
Our 2015-2016 Goals

- 40 percent reduction in hospital-acquired conditions (HACs)
- 10 percent reduction in readmissions
- 25 percent reduction in serious safety events (SSEs)
Jeanette M. Teets
Children’s Hospital of Philadelphia

CAUSE ANALYSIS 101: RCA
OVERVIEW
• Opened in 1855 as the first children’s hospital in the United States

• 537-bed Main Hospital and Children’s Seashore House devoted primarily to inpatient care and rehabilitation for children with chronic illnesses and severe developmental disabilities

• Large Ambulatory Network with 4 Ambulatory Surgical Facilities
RCA Methodology

STANDARDIZATION
SEC & SSER Patient Safety Measurement System for Healthcare

- Common definitions for classifying events
- Based on deviation from generally accepted performance standards and degree of harm that results to the patient

- Volume-adjusted measure of events resulting in moderate to severe harm or death
- Intended to be used initially as an internal metric of preventable harm and measure of safety performance
A deviation from generally accepted performance standards (GAPS) that...

**Serious Safety Event**
- Reaches the patient
- Results in moderate to severe harm or death

**Precursor Safety Event**
- Reaches the patient
- Results in minimal harm or no detectable harm

**Near Miss Safety Event**
- Does not reach the patient
- Error is caught by a detection barrier or by chance
The Known Complications Test

Four questions:

1. Was the procedure, treatment, or test appropriate and warranted based on nationally recognized standards of care?
2. Was the complication a known risk, was it anticipated, and did the care team plan ahead to take steps to prevent it?
3. Was the complication identified in a timely manner (i.e. at the time of occurrence)?
4. Was the complication treated according to the standard of care and in a timely manner?

If the answer to **ALL four questions** is YES, the event is considered a known complication and not a Safety Event.

If the answer to **ANY question** is NO, the event is a Safety Event.
Safety Event Decision Algorithm

Was there a deviation from generally accepted performance standards (GAPS)?

Yes → Did the deviation reach the patient?

No → Not a Safety Event

Yes → Did the deviation cause moderate to severe harm or death?

No → Near Miss Safety Event

Yes → Serious Safety Event

No → Precursor Safety Event
<table>
<thead>
<tr>
<th>Serious Safety Event</th>
<th>SSE 1</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSE 2</td>
<td>Severe Permanent Harm</td>
<td></td>
</tr>
<tr>
<td>SSE 3</td>
<td>Moderate Permanent Harm</td>
<td></td>
</tr>
<tr>
<td>SSE 4</td>
<td>Severe Temporary Harm</td>
<td></td>
</tr>
<tr>
<td>SSE 5</td>
<td>Moderate Temporary Harm</td>
<td></td>
</tr>
<tr>
<td>Precursor Safety Event</td>
<td>PSE 1</td>
<td>Minimal Permanent Harm</td>
</tr>
<tr>
<td>PSE 2</td>
<td>Minimal Temporary Harm</td>
<td></td>
</tr>
<tr>
<td>PSE 3</td>
<td>No Detectable Harm</td>
<td></td>
</tr>
<tr>
<td>PSE 4</td>
<td>No Harm</td>
<td></td>
</tr>
<tr>
<td>Near Miss Event</td>
<td>NME 1</td>
<td>Unplanned Barrier Catch</td>
</tr>
<tr>
<td>NME 2</td>
<td>Last Strong Barrier Catch</td>
<td></td>
</tr>
<tr>
<td>NME 3</td>
<td>Early Barrier Catch</td>
<td></td>
</tr>
</tbody>
</table>
Getting Started

• Some Key Elements:
  – Scoring Team
  – Ensure you are hearing about cases
  – Standardized Methodology Implementation
    • HPI Training
  – Database (all inclusive)
  – Coding Following the Event
  – Inter-Rater Reliability of the Data
How SSEs are Classified

• A consistent group evaluates cases to determine deviation in GAPS, and assesses the level of harm and assigns a score to the event
  – Uses consistent, structured approach
  – Most effective with good “fact finding”

• Team needs strong support from senior leaders and strong sense of internal trust
Best Practice Tips in Safety Event Classification

• Identify a consistent group of people to serve as a “Safety Event Review Panel” to provide expertise, consistency, and integrity in event classification. The group should be a mix of clinicians and methodology experts and senior enough to gain organizational trust.

• When classifying an event, use the SEC algorithm and always ask ALL the questions – e.g. Was there a deviation? Did the deviation reach the patient? What was the level of harm?

• Charge one person with the responsibility for thinking/asking about precedent.
Best Practice Tips in Safety Event Classification

• Keep a record of challenging event classification cases and classification rationale. This record provides a useful reference when assessing similar future cases and enables the group to look at changes in their own perspectives in event classification.

• What happens in the discussions, stays in the discussions. The group speaks with one voice outside the meetings.
RCA Guiding Principles

• **It is about the process:**

  – Errors must be accepted as system flaws, not character flaws
  
  – Errors are seen as consequences not causes
  
  – It is the process not the individual who failed
  
  – It is the cause of the error, not the error itself that leads to productive prevention strategies
Human Error – A Symptom, Not Cause

Human error is not the cause of failure, but a *symptom of failure*

Human error – by any other name or by any other human – should be the *starting point* of our investigations, not the conclusion

Root Cause Analysis (RCA)

A structured problem-solving technique that results in one or more *corrective actions to prevent recurrence* of an event

- Technique involves an evidenced-based understanding of the fundamental causes of error and events
- A key management function for correcting serious deviations of outcomes from expectations

The goal of a Root Cause Analysis is to find out:

- what happened
- why it happened
- what to do to prevent it from happening again
Interviews

• One on one is best practice
• Critical to finding out what happened and why
• Open ended questions
• Avoid judgement – It is amazing what you find out…..
• Be aware of the need to alert their manager if they are in distress - “second victim”
But to understand failure

• Questions are not
  - Where did they screw up?
  - Why didn’t they notice what we find important now?
• Question is:
  - Why did it make sense for them to do what they did?

Why did it make sense?

• To understand why people did what they did...
• Reconstruct the world in which they found themselves at the time
3 Meeting Model

RCA Owner, Stakeholders & Subject Matter Experts

EVENT OCCURS
- Stabilize situation
- Control evidence

Meeting #1 (Facts)
- Review Charter, Exe Sponsor, Team Leads
- Confirm scope of event
- Identify & coordinate interviews & data gathering

Meeting #2 (Causes)
- Agree on facts & proximate causes
- Build consensus for possible root causes

Meeting #3 (Corrections)
- Consensus on root causes
- Finalize Corrective Action plan: Owners and due dates

RCA Analysts

Investigate, determine SOE & proximate causes

Determine individual and system causes

Confirm root causes and conceptualize action plan

SOE: Sequence of Events
The Root Cause

• A condition that, if corrected, prevents recurrence of the event
• Typically 1-3 root causes per event
• Four critical attributes:
  – Proven cause and effect relationship
  – Condition is substandard
  – Within management’s control to correct
  – Cost effective to correct
Root Cause Statements

You probably haven’t gone deep enough if...

• You start with the words “failure to...” and end with a process or action (e.g. Failure to do a time out”)

• You restate errors made as the root cause (e.g. “Inadequate preparation for the procedure” or “Radiologist did not call report to the nursing unit as per established process for STAT orders”)

• You describe the lack of a process that should be long standing but don’t describe why it is lacking (e.g. “lack of process for review of prior orders when completing a 24-hour chart check” or “inattention to detail – no sponge count done prior to procedure”)
Test for Comprehensiveness

*Have we gone far enough? Have we dug deep enough?*

- Taguchi Method: Ask “Why” five times
- Why Staircase: Keep asking the question “why” as long as the answer is more significant. Stop when the answer is less significant
- Stop when the root cause condition is an isolated occurrence
Proximate Causes

• Direct causes also called *Proximate Causes*
• They can occur in three ways:
  – **Equipment Failures** – equipment (or medical device) failure/malfunction contributes to 10% of all patient safety occurrences
  – **Inappropriate Acts** – human error contributes to 90% of all patient safety occurrences
  – **External Triggers** – rare, unusual, and unpreventable events such as tornadoes, hurricanes, etc.
Inappropriate Act
(a term for human error or mistake)

A human error that violates expectations or takes a task outside of acceptable limits

– An act that clearly violates expectations, regardless of the consequence

– An act that results in an undesired or unwanted consequence – an act that led a task or system outside of acceptable limits

– One of three kinds of direct causes (equipment failures and external events are the other two)
Three Types of Corrective Actions

**Remedial Action:** Designed to correct the condition; typically taken immediately after discovery; designed to mitigate immediate risk

**Intermediate Action:** Short term actions to reduce risk of recurrence during implementation of long term actions

**Action to Prevent Recurrence:** Long-term actions designed to prevent recurrence of the event
Action Plans

• Consider generic implications of each root cause.
• Develop corrective actions to prevent recurrence (CATPR) for each root cause.
• Consider corrective actions for contributing factors (not the root) that are high-risk or substandard.
• Address the extent/scope of the condition that exists (this may cross multiple areas)
Monitoring for Action Plan Completion

- Create control loop through Executive Sponsor/Owner.  
  *Action item owners must report to the executive owner when the action items are completed.*

- Create database of required actions and issue periodic reports (or place action plans on Shared Drive for easy access).  
  *Action item owners enter completion information directly into report or action plan on shared drive; executive owner reviews for completion.*

Review action plan completion at senior leadership and safety oversight meetings.
Human Error Classification

Based on the Skill/Rule/Knowledge classification of Jens Rasmussen and the Generic Error Modeling System of James Reason

<table>
<thead>
<tr>
<th>Activity Type</th>
<th>Skill Based</th>
<th>Rule Based</th>
<th>Knowledge Based</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Familiar, routine acts that can be carried out smoothly in an automatic fashion</td>
<td>Problem solving in a known situation according to set of stored “rules,” or learned principles</td>
<td>Problem solving in new, unfamiliar situation for which the individual knows no rules – requires a plan of action to be formulated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Error Types</th>
<th>Slips</th>
<th>Lapses</th>
<th>Fumbles</th>
<th>Wrong rule</th>
<th>Misapplication of a rule</th>
<th>Non-compliance with rule</th>
<th>Formulation of incorrect response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Error Prevention Themes</td>
<td>Self checking – stop and think before acting</td>
<td>Educate if wrong rule</td>
<td>Think a second time if misapplication</td>
<td>Non-compliance – reduce burden, increase risk awareness, improve coaching culture</td>
<td>Stop and find an expert</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Error Probability</th>
<th>1:1000</th>
<th>1:100</th>
<th>3:10 to 6:10</th>
</tr>
</thead>
</table>

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Systems Thinking & Analysis Technology

System & Management Failure Modes
(26)

Individual Failure Modes
(20)

Inappropriate Act

- Competency (3)
- Consciousness (6)
- Communication (3)
- Critical Thinking (4)
- Compliance (4)

- Structure (5)
- Culture (8)
- Process (5)
- Policy & Protocol (4)
- Technology & Environment (4)
## Individual Failure Modes

**HOW** the individual experienced the error

<table>
<thead>
<tr>
<th>Mode</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency</td>
<td>The person does not have the knowledge of how to perform the task or a well-developed skill in performing the task.</td>
</tr>
<tr>
<td>Consciousness</td>
<td>The person knows exactly what to do and how to do it, yet they fail to carry out the task or they do it incorrectly because their thoughts are not on – or fully on – the task at hand.</td>
</tr>
<tr>
<td>Communication</td>
<td>The person receives information and either hears it incorrectly or ascribes incorrect meaning to the information.</td>
</tr>
<tr>
<td>Critical Thinking</td>
<td>The person fails in the cognitive processing of information or in decision making based on information.</td>
</tr>
<tr>
<td>Compliance</td>
<td>The person knows the performance expectation, thinks about it at the time, and makes a choice to act differently.</td>
</tr>
</tbody>
</table>
# System Failure Modes

**WHY** the individual experienced the error

<table>
<thead>
<tr>
<th>Structure</th>
<th>The organization did not provide the people, resources, or oversight to support the process or activity being performed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture</td>
<td>The organization’s values and behavior expectations for leaders, physicians, and staff serve as a counter-influence to safe, reliable individual and team performance.</td>
</tr>
<tr>
<td>Process</td>
<td>There are deficiencies in the design of the expectations or flow of the work process expectations</td>
</tr>
<tr>
<td>Policy &amp; Protocol</td>
<td>There are deficiencies in the documents – policies, procedures, and job aids – that are intended to support the work process and guide individual decision making.</td>
</tr>
<tr>
<td>Technology &amp; Environment</td>
<td>The design of the workplace, equipment, and information systems makes it difficult for the person to carry out the task at hand.</td>
</tr>
</tbody>
</table>
ACCOUNTABILITY

Executive Sponsorship for Root Cause Analysis
Executive Sponsor/Owner

The RCA Executive Sponsor provides executive leadership for the root cause analysis (RCA). The RCA Executive Sponsor:

- Is always a senior executive of the organization.
- Often (but not always) is responsible for the area where the event occurred.
- Understands the purpose and process of root cause analysis.

Responsibilities

- Ensures stabilization of the immediate situation
- Charters the RCA Team
- Projects urgency, establishes priority, and allocates resources
- Meets with the RCA Team Leader/Team Members and Stakeholders to understand investigation progress
- Removes investigation or action planning roadblocks
- Communicates investigation status to other senior leaders
- Demonstrates responsibility for the root solution and implementation of corrective actions
- Provides reports to hospital committees and other oversight groups
Family Engagement

- If appropriate, find out what they saw during the event
- Encourage participation in the RCA (family faculty)
- Part of the action planning
- Participation in the safety meeting where the RCA is reviewed
Questions

• Please type your questions and/or comments in the Question Box on the right-hand side of your screen.

• We will address them at the end of the webinar.

Contact Info:

teets@email.chop.edu
(267) 426-7368
HOSPITAL SHARING
UH Rainbow Babies and Children’s Hospital – The Cause Analysis Journey

Stephen R Czekalinski MBA, RN, BSN
Rainbow at a Glance

Licensed Beds: 244  
Medical Staff: 775  
Residents/Fellows: 162  
Nurses: 500  
Inpatient Discharges: >9,000  
Outpatient Visits: >580,000  
Average LOS: 6.1 days  
Medical Divisions: 15  
Surgical Specialties: 11
Our Journey Begins

• Hospital within a hospital
• Followed system-wide policy/procedure for RCA
  – Critical/Sentinel Events, per JC recommendations
• Run by Risk Management (adult med surg background)
• Multitude of RCAs…Repeat events…
Our Journey Begins

• Summer 2011
  – Ohio Children’s Hospital Association Solutions for Patient Safety (OCHSPS) partnership with Ohio Business Roundtable, Cardinal Health, and Healthcare Performance Improvement (HPI)
  – 8 Ohio Children’s hospitals trained in HPI methodology
    • 2-day educational course
    • Risk Management, Quality Staff (RN/physician)
    • Followed by monthly webinars/quarterly learning sessions
Making Way for Change

• HPI Methodology Implemented
• Key Changes
  – 3 meeting process
  – Charter
  – Leadership ownership/involvement
  – Interview process for involved staff
• Root/Proximate Causes
• Action Items
• Change
  – Culture
  – Process
  – Practice
  – Outcomes
• Open to feedback
  – Hospital within a hospital
  – Roles of Risk vs Safety vs PI
• Measuring success
  – Involved staff satisfaction
  – Action item completion
  – Repeat events
Leadership Involvement

• Senior Leader/Executive Sponsor “Ownership” of RCA
  – CNO, CMO, VP, Director of Quality, Director of Nursing, etc.
  – Coordination of calendars
  – Facilitation of difficult outcomes
  – Follow through on action items
  – Report out to hospital leadership group
Loop Closure

• Changes based on new methodology
  – Involved staff
  – Department
  – Hospital
  – Parents/Family

• Challenges/Opportunities
“It depends on where you think we’re going.”
Lessons Learned/Next Steps

- Sustainability
- Changes in personnel/leadership
- Analysis of classification
  - Process, activity, individual, system, etc.
- Changes to presentation
- System-wide inquiry
Questions

• Please type your questions and/or comments in the Question Box on the right-hand side of your screen.

• We will address them at the end of the webinar.

Contact Info:
Stephen.Czekalinski@uhhospitals.org
(216) 286-6926
Our Unit Based Cause Analysis Approach

Susan Teman, BSN, RN, CPPS
Clinical Integration Specialist-Simulation
Helen DeVos Children’s Hospital

- Located in Grand Rapids, Michigan, part of Spectrum Health.
- Safety work initiated in 2007
- Moved to new building 1/11/11
- 236 beds (after opening of 5th floor, 1/14/14)
- 14 stories, approximately 450,000 sq. ft.
- Full specialty children’s hospital; acute care pediatrics, PICU, NICU, PHO, sedation, child life, surgery, emergency, radiology, trauma, cardiology, cardiovascular surgery
**Apparent Cause Analysis (ACA)**

A limited investigation of an event that is often performed instead of RCA for less-significant events (e.g. Precursor Safety Events or Near Miss Safety Events)

- ACA should identify corrective actions and collect information necessary to support future Common Cause Analysis
- As with an RCA, any immediate safety issues need to be addressed at the time of the event

The goals of an Apparent Cause Analysis are to:

- Correct conditions adverse to quality
- Support future trending and monitoring efforts—ongoing find and fix
## Comparison

<table>
<thead>
<tr>
<th>Root Cause Analysis: RCA</th>
<th>Apparent Cause Analysis: ACA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>• Facilitated by a Patient Safety Process Manager</td>
<td>• Performed by 1-2 people</td>
</tr>
<tr>
<td>• Multidisciplinary team of 8-10 people</td>
<td>• More of a review of what occurred. Interviews to learn who did what and why.</td>
</tr>
<tr>
<td>• Deep dive to get to the root cause</td>
<td>• Local/departmental level</td>
</tr>
<tr>
<td>• Develop Corrective Actions To Prevent Recurrence (CATPR)</td>
<td>• Performed on Precursor Safety Events (PSE) and Near Miss Events (NME) that have minor or no harm</td>
</tr>
<tr>
<td>• Performed on SSE and those events that pose a serious threat to the safety of our patients, families and staff</td>
<td>• Event is entered into our electronic reporting system</td>
</tr>
<tr>
<td>• Assigned an Executive Sponsor</td>
<td>• All ACAs are sent to the patient safety team for coding, tracking and trending to the Trends reported to the patient safety committee periodically</td>
</tr>
<tr>
<td>• Findings and updates reported back to senior leadership, board of trustees and our Patient Safety Committee</td>
<td>• Included in our annual common cause analysis</td>
</tr>
</tbody>
</table>
Unit Based Cause Analysis Team Development

- Unit based resources
- HDVCH utilizes a variety of team members
- CNS, managers or supervisors, safety coaches
- Education on cause analysis is provided
- Risk management and Safety provide support on first ACAs on each unit
- Results are compiled in the risk management incident reporting system database
- Utilized our Patient Family Advisory Council in development of the program to provide feedback
HDVCH ACA Toolkit

- ACA Standard Work
- ACA Report Sheet
- ACA Guideline Questions
- Agenda Template
- Ground Rules
- Timeline
- Example Timeline
- Attendance Sheet
- Action Item Form
<table>
<thead>
<tr>
<th>Definition</th>
<th>An ACA is a local (department, unit, division) focused approach to evaluating an event. Limited investigation of an event. Should identify remedial corrective actions and collect information necessary to support future common cause analysis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triggers</td>
<td>Broad Scope Organizational Issues Multifactoral complex issues</td>
</tr>
<tr>
<td></td>
<td>Request by the department Department manager in conjunction with clinical risk manager determines the need for ACA</td>
</tr>
<tr>
<td></td>
<td>Manager or designee, physician leadership, CNS and/or nurse educator as appropriate to attend Director of the area will designate a lead for the ACA team</td>
</tr>
<tr>
<td>Develop list of leaders for invites</td>
<td>All team members that provided care during the incident should be invited (physicians, nurses, RT, techs, etc). Expertise needed for action planning</td>
</tr>
<tr>
<td>Develop list for ACA invites</td>
<td>Review medical record Interview those involved in event and identify who did what and why Develop a timeline of the event based on chart review and interviews Gather paperwork for meeting: Agenda, ground rules, sign in sheet, timeline, action sheet Review best practices to identify deviations from generally accepted practice Decide and arrange best time to meet for team and send invites</td>
</tr>
<tr>
<td>Prior to meeting</td>
<td>Introductions Read ground rules Review case - talk through timeline, utilize ACA question list to determine system and process improvement opportunities Identify inappropriate acts (who, what, where, why and how of an act) during discussion/opportunities for improvement and construct corrective actions based on those identified Facilitate team decision of action items Assign a process holder to each action item</td>
</tr>
<tr>
<td>During Meeting</td>
<td>Manager follows up and completes action item list Manager and Clinical Risk Manager completes ACA report paperwork Findings shared with staff/unit/department/division</td>
</tr>
<tr>
<td>What needs to be done after the meeting?</td>
<td></td>
</tr>
</tbody>
</table>
Apparent Cause Analysis Process

1. Investigate the event
2. Identify the detectable causes
   - Inappropriate acts, or human errors
   - Equipment failures
3. Develop the Apparent Cause Statement
4. Validate the significance of the event
5. Define actions to address any gaps in the system
6. Engage patient/parents to review once completed and before action plan is launched
# Agenda Template

**Meeting Agenda**

<table>
<thead>
<tr>
<th>Key information</th>
<th>Key Roles:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of meeting: ACA</td>
<td>Facilitator:</td>
</tr>
<tr>
<td>Date:</td>
<td>Minute Taker:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Start Time:</th>
<th>End Time:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Meeting Location:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Process Owner</th>
<th>Desired Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introductions and Safety Story</td>
<td>Facilitator</td>
<td>Meeting Team Members and share safety story</td>
</tr>
<tr>
<td>Purpose of meeting &amp; Confidentiality</td>
<td>Facilitator</td>
<td>Gain an understanding of the ACA process</td>
</tr>
<tr>
<td>Review Timeline of event</td>
<td>Group</td>
<td>Gain an understanding of Patient Safety Event; clarify or add information</td>
</tr>
<tr>
<td>Identify Possible Barriers to Process</td>
<td>Group</td>
<td>Identify system barriers/opportunities for improvement</td>
</tr>
<tr>
<td>Identification of next steps</td>
<td>Group</td>
<td>Development of action plan and identification of key stakeholders/process owners</td>
</tr>
</tbody>
</table>
Task Analysis to Identify Direct Causes

A comparison of what occurred to what should have occurred and identify the gaps

<table>
<thead>
<tr>
<th>What Should Have Happened</th>
<th>What Actually Happened</th>
<th>Direct Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Red</td>
<td>Red</td>
</tr>
<tr>
<td>Orange</td>
<td>Cyan</td>
<td>Cyan</td>
</tr>
<tr>
<td>Yellow</td>
<td>Yellow</td>
<td>Yellow</td>
</tr>
<tr>
<td>Green</td>
<td>Green</td>
<td>Green</td>
</tr>
<tr>
<td>Blue</td>
<td>Light Pink</td>
<td>Light Pink</td>
</tr>
<tr>
<td>Purple</td>
<td>Purple</td>
<td>Purple</td>
</tr>
</tbody>
</table>
What *Should* Have Happened:

- MD writes medication order legibly and using accepted order notation
- Pharmacist reviews order for completeness and therapeutic appropriateness
- Pharmacist enters order into Cerner pharmacy management system
- Pharmacist reviews and responds to Cerner alerts regarding order
- Pharmacy Tech prepares order
- Pharmacist reviews order and releases to Unit
- RN receives med, performs 5 rights, and administers med to patient

What *Actually* Happened:

- MD unclearly writes order for 5 units as 5U using an unsafe abbreviation not permitted by hospital policy
- Pharmacist mistakes 5U as 50 units and does not note that “units” is missing from the order
- Pharmacist enters order into Cerner pharmacy management system
- Pharmacist reviews and responds to Cerner alerts regarding order
- Pharmacy Tech prepares order
- Pharmacist reviews order and releases to Unit
- RN recognizes the dose error when performing the 5 rights and comparing the med label to the MAR

**Inappropriate Acts**
As these are identified, this is where the focus of the action plan will begin
Validate Significance

Rule-out that the outcome of the occurrence was significant (and needed a root cause analysis)

Practical assessment of extent of condition
- **Isolated** – One machine, one person, one calculation, one day, etc.
- **Local** – All of that type of instrument, all of third shift, every time that calculation is performed, etc.
- **Global** – All procedures, all machines, all calculations, etc.

Escalate conditions that are significant
Lessons Learned

• Fast timelines: Interview quickly so information is fresh
• Close the loops
• Focus on system issues
• Ensure and protect confidentiality
• Be ok if you can’t identify anything
• Realize hindsight is 20/20
• Collaborate with the Quality and Safety department and Risk
Lessons Learned

• Have all stakeholders involved
  • Care management, respiratory therapy, pharmacy, etc
• Stick to the facts
• Refer to other groups
• Look for transportability
• Be committed
  • It takes resources
• Communicate, communicate, communicate!!!
Questions

• Please type your questions and/or comments in the Question Box on the right-hand side of your screen.

• We will address them at the end of the webinar.

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AUDIENCE Q&A
Thank you!
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