

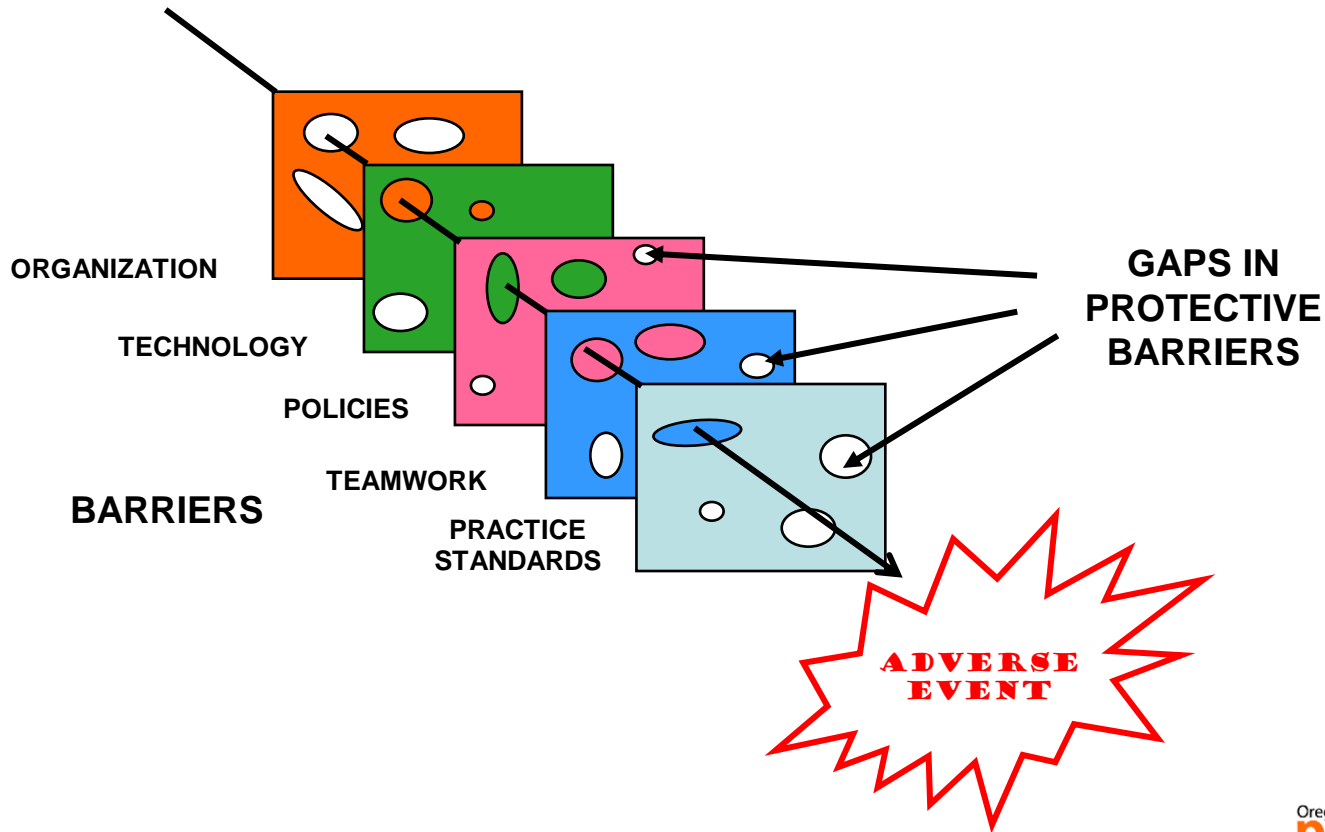
Effective Adverse Event Investigation

Preventing the
Next Event

Leslie N. Ray PhD, RN
Field Coordinator

Primary Purpose - Prevention

★ Plug the holes in/add system protections ★



Tools

- Barrier Analysis
- 5 Whys
- Diagramming
 - Flow/Sequence
 - Fishbone
 - Precursor
- Change Analysis
- Logic Tree
- Apparent Cause Analysis



Effective Investigation Characteristics

- Complete
- Thorough
- Credible
- Strong action plans

Complete?

Description would allow someone else to recreate the event and get the same result:

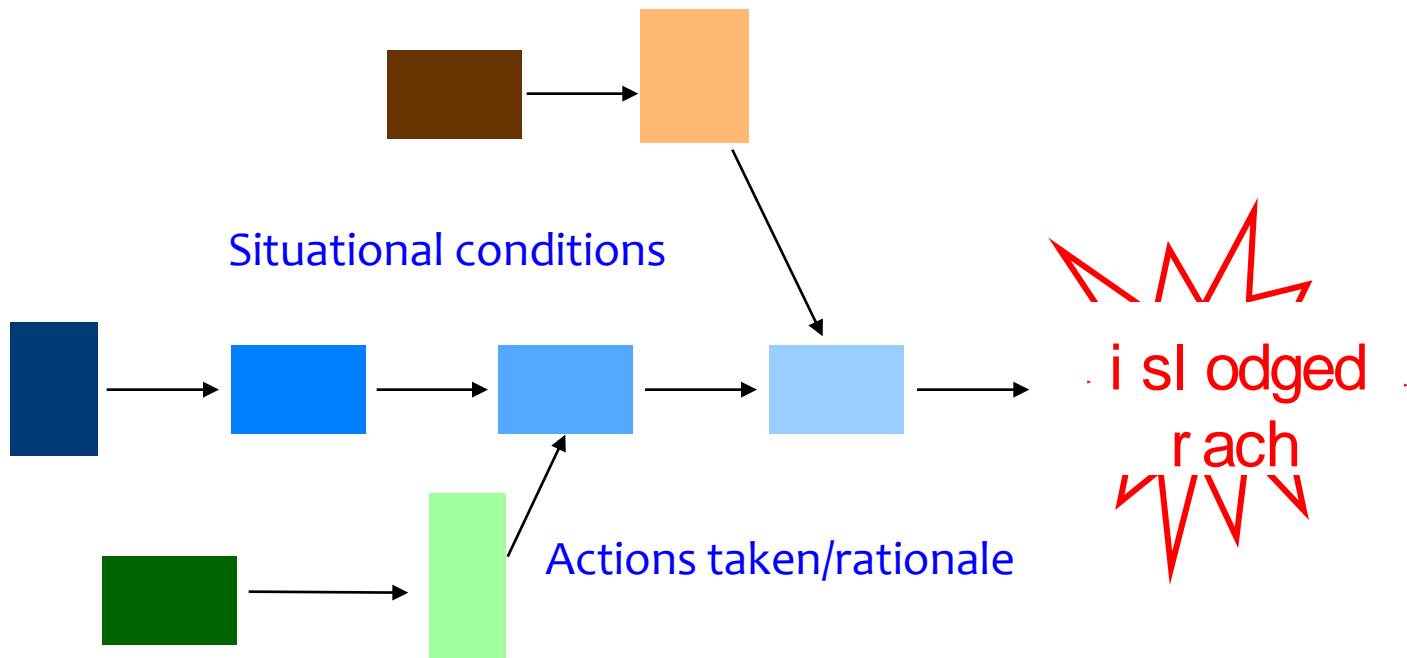
- ✓ explanation of how event occurred
- ✓ sequence of actions leading to event
- ✓ relevant situational conditions
- ✓ rationale for actions taken

Complete - Example

62 year old gentleman with trach, discharged and waiting for nephew to pick him up was found with trach dislodged, low O₂ sats, and apneic. Was obtunded, but arousable.

Patient was resuscitated, placed on a ventilator and transferred to the ICU, where after a 2 day stay was discharged home with no noticeable effect from event.

Complete



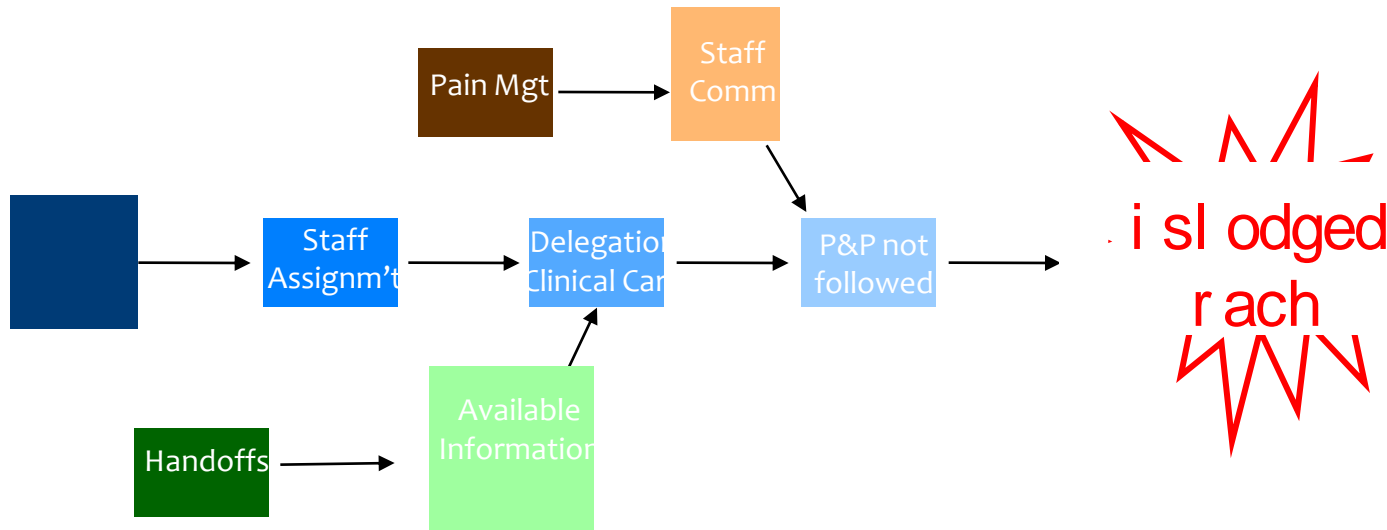
Thorough?

- System-level contributing factors
- At least 1 root cause, if changed, is likely to reduce future risk

Thorough - Example

- Hand-off/shift reports
- Available information
- Among hospital personnel
- Policy/procedure not followed
- Staff assignment/work allocation
- Delegation of clinical care
- Handoffs
- Pain Management
- Availability of Patient Information

Thorough



Root Causes as
Cause-Effect
Statements

Because handoff did not accurately describe patient status, charge nurse took patient and did not do required Q10 check

Lack of complete hand-off information resulted in inappropriate patient assignment

Credible?

- Sr. Administration involvement
- Consistency between description, CF, and identified causes/action plans

Credible - Example

- Sr Admin briefed, present at RCA/debriefed, Board report
- Consistency between description, CF, and identified causes/action plans

Hand-off/shift reports \Longrightarrow Handoffs

Available information \Longrightarrow Availability of Patient Information

*Among hospital personnel
Policy/procedure not followed
Staff assignment/work
allocation
Delegation of clinical care*

Pain Management

Strong action plans?

- Set up barriers to human frailties
 - Inattention
 - Short cuts

system level actions that ↓ the risk of future events & correspond to root/other causes

Strong action plans- Example

- Develop handoff guidelines
- Train staff/audit
- Develop process for how pts will be returned to floor from ancillary departments

- Provide inservice on pain management policy and documentation requirements
- Audit

- Change EMR to allow nursing staff access to ancillary notes

Strong action plans - Example

- Develop handoff guidelines
- Train staff/audit
- **Develop process for how pts will be returned to floor from ancillary departments**

- Provide inservice on pain management policy and documentation requirements
- Audit

- Change EMR to allow nursing staff access to ancillary notes

Case Discussion

64 year old admitted following a fall at home and history of renal insufficiency to the medical unit with mild urinary tract infection, hypokalemia, and mild anemia. At 2200 on 7/12, the patient was found on the floor after trying to get to the bathroom. He sustained skin tears. At 0700 on 7/13, patient fell again, sustaining a left hand fracture, and a subcapital left femoral neck fracture. Patient underwent an uncomplicated ORIF. On 7/17, he was able to sit and stand with moderate assist and pivot transfer with 2 people. He was discharged to an SNF on 7/18/08. Analysis revealed staff's failure to recognize, and failure to plan for patient-even after he had fallen once and proven to be a fall risk. Fall policy was deemed inadequate after policy review. Notifications following serious event were lacking. Assistant Director of Patient Care Services reported that ALL clinical staff know how to access or request for a sitter.

Case Discussion

Findings

Primary/charge nurses did not adequately plan or provide for the patient after he had fallen once and proven to be a high fall risk.

Nursing staff did not notify Risk Management of the event in a timely manner.

The Fall Policy needs to be reviewed and revised to include providing a sitter for a patient with a prior fall.

The Fall Form needs to state:
“Submit to the house supervisor.”

Action Plans

Staff will provide a sitter for a patient who has fallen.

Improved communication to Risk Management by having staff report all Incidents with serious injury to the house supervisor during their current shift, who will notify Risk Management.

Review/submit policy for revision

Add the correct verbage to the Fall Form to guide staff in proper chain of reporting falls