Developing & Implementing a Patient Safety Reporting System

New Jersey PSIC

May 2005

Goals for Legislation

- Strengthen patient safety
- Promote a systematic analysis
- Emphasize confidentiality
- Sets up reporting system

How Will Information be Used?

- Hospital review of events & RCA
- DHSS review of events & RCA
- Summary of reports
- Medical Alerts
- Work with hospitals

Process for Reviewing Event Reports/RCAs

- Started February 1 using forms and fax
- Review each form submitted
- May ask for additional information
- Confirm receipt of event form
- RCA due in 45 days
- Also confirm receipt of RCA
- Confirm that RCA is accepted

Requirements for RCAs

- STEP 1: Facts of Event
- STEP 2: Causality
- STEP 3: Action Plan/Measures

Teaching Method

- Explain the process
- Model an example
- Lead an example
- Utilize repetition
- Build knowledge base

Model Repetition Engagement

Case Example

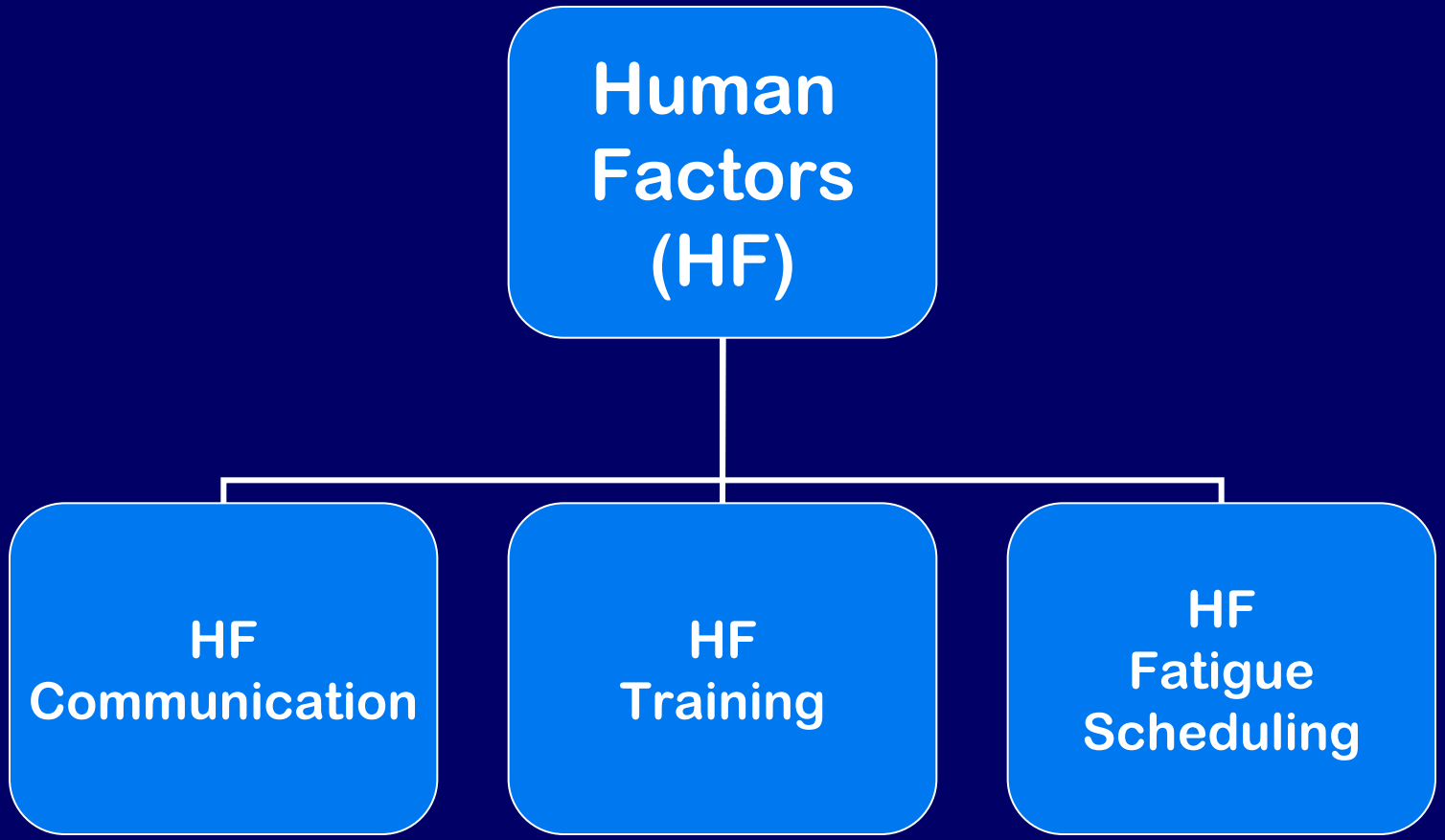
Initial Event Report

- 42-year-old male admitted for right knee arthroscopy on 12/23/04
- Surgery performed on left knee
- Patient informed

Step 2: Causality

- Determine pertinent areas
- Focus on pertinent areas
- Formulate causal statements

Areas of Causality



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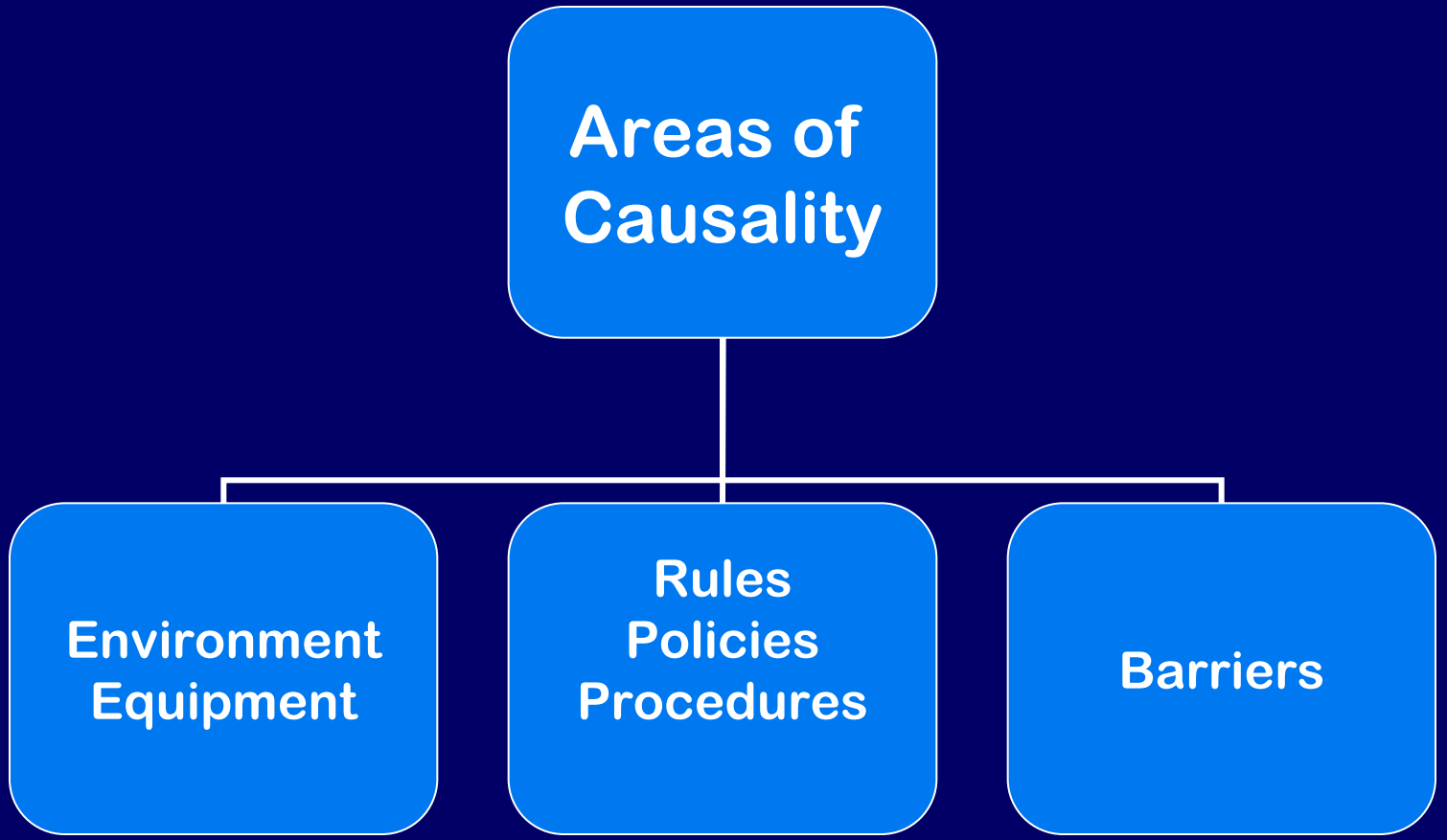

5 Rules of Causation

- Must show “cause and effect”
- No negative descriptions
- Human error must have preceding cause
  - Systems, not people
- Violations of procedure must have preceding cause
- Duty to act-only if pre-existing

RCA Process

- Report of event ⇨ Description of Event
- Triage questions ⇨ Areas of causality
- Info. from causality ⇨ Causal statements
- Action plans ⇨ Outcome measures

Teaching Method

- Explain the process
- Model an example
- Lead an example
- Utilize repetition
- Build knowledge base

Model Repeat Engage

Apply Triage Questions to Event

Surgeon Enters & Cuts (Triage Questions)

- Was environment/equip. involved in any way? ⇨ Env/Eqp
- Were rules/policies/procedures - or lack thereof - a factor? ⇨ R/P/P

Focus on Areas of Causality

Areas of Causality

R/P/P	BARRIER	ENV/EQP	HF
Surg.site mark-not consistent	**Surg.site mark why failed?**	**Change in OR**	Resident unfamiliar (HFT)
Time-Out why not done?	Time-Out why failed?	Equipment positioning	**Tech silent (HFC)**

No Time-Out
Applying R/P/P Questions

#2: Were key processes monitored?	No
#7: Were all staff oriented?	No
#8: Were there existing P/P?	Yes
#11: Were they used daily?	No

Incision on Wrong Knee

- Time-Out not done ⇒ No monitoring

Causal Statement

[*Something*] increased the likelihood of [*something*] happening……..

Causal Statement #1

Lack of monitoring of the Time-Out Policy increased the probability that it would not be part of the pre-operative routine, thereby increasing the probability of wrong site surgery.

Scrub Tech Silent
Applying HF/Comm. Questions

#5 Was communication among team adequate?

No

#13 Did culture support/welcome observations?

No. Staff afraid to speak

Incision on Wrong Knee

- Time-Out not done ⇒ No monitoring
- Resident preps "no X" knee ⇒ Different protocols
- Staff silent ⇒ Culture does not support input

Causal Statement # 3

Incision on Wrong Knee

- Time-Out not done ⇒ No monitoring
- Resident preps “no X” knee ⇒ Different protocols
- Staff silent ⇒ Culture does not support input
- Change of OR ⇒ Mirror images invites confusion

STEP 3: Action Plan

- Addresses the cause
- Specific and concrete
- Doable
- Consult process owners
- Designate point person
- Monitor and measure outcomes

Examine Causal Statements

- Create action plans for each cause
- Actions prevent or minimize future adverse events
- Examine each cause; pick strong rather than weak action

Develop Action Plan
for
Causal Statement #1

Causal Statement #1

Lack of monitoring of the Time-Out Policy increased the probability that it would not be part of the pre-operative routine, thereby increasing the probability of wrong site surgery.

Action Plan #1

- Stronger ⇨ ?
- Intermediate ⇨ Designated staff
- Weaker ⇨ Memo to staff

Action Plan #1

- Designated staff use check-list to ensure a time-out for each surgery; two signatures
- Check lists reviewed weekly to ensure that time-outs occurred; records kept
- Number of wrong site surgeries monitored

Develop an Action Plan for Each Causal Statement

- Be specific
- Choose strong rather than weak actions
- Choose permanent over temporary
- Monitor effectiveness

Goal : minimize event recurrence

Culture of Safety

- Confidentiality
- Blame-free
- Empowerment
- Recognition
- Leadership

Next Steps

- FRANCES TO DEVELOP

Questions