focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

Root Cause Analysis Studies Incidents To Reveal System Failures

BY PAUL A. GLUCK, MD, ASSOCIATE CLINICAL PROFESSOR, UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

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Editor's note: In the 2002 NPSF annual report, Jennifer Dingman of Pueblo, Colo, tells the painful story of her 78-year-old mother's death in 1995 due to a series of medical errors. (See story on page 2.)

To gain greater insight into the factors leading to the death of Jennifer's mother, Focus *asked NPSF board member Paul Gluck, MD, to perform a root cause analysis on her case. The stories about Jennifer's mother in this issue and in the 2002 NPSF annual report are based on a 75-minute telephone interview that* Focus *editor Susan Raef conducted with Jennifer Dingman. Dr. Gluck listened to the interview tapes to familiarize himself with the case; his evaluation is based on that information.*

Applying the principles of root cause analysis

Root cause analysis is an opportunity for health professionals to take a step back and gain a deeper perspective on near misses and incidents where a patient has been harmed. The object is not to place blame but to identify system weaknesses so they can be corrected to prevent future harm to patients.

A formal root cause analysis looks at a case from several vantage points—including, in most instances, that of the patient and the family. The incident must be evaluated from the perspective of the physicians, nurses, administrators, and other individuals involved directly or indirectly with the patient's care. Because this article is based only on information gathered from the patient's daughter, the observations are intended merely as a starting point for more in-depth evaluation.

What is root cause analysis?

Root cause analysis (RCA) is a *retrospective,* multidisciplinary evaluation. It looks back over the course of the patient's care to try to find the reasons why there was a problem.

Seldom, if ever, does a root cause analysis reveal that only one thing went wrong; most of the time, there are multiple factors that contributed to the incident. This is an important point to consider in any investigation.

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How does RCA differ from failure mode effects analysis?

Another tool used to help improve patient safety is failure mode effects analysis or FMEA. Unlike RCA, FMEA is a *prospective* evaluation. RCA looks at an incident retrospectively and asks, "Why did this happen?" FMEA examines a critical process that has the potential to harm patients and asks, "How can we change this process of care—the equipment we use, the way we do things—to minimize the risk to patients?" Both RCA and FMEA employ multidisciplinary evaluations.

What went wrong in the case of Jennifer Dingman's mother?

Usually, talking with all the people involved in an incident and drilling down deeply into the root causes reveal half a dozen areas that may have contributed to the problem. The interview with Jennifer Dingman revealed 3 potential root causes of the problems that occurred with her mother's treatment.

1. **Communication.** The most obvious cause of many problems in this case is a lack of proper communication. At several points in the course of treatment for Jennifer's mother, there seemed to be a breakdown in communication

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—between the patient, her daughter, and the physicians; between the patient, her daughter, and the nurses; between the physicians and the nurses; and between the physicians.

This doesn't necessarily incriminate the physicians. In one instance, when the physician called back and said the patient didn't need anything to be done differently, it's not clear whether or not the physician had already spoken to the nurse and gathered objective data before returning Jennifer's call.

In an RCA, all the people involved should be sitting around the table discussing what happened, rather than considering the story from one side only. Maybe the physician had already spoken to the nurse and had received information. The problem may not have been physician arrogance—perhaps the problem was that the nurse was either not given the proper clearance or given incomplete data, which would have made the situation seem different from what the patient's daughter had perceived. That underscores the need to have everyone talking with each other, rather than hearing the story from a single perspective.

2. **Environment.** The second area to examine—the hospital environment—goes beyond direct medical care, which is something root cause analysis should do. In this case, the environment probably didn't contribute to the illness of Jennifer's mother, but it could have. Jennifer told the hospital staff that the temperature in her mother's room was 58 degrees and the problem was not corrected.

   While the temperature may not have contributed to the outcome, it's obviously not a good environment. Another problem that posed a hazard was the patient's broken bed. This is an additional potential root cause for the

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Paul A. Gluck, MD, is an associate clinical professor at the University of Miami School of Medicine, and serves on the NPSF board.

A Daughter Copes with Loss

BY SUSAN RAEF, EDITOR

A pharmacist told Jennifer Dingman he believed her mother was having an adverse reaction to her diabetes medication. "When my mother mentioned this to her physician," Jennifer recalled, "he said, 'If you don't want to take the medicine, you'll need to go somewhere else.' My mother did, but the second physician agreed that the medicine was not problematic.

"Unfortunately, I never looked at the printout that came with the medication," Jennifer said. "If I had, I would have seen that my mother was having 8 out of the 10 adverse reactions—including an inability to urinate.

"When my mother called her physician shortly before Christmas to complain about this, he assumed she had a urinary tract infection and prescribed antibiotic drugs over the phone. By January 4, my mother had a 103-degree fever. Her face was jaundiced, her legs were swollen, and she was having trouble walking.

"My husband and I took my mother to the emergency room, where she was catheterized and immediately filled up several bags of urine," Jennifer recalled. "When the physician arrived six hours later, he diagnosed my mother with pneumonia and kept her in the hospital. After several days, he ordered the catheter removed—but didn't give orders to measure her urine output.

"The physician also kept my mother on the diabetes medication," said Jennifer. "When the catheter was removed, she started to fill up with fluid again. By that evening, she was feeling very ill and had pain radiating down her left arm. The nurse called the physician. Because my mother had once suffered from gout, he prescribed gout medication over the phone without coming to see her."

Her mother's condition grew steadily worse, yet the nurses seemed unconcerned that she hadn't urinated. "My mother started to become very frightened, saying 'Help me! I'm not going to make it through this night! Please make them help me!'" Jennifer said.

"On January 7, my mother coded and was put in the ICU on life support," she recalled. "There was one mistake after another in her ICU care. My mother was in a coma for seven weeks before she died."

Jennifer's experience led her to develop a deep sense of compassion for everyone involved in health care; she has since founded a group called PULSE—Persons United Limiting Substandards and Errors in Health Care, which now has chapters in 16 states. Jennifer also serves on the NPSF Patient and Family Advisory Council. "The best thing is to work with NPSF," she said. "Together we have the power to make the system better." **NPSF**

Contact Jennifer Dingman at pulsecolo@msn.com.

To view the story of Jennifer Dingman's mother in the 2002 NPSF annual report, visit www.npsf.org/download/2002annualreport.pdf.

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NPSF Board Member Jeffrey B. Cooper, PhD, Wins John M. Eisenberg Patient Safety Award

Jeffrey B. Cooper, PhD, director of biomedical engineering at Partners HealthCare System, Inc., Boston, has been named a winner of the 2003 John M. Eisenberg Patient Safety Award. Cooper, associate professor of anesthesia at Harvard Medical School and an NPSF board member, will receive the award from the National Quality Forum and the Joint Commission on the Accreditation of Healthcare Organizations on Sept. 30.

The Eisenberg awards recognize the lifetime achievements of individuals who have made significant and lasting contributions to improving patient safety. The awards also honor individuals and organizations who, through a specific initiative or project, have made a significant contribution to patient safety in the areas of advocacy, system innovation, or research.

In 2002, Eisenberg awards went to NPSF board member Julianne Morath, RN, MS, of Children's Hospitals and Clinics, Minneapolis, as well as the Veterans Health Administration National Center for Patient Safety in Ann Arbor, Mich, led by NPSF board member James Bagian, MD. **NPSF**

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multidisciplinary group to evaluate. The environmental staff would need to be sitting at the table during the root cause analysis to say why that was a problem. And from a clinical perspective, the root cause analysis would examine how the low temperature or the broken bed could have contributed to the situation.

3. **Nurse staffing patterns.** At one point in the interview, Jennifer said the physicians told her the nurses were terribly understaffed and very busy; a short while later, she said they were all sitting around the nurses' station eating and talking. Those two thoughts may not be contradictory. If they were so understaffed, maybe they couldn't take time to have lunch or dinner—so they were eating at the nurses' station because they were so busy.

   The root cause analysis should also examine the nursing staffing patterns at the time of the incident. Research has shown a direct correlation between nurse understaffing and poor patient outcomes. A 2002 *Journal of the American Medical Association* study,[1] for example, looked at the association between the patient-to-nurse ratio and patient mortality, failure to rescue among surgical patients, and factors related to nurse retention.

   The study found that each additional patient per nurse was associated with a 7% increase each in the chances of failure to rescue and of dying within 30 days of admission. A 23% increase in the likelihood of nurse burnout and a 15% increase in the chances of job dissatisfaction were also linked to nurse understaffing.

Healing and understanding the problem

After Jennifer related the clinical facts of her mother's case, she began talking about system problems. Despite all the difficult emotional times she has experienced and all her frustration, Jennifer now understands that the physicians are probably as upset as she about what happened to her mother. She acknowledged that fault lies not with the individual physician, but with a broken system.

NPSF is very fortunate to have Jennifer involved in the Patient and Family Advisory Council. She has demonstrated an understanding and compassion for everyone involved in the healthcare system and is committed to working with NPSF to improve the safety of patients. It is rare for someone who suffers this kind of tragedy to arrive at a point of understanding and healing. **NPSF**

Save the Dates!

Integrity & Accountability in Clinical Research Conference Nov. 2-4, 2003, Washington, DC

NPSF's second annual clinical research conference will cover issues ranging from bioterrorism to vulnerability. To register, go to *www.researchsafety.org* or call Carol Lieser at 760-323-9505. Register by Oct. 15 and save!

Sixth Annual NPSF Patient Safety Congress: Let's Get On With It! May 3-7, 2004, Boston

This conference will explore how to envision, build, and sustain a culture of safety. For details, visit *www.mederrors.org* or contact Carol Lieser at 760-323-9505 for exhibitor and sponsorship information.

Reference

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Promoting Heedful Interrelating and Collective Competence in the Emergency Department

BY ROBERT L. WEARS, MD, MS, AND KATHLEEN M. SUTCLIFFE, PhD

The complexity of health care requires multiple handoffs between different parts of the system. Each handoff is a point of vulnerability where information can be lost or distorted, authority and responsibility can become confused, and small failures can go undetected. At the same time, these linkages between parts of the system are critical to its success. Weick[1] calls them the "relational infrastructure of medical systems."

The quality of these interrelations—the extent to which they are more or less heedful—plays a fundamental role in the organization's successes or failures. Heedful interactions are those in which people are attentive and conscientious but, more importantly, aware of how they fit into the big picture or how their work contributes to the overall goals of the system. Conversely, heedless interrelations are habitual, rote, and narrowly limited to the task at hand.[2] Heedful interactions help build a collective mind or competence where activities are coordinated and subordinated to a higher goal.

Interrelating in the emergency department

The emergency department (ED) is a natural laboratory for studying these interrelationships. In most hospitals, the ED interacts frequently with every other part of the organization and accounts for at least half of the admissions. In many ways, EDs are microcosms of their institutions, reflecting both their strengths and weaknesses. Research observations on safety in emergency care have noted both successes and failures in interrelating that demonstrate the concept of heedfulness.

The following case illustrates heedlessness and failure. (Note that only the interactions are presented. Many issues important to the outcome of the case have been omitted.)

Case in point: Heedless interrelating

An overdose patient in the ED had a severely elevated acetaminophen level requiring treatment with an antidote, N-acetylcysteine (NAC), to prevent irreversible liver failure. To be effective, the treatment must be started within 8 hours of ingestion and continued every 4 hours for a total of 17 doses. The ED physician ordered the loading dose of NAC and called the ICU team to admit the patient.

The ED physicians then changed shifts and, some hours later, the ICU team told the second ED physician that the patient did not require ICU care but should be admitted to the ward team instead. The ward team evaluated the patient and wrote orders for continuing NAC but the patient stayed in the ED due to a lack of beds.

After a nursing shift change, the admission orders were taken off but, before NAC could be given, a bed on the ward became available. Because the ED was overcrowded with admitted patients, the ED nurse transported the patient to the ward before administering NAC.

The ward nurse noted the NAC order was written in milligrams per kilogram. However, he did not know the patient's weight and was reluctant to wake the sleeping patient to weigh him. He therefore delayed administration of the antidote until near the end of his shift. The second dose of NAC was eventually given about 16 hours after the loading dose. The patient developed liver failure and died.

This case involved multiple pathways of interrelating (see Figure 1). Although there were at least 7 known, direct two-way interactions regarding this patient's care, critical information about the necessity and timing of subsequent doses of NAC was missed and the authority and responsibility for ordering them became confused. The interactions were not effective because they were heedless; the participants acted conscientiously but, as it were, in isolation.

Although members of the staff completed their individual tasks, they failed to grasp the relationship of their work to the overall project. Result: All the small jobs were successful but the outcome was tragic.

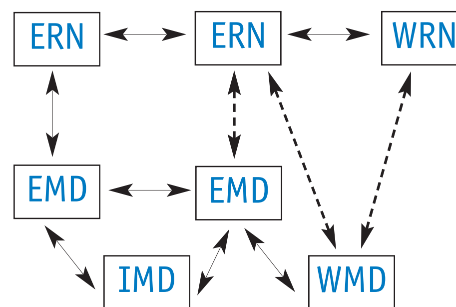

Figure 1. Primary interrelations. *Solid arrows indicate known, direct interactions. Dotted arrows indicate indirect (eg, written), presumed, or potential interactions. ERN = ER nurse, EMD = ER physician, WRN = ward nurse, WMD = ward physician, IMD = ICU physician.*

What caused the heedlessness?

Several factors may have contributed to heedlessness in the interrelation among this patient's caregivers.

- Production pressures on the workers were high. Each caregiver was simultaneously managing multiple serious problems competing for priority. Under such conditions, people tend to reduce their cognitive load by narrowing their attention, reducing the number of people they interact with, and relying more on protocols and over-learned responses. They tend to focus more on the local situation rather than the joint situation.[2]
- All but 2 of the interactions in Figure 1 crossed either professional or specialty boundaries—a common problem in the ED.[3] Interactions across such boundaries tend to be more problematic because the participants do not share common world views, languages, and skills. Some have observed that communication among diverse as opposed to homogeneous participants tends to limit its subject matter to areas of commonality.[4,5] Paradoxically, therefore, participants may unconsciously withhold their special expertise just when it is most needed.
- Some elements of medical culture, particularly physician culture, do not support heedfulness. Weick and Roberts[2] point out that "... a culture that encourages individualism, survival of the fittest, macho heroics, and can-do reactions will often neglect heedful practices."
- There are often goal conflicts between different parts of healthcare organizations that mitigate against heedfulness if it might subvert a group's formal or informal goals. An example of such conflicts and how they reinforce heedless interrelating is given by another observed behavior, that of "selling a patient."

What is *selling a patient*?

The lay public might be surprised by the notion that healthcare workers often are not eager to take on new patients. New patients represent additional work, the quantity and difficulty of which are generally unknown. In settings where clinicians are already overworked, unofficial goals of minimizing work by resisting new patients or attempting to deflect them to someone else are common.

For ED physicians, this resistance can present an obstacle to continuing patients' care by admitting them to the hospital or referring them to a specialist. Therefore, emergency physicians develop strategies of "selling a patient" to a consultant—emphasizing the aspects of the picture that make the admission or referral seem necessary and compelling, and minimizing those that do not. In the ED, this is generally spoken about in terms of "... doing the best thing for the patient, no matter what it takes." But because admission often is also a way to minimize the emergency physician's work, this behavior may not always be as principled as it seems.

The fact that "selling a patient" occurs often enough to have a name indicates that heedless interrelating is common in this setting—that similar patterns of heedlessness may also affect interactions among other "silos" in healthcare institutions. This phenomenon bears investigation because, in complex situations where individual comprehension may not be sufficient, using collective competence to enhance individual competence can make the difference between success and failure.

Limited steps have been taken toward building the sorts of cooperative, mindful teams of caregivers who would show collective competence and resilience in the ED but many challenges remain.[6] The larger task of fostering heedful interrelations across professional and organizational boundaries may be more difficult still but it offers even greater promise because the gaps are simultaneously larger, yet harder to see. **NPSF**

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as I see it

Developing a Patient Safety Committee: One Hospital's Experience

BY HOWARD S. COHEN, MD, PATIENT SAFETY OFFICER, OSF SAINT FRANCIS MEDICAL CENTER, PEORIA, ILL

Today, most hospitals have a patient safety committee that leads efforts to develop a safety culture and make patient care safer. For the past 2 years, as patient safety officer and co-chair of such a committee, I have come to believe there are 6 key attributes needed for success. As our organization has come to understand this, we have re-created our committee—its membership, functionality, and how it relates to the hospital and our medical staff.

Six keys to a successful patient safety committee

1. The committee must include the CEO, senior administrators, and key physician leaders. Having knowledgeable and engaged leadership is critical to becoming a learning organization with a strong safety/quality culture.
2. The committee must meet frequently, work as a team, and feel accountable for measurable success. Except for peer review, hospitals and their medical staff should move to merge their safety/quality improvement committees into a single infrastructure that includes hospital safety.
3. Risk management staff should be active participants in the patient safety/quality effort.
4. Depending on state laws, the committee should be structured to protect the confidentiality of the discussions, though the outcomes of those discussions should be communicated broadly.
5. A supportive infrastructure must be in place. Work should be delegated to a broad variety of hospital and medical staff with the understanding that the work is being requested on behalf of the committee.
6. Committees should include patients and families.

OSF Saint Francis Medical Center, a 730-bed hospital in central Illinois, serves as a regional referral center and is a state-designated trauma center and perinatal center. OSF is also the major teaching affiliate for the University of Illinois College of Medicine at Peoria. The medical staff model is that of a community hospital, with private-practice physicians, university faculty, hospital-employed physicians, and OSF medical group physicians.

Overlapping committees

In 2001, the Quality Council was responsible for hospital quality, including clinical outcomes, process improvement, staff development, and patient satisfaction. At the same time, the medical staff had a separate committee infrastructure, including its own quality improvement committee. Though these 2 committees had similar areas of interest, they did not jointly define priorities or assign resources. Policies that affected the hospital and the medical staff had to be approved by both. The Pharmacy and Therapeutics and Infection Control committees were also medical staff entities. Hospital participants on these committees were ad hoc members without voting privileges.

Launching multidisciplinary teams

In 2000, we chartered our Patient Safety Enhancement Committee to direct our work and create our safety plan, as well as policies for non-punitive reporting, sentinel events, and disclosure. This multidisciplinary committee included hospital administrators and key physicians, and was co-chaired by the chief operating officer and the president of the medical staff.

We also chartered a multidisciplinary Clinical Effectiveness Team of key medical staff department chairs, outcomes managers, and several mid-level administrators. This group was responsible for overseeing clinical quality initiatives including collaborative efforts, as well as defining improvement priorities and recommending resources. Specific patient safety improvement initiatives also reported to this group. I co-chaired this committee with the chair of the Medical Staff Quality Improvement Committee.

Both of these committees reported to the Quality Council. In early 2002, we felt the Quality Council could be disbanded and we could discuss patient safety and quality during hospital administrative team meetings, which medical staff officers also attended. This didn't work, however, because we were competing with other administrative priorities on their agenda.

Streamlining infrastructure

At this point, we recognized a need to re-create our quality/patient safety infrastructure. Neither the Patient Safety Enhancement Committee nor the Clinical Effectiveness Team could make decisions or assign resources, and we couldn't get the attention of our administration. We created a Quality/Safety Board to replace the Patient Safety Enhancement Committee and the Clinical Effectiveness Team. The new board included the CEO, all senior hospital administrators, medical staff officers, other key physicians, the patient safety officer, quality management director,

Howard S. Cohen, MD, is the patient safety officer for OSF Saint Francis Medical Center in Peoria, Ill.

compliance officer, risk manager, and the chair of the patient care council.

The Hospital Safety Committee reports to this board, as there is overlap with hospital safety, including employee and patient safety. The board is co-chaired by the patient safety officer and the chair of the Medical Staff Quality Improvement Committee. To offer the board protection under the Illinois Medical Studies Act, it was created as an ad hoc committee of the medical staff.

Voting privileges

As in many hospitals, there is a certain amount of "we-they" tension between the medical staff members and the hospital administrators on our board. The physicians see certain problems as the hospital's responsibility, such as having a correct identification band on each patient. Other decisions made by the Quality/Safety Board still have to go through the medical staff approval process. Though we try to reach consensus, the hospital administrators felt that all board members should have voting privileges and, since this was an ad hoc committee of the medical staff, this had to be approved by the Medical Staff Executive Committee.

Initially, the board met monthly and focused on issues of patient and hospital/employee safety and quality review, identifying and prioritizing issues, and assigning resources. The board also discussed critical/sentinel event analyses and recommendations, compliance with JCAHO safety goals, key safety and quality measures, sentinel event alert recommendations, and other strategic patient safety and quality issues. The hospital's patient safety projects are overseen by the board, including our involvement in the IHI Project Impact, the OSF Corporate Patient Safety Collaborative, internal Six-Sigma projects related to patient safety and quality, and several statewide and national collaborations.

Conducting review meetings

We developed a subgroup to work on behalf of the board, including the patient safety officer, risk management, quality management, the pharmacy director, one nursing care director, and the compliance officer. The group meets weekly to review sentinel event alerts, other potential risk issues identified from external and internal sources, such as occurrence reports and administrative patient safety rounds, and action items from previous critical/sentinel events.

To promote more in-depth discussions, the board has recently started meeting bimonthly, with one month's meeting dedicated to safety and the next centered on quality. We narrowed our patient safety focus to reducing adverse events related to medical error and our patient quality focus to reducing adverse events related to care. This has helped clarify the agenda of each meeting.

Including all stakeholder groups

In the long run, the goal of improving patient safety is synonymous with reducing organizational risk. But in the short term, there is concern that risk management's presence on our board and at root cause analyses may jeopardize protection under the Medical Studies Act in Illinois. We think the insights offered by risk management outweigh that concern.

To further integrate hospital and medical staff safety/quality infrastructure, our goal is for the current Medical Staff Quality Improvement Committee to merge into the Quality/Safety Board. The medical staff will still need to maintain a quality assurance committee for peer review. Though a certain amount of tension between the hospital and physician leadership helps drive improvement on both sides, patient safety and quality improvement would ideally be directed jointly by the hospital and medical staff.

We have not yet included patients and families directly on the board. Current board concerns include increased patient anxiety about safety and heightened medical-legal concerns. I have shared some of our work with our patient and family advisory committees and have listened to their concerns; I am planning a grand rounds presentation on patient safety built around stories told by members of our Children's Hospital Family Advisory Board. We are surveying 10 patients each month on their perceptions of the safety of our care related to medications, hand washing, and other issues. Besides making board members aware of this work, I have kept them apprised of what other hospitals have done in this regard to develop their comfort with the idea.

Our Quality/Safety Board plays a key role in leading the development of our safety culture and safer patient care. As we have gained a better understanding of what is needed to be effective, we have changed the board's membership as well as its relationship with the rest of the hospital infrastructure. Because our board is still evolving, it will continue to make strategic changes to meet our goals. **NPSF**

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Coming to US hospitals in 2004

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ISMP to Reissue Medication Safety Self-Assessment

The Institute for Safe Medication Practices (ISMP) has received a $285,000 grant from the Commonwealth Fund to issue Phase II of the ISMP Medication Safety Self-Assessment® for US hospitals. As with the 2000 survey, the American Hospital Association (AHA) and the Health Research and Educational Trust (HRET) will be collaborating with ISMP to complete this project.

The grant will provide the resources needed to amend and redistribute this self-assessment to US hospitals in 2004, and to compare data from a subset of these hospitals to data from the 2000 assessment for the purpose of evaluating progress over the past 3 years.

The first project allowed US hospitals to gauge their use of nearly 200 medication safety systems and practices, identify areas of weakness, and establish baseline data of medication safety efforts in hospitals for use in evaluating improvement over time. The findings of the 2000 assessment will appear in an upcoming issue of the *Joint Commission Journal on Quality and Safety*.

This project is part of an ongoing medication safety partnership between HRET, AHA, and ISMP and includes *Pathways for Medication Safety,* a set of 3 tools created in response to medication system gaps identified during analysis of the 2000 assessment. NPSF staff served on the advisory committee for the project's content development. **NPSF**

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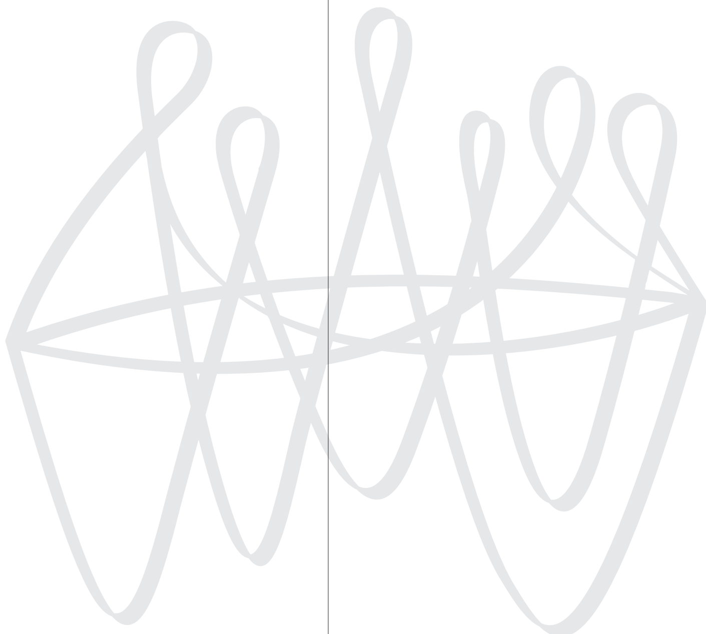

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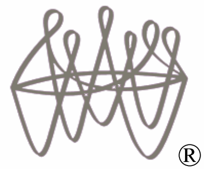

September 2003

Dear Friend of NPSF:

In order to help defray the costs of providing this informative quarterly newsletter to you, NPSF is requesting an annual subscription fee of $25, which covers annual NPSF membership dues. As an NPSF member:

- You will receive regular updates on patient safety information, resources, and events, as well as a subscription to NPSF's quarterly newsletter *Focus on Patient Safety.*
- You will become part of a national network of individuals interested in and working toward improving the safety of patients.
- Your voice will be heard at the national level through surveys and special events.

In addition, if you sign up now, your Welcome Packet will include:

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<tr><td>City:</td><td>State:</td><td colspan="2">ZIP:</td></tr>
<tr><td>Email address:</td><td>Phone:</td><td colspan="2">Fax:</td></tr>
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