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2016 NCSBN Discipline Case Management Conference - Root Cause Analysis and Action: A Blueprint for Prevention of Harm

Event
2016 NCSBN Discipline Case Management Conference

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Presenter
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- [Patricia] It's a delight to see you here today. Thank you, Kathy, for that great introduction. It was short. That always makes it great. I want to spend a few moments just telling you... First of all, how many of you know the National Patient Safety Foundation? Raise your hand if you're familiar with us. Okay. So probably about half of the folks in the room. We're a small nonprofit. We've been in existence since 1997, and we're based out of Boston, Massachusetts. And our role is, as Kathy noted, to create a world where patients and those who care for them are free from harm. We added the "and those who care for them" in 2014, when we updated our strategic plan. Because the caregivers, whether they be professional caregivers or family caregivers, have so many issues and are not well cared for. We can't have safe patient care if our workforce, and if those who are caring for patients outside of the workforce, are not properly cared for. So there's a lot of information that we have on our website. It's www.npsf.org. A lot of resources, including the report that I'll be talking about today, which I encourage you to take a look at, and as Kathy described, it is an advance in the way that we're looking at understanding why things go wrong in the healthcare setting. How many of you who are here today are nurses? Okay, maybe I'll flip this. How many are not nurses? Oh, wow. I might be confused. I know it's early. But I didn't see the proportionate amount of hands up or down. Are some of you double-teaming this morning? Okay. That may be the case. I'm very proud to be a nurse, and I've had a lot of opportunity in my career, as you have, to take on new roles in nursing. I'm also proud to say I have a daughter who passed the NCLEX exam a few years ago. Unfortunately, she's chosen a career coaching college lacrosse instead. So I'm trying to work on getting her a job if anyone is out there looking for really good folks to join the nursing profession. But I do want to thank the National Council of State Boards of Nursing. We've been partners for many, many years. They've been a part of our Patient Safety Coalition, which is a group of organizations that come together to help us advance patient safety. We've endorsed the Multistate Licensure Compact, and likewise the National Council of State Boards of Nursing has endorsed the report that I'm going to share with you today. I will be digging into that for just a moment. So the title of our report is really kind of characterizing this new blueprint that we have on how to understand why things go wrong, and really to

prevent them from happening again. Kathy asked about initials. You see the CPPS up there. One of the programs that we actually have is a certification program for the Certified Professional in Patient Safety. For many of you who are in tune with the safety movement, you'll see that safety is really becoming a profession in and of itself. I'd like to start off by talking to you about some important things that are going on. How many of you went to dinner last night? Most of you in the room. That was a really great dinner. Did you see the front page of the USA Today? Okay. Guess what? The Navy is banning alcohol in Japan. Banning alcohol in Japan. So not in Norfolk, thankfully, but in Japan. A couple of other things that have been going on is it's raining out. Our audio/visual man didn't know this morning that it was raining out. But I know that many of you probably looked out and saw the skies. Other interesting news, guess what happened to Mark Zuckerberg from Facebook? He got hacked. Isn't that awesome? Mark Zuckerberg did not follow the instructions from Facebook to change his password. Do you know what his password was? "Dadada," that is such a guy thing, such a parent thing. A dad has to always believe that the first thing his kid is going to say is "dadada." Most of us know that it's "mamama," and so I find that interesting. Then, the other important thing that I thought you should know, if you haven't already heard, is that we know that Twinkies came back. Right? How many of you eat Twinkies? You're so lying. So lying. Well, guess who bought the Playboy Mansion? The person who owns Hostess Cupcakes, in part because of that takeback of Twinkies. So for all of the folks who brought Twinkies back, we've been able to see the legacy of the Playboy Mansion now continue on and I'm sure that that's really meaningful for all of you. The other thing that happened this morning... Almost always when you talk and when you travel a lot, and people like Kathy know this, you almost always have great material to talk about to open up the talk. I was coming down to Norfolk, I had a relatively uneventful trip. So I actually looked at a story that came up last week I'm going to share with you. But I did have this moment this morning, and I think it's really important for case discipline people to know about it, because it has to do with a discipline that my daughter needs to receive when I get home. She's 23 years old. This is not the nurse. This is the criminal justice major. She also coaches lacrosse. I'm really glad I put both of those kids through college. But you may notice as I'm walking around, a little problem, besides the toe cleavage in my shoes. I actually don't have my black shoes. My daughter took them out of the suitcase that I packed on Saturday. So if you see me floating around with shoes that you don't think look good and that should be black, I want you to know they would have been had it not been for her. There's a little need for some case discipline when I get home. I almost thought about putting her text number up on the slide, so you could like send her nasty texts. But the material that I did prepare for you is something that really I found on the internet. I get alerts every day. Many of you probably have Google Alerts set. You might search your kids, for example, which I do. I have a Google Alert set for all three of them, and that's always interesting. But thanks to Al Gore, if something weird doesn't happen to you, you only have to go on the internet and find something that might be of relevance to your talk. So I want to tell you about something that happened last week in New Hampshire. Who's here from New Hampshire? I saw some... Okay, two people from New Hampshire. Am I missing anyone from New Hampshire? Okay, good. You may have seen this. So last week, I got a safety alert and it's a rather unusual one. The New Hampshire Department of Transportation declared that there was no one hurt in a tollbooth accident that occurred on the 31st of May, which is good because this is what the accident was. Since I know you're all into understanding why things go wrong and how things go wrong, I thought you would enjoy this. I thought you would

especially enjoy the fact that the Department does stress that only one car should go through the tollbooth at a time. Okay, some things you can't make up on the internet. So my New Hampshire colleagues, did you see this in the news? Okay, good. So let's talk about what happened next. As a result of Al Gore, we also have this ability to do root cause analyses on the internet in real-time, and it's this crowdsourcing approach to root cause analyses that can actually happen. So when you read the Comments box, below the news stories, and this news story got all over New England and it may have gone beyond, by the way, because it's just a classic picture of weird stuff that happens. Someone asked a question. "How on Earth does something like this ever happen?" So the root cause analysis question is called for, and then in the comments that come up in the Comment box, "Well, someone was either texting or talking on their phones, in spite of the fact that New Hampshire now has a hands-free law in place," pretty new. "Or they're not very courteous, or they're just two clowns thinking it would be funny." So these are some of the causation statements, and we'll talk about causation today. "They were sharing the toll." I think it's wonderful. This is my favorite of all of the comments, because this person is probably a nice, chill person who goes to yoga and is just like okay with the world, and looks at the glass half-full. "Everyone wants to be first at the tolls. There's a lot of lane swapping in order to be one car ahead." That's true. We all know that that's human behavior. Right? "Squeeze play, this is the athletic approach to things." "There's one in-stater, and there's one incoherent, out-of-state driver," and if you noticed on the license plate, one was a New Hampshire license plate. But I think the New Hampshire person is also incoherent, because they have a readily recognizable license plate. It's "JPG6." So it's not like a six or eight-letter license plate. It's somebody's initials, and I bet one of you, investigators, could probably do a search during my talk and find out who owns that license plate. "This never would've happened by anyone from Bedford, New Hampshire. Are either of you from Bedford?" Okay. Bedford is where the tollbooths are. So this is the person who's very superior, and there's no way that anyone from Bedford could've been involved in this. Even though it is exactly at the exit to Bedford, New Hampshire, so there's a good chance it could've been. "It wouldn't have happened if there were no tolls." That's another good kind of action plan we could think about to prevent some of these accidents from happening again. Then, "Get rid of the tolls because guess what? If this gets worse and we look into the future, and this was like an oil tanker, a gas tanker, everyone is incinerated," which is really not funny. But it's kind of the way we think about actions and solutions to problems, because it could get worse. Finally, "Either way it happened, hello. Everyone is in full agreement that insurance should not pay the claims." So that is the root cause analysis work that I wanted to share with you from something that happened just a few days ago, and I hope you enjoyed that as an opening. We're going to be digging on more seriously into what we're talking about today. We're going to talk about methods and techniques that lead to more effective and efficient RCAs, and that would be the RCA2 report and recommendations that I'll share with you. We're going to talk about some of the tools that are included in that report, and we're also going to spend some time in particular talking about clearing credible action plans to ensure that the safety improvements that we put in place are sustainable. How many of you look at RCAs as a regular part of your job? Okay, only a couple people. Let's turn it back to those who are in nursing or were practicing as a nurse. How many of you have ever been involved in an RCA and written them? Okay. How many of you think the quality of RCAs is excellent? Okay. How many of you would think it's the total opposite of excellent? You can raise your hands. Most people think that RCAs are pretty well not done. We do, in healthcare, positively excel at acknowledging other people's errors. I

mean, this is a human behavioral approach that we actually have. Here's a quote from a woman who's a business professor at Harvard. She says, "In fact, if it's sweet to be right, then let's not deny it. It is downright savory to point out when someone else is wrong." This is so true, but it has been so much of a handicap for us in being able to advance our understanding of why things go wrong, and to address those issues that are causing things to go wrong. Because boy, it's always like pointing that finger is part of the DNA, I think, of people that are educated in the healthcare arena. And we are hardwired to remember and think about the negative. We think a lot about errors we've made. How many of you've ever made an error in your clinical practice? Okay. So for the record, for those who aren't looking around the room, that's a good half of the room. I will say, the error I made... Who's from Massachusetts? Okay. All right. You don't know my name. You don't know my identity. But this was a long time ago. I actually made an error when I was supervising student nurses in a clinical setting, when I oversaw the student drawing up and administering the wrong antibiotic, a lookalike, soundalike antibiotic. I was a new graduate of the master's program, I was teaching, I was working full-time in a hospital, I was working full-time in my academic setting, and I was also taking doctoral classes. I never told this story until about two and a half months ago, when I spoke to a class that was being inducted into the National Nursing Honor Society. I had to tell them stories. We couldn't use slides. The story that I told for the very first time in my career was how terrible I felt when I made that mistake. It was an error that I know I made, and I didn't go to work that day intending to make it. I also didn't go to work that day understanding the impact of fatigue. I worked 12 hours, 7 p.m. to 7 a.m., went down the stairs to the same hospital, to the clinical setting, supervised students for seven hours. Honestly, from what I knew and what I've learned in patient safety, I really now can look back on that event and kind of do a root cause analysis on that, that I would not have been able to have done back then. What happened when we made mistakes in healthcare a couple decades ago? What would you do? What would you normally have to do? You'd fill out an incident report. Right? You'd fill out an incident report. That's what happened with me. Went in, stopped the infusion right away, and made sure that the patient was okay. Went with my tail between my legs to the nurse manager and said, "What am I going to do?" I was sure I was going to be fired from my academic job. I was sure I was going to be fired from my job, because I was teaching in the same setting I was working. I was sure that I should not belong in nursing, that I did not belong in nursing, and I was devastated for months, years. Even when I told the story a couple of months ago, I still felt that devastation because I thought, "There's no way I should have the right to care for patients if I couldn't protect the patient, and there's no way I should be teaching if I couldn't be perfect." What we know about errors that happen in healthcare is that the vast majority of errors do not occur because people go to work wanting to hurt someone. They go to work very often in systems that are chaotic and confused, and changing, and have enormous production pressures, and create a lot of opportunities for things to fall through the cracks. If I had left nursing several decades ago when this happened, and if you had left nursing... Because did some of you think about whether or not you should be a nurse when you made that mistake? Yeah? I mean, it's a terrible feeling. Look where we would be today if we didn't have all of you sitting in this room who've made a mistake, who have understood what it feels like to make a mistake, and yet are coming to work every day to ensure the protection of the patients and the public, and that is really commendable. But it's really difficult to get past those errors when they occur. So I want to talk to you a little bit about RCA2, and give you a little bit of background on where it came from. For the most part, we know that root cause analyses that have been done

in healthcare have suffered from many disadvantages. In many cases, and I'm going to talk about this a little bit more later, leadership is not understanding and they do not necessarily advocate for good root cause analyses. They actually don't think of this as the real work that we need to be doing. There's a lot of focus on what went wrong, and less focus on "How do we prevent future harm occurring?" That is really the criticality and the importance of root cause analysis. We're going to talk today about how RCAs are typically based on harm versus risk, and that's one of the unique contributions that a report makes. The RCAs still tend to be very reactive in addressing what went wrong and not thinking about what could go wrong. I would also suggest to you, and many experts sitting around our roundtables said, "Why don't we do RCAs on things that go well?" We don't. We don't look at the things that go well. The most common way we learn is based on what goes wrong. We're going to talk about the punitive aspects of RCAs. There's incredible lack of standardization, and inconsistent processes and teams, and tools, and you will see that many of the RCAs that are done have very weak actions in place. That's also something that is emphasized in this report, and that's where the second A comes into this report for root cause analyses and action. So we'll spend some time talking about that. We very commonly don't close those loops for learning and giving feedback, and we'll spend some time on that. There's often not even transparency or exposure within organizations when things go wrong. We often also exclude key stakeholders, including patients and families. And again, these are all topics that I'll hit on. Some of the slides you see might be a little bit different in your booklet. But I can reassure you that in the report, all of this material is there. One of the first times I did a talk on root cause analysis, I thought it might be interesting to take a look at what "root" really meant. "Root" is a noun, and it is also a verb. I sat back and reflected on it, and it may sound a little bit kind of on the hokey side, but I thought, "How about if we just really thought about root cause analysis in a way that's not so negative?" It always connotes something bad, and it's always something that nobody wants to touch and be involved in. But when we look at the concept of "root" as a noun, it's a part of the organ or a physical structure by which it's attached to the body. Those roots normally bring up the nutrients to help that organ flourish. In some cases, like my neighbors, they haven't figured this out yet, they put way too much fertilizer on their grass every year, they have a sprinkler system. They want to have the best lawn in town, and for about a week or two in the spring they do, and then they over-fertilize it. Then, the stuff that comes up through the roots of the grass is actually so toxic that they kill their grass. This has been going on for about 30 years, and they still haven't figured it out yet. We watch and laugh every spring. It looks really bad this weekend too, by the way. But from a verb, when we think about "root," it's really intended to mean to encourage a team or a contestant by cheering or applauding enthusiastically. I think if we can look at root cause analysis and start to shift the mental mindset from something that's very negative to thinking about this is really a wonderful tool to help us learn how we can understand not only what went wrong, but how we can prevent things from going wrong in the future. So a little bit about why we've re-architected root cause analyses into RCA2. We have gotten lots and lots of feedback from organizations around the world that have said, "Our root cause analyses really aren't that great. They're not helping. We're not creating sustainable change, and our problems are happening over and over, and over again." So we convened an expert panel about a year and a half ago from people from different disciplines. Their names are on the list at the end of the slide deck that you have. And we pulled them together to figure out, "How can we learn from the very best of the best and most successful of practices in root cause analysis?" This team developed the concept of root cause analysis and action, or RCA2,

and that again is a full report with a full set of tools, by the way, which you can use, it's freely available. In order to help understand, how we can make accident investigation or adverse events analysis go more smoothly. We did receive a grant from the Doctors Company Foundation, they're a malpractice insurer. And I do want to just clarify that they had no bias. They had no influence or content over the report. And by the way, they have continued to fund this next phase of the report that Kathy mentioned earlier today. Where, we're working on a root cause analyses web series, because we've had such an incredible demand for this. We released our report last spring. We held our webcast in July, the middle of July. I think it was the week after the 4th of July. And we have a lot of people that tend to join our webcast. But we had over 7500 unique addresses on our web cast, with many of them having multiple people involved in the webcast. And this is also archived on our website as well. That tells you something, in the course of the nice warm summer you're getting that many people to come to a webcast. And it still is by far in large the most sizable webcast that we've had. The key elements that are unique about this process are, first of all, "Hey, good idea." Let's standardize how we do RCAs. Let's focus on risk-based severity versus harm-based severity. And, let's take system approaches to improving root cause analysis. Let's ensure that our action is strong and robust, and leads us to sustainable improvements. So I want to break down some of those elements. But I, first, I would like to spend a little bit of time on leadership. And when I speak about leadership I'm talking about, clearly, people who are middle managers. But in particular, the C suite and executive teams, as well as governance bodies who really have a critical role to play in improving how we understand what went wrong and what we should do about it? We did this survey a couple of months ago as a follow-up to our RCA2 report. We had about 370 people that responded to this report. And the vast majority of them were implementing some or all of the recommendations. But the main reason why a minority of the respondents...and this was about 45 responds said, "We're not implementing it." Major reason: We have lack of leadership buy-in to improve the way we do root cause analyses. And just as a quick subset of what we commonly hear about leadership and root cause analyses are that, leaders kind of know that they need to be done, but they don't take a total systems approach to safety. So many of the safety initiatives that we see are knee jerk reactions and piecemeal approaches. When an individual problem comes up, the organization rushes and rushes to figure out a way how to deal with that individual problem. Without understanding that there's a lot of systemic issues that really impact whether our cultures and environments of care are indeed safe. And we just released a report on this called "Free From Harm," which is also available on our website. Where we talk about what a total systems approach to safety looks like. Sometimes they don't have aware of the criticality of the importance of the process. They probably do, if they're finally getting to the work you're doing. They often do not see or hear stories. The executives, governance bodies, Boards of Directors often don't share these stories or talk about harm regularly at their board meetings. We know, that, from surveys that we've done and that others have done. We also know that people don't consider root cause analyses to be part of real work. It's something that's bolted on as extra time, but we don't have protected time to do that. And, in fact, we don't have the core teams that are assigned to do RCA, and I'll talk about that in a little bit. There's still, in many environments, the cultures of shaming and blaming when something goes wrong. We're actually doing a major program right now, with the American College of Healthcare Executives, to really address the issues of cultures of safety, and moving beyond that. And quite frankly, we see people oftentimes at the leadership level only pay attention if, guess what, it gets out into the internet that Al Gore

created, and it causes a PR crisis for the hospital. And I'm not trying to be derogatory in my comments, but these are very real areas of feedback that we have received about what our leaders need to know and understand about improving safety. One of the main changes to the RCA2 report, a main area of emphasis is on the concept of risk-based prioritization. And we know right now that most RCAs are done on the basis of harm. So if a patient dies or is permanently injured, we typically will do RCAs because we have to, as part of what we're doing. But this process of RCA2 uses a transparent and formal system, risk-based prioritization system, to identify the adverse events, the close calls, and the system vulnerabilities that require RCA2 review. And it incorporates not only the severity of the patient, and harm that's done to them, but also the probability that some type of event will occur in the future. And I'm going to show you the matrix on that in just a moment. This process also allows for aggregated review of similar events to occur. So the process I'm describing can be used for the singular event. But it also provides a framework for some of those very common things like close calls. Close calls occur about 10 to 300 times more frequently than harm events actually do. But they are commonly the precursors that, if we addressed, we could really sustainably reduce risk and correct vulnerabilities before harm actually gets to the patient. So this risk-based prioritization schedule, which is outlined in the report. This photo is a little bit more clear than the eye chart that you have in your packet. Looks at the combination of severity and frequency. So anything that is catastrophic or major, in terms of severity, automatically is something that indicates a root cause analysis and action plan can be done. But depending upon the frequency of perhaps maybe a moderate type of injury, if that's something that's happening very commonly within an organization, we encourage organizations to aggregate data that they have about close calls. And also do RCAs on those as well. You should also notice on the report that, well, the risk-based prioritization here is focused on the patient. That the RCA2 reports are also very suitable for things that happen to visitor and any safety issues when they come into the facility. And, also, for any equipment and facility harm as well. So it's a very comprehensive tool kit for taking a look at things that go wrong, that certainly involve the patient, but can go beyond that. The tool that I talked about earlier that allows us to combine the degree of harm with the risk of occurrence is called the Severity Assessment Code Matrix. Have any of you heard of this before? Anyone? No. Yeah, a couple hands going on up. This is a tool that's been used for many, many years by high-risk industries. The VA has used it, if we have any VA folks in the room. But it's a tool that basically helps people analyze an event to determine whether an RCA2 should be done on the event itself? So if something is scored a two or a one, the likelihood of it being an urgent need to do an RCA2 on is lower, than if it is a three. And there's more detail on this, but I show you it because it provides kind of a cross tab approach to helping understand what goes wrong. And it also serves as a basis of encouragement for organizations to look at things where, maybe, harm isn't catastrophic. It might be more moderate. But because the frequency is so high it can stimulate people to take a look at some of those close calls that we don't often understand. There are several critical elements of the RCA2 process. And I want to go into those. I'm going to talk about a few things. This cartoon says: To address this mistake, we must use root cause analysis. And I'll begin by saying, "It's not my fault." And how many of you have heard, "It's not my fault. Somebody else did it." Again, if you've been in the healthcare setting it's, unfortunately, been a lot of the cultural way that we have approached things that go wrong. This report came out about a month ago. It came out from AHRQ, the Agency for Healthcare Research and Quality. And this is their survey on patient safety culture surveys. It's the consolidated results of

surveys that were done in the hospital setting. How many of you have worked at institutions that do the surveys of patient safety culture scores? Okay. Let me just tell you a little bit about this, because if you're doing accident investigations and other things, I think it's important to know that there are validated tools out there that are able to identify what the culture scores are for safety on different units. And as we know it, safety cultures are very local phenomenon. We can have the highest rank, no matter what report card you look at, in terms of patient safety healthcare organization out there. And if you do this survey, which organizations commonly do about every two years, you can identify the areas of risk that might exist within a particular unit. So let's just say the OR, for example, has a very low culture score. It's important to understand that those are often very important systemic and environmental factors that can contribute to worse outcomes. And there's very clear evidence that shows that surveys of patient safety culture scores are associated with events of harm and degrees of safety. So very commonly in the hospital settings for all the years that this survey has been done, the lowest positively rated item in the survey and patient safety culture scores...and I think there's about 42 items, and they're clustered into about nine or 10 categories. Is the non-putative response to error. Only 45% of people in the recent survey compilation that was just published agreed that they work in environments where mistakes are not held against them and that mistakes are not going into their personnel file. And many people/experts, including Lucian Leape, who is the father of modern patient safety movement, and for whom our think tank at NPSF is named -- the Lucian Leape Institute. Believes that the biggest single reason why we can't improve patient safety is, we blame people for making mistakes. And we know there's a lot of complaints about staffing. But staffing even rated higher. It's not great. It's 54%. But I wanted to point that out, because we really still have many folks who are operating in environments of fear. And if you're looking at events that come to you. Of curiosity, might be the question, I wonder what those survey of Patient Safety Culture scores were for this particular unit? I don't think we're including these as often as we could in root cause analyses. And it might be something to think about. Because, very often, there are so many factors that will influence why things went on. We've talked a little bit about blame. And I know that this is something that you focus a lot of time on your investigating. And I have enormous respect for the work you do. You are really taking on some very, very tough challenges, and really critical challenges to ensure the public protection out there. Blameworthy events, as we define in the RCA2 report are not events that we encourage the RCA2 team to investigate. If something is determined to be blameworthy either, at the outset or part way through the investigation. Then the team which I'll talk about in a minute is encouraged to escalate that to the proper part of the organization, whether it's human resources, or the credentialing office, or the professional discipline office, as it may be called. So that it can be dictated and dealt with by whatever the organization rules are, whatever the state and federal statutes are. How many of you use the Just Culture Model in your state board activity? It's about 26 states right now that use the Just Culture, Kathy? Is it a little higher? I think I was taking a look at that. The Just Culture Model is something that we really encourage people to deploy in the root cause analysis. To not, again, immediately blame people. And we don't believe in a blameless culture. But when it is appropriate and when there is blameworthiness, that those events should be handled appropriately. If you can't read what these fishes are saying on the mouth. The little one to the left is saying, "There's no justice in the world." The middle one is saying, "There is some justice in the world." And then the big fat fish is saying, "There is total justice in the world." And that is something, again, that is so important when we hear about things that go wrong in

organizations that don't use Just Culture Models to determine whether or not there was intentional egregious reckless behavior that was going on, as compared to something that happened because of a human error that quite frankly was probably propagated in many ways by a lot of the environmental factors that are going on in this system. The RCA2 report takes a really firm stance on getting the analysis and the investigation going, immediately. And, obviously, the first thing that we need to do when something goes wrong, is to take care of the patient and the family. And ensure that their immediate needs are met. But we do strongly suggest that the review process being started within 72-hours, using the risk-based prioritization matrix as a first step. And that it be completed within 30 to 45 days. And some people complete it within 30 to 45 days, as many organizations require. But the quality of their completion isn't always quite so strong. We're going to talk about the team in a minute. But I just want to mention here, in terms of timing, again, that this is not something that you just randomly pull a team together to investigate. Organizations, really, should have plans in place for deciding who's on that team, and ensuring that there is protected time, and that there are scheduled meetings that are in place if those meetings don't need to be held. If there have not been any events, that's fine. If an event does occur there are several meetings that are likely necessary to take place for the core team to do their work. And the team membership, overall, is a core team in the view of our RCA2 recommendations with fairly dedicated people. There can be some transition to this core team that does the actual review, depending upon the nature of what the event was that happened. We encourage that these team members have a fundamental knowledge of the subject area, and root cause analysis process. Not everyone needs to have the same skill set. You don't want everyone having the same skill set coming to the table. Conflicts of interest need to be minimized. So lots of times people will say, "Should the staff member or the manager of the staff member be involved in the RCA2 process?" And our advice is: No, because...inherently they should be interviewed, but not involved on the core team because of the inherent bias, which is very, very real. We encourage the teams to be capped to about six or so team members. The team lead needs to be experienced and skilled. And, again, this is something that needs to be designated and developed as part of the real work that needs to go on within an organization. There's a lot of questions that we get about patients and family members. And whether or not patients and family members should be involved in the RCA2 process? And we do believe, as this publication notes, that when properly handled involving patients and family members in RCA2 or post event analysis can, in fact, be very helpful. And it really is an important part of the RCA team and those who are involved in caring for the patient and family, to determine whether or not the patient and family member is willing and able to provide information. Because, it's so important. They see so many things that we don't normally see in the course of care, that can contribute to us making improvements, and addressing fracture lines and fault lines that exist within the organization. We do emphasize and we do believe that, whenever possible a patient representative should be included on the RCA2 team. So I don't know how many of you have ever worked with someone, for example, who's on a Patient and Family Advisory Council. But as we look at the sophistication, and the vision, and the capabilities of what patients and family members bring to our ability to improve the safety of care, they can be massive contributors. How many of you know of the Betsy Lehmann story that occurred in the state of Massachusetts? Massachusetts people will know this. Betsy Lehmann was a Boston Globe reporter who actually received an overdose of chemotherapy -- a substantial overdose -- and it killed her. And the state of Massachusetts funded the Betsy Lehmann Center many years ago. And this happened, and

this is public information at the Dana-Farber Institute, which is as many of you know, is just a premier cancer center. Today, the Dana-Farber Institute has over 100 committees. And every single one of their committee's has a patient and a family member on those committees. They are phenomenal contributors. If a patient and family member hasn't shown up for the meeting, the meeting doesn't start without them. They're considered to be that vital. And many other organizations like the Dana-Farber have figured out ways to really meaningfully include patients and family members into the work of improving safety and quality of care. And that doesn't count: Where do we put the flowers in the lobby? That's not a meaningful contribution for a patient and family member. The report includes examples of different types of team members, and what their role could and should be in either the interview process or in serving on the core team. And you will see that we do in fact note that families and the patients who are involved in the event can and should be interviewed to the extent possible. But they really should be on the core team. But the patient representative, if at all possible within organizations, should be. How many of you have public members on your boards? Okay. Yeah. So you know what I'm talking about, when I talk about patients, and family members, and the public. However, when I go back to that survey...and the cartoon on the right says, "I have metal fillings in my teeth. My refrigerator magnets keep pulling me into the kitchen, and that is why I'm overweight." Do you guys have fridge magnets in you? So really, we do know that patients and family members can contribute a lot. But in the survey that we just did, when we ask people, which components of the RCA2 process are you likely to implement? Nearly all of them were rated very high, in terms and the likelihood of implementation. But look at the numbers. Engaging patients and family members in process: only 18%. And providing feedback to patients and family members after completion of the process where a patient has been harmed: only at 27%. You feel good about those numbers? We've got some good work to do on that. This can be one of the import elements of our next webcast series. We have an interviewing secession going on, I know, after this section. The, I-know-a-guy team, over here, for you guys going will spend a lot of time on interviewing, best practice, and successful practices. And we do outline tips for interviewing in our report in appendix three. The goal, really, of interviewing is, really, to discover the facts and the information that are going to help identify system issues and, ultimately, lead to effective and sustainable solutions. We often ask the question of, where did people go wrong? But, instead, one of the questions...and this might be something you might want to take back with you into your practice. Is to say, "Why did their action makes sense to them at the time?" Those are two very different questions. And I know many of you are experienced and, probably, highly proficient interviewers. But I can tell you, in the healthcare delivery system right now, in the front lines of care, we don't have folks who are really all that well-trained in interviewing. So there's a lot of questions in there. There's best practices: Not including anymore than one to two members of the RCA2 Review Team in an interview. I already talked about supervisors not being present, only interviewing one person at a time. Being prepared with questions. And patients having...the patient, they want to have themself and a family member be involved in, to the extent that your organization deems appropriate. Sometimes it does include legal counsel. And there is a movement on communication and resolution programs, how many of you have heard of these programs? Sometimes called Disclosure and Apology Programs. Raise your hands if you've heard. Okay. This might be an interesting session for a future conference. But we all know that one of the major reasons why we see cases escalate to litigation is because patients don't receive two things. Number one, they don't receive an apology. In some cases, they don't even receive an

acknowledgment that anything was wrong. And they don't receive an explanation of how it's going to be prevented in the future. And this is critical work for the learning of an organization. And it's critical work for ensuring that, as we look at things that go wrong, that we're thinking about all of the players that are involved in these situations, and treating them with the respect and the engagement that they deserve. And other things include, and you'll hear about this in the interview session if you're going to it. You've got to be a good interviewer. If someone's going to be in scrubs and you're going and interview them, you don't go in with a black tie suit. And you don't call people into the carpeted areas of the hospital, because you have to interview...am I right on this I-know-a-guy people? Okay. You want to interview them in environments that are safe and comfortable for them. And you want to ensure that the tone of the questions that you're asking is balanced and is focused on understanding. And that you thank people for being a part of that investigation. Causation is something that sometimes is short-circuited, I would say to put it nicely, when we have accident investigations. Lots of times people will say... I'm going to show you an example on this. "I found out the reason why it went wrong..." And then the whole investigation stops there. There are a lot of tools and resources in the report to help improve...and I believe, even in your roles, although you're not doing root cause analyses in the clinical care environment. I think there's some good things that you can take back into practice. Because, they can really improve the way we understand how things go wrong. There are causal diagrams that are shown in the report. And there is always the emphasis on asking, why? Why? Why? Over, and over, and over again. In fact, there is a rule of causation. The five rules of causation that actually exists. And this is somewhat of an eye chart. Actually, the next slide will be the eye chart. But this is...to document the system vulnerabilities as causal statements: With a cause, the effect, and how the event came to be. So something, which is the cause, led to something, which is the effect. Which, increases the likelihood that the adverse event will occur. An example that you might see...and we see this all the time, unfortunately. Is that, "Well, the nurse gave the wrong dose of a drug." The nurse gave the wrong dose of calcium, for example. But if we really were to think about the five rules of causation that are in the report, this is perhaps a better causal statement. "A volume of activity and noise in the ICU," which is the cause, "led to the nurse being distracted when reviewing medication orders," which is the effect. "Which, increased the likelihood that the wrong dose would be given," which is the event. The reason why I'm sharing this with you is because we receive countless stories. And I actually sit on the Bored of Directors of MITSS -- Medically Induced Trauma Support Services. Which is an organization, nonprofit, that is focused in on helping caregivers who are a part of things that go wrong. Because it's very, very traumatizing for them. But all too often we stop at, "Well, the nurse gave the wrong dose of calcium." And what happens? We fire the nurse. And what happens? We take away her license. And what happens? And, this is very serious. In many cases, we have huge rates of depression, and anxiety, and suicide rates that are climbing. We do a lot of work on workforce safety, and it's amazing to see how unsafe our workforce actually feels right now. The five rules of causation are in the report. I'm going to take you to the second line item down. One of the rules says to use specific and accurate descriptives for what occurred, rather than negative and vague factors. This is not in your slide, but it is in the booklet that is online. So an incorrect statement would be to say, "Well, the manual was poorly written." Which we know most people read manuals, right? Instructions for use. A lot of them are not well-written. So a correct statement if we think about the cause, the effect, and the event, might be, "The manual, like the slide, had 8-point font. It had no illustrations. The nurses never read the manuals, and it

increased the likelihood of incorrect programming of the pump, which might be why that medication error actually happened." And the other rules of causation that are here, are very, very helpful to know and understand. And can be applied again in the work that you do. Flow diagramming is outlined in the report, itself. This is a graphic portrayal somewhat we know and don't know. It actually starts the beginning of the RCA investigation. And then becomes more populated, as the team has a growing understanding of what happened with the event. It allows the team to correct...to conduct gap analysis, to fulfill and populate that understanding of the event. And really connect as a strong roadmap for analysis. How many of you see any flow diagrams in your investigations? One? I think I might have saw one hand go up. These tools and approaches are extremely helpful for understanding what went wrong. The action hierarchy I want to spend the last few minutes on...most my time on is really critical. Because, even if we do a really good investigation...you know why most RCAs fail? Anyone have any ideas why they fail? Yeah, you do. You definitely do. It's because we don't have strong plans in place that will really ensure that the event doesn't happen again. We do things like this: We put up signs that say, "Remember to do X, Y, or Z." Or, we do in-servicing, "Take another in-service." Sometimes when I made my mistake, the nurse manager on the end said, "Fill out this incident report and do better the next time. Do better the next time." Okay? And we've come a long way since then, with our understanding of how to handle issues when things go wrong. But this is truthfully probably the weakest link in the whole part of the process. The Action Hierarchy has been around for many, many decades. And it's been used by a variety of organizations. The VA has used it, the CDC uses it. It's part of our RCA2 report. And the reason why I say, "No censorship," on this. Is that, the RCA2 team is responsible for identifying the strongest actions possible for every causal statement that they identify in the RCA2 process. And the weaker things are the things that we typically do. We say, "We'll do double checks. Let's put up warning signs." I work with a board member who does this story of, some people...when you have little kids that want to jump in swimming pools, and they're toddlers, you don't put up a sign that says, "Don't jump in the pool without your floaties." Because it simply doesn't work. And, unfortunately, even though we do use warning signs, and they can be reminders. They are not as bulletproof as stronger actions would be. Some of the stronger actions, which are on the left side of this slide, include forcing functions. Things that don't let you proceed. For, as much as we don't like electronic health records, which by the way I think Al Gore also invented since he invented the internet. So there's a really direct link that goes back when you look at the six degrees of separation. Having those controls in place, simplifying the process, standardizing. If you think about, how many organizations...if you have 10 orthopedic surgeons, you might have 10 different surgical kits. Because, we still cater to the preferences of people. And we still don't understand how important standardization is to our process. Because we spend time on the weaker actions, we're relying on humans. And humans are fallible, as we've seen in that toll booth thing. For whatever reason, they're fallible. And when I made my mistake, I was fallible. All of the mistakes that you've made. And the stronger actions have less reliance on humans. And we strongly suggests that when people are looking at action plans, that you look for...and don't accept an action plan if it doesn't have strong and moderate actions in place. If you have weak actions in place, they should only be temporary and brief measures, before that plan should evolve into having really strong actions in place. And measurement is critical. For every causal statement, we encourage people to establish a measurement plan that includes process and outcomes measures. And there has to be somebody that owns the process. And by the way, this is not the RCA2 team. It might be

the nurse manager on a unit that owns a process. Or it might be the Director of Quality who owns the responsibility for measurements and, hence, reporting. And there should be clarity on knowing who that person is? How are they going to measure it? And the dates by which it should be measured. And this accountability that is often not embedded into RCA processes. I have two examples of processes and outcomes measures here, that are much more meaningful, and measurable, and smarter than the ones that we typically see. And the measurement of effectiveness is something that should be ongoing. It's not something that should happen at a single point in time. Because a single point in time measure, as we know, does not give us an indication of sustainability. Feedback, as we talked about, is so lacking in root cause analyses. And we have a strong emphasis on feedback going to the leadership team, to the staff, to patients and families, and to the community. The Brigham and Women's Hospital, Betsy Nabel, who's the president, actually does a blog if you want to read it. It's actually quite good. They actually tell stories about the errors that happened at The Brigham and Women's. They say why they happened and what they're doing about it. It's publicly available. You need to have confidence in an organization, about transparency. That's a great example of one that is taking a leading edge. And then, there are also indications in the report for warning signs of ineffective RCAs, that tie into risk about causation, human error being identified as the cause that is not on an effective RCA2. Not having the strong actions, as I mentioned. The event review taking a really long time, and having little confidence that the recommendations are not going to significantly reduce risk. So my summary today is, first of all again, to acknowledge the really important job that you have, to give you some insight into what's happening. We have hundreds of hospitals now, that are doing innovative approaches with the RCA2 report. And we're hoping this will sure up their understanding of why things go wrong, and reduce the risk of those happening in the future. The second, A, is absolutely vital. The first one is as well, but the second one is really, really important, in order to be able to ensure that corrective actions are sustainable. It's important, again, because we want to prevent the risk of future recurrence. But really truly understanding what happened? And, also, taking this opportunity to do a better job of understanding how accidents occur, and improving care for patients, and also for our workforce. So I thank you for your time and attention to this. A nice quote: The measure of success isn't whether you have a tough problem to deal with it, but whether it's the same problem you had last year. And I think this is something that's all too familiar with you. If you'd like to download the report, it's widely available for you. And thank you to the NCSBN for endorsing the report, itself. So I think I might be at my time, Kathy? - [Kathy] Five-minutes. - Five-minutes. Okay. Can I take a question or two if there might be any in the room? Comment? Run to the mic. Okay, you're there first. Hello. - [Woman] Thank for that report. I have a question. Can you clarify a little bit more how blameworthiness is established? - Yes. Blameworthiness is established in a variety of ways in the report. And sometimes blameworthiness, as you know, is something that you know right away. And sometimes you don't know. But if you a suspicion over time, as you're collecting facts in the report. First of all, if something is egregious and you know it, that automatically gets escalated. But sometimes we find out there have been repetitive patterns of behavior, or a person has failed to wash their hands, or they have a history of frequent surgical site infractions. Those are the kinds of things that we're starting to see organizations take a closer look at. The Vanderbilt system does a really nice job of understanding blameworthiness in their professional accountability systems. Because, sometimes when something happens, it's truly a human error, and there are ways that Vanderbilt is teaching people to understand and interview to

decide whether something is, "Okay, I have to have a cup of coffee conversation with Patricia. I notice she didn't wash her hands." And someone comes in and has that conversation. And say, "Patricia, I know that's not like you. And I'm sure that this is something you realize is not good and it shouldn't happen again." If you escalate it to a cup of espresso conversation, and you have the espresso-types of folks that you're dealing with. And you can't remediate behavior and you can't assess and identify time for changes in behavior. Those are employees that fall into a higher risk path. And they can be remediated. And, actually, the Professional Accountability system that is on the Vanderbilt website, does a very good job of giving information on how you can deal with it, and assess folks to determine whether or not they are common perpetrators or violators? Or whether their acts for really, really, egregious or not. We had someone else with a question. - [Eric] Can you hear me? - I can hear you. - Eric St. Ange [sp] from the great state of Michigan. That was an excellent presentation. I've got two question. One, what happened after you reported your medication error? And then, two, how do you set up that Google Alert for your kids? - Okay. All right. So for...let me handle that Google one, first, because I think that's really important. Most people probably want to know that. So if you did a search. So my daughter's name is Molly McGaffigan. You can put her in your search engine, right now. You'll find out a lot of cool things about my daughter. She's a great kid. But then things will pop up. And then, if you go to the bottom of that first page, you'll see a little thing that says, set up an alert. You click that button, and it says, "Do you really want to set up alert for Molly McGaffigan?" And the answer's, "Absolutely, I want to set up an alert." So it sends you a message to your email because it asks you for your email address. And then you can find out whenever Molly McGaffigan is mentioned. Most of the times it's my daughter. Sometimes it's another Molly McGaffigan. But then, you can figure that out that way. And, also, you can do Google Alerts, you can search Google Alerts, and that can do it as well, too. So for any of you who want to know what your kids, or ex-husbands, or whatever might be doing that's a good alternative. What happened to me, unfortunately, was very little when I made that mistake. I filled out the incident report. And I remember the nurse manager being very kind to me but she clearly wasn't happy, and I don't blame her. And I did not receive any support after I made the error. When I went back to the school I was teaching, and I told my supervisor that I made a mistake, I never saw the results of the incident report, which is not uncommon. How many of you had incident reports you've written up? Did you ever see what happened with them? No. They used to go into this big black cloud. What happened to me was, I almost quit the nursing profession. That's how it was handled. It was through my good Irish guilt that took me down this tunnel of real shame, depression. I thought I should immediately quit. I thought should I kill myself? And this is a serious issue for healthcare providers. Because, even though there was no harm that happened, I was supposed to be perfect. And that's how we think of healthcare providers. But it's important for us to know that we're not. So I had no close loops. I can tell you the way it's handled now is lookalike/soundalike antibiotics and packaging have been dramatically reduced. Pharmaceutical companies have been engaged in making sure that those risk factors are mitigated. We didn't have pyxis machines at the time. We just had drawers where you had medications -- medication drawers. You'd have everything in there you'd want to, including all the scheduled drugs that you're going to be talking about for some of this meeting. I mean you could just grab anything. So it was so easy -- they were in alphabetical order -- to pick one and make that mistake. So, unfortunately, what happened to me mostly happened to me in the last few months. Where I really started thinking about how important it was to think about the caregiver when something went wrong. I wasn't fired. It is

probably one of the reasons why after two years in teaching I stopped teaching now. So this has been a pleasure. We're getting our time, right Coleen? I want to thank you for your attention this morning. Don't tell Molly McGaffigan if you find out how to contact her, about the shoes. I'll deal with it when I get home. She is a great kid. And I hope you have a wonderful rest of conference. And I look forward to learning so much from all of you. Thank you.