When bad things happen to good nurses: Discovery to recovery

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It's time to talk...

...about transparency
Objectives:
discover your challenges, recover your staff!

• Identify the key elements of a Root Cause Analysis
• Identify the key elements of a Failure Mode Effects Analysis
Key definitions:

- Sentinel, never, or headliner events
- Quality and safety management
- Culture of safety/Just culture
- Root cause analysis
- Failure mode effects analysis
- Causal tree/Risk priority numbers
- Team versus group
- Value conflict
Sentinel, never or "headliner" events

McGraw-Hill Concise Dictionary of Modern Medicine:

A term used by The Joint Commission for a 'headliner' event that may cause an unexpected or unanticipated outcome or death, and trigger an investigation of a hospital's policies (and the dreaded site visit!)

Segen's Medical Dictionary:

A term for a ‘headliner’ event that may cause an unexpected or unanticipated outcome, death or serious physical or psychological injury, or the risk thereof
### Examples of "headliner" events:

- Retained foreign objects (unintended)
- Transfusion error
- Wrong patient, wrong site surgery, wrong procedure
- Delay in treatment
- Fire
- Inpatient drug overdose
- Medical equipment related
- Infection related
- Medication errors
- Anesthesia related
- Operative or post-operative complication

Sentinel event settings include hospitals, ambulatory care centers, office based surgical centers, home care, long term care and behavioral health centers.
<table>
<thead>
<tr>
<th>Sentinel event outcomes : January 2004- June 30, 2011 (Summary data of Sentinel Events reviewed by The Joint Commission)</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient death</td>
<td>3032</td>
<td>61.8%</td>
</tr>
<tr>
<td>Loss of function</td>
<td>459</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other (includes unexpected extended or additional care and psychological impact)</td>
<td>1418</td>
<td>28.9%</td>
</tr>
<tr>
<td>Total patients impacted (multiple patients may be impacted by a single event)</td>
<td>4909</td>
<td>100%</td>
</tr>
</tbody>
</table>

Data limitations:
The reporting of most sentinel events to The Joint Commission is voluntary effecting the relative frequency or trends in these events over time.
Quality and safety management

- The Institute of Medicine defines *quality* as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with *current* professional knowledge:”
  - Use of indicators (expression of standards)
    - 5 D’s: death, disease, disorder, discomfort, dissatisfaction
  - The IOM defines *safety* as “the prevention of harm to patients”:
    - The foundation upon which all aspects of quality care are built
      - Prevention of errors and learning from errors
      - Safety involves patients, health care professionals and organizations
Positives Cultures

- Just Culture
  - Balances system weaknesses and personal accountability
  - No shame or blame without consideration of contributing factors (human error, policy)
  - “Safe” reporting systems
  - Reasonable and effective
  - Empowers staff to correct weaknesses

- Culture of safety
  - Identifies high risk, error prone nature of the work
  - Promotes reporting of errors without fear of retribution
  - Multidisciplinary and organizational wide resources and solutions

Many errors are system errors and should not promote individual blame. A positive culture promotes communication, trust and the confidence that preventive measures will work!
Safety reporting

- Readily available
- Non-threatening
  - Safety reporting rather than incident/accident
- Ease of use
  - Computer or paper documentation
    - Generous timeline
    - Drop down menus/check boxes
- Promotes “storytelling”
- Documents both errors and “near misses”
- Promotes investigative processes
- Requires recognition and follow up
### Essential to discovery

- **RCA**: a problem solving method aimed at identifying root (base) causes of problems
- Often considered a tool for continuous improvement
- Defines a sequence of events (timeline)
- Transforms reactive cultures into proactive cultures
- May be viewed as a cultural threat
- This is the lowest level of fact related to an incident

- **FMEA**: a procedural method aimed at identifying severity and likelihood of failure
- Effects analysis is the study of the consequence of failure
- Failures are based on past experience
- Redesign of processes is imperative
Key elements of a Root Cause Analysis:

Purpose and intent

- Initiation
  - Timing
  - Process
- Limitations
  - Corrective actions
  - Causal root trees
- Outcomes
  - Desirable
    - Robust process improvement
  - Undesirable
Tools for discovery in RCA

- **Causal Tree:**
  - Work backwards
  - Be non judgmental
  - Separate fact from fiction
  - Find the ROOT cause by first finding out what, then asking:
    - Why?
    - Why?
    - Why?
    - Why?
    - Why?
Classifications (aka "domains") of root causes of harm

- **Latent failure**
  - Removed from the practitioner/clinician and related to the decision making aspects of the organization policies, procedures and allocation of resources

- **Active failure**
  - Direct contact with the patient

- **Organizational systems failure**
  - Indirect failures involving management, organizational culture, protocols/processes, transfer of knowledge and external factors

- **Technical failure**
  - Indirect failure of facilities or external resources
Pearls to conducting a successful RCA

- All investigations are not equal
- Interview everyone
- Document all statements on individual note cards
- Keep to facts, not opinions
- Weigh human factors
- Consider causal factors
  - Behavior
  - Conditions (environmental, weather, maintenance records)
  - Management
- Remember, that the event itself is never a root cause!
  - But it may be a symptom
- Do not stop too soon
  - Multiple root causes can be possible
Key elements of a Failure Mode Effects Analysis:

- Initiation
  - Timing
  - Process
- Limitations
  - Tools
    - Risk priority numbers
- Outcomes
  - Desirable /undesirable
    - Compliance/non compliance to process change
    - Event avoidance/reoccurrence
Tools for discovery in FMEA

- Risk priority numbers (RPN)
- Value measurement
  - Determine areas of highest concern
- Action plans are based on RPN
  - \( S \times O \times D = \text{RPN} \)
  - Severity
    - Remember the 5 Ds
    - Dissatisfaction, discomfort, disorder, disease, death
  - Occurrence (likelihood)
  - Detection (likelihood)
<table>
<thead>
<tr>
<th>Rating</th>
<th>Description of severity</th>
<th>Rating</th>
<th>Likelihood of occurrence</th>
<th>Rating</th>
<th>Likelihood of detection</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very low or none</td>
<td>1</td>
<td>Very low or none</td>
<td>1</td>
<td>Very high</td>
</tr>
<tr>
<td>2</td>
<td>Minor</td>
<td>2</td>
<td>Minor</td>
<td>2</td>
<td>High</td>
</tr>
<tr>
<td>3</td>
<td>Moderate to significant</td>
<td>3</td>
<td>Moderate to significant</td>
<td>3</td>
<td>Moderate to probably</td>
</tr>
<tr>
<td>4</td>
<td>High</td>
<td>4</td>
<td>High</td>
<td>4</td>
<td>Possible</td>
</tr>
<tr>
<td>5</td>
<td>Very high or catastrophic</td>
<td>5</td>
<td>Very high</td>
<td>5</td>
<td>Not likely</td>
</tr>
</tbody>
</table>

- 5 is the highest severity and may indicate death or dismemberment
- 5 indicates that in spite of best efforts there are opportunities for this event to occur
- 5 indicates that even if the event is serious and there is a likelihood that it may occur, detection is unlikely
For example:

- A patient is admitted directly to the OR with a closed head injury:
  - What is the risk of wrong site surgery?
  - Severity: 5 (patient is likely to die if the wrong side is explored)
  - Likelihood: 5 (situation is chaotic, there are no consents, no site markings)
  - Detection: 5 (it is not likely the surgical team will realize which side of the head is involved)
  - RPN: \(5 \times 5 \times 5 = 125\)

- A patient is admitted to the OR with a closed head injury after an emergency room work up including MRI/CT:
  - What is the likelihood of wrong site surgery?
  - Severity: 5 (patient is likely to die if the wrong side is explored)
  - Likelihood: 3 (there are radiographic images, IDs, consents but still an urgency)
  - Detection: (it is most likely to be detected by staff based on consent, studies and hand off)
  - RPN: \(5 \times 3 \times 1 = 15\)
A patient is admitted directly to the OR with a closed head injury:
- RPN: \( 5 \times 5 \times 5 = 125 \)

How can the RPN be decreased in this case?
- The severity of injury is beyond our control...
- The likelihood of the occurrence could be effected by process change...
- The possibility of detection is well within our scope....

A patient is admitted to the OR with a closed head injury after an emergency room work up including MRI/CT:
- RPN: \( 5 \times 3 \times 1 = 15 \)

Is this risk acceptable?
- The severity of injury is beyond our control...
- The likelihood of the occurrence could be effected by process change...
- The possibility of detection is working
Pearls to conducting a successful FMEA

- The FMEA work group should be familiar with the area of concern
- RPNs are only relative to one another in the same analysis and not others
- Meant only as a prioritization ranking and may not reflect immediate needs of a unit
- The group should be cohesive and productive
- The FMEA study is unrelated to corrective actions but should make recommendations for process improvement
- Limit the measurement of RPN to a manageable scale
- Explore higher level RPN methods
  - Emphasis may not be on severity but occurrence
  - Risk ranking tables/charts may be more effective visually
Essential to recovery

Understanding team dynamics and value conflict in nursing
Workplace dynamics

- **Team:**
  - A collection of (purposeful) individuals brought together to share information and make decisions that will result in a performance that is greater than the sum of individual input and realization of a common goal
  - You cannot heal a “team” if you don’t have a team!

- **Group:**
  - A collection of (random) individuals brought together to share information and make decisions that will result in the completion of individual tasks not necessarily related to a common goal
  - Staff have been meeting with groups of investigators (Q& S, DPH, CMS)
**The goal is task completion**

**The goal is collective performance**

**The synergy is positive**

**Group:** RCA Outsiders

**Team:** FMEA Insiders

**The synergy can be neutral or negative**

**The skills are random and varied**

**The accountability is individual** and to the team (mutual)

**The skill set of the individuals complements one another**
Value conflict in nursing

- This is the situation in which nurses believe and react to the loss of control over the workplace environment related to the detriment of patient care, according to the individual nurses values.

- The nurse has an image of ideal nursing care that he/she is unable to facilitate due to factors beyond his/her control.

- Leads to frustration and withdrawal of the nurse and may be related or lead to disruptive behavior.

- According to J. Manatone in the 2006 article, *The cost of bad behavior in OR*, published in Modern Healthcare, the role of disruptive behavior and conflict in the OR can contribute to adverse events. The responses of nurses, physicians and anesthesiologists concluded that disruptive behavior could be linked to 67% of adverse events, 58% of compromised patient safety and 28% to patient mortality.
The Joint Commission issued a Sentinel Event Alert on July 9, 2008 amending its Leadership Standards to include among other requirements/recommendations:

• Develop an organizational process for addressing intimidating and disruptive behaviors (LD.3.10 EP 5) that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees.

• Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution.
### Nurturing your nursing team:

*what they want to know and need to know*

### Want to know:
- Harm to patient or team members
- “Fault”
- Confidentiality
- Corrective actions
  - Unpaid loss of work
  - License status

### Need to know:
- Harm to patient or team member
- Process
  - Timelines
  - RCA
  - Corrective action
- Support networks
  - Employee assistance
  - Legal representation
  - Counseling
The saying goes that a good manager accepts a little less credit and a little more blame than is due ... in a *just* culture, a culture of *safety*, a *positive* culture, this neutral approach will help reassure staff so that recovery can begin...
Where to begin, how and when...

- Complete staff surveys
  - Anonymous
  - Comprehensive
    - Include all staff
    - Ask all questions
- Identify issues
  - Policy/Procedure
    - Does procedure follow policy
  - Personnel
- Initiate process change
  - Action plans
  - Communication
- Provide necessary education
  - Documentation of education
  - Documentation of compliance
- Feedback and follow up

A.S.A.P.
Take home messages!

Three implications for your nursing practice

- “The very first requirement in a hospital is that it should do the sick no harm.” Florence Nightingale
- But, as humans, we will all make a mistake at some point.

- “Success does not consist in never making mistakes but in never making the same one a second time.” George Bernard Shaw
- An effective RCA and follow up FMEA will help us learn from our mistakes and avoid them.

- “I believe in recovery, and I believe that as a role model I have the responsibility to let young people know that you can make a mistake and come back from it.” Ann Richards
- We can help our teams to heal!
Remember, when bad things happen to good nurses, discovery and recovery is a process, not a problem!
Questions?
References and recommended reading:

- Mitchell PH, Lang NM. Framing the problem of measuring and improving healthcare quality: has the Quality Health Outcomes Model been useful. Med Care. 2004;42:II4–11. (PubMed: 14734937)