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

Human Factors (HF)

- HF Communication
- HF Training
- HF Fatigue Scheduling
Areas of Causality

- Environment
- Equipment
- Rules Policies Procedures
- Barriers
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/equipment 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

<table>
<thead>
<tr>
<th>R/P/P</th>
<th>BARRIER</th>
<th>ENV/EQP</th>
<th>HF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surg. site mark-not consistent</td>
<td><strong>Surg. site mark why failed?</strong></td>
<td><strong>Change in OR</strong></td>
<td>Resident unfamiliar (HFT)</td>
</tr>
<tr>
<td><strong>Time-Out why not done?</strong></td>
<td>Time-Out why failed?</td>
<td>Equipment positioning</td>
<td><strong>Tech silent (HFC)</strong></td>
</tr>
</tbody>
</table>
No Time-Out
Applying R/P/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.
#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   $\rightarrow$ No monitoring
- Resident preps   $\rightarrow$ Different protocols
  "no X" knee
- Staff silent   $\rightarrow$ Culture does not support input
- Change of OR   $\rightarrow$ 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