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Residency and Fellow Participation in Root Cause and Intensive Analysis 2015-16

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The purpose of this document is to familiarize you with two processes that help with quality improvement known as a root cause analysis and an intensive analysis. Further, to explain your role in the process and the importance of your **active** participation.

Objectives:

- To understand the difference between a root cause and intensive analysis and be able to articulate when each would be appropriate.
- To learn about the importance of patient safety and quality through participation in these processes.
- To gain appreciation and insight into the importance of your role in examining medical and system errors as it relates to quality improvement and Just Culture.
- To contribute to improving quality, safety, and systemic processes through and collaborative engagement with BSOM and Premier Health.

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What a Root Cause or Intensive Analysis ***IS NOT:*** Whether you have been included in participation due to a part you may have observed or had in the incident, or, whether you have been asked to participate as part of your learning, this process is meant to be constructive and solution-focused. This is not a blame game. It is not about finger pointing. Most mistakes, (including error, omissions, neglect, slips, oversights, etc.), are made by well-intentioned professionals trying to do the right thing. Further, there are almost always systemic challenges which contribute to the error being made in the first place. Your experience and feedback are valuable- you have much to contribute!

What it **IS** about is "Just Culture": Shared accountability in managing risk, identifying and encouraging opportunities for incident-reporting to promote growth and learning, and implementation of findings to improve quality and safety. It's about asking what happened, Why did it happen, and How can we prevent it from happening again? It's also about assessing "at risk" behaviors where risk may not have been recognized or mistakenly believed not to have been there. This requires coaching. Finally "Reckless Behavior*", a very small percentage of cases*, where guidelines, protocols, and risks were known but ignored or over-looked. This behavior requires remediation.

You may want to read:

1999- IOM published "To Err Is Human" www.iom.edu

2001 – IOM published "Quality Chasm Series" www.iom.edu

- **These two publications were the first of many milestones in the evolution of patient safety & quality.**
- **Brought attention to size and scope of patient safety problems for hospitals, providers and 3rd party payers.**
- **First presentation of the enlightened view of looking at systemic failures, reducing blame, and increasing transparency.**

Root Cause Analysis: According to the AHRQ, (Agency for Health Care Research and Quality), A Root cause analysis (RCA) is a structured method, *(also a Six Sigma Process),*used to analyze serious adverse events. Initially developed to analyze industrial accidents, RCA is now widely

deployed as an error analysis tool in health care. A central tenet of RCA is to identify underlying problems that increase the likelihood of errors while avoiding the trap of focusing on mistakes by individuals. The goal of RCA is thus to identify both active errors (errors occurring at the point of interface between humans and a complex system) and latent errors (the hidden problems within health care systems that contribute to adverse events).

RCAs should generally follow a pre-specified protocol that begins with data collection and reconstruction of the event in question through record review and participant interviews. A multidisciplinary team should then analyze the sequence of events leading to the error, with the goals of identifying how the event occurred (through identification of active errors) and why the event occurred (through systematic identification and analysis of latent errors.) The ultimate goal of RCA, of course, is to prevent future harm by eliminating the latent errors that so often underlie adverse events. This is often achieved by "Asking the 5 Whys." At the end of the 5 whys, you usually have your answer. **The Joint Commission has mandated use of RCA to analyze sentinel events,** (such as wrong-site surgery), since 1997.

Sentinel Event: TJC defines a sentinel event as "an unexpected occurrence involving death or serious physical or
psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase 'or the risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called 'sentinel' because they signal the need for immediate investigation and response.
The terms 'sentinel event' and 'error' are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events."

Never Event:

The National Quality Forum's Health Care "Never Events" (2011 Revision)
Surgical events
Surgery or other invasive procedure performed on the wrong body part
Surgery or other invasive procedure performed on the wrong patient
Wrong surgical or other invasive procedure performed on a patient
Unintended retention of a foreign object in a patient after surgery or other procedure
Intraoperative or immediately postoperative/postprocedure death in an American Society of Anesthesiologists Class I patient
Product or device events
Patient death or serious injury associated with the use of

contaminated drugs, devices, or biologics provided by the health care setting
Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used for functions other than as intended
Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a health care setting
Patient protection events
Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
Patient death or serious disability associated with patient elopement (disappearance)
Patient suicide, attempted suicide, or self-harm resulting in serious disability, while being cared for in a health care facility
Care management events
Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
Patient death or serious injury associated with unsafe administration of blood products
Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a health care setting
Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
Artificial insemination with the wrong donor sperm or wrong egg
Patient death or serious injury associated with a fall while being cared for in a health care setting
Any stage 3, stage 4, or unstageable pressure ulcers acquired after admission/presentation to a health care facility
Patient death or serious disability resulting from the

irretrievable loss of an irreplaceable biological specimen
Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
Environmental events
Patient or staff death or serious disability associated with an electric shock in the course of a patient care process in a health care setting
Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances
Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a health care setting
Patient death or serious injury associated with the use of restraints or bedrails while being cared for in a health care setting
Radiologic events
Death or serious injury of a patient or staff associated with introduction of a metallic object into the MRI area
Criminal events
Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
Abduction of a patient/resident of any age
Sexual abuse/assault on a patient within or on the grounds of a health care setting
Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting

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Most Never Events are very rare. However, when Never Events occur, they are devastating to patients—71% of events reported to the Joint Commission over the past 12 years were fatal—and may indicate a fundamental safety problem within an organization.

The NQF's Never Events are also considered sentinel events by the Joint Commission.

Adverse Events: The term “adverse event” describes harm to a patient as a result of medical care, but that does not meet criteria for a sentinel or never event. It is important to note that the harm may be psychological.

Intensive Analysis:

Generally Speaking the review process follows a similar format but we o not utilize the Joint Commission RCA Template and the meeting is generally streamlined and shorter.