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Prevention of Medical Errors
To Err is Human

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Learning Objectives

- Upon completion of the course participants will be able to:
  1. Explain the purpose of root cause analysis and how it can prevent errors in occupational therapy
  2. Discuss the potential for the occurrence of medical errors in occupational therapy practice and how to avoid them in the work environment to promote patient safety.
  3. Promote patient/client safety within the occupational therapy environment and interdisciplinary team, through processes that prevent errors.
  4. Describe the factors that give rise to medical errors in occupational therapy practice, and analyze the presence and impact of these factors in their work environment, including medications and their side effects.
Dedicated to My Mom

- WWII Vet died of a medical error
- They forgot to change her pacemaker battery

Gertrude Leonard Kornblau

The Titanic

Titanic By Unknown photographer, photo taken on April 11, 1912 [Public domain], via Wikimedia Commons

Sinking of the titanic Engraving by Willy Stöwer: Der Untergang der Titanic 31 December 1911 https://commons.wikimedia.org/wiki/File:St%C3%B6wer_Titanic_(colorized).jpg
**Hindenburg Disaster**

May 6, 1937 the world’s largest “airship at the time Hindenburg exploded killing more than 30 people over New Jersey. It had made 20 successful crossing in one year before it exploded.


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**NASA Spokesperson**

- “We’re going to
  - Find the cause of the mishap,
  - Fix it, and
  - Move on”

[https://www.flickr.com/photos/nasacommons/16307098620/in/dateposted/](https://www.flickr.com/photos/nasacommons/16307098620/in/dateposted/)
Spiderman on (off?) Broadway

- 2013-4th accident in a mo.
- stuntman playing the web-slinger fell about 30 feet into a stage pit.
- safety tether failed.
- Official Cause: Human Error ???

Amtrak's Hoboken Accident - 9/29/2016

- The NTSB formed the following technical investigative working groups:
  - Operations
  - Human Performance
  - Survival Factors
  - Signal Systems
  - Track and Engineering
  - Mechanical/Equipment
  - Event/Video Data Recorders

Amtrak's Hoboken Accident - 9/29/2016

- New Jersey transit officials issued immediate Policy:
  - Conductors must walk to the front of the train as they approach the station and stand beside the operator as they move the train toward the end of the line
- Cause? The train engineer operating the train had undiagnosed sleep apnea.
- Prevention? Require sleep apnea testing for train operators


You Can’t Erase These Errors and Start Over

Image by Flickr user Daniel Novta /Creative Commons licensed. https://www.flickr.com/photos/vanf/5006945413/
Stephen Covey

- "Insanity is continuing to do the same thing and expecting different results."

Risk Analysis in Occupational Therapy Practice

- What are the risks in Occupational Therapy Practice?
- How do we recognize them?
- Why do we study this?

What Causes Medical Errors?

Ooops!

Image by Flickr user i a wals/Creative Commons licensed

What Causes Errors?

- Research shows the following contribute to errors in the workplace:
  - Sleep loss
  - Circadian Resynchronization
  - Fatigue
  - Workload


What Causes Errors?

- Training issues
What Causes Medical Errors?

- Education issues

By Illustration: Sapna Khandwala, Public Library of Science [CC BY 2.5 (http://creativecommons.org/licenses/by/2.5)], via Wikimedia Commons
https://commons.wikimedia.org/wiki/File%3AClinical_Medicine_101_-_journal_med.0020111.p001.png

Doctors vs. Lawyers?

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https://www.flickr.com/photos/141290938@N03/6683841243

Continued
What Causes Medical Errors?

- Poor Communication

By Jack M. Kartush, MD (Own work) [CC BY-SA 4.0 (http://creativecommons.org/licenses/by-sa/4.0)], via Wikimedia Commons. https://commons.wikimedia.org/wiki/File%3AErrow_reduction_-_OR_Check_board_of_patient_name%2C_surgical_site_and_allergies_Kartush.jpg

MISTAKES WILL HAPPEN

Public Domain Library of Congress Theatrical Poster Collection
“Hmmm…Was the patient ‘released’ or ‘deceased?’”

By Mimooh (Own work) [CC BY-SA 3.0 (http://creativecommons.org/licenses/by-sa/3.0)], via Wikimedia Commons. https://commons.wikimedia.org/wiki/File%3AUAMed_classifier2_by_mimooh.svg

“Or did he say hearts and minds?”

By Mimooh (Own work) [CC BY-SA 3.0 (http://creativecommons.org/licenses/by-sa/3.0)], via Wikimedia Commons.
Miscommunication and Parents

- Study: surveyed both parents & physicians at time of hospital discharge to identify caregiver & clinician perspectives on communication during hospitalization.
  - More than 1 in 7 parents reported miscommunications, and also were more likely to perceive an adverse event occurred during hospitalization and to be less satisfied with overall care.
  - Only 1 in 27 attending physicians reported communication problems
  - Both groups identified conflicting information
  - Parents also reported delayed information


Parents and AE

- Research shows parents often report medical errors and preventable AE physician miss.
  - 1 in 10 parents caught medical errors physicians missed
  - Parents are an untapped resource for preventing med errors

Germs

- **Study: Henry Ford Health System** found hand-washing rates improved significantly, after they showed hospital staff millions of bacteria found on common surfaces.
- A previous study found emotions motivated people more effectively than traditional messaging, so this study aimed to evoke the feeling of disgust in health-care personnel.

“Now where it that extra clamp?”

PublicDomainVectors.org

4 Main Categories of Errors

1. Medication Errors
2. Surgical Errors

Llywrch. [CC BY-SA 2.5 (http://creativecommons.org/licenses/by-sa/2.5)], via Wikimedia Commons
https://commons.wikimedia.org/wiki/File%3ASurgical_staples1.jpg
3. Diagnostic Inaccuracies

- Ex. – not all heart attacks are accompanied by chest pains.
  - In one study, ¼ of people without chest pains were misdiagnosed compared to 2% of people w/ chest pains
  - Older people, women & diabetics more likely to not have chest pains
  - People not diagnosed were less likely to receive blood thinners and other treatment


4. System Errors

- Instead of 10 units per millimeter, twins received 10,000 units
- 1000 times the proper dose
- Vials are nearly identical

May 14, 2008
Background....
Institute of Medicine Report

- 1999 “To Err is Human: Building a Better Healthcare System”

Epidemiology

- Account for 44,000 to 98,000 deaths per year in the U.S.
- >8th leading cause of death in the US
- More people die from medical errors than
  - Breast cancer
  - AIDS or
  - Motor vehicle accidents (MVAs).
HealthGrades’ Study (7/27/04)

- Disputed IOM report - it underestimated #s
  - HGS Looked at 3 years of Medicare data in 50 states
    (pop represented approx. 45% of all patients 2000-2
    excluding obstetrics patients of course)
    - Included the following as errors (not included in IOM report):
      - Failure to rescue dying patient
      - Death of low-risk patients from infection
    - Findings:
      - as many as 198,000 people die each year from preventable
        errors (IOM 98,000)
      - 1.14 million "patient-safety incidents” occurred among 37
        million hospitalizations
      - 1 out of every 4 Medicare pts. hospitalized 2000-2002 who
        experienced a patient-safety incident died

HealthGrades’ 2004 Study

- If CDC had annual list of leading causes of death included preventable medical errors:
  - #6th (IOM said >8)
  - Ahead of
    - diabetes
    - Pneumonia
    - Alzheimer’s Disease
    - And renal disease

continued

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**Leading Causes of Death**

![Graph showing leading causes of death](image)

NOTE: Due to coding changes for chronic lower respiratory diseases (CLRD) between ICD–9 and ICD–10, which prevent the direct comparison of trends prior to 1998 and after 1999, rates for CLRD are only shown for 1999 onwards.

SOURCE: CDC NCHS, Health, United States, 2016, Figure 8. Data from the National Vital Statistics System (NVSS).

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**Johns Hopkins 2016 study**

- According to CDC, in 2013,
  - 611,105 people died of heart disease,
  - 584,881 died of cancer and
  - 149,205 died of chronic respiratory disease

- According to Johns Hopkins:
  - The newly calculated figure for medical errors puts this cause of death behind cancer but ahead of respiratory disease, making it the 3rd leading cause of death.
  - 10% of all deaths are the result of medical errors

**Cost of Preventable Medical Errors**

- $17-29 million
  - Over 1/2 of which is health care costs
- 6,000 Americans die from workplace injuries
  - 7,000+ die of medication errors (in & out of hospital)
    - 2 out of 100 admissions experienced a preventable adverse event resulting in:
      - + hospital costs of $4,700 per admission or
      - $2.8 million for a 700 bed teaching hospital annually

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**CMS Hospital Data**

- HHS Office of the Inspector General studied adverse events in hospitals among Medicare beneficiaries
  - nationally representative random sample of 780 Medicare beneficiaries from all beneficiaries discharged from hospitals during October 2008.
  - 27% of hospitalized Medicare beneficiaries experienced adverse events or temporary harm events
  - 44% of all events were preventable and 51% were not preventable
  - Cost of preventable harm to Medicare beneficiaries = $4.4 billion a year in hospital costs

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**CMS SNF Data**

- HHS OIG used a two-stage medical record review to identify AE for a sample of 653 Medicare beneficiaries discharged from hospitals to SNFs for post-acute care.
  - Sample beneficiaries had SNF stays of 35 days or less
  - Estimated 22% experienced AE during their SNF stays
  - Additional 11% experienced temporary harm events during their SNF stays
  - 59% of the adverse events and temporary harm events were clearly or likely preventable


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**CMS SNF Data**

- Attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care.

- Over half of the residents who experienced harm returned to a hospital for treatment, with an estimated cost to Medicare of $208 million in August 2011.
  - This equates to $2.8 billion spent on hospital treatment for harm caused in SNFs in FY 2011


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CMS Rehab Hospital Data

- HHS Office of the Inspector General studied adverse events in rehabilitation hospitals among Medicare beneficiaries
  - reviewed a nationally representative sample of 417 Medicare beneficiaries discharged from rehab hospitals in March 2012
  - About 29% of Medicare beneficiaries experienced adverse or temporary harm events during their rehab hospital stays, resulting in temporary harm; prolonged stays or transfers to other hospitals; permanent harm; life-sustaining intervention; or death.


CMS Rehab Hospital Data

- 46% of these adverse and temporary harm events were clearly or likely preventable
- Physicians attributed much of the preventable harm to
  - substandard treatment, inadequate patient monitoring, and failure to provide needed treatment.
- Nearly ¼ of the patients who experienced adverse or temporary harm events were transferred to an acute-care hospital for treatment
  - with an est. cost to Medicare of at least $7.7 million in 1 month, or
  - at least $92 million in one year, assuming a constant rate of hospitalization throughout the year.

**Study of 10 NC* Hospitals**

- Why North Carolina? Lots of safety programs
- Conducted from 2002 to 2007 in 10 North Carolina hospitals, found:
  - harm to patients was common and
  - the number of incidents did **not** increase over time.
- The most common problems were complications from procedures or drugs and hospital-acquired infections.

**Findings from NC**

- ≈ 18% of patients harmed by medical care,
  - some more than once, and
  - 63.1 percent of the injuries were judged to be preventable.
- Most of problems were temporary & treatable,
  - some were serious
  - Few - 2.4 percent — caused or contributed to a patient’s death
Findings from NC

- No improvement over the 6 years studied 02- 07
- Infection were the most preventable – Almost 75% of them:

<table>
<thead>
<tr>
<th>Infection</th>
<th>Preventable/Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary Tact Infection</td>
<td>24 out of 31</td>
</tr>
<tr>
<td>Surgical Site Infection</td>
<td>10 out of 17</td>
</tr>
<tr>
<td>Pneumonia Not Related to Ventilator</td>
<td>9 out of 11</td>
</tr>
<tr>
<td>Sepsis or Bacteremia Not Related to Catheter</td>
<td>8 out of 10</td>
</tr>
<tr>
<td>Catheters in Arteries/Vein</td>
<td>8 out of 9</td>
</tr>
<tr>
<td>Ventilator Assisted Pneumonia</td>
<td>6 out of 8</td>
</tr>
</tbody>
</table>


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Study – Insurance Industry

- Estimates that measurable medical errors cost the U.S. economy $19.5 billion in 2008 in the non –Medicare Population. (Society of Actuaries (SOA))

  - Ledue, L., Study: Medical errors cost U.S. economy almost $20 billion in ’08 (2010, August 9). Health Care Finance News
Non-Medicare Population

- $\approx 17$ billion to provide inpt, outpt, & drugs to people affected by medical errors
- $1.1$ billion - from lost productivity from related short-term disability claims, &
- $1.4$ billion - lost through increased death rates among individuals who experienced medical errors.

Other Findings

- 6.3 million measurable medical injuries in the United States in 2008;
  - SOA and Milliman estimate that 1.5 million of them were associated with a medical error.
- Average total cost per error $\approx 13,000$.
- Inpatient setting – $\approx 7\%$ of admissions result in some type of medical injury.
- Measurable medical errors resulted $> 2,500$ avoidable deaths & $> 10$ million excess days missed from work due to short-term disability.
Additional Findings

- Approximately 55% of the total error costs were the result of five common errors:
  - Pressure ulcers;
  - Postoperative infections;
  - Post laminectomy syndrome;
  - Hemorrhages complicating a procedure &
  - Mechanical complications of devices, implants or grafts;

Total Cost

- Medicare Population-hospitals $4.4 billion
- Medicare Population Rehab hosp $92 million
- Medicare Population SNFs $2.9 billion
- Non Medicare Population $19.5 billion
  Annual Cost/Preventable Errors = $26.392 billion
- Another study claimed the estimated total cost of direct medical costs caused by measurable medical errors in the US was $17.1 billion in 2008 dollars.
  - (**Only included Medicare enrollees with retiree medical coverage & no Medicaid recipients or no one uninsured)

Medical Errors

• Occur in all settings

Medical Errors

• Cause repeat tests $$$
• Increase insurance costs
• Psychological & physical discomfort
• Lost productivity
Errors Occur at all Stages of Care

- Diagnosis
- Evaluation
- Treatment
- Prevention


Contextual Problems

- Multiple providers of care
- Third party payment systems provide little incentive to improve safety
- No rewards for safety or quality

Image by Flickr user Ilmicrofono Oggono/Creative Commons licensed. Courtesy of www.audio-luci-store.it. https://www.flickr.com/photos/115089924@N02/16079083419
**IOM Report Recommendations**

- “Break the cycle of inaction”
- A “comprehensive approach to improving patient safety”
  - needed for a large complex problem

**IOM Report Recommendations**

- “Enhance knowledge and tools
- “Break down legal & cultural barriers”
- No less than a 50% reduction in errors over 5 years.
Definitions

- “Safety”: freedom from accidental injury
- “Error”: the failure of a planned action to be completed as intended or
  - The use of a wrong plan to achieve an aim.

Errors Depend on 2 Kinds of Failures *(according to James Reston)*

- Correct action does not proceed as intended (an error of execution) or
- The original intended action is not correct (an error of planning)
Not all errors result in harm

- Preventable adverse events: an injury resulting from a medical intervention
  - Not due to the patient’s underlying condition

Adverse Event

- Untoward incidents,
- Therapeutic misadventures,
- Iatrogenic injuries or
- Other adverse occurrences
- directly associated with care or services provided within the jurisdiction of a medical facility.
Adverse Events

• Can result from acts of commission or omission

Classical Medical Adverse Events

• Falls
• Suicides or attempts
• Failing to order a test or read results and act
• Medication errors
  – Would be 5th leading cause of death if ranked as a LCD (Beers)

Fae, [CC BY 4.0 (http://creativecommons.org/licenses/by/4.0)]. via Wikimedia Commons https://upload.wikimedia.org/wikipedia/commons/0/01/A_ridiculous_figure_comprising_of_medicine_bottles_and_table_Wellcome_L0020250.jpg
**Medication Errors**

- Very Common
- Systematic review in primary care shows:
  - Error rates between <1% and >90%, depending on the part of the system studied
  - the prescribing stage is the most susceptible
  - the elderly (over 65 years), and children (under 18 years) are more likely to experience significant errors.

Medication Errors - Cost

- 2016 Study published looked at the financial burden of medication errors in hospitals with and without patient harm
  - Error rate=0.8 per 100 admissions, or 1.6 per 1000 patient days
  - Most occurred at the medication administration stage
  - The most frequent types of errors were wrong time, wrong medication, wrong dose, and omission errors.
  - Treatment costs attributable to medication errors were $8,439-$8,898 (depending on the methodology used)
  - Bottom line = significant cost even without patient harm


Beer’s List

Manuscripts and Archives Division, The New York Public Library. We Need More Than Magic (With Miller Beer sign) Retrieved from http://digitalcollections.nypl.org/items/510d47e4-103d-a3d9-e040-e00a18064a99
Older Adults are More At risk for Medication Adverse Events

- “They take more medications, which increases their risk for drug-drug interactions and adverse drug events.
- Age-related changes in pharmacokinetics and pharmacodynamics that go unrecognized can result in higher than necessary doses and inappropriate drug selections.”


Beer’s list

- 1991 – Dr. Mark Beer and colleagues published a methods paper describing the development of a consensus list of medicines considered inappropriate for long-term care facility residents.
  - Defined inappropriate drug use as where the potential risks outweigh the potential benefits or the potential for adverse events
- 1997 – Beer published the list, results of a consensus panel of 6 experts. They agreed upon 28 therapeutic classes/medications to avoid in the community and nursing home dwelling elder (65+).
- Updated again in 2003, 2012, and 2015
Improper Medication Use

• A 2000 study found
  – between nearly one in four (23.5%) and one in seven (14.0%) elderly patients received an inappropriate medication as defined by either the Beers list of 20 inappropriate medications or Modified Beers list
  – 40.3% of nursing home residents received inappropriate meds
  – Risk factors:
    • # of prescriptions, Female, 80+, Medicaid beneficiary


By CDC [Public domain], via Wikimedia Commons
https://upload.wikimedia.org/wikipedia/commons/a/ab/Prescription_medication_being_dispensed.tif

Improper Medication Use (2012 Criteria)

• In a sample of community-dwelling older adults, 43% used at least one potentially inappropriate medication (PIM) under the 2012 Beers criteria, with non-steroidal anti-inflammatory drugs (NSAIDs) the most common PIM (10.9%) and Benzodiazepines (9.3%)
• Rate declined from 45.5% in 2006-2007 to 40.8% in 2009-2010. (NSAIDS declined to 4.7%)
• Prevalence of PIM was 30.9% (using a qualified definition that allowed selected exceptions mentioned in the rationale associated with each drug category – more restrictive)

Improper Medication Use (2012 Criteria)

- A study using Medicare data and the 2012 Beers criteria, found the point prevalence in each calendar month of potentially inappropriate medications used in adults ≥65 years was 34.2 percent in 2012.
  - A decrease from 37.6% in 2007.
- The strongest predictor of PIM use was the # of drugs dispensed, age 70 and older. People seen by a geriatrician were less likely to receive a PIM.


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Research shows:

- PIM is associated with re-hospitalizations for community-dwelling elder
- Increased risk of death for some
- Nearly 2/3 of hospitalizations were due to unintentional overdoses
- Nearly ½ of these hospitalizations were among adults 80+ years of age
- Four medications or medication classes were implicated alone or in combination in 67.0% of hospitalizations: warfarin, insulin, oral antiplatelet agents, and oral hypoglycemic agents

**Relevant Changes to 2015 Beer List**

- Avoiding prolonged use of proton pump inhibitors because of risk of Clostridium difficile infections (C-diff) and bone loss and fractures
- The language regarding **avoiding antipsychotics in delirium and dementia** was strengthened.
  - Avoiding nonbenzodiazepine, benzodiazepine receptor agonist hypnotics regardless of duration of exposure
- Updated tables on drugs to avoid or reduce dosage based on kidney function
- Updated table on drug-drug interactions

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**Relevant Changes to 2015 Beer List**

- The language about medications to avoid with patients with a history of falls and fractures was changed to stress that if one of providers must prescribe one of the medications on the list providers must try to reduce other medications the patient takes that may also increase the risk of falls and fractures.

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Why should Occupational Therapy Practitioners care about the Beer’s List?

- We will see things others do not
- Adverse events include
  - Increased risk of falls in general and during occupational therapy
  - Delirium
  - Increased fatigue
  - Other changes that affect occupational performance
- We may also see behavioral changes in children from inappropriate medications.

Beers Criteria

- Updated in 2015 by the American Geriatrics Society.
- You can download it the journal article here with the charts and tables:
- Or tables only with suggested substitutes from:
CMS’s High Risk Medications

- You can download one version of CMS’ high risk medications here with alternatives:
  - https://www.yourmedicareolutions.com/sites/default/files/2017_Selected_High_Risk_Medications_Alternative_Table-508.pdf

- You can download a pocket version of the Beer’s list with the 2017 CMS high risk medications incorporated and recommended alternatives here:

Medication Errors in Children

- Greater than 70% of drugs used in pediatrics have not been studied scientifically in children to assess safety.
- Dosing varies from premature neonates to obese adolescents yielding a possible 400-fold dosing error
- “Factor of 10 errors or decimal place errors are common.”
- Most drugs are available in unit dose packaging for adult patients, which means pharmacists have to repackaging drugs, inserting more possibility of human error.


**Medication Errors in Children**

- 2014 study found a child receives the wrong medication or the wrong dose every 8 minutes in the US.
- Nearly 700,000 kids under 6 experienced an out-of-hospital medication error between 2002 and 2012.
  - Of those episodes, 1 out of 4 children were under a year old.
  - The younger the child, the greater the likelihood of an error.
  - Though 94% of the mistakes didn't require medical Tx, the errors led to 25 deaths & about 1,900 critical care admissions.
  - One parent may give a child meds and the other parent also gives the child meds.


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**More Classic Adverse Events**

- Needle sticks
- Isolation errors
- Introducing an infection
- Cutting off the wrong leg

By William Rafii of the William Rafii Institute (Wikipedia (EN)) [Attribution], via Wikimedia Commons  
https://commons.wikimedia.org/wiki/File:Syringe_and_hyphenatedermic.jpg

Never Events F/K/A/ Sentinel Event

- An unexpected occurrence
  - involving death or serious physical or psychological injury,
  - or the risk thereof.
- Should never happen in a hospital

Never Events

- The term “never events” refers to a specific list of serious events, such as surgery on the wrong patient, that the National Quality Forum deemed “should never occur in a healthcare setting.”

Never Events

- Serious injury specifically includes loss of limb or function.
  - The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
- Such events were called "sentinel" because they signal the need for immediate investigation and response.
- They are now called “Never Events”

Image by Flickr user CJ Anderson/Creative Commons licensed

Medicare’s Do-Not-Pay List 2008

- Never events:
  - Wrong blood type transfusions
  - Air embolisms
  - Objects left in after surgery
- Falls
- Pressure ulcers
- Infections from catheters
- Wrong site surgery etc.
- Blood clots in the leg following knee or hip replacement
- Extreme blood sugar complications

Image of Medicare stamp by Colorado State University/ContinuedE DuPont

Continued

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### Medicaid Do-Not-Pay List

**Category 1 – Health Care-Acquired Conditions (For Any Inpatient Hospitals Settings in Medicaid)**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Object Retained After Surgery</td>
<td></td>
</tr>
<tr>
<td>Air Embolism</td>
<td></td>
</tr>
<tr>
<td>Blood Incompatibility</td>
<td></td>
</tr>
<tr>
<td>Stage III and IV Pressure Ulcers</td>
<td></td>
</tr>
<tr>
<td>Falls and Trauma; including Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, Burns, Electric Shock</td>
<td></td>
</tr>
<tr>
<td>Catheter-Associated Urinary Tract Infection (UTI)</td>
<td></td>
</tr>
<tr>
<td>Vascular Catheter-Associated Infection</td>
<td></td>
</tr>
<tr>
<td>Manifestations of Poor Glycemic Control; including: Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity</td>
<td></td>
</tr>
<tr>
<td>Surgical Site Infection Following coronary bypass, bariatric surgery, or orthopedic procedures</td>
<td></td>
</tr>
<tr>
<td>Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement <strong>with pediatric and obstetric exceptions</strong></td>
<td></td>
</tr>
</tbody>
</table>


### Medicaid Do-Not-Pay List

**Category 2 – Other Provider Preventable Conditions (For Any Health Care Setting)**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong Surgical or other invasive procedure performed on a patient</td>
<td></td>
</tr>
<tr>
<td>Surgical or other invasive procedure performed on the wrong body part</td>
<td></td>
</tr>
<tr>
<td>Surgical or other invasive procedure performed on the wrong patient</td>
<td></td>
</tr>
</tbody>
</table>

**Medicare Penalties for Hospital Acquired Conditions**

- In addition Do Not Pay list, in 2015 Medicare began to penalize hospitals with the highest rate of hospital acquired conditions rates, 1% of their Medicare payments
  - 2015 – Medicare added surgical site infections to its analysis
  - 2016 – frequency of superbugs *Clostridium difficile* and MRSA.


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**World Health Organization 6/24/08**

List of simple check lists to decrease surgical complications
- Count sponges
- Mark surgery site
- Checking for allergies

Courtesy of the U.S. National Library of Medicine, Bethesda, Maryland
Right/Left Errors

- Put your hand over your heart like you are saying the pledge
- On your left hand, your thumb and first finger make and “L”

Image by Flickr user Ian Barbour/Creative Commons licensed. https://www.flickr.com/photos/barbourians/8850383221/

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What about Occupational Therapy Adverse Events?

Occupational Therapy Study of Practice Errors

- Scheirton, Mu, & Lohman,
  - Qualitative study
    - 35 occupational therapists
    - From 4 states
    - Who practice in physical rehab settings
    - In 4 focus groups

Scheirton, Mu, & Lohman

- Causing physical harm to the patients
- Delaying patients’ discharge
- Creating unrealistic treatment or prognosis expectations or both
- Providing unneeded services, and
- Failure to provide needed services
Scheirton, Mu, & Lohman
Adverse Events

- Ripping of patients’ fingernails
- Causing patient fatigue
- Skin scratches

Image by Flickr user Judit Klein /Creative Commons licensed. https://www.flickr.com/photos/juditik/6194671198/

Classic Occupational Therapy
Adverse Events

- Failing check a splint for proper fit and causing pressure sores
- Patient falls out of bed because the OT/OTA left the bedrails down
- Spreading infection between patients by not washing hands between patients
- Patient falls because OT/OTA misjudges the patient’s status or abilities or was distracted and not paying close enough attention to the patient.
**Classic Occupational Therapy Adverse Events**

- Failing to observe and document medication side effects causing complications later
- Failing to report medication side effects to the physician
- Patient falls due to failure to use an ambulation belt

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https://www.flickr.com/photos/expertinfantry/5467572310

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**Adverse Events in Occupational Therapy**

- Aggressive PROM in someone with an arthritis flare-up
- Leaving a patient unattended during a swallowing assessment & the patient aspirated during the assessment
- Spinning a child into a coma during SI intervention
Adverse Events in Occupational Therapy

- Causing an MI by pushing an ICU patient too aggressively re: functional activities
- Failing to dispose of a razor in the clinic enabling another patient to get cut by the used razor
- Leaving a patient with a falls risk unattended and the patient fell and fractured an arm and a hip

Adverse Events in Occupational Therapy

- Abandoning cases when care was initiated and a person was uninsured--resulting in development of a post op hand deformity
- Contributing to lost range of motion when a burned hand was not properly splinted/clinically managed

Scott, I Flickr user Scott, I-Dept of Foreign Affairs /Creative Commons licensed. https://www.flickr.com/photos/dfaaustralianaid/10686934264/
Adverse Events in Occupational Therapy

- Making right splint instead of a left splint
- Making the wrong splint because of failure to call the doctor when he ordered the wrong one
- Spreading a bacterial infection by failing to wash toys in between patients/clients in a pediatric clinic.

Image by Flickr user sammynebook/Creative Commons
https://www.flickr.com/photos/34399400@N05/6629810149

Adverse Events in Occupational Therapy

- Transferring a patient to bed where the bed locks do not work, causing the patient to fall
- Failing to lock the wheelchair causing the patient to fall
- Beginning activities with too much resistance, too soon after a recent tendon repair.
- Splinting a hand in an incorrect position after a surgical procedure.
Adverse Events in Occupational Therapy

• Accurately assessing but failing to report motor and sensory loss (indicative of a compartment syndrome) in a patient seen following an acute burn injury--
  – leading to the need to perform an amputation vs facilitating a surgical response to save the limb via an escarotomy

Adverse Events in Occupational Therapy

• Working without sufficient medical background information and misinterpretation of findings that could either contribute to direct client injury or indirect injury (i.e. loss of benefits)
Adverse Events in Occupational Therapy

- Causing painful shoulder-hand syndrome, subluxed shoulder or regional complex pain syndrome in a patient who is post-stroke though excessive use of pulleys or failure to stabilize the shoulder.
- Performing regular message on an edematous hand, while failing to properly adjust a sling so that the hand remains in an inverted position and edema increases.

Adverse Events in Occupational Therapy

- Causing torn rotator cuffs in a older adult as a result of repetitive use of pulleys and treatment by 4 different therapists
- Using a 5 year old to interpret for instructions for a home program which results in a patient falling (US Study)
**Classic Medical Adverse Events**

- Communication problems among the root causes of 59% of serious adverse events reported to the Joint Commission
- People with LEP who experience AE
  - more likely to be harmed, the adverse event was more frequently caused by a communication error, and the harm was more likely to be serious, compared to ES patients


---

**Scheirton, Mu, & Lohman Sentinel Events**

- Burns,
- Blisters
- Falls
- Tendon tears
- Back flow of urine
- Unintended (bone) pin or intravenous tube removal
- Contributing to the death of a patient.
**Sentinel (Never) Events in Occupational Therapy**

- Sentinel Event
  - OT - root cause of a patient’s death
- “Lopping off” a desensate finger in a wheelchair spoke
- Burning a patient with a hot pack who had a cancer dx and lost sensation
- Putting a person in a whirlpool tank who was post op day 1 post a grafting procedure

---

**Error Reduction in Occupational Therapy**

- How do we reduce errors in Occupational Therapy and other errors in our work environment?
- How do we improve patient/client outcomes?
**Philosophy: Human vs. System Error**

- Lucian L. Leape, MD, "Errors must be accepted as evidence of systems flaws, not character flaws”
- Moray (1994) "...the systems of which humans are a part call forth errors from humans, not the other way around.”

**System Error vs. Human Error**

- Whose fault is it if a patient falls out of bed?

---

**What causes Practice Errors in Occupational Therapy?**

- Scheirton, Mu, & Lohman
  - Inexperience
  - Not listening to patients
  - Rushed - Productivity pressure
  - Too many patients
  - Fatigue
  - Therapist misjudgment (i.e. pt’s weigh bearing status, tolerance levels or cognitive status or level of understanding)

**Additional Causes**

- Scheirton, Mu, & Lohman
  - Lack of attention
  - Communication breakdown - “no one let me know about the change in status”
  - Lack of education or training
  - System errors (wrong or unclear doctor’s orders)
    - unclear, insufficient, or illegible documentation
Conclusions

- Scheirton, Mu, & Lohman
  - Most occupational therapy practice errors could be avoided “with more attentive practice.”
  - Question authority - hesitancy to question authority “may have contributed to practice errors.”
    - Need for assertiveness training?
  - Since being rushed can cause medical errors, the efforts to decrease time ($) with patients may actually cause “more expensive & harmful errors.”
  - Making errors has emotional effects on occupational therapists.
  - Therapists report that they make positive changes in response to making errors & learn from the experience.

Mu, Lohman & Scheirton # 2

- 245 (out of 994) OTRs working in geriatrics or rehab responded to a survey.
- Looked at several factors:
  - # years in practice
  - Relationship between disclosure and non-disclosure of errors on practice
  - Types of coping strategies used by OTRs and
  - Work site administrators responses to errors
  - (Mu, Lohman & Scheirton, 2006)
**MLS #2**

- Majority of practice errors occur during intervention 87.9%
- Top 3 causes of medical errors:
  - Misjudgment 74%
  - Lack of preparation 46%, and
  - Lack of experience 44.1%
  - Other notables
    - Inadequate therapist knowledge 33.5%
    - Miscommunication between professionals 32.7%

---

**Impact on Practice**

- 68.2% changed their treatment approach as a result of the medical error
- 83.3% paid more attention to detail
- 92.3% reflected on the error
- OTRs practicing 2-5 years perceived a higher impact on their practice than those who practiced 11 years or more.
Coping Strategies

- Top 5 are constructive coping strategies
  - Promised to self that next time things would be better: 71.8%
  - Concentrated on next step: 64.5%
  - Tried to keep feelings from interfering: 55.5%
  - Made a plan and followed it: 53.5%
  - Apologized to patient: 48.1%
- Defensive strategies:
  - Criticized self: 40%

The Role of Apology

![Image of sheet music with the title "I'm sorry that I did!"]

**Work Site Responses to Errors**

- 81.2% “I got emotional support I need from colleagues”
- 77.6% “My colleagues tried to put my error in perspective”
- 49.0% “I was required to follow reporting procedures”
- Few reported sites that were judgmental

**Study: Perception of new graduates**

- Of near-misses and mistakes in workplace
- Australian survey of 228 new grads online
  - Rural location, structured supervision, and registration status influenced perceptions and reporting of practice errors
  - Near misses were reported more often than mistakes
  - Hand rehab and geriatrics had the highest percentages of near misses and mistakes
**New grads 2**

- 18.7% reported experiencing near-misses and 8.0% mistake that put the client at risk
- Participants who had structure supervision felt that workplace colleagues encouraged reporting practice errors
- All respondents who reported a mistake said they would do so again


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**Mu, Lohman, Scheirton, 3**

- Qualitative Study to investigate strategies to prevent or reduce practice errors
- 34 OTs in Physical Rehab and geriatrics
  - 4 focus groups practicing at least one year

(Mu et. al, 2011)
**Themes**

- Strengthen orientation and mentoring for new therapists
- Ensure competency through performance competency checks
- Enhance existing or establish new safety policies and procedures
- Advocate for the profession and for systemic change

**Error Reduction in Occupational Therapy**

- Pay more attention to clients
- Practice evidence-based practice
- Supervise closely
- Mentor staff
- Stay current - read journals, etc.
- Ask for help and encourage others to do so
- Make sure your staff maintains competence
- Refer when a patient is beyond your expertise
**Error Reduction in Occupational Therapy**

- Improve communication with other team members
- Review the EHR/chart before you treat the patient.
- Peer review system
- Focus on systems and processes not individuals
- Make sure treatment precautions are clearly indicated on all occupational therapy evaluations and other documentation
- Patient safety initiatives

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**Error Reduction in Occupational Therapy**

- Promote a culture of improving outcomes
- Capture reliable clinical data on where, when, & how errors occur
- Automate whenever possible
- Protocols
Look at Human Factors such as

- Communication and flow & availability of information
- Training - special or CEU
- Fatigue/scheduling - influence of stress or other environmental factors

Look at

- Environment and equipment
- Rules policies and procedures
**Prevention**

- Processes to improve patient outcomes in occupational therapy
- Reporting Medical Errors
- Legal and Ethical Issues in reporting

**Recommendations for Prevention**

- Avoid reliance on human memory
- Computerized monitoring of ADE
- Computer-generated reminders for follow-up testing
- Standardized protocols
  - Ideas for Occupational Therapy Practice
Other Recommendations for Prevention

- Put a system in place
- Fix equipment
- Consistent practitioners
- Document, Document, Document
  - Avoid abbreviations (Joint Commission’s requirement)
  - Write legibly

Root Cause Analysis

- A process for identifying the basic or contributing factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.
- Goal: prevent recurrence
**Root Cause Analysis**

- is a set of processes by which
  - the underlying causes of adverse outcomes may be identified
  - with the goal in mind of preventing the reoccurrence of such events.

**Root Cause Analysis**

- RCA is a structured facilitated team process to identify root causes of an event that resulted in an undesired outcome and develop corrective actions.
  - The RCA process provides you with a way to identify breakdowns in processes and systems that contributed to the event and how to prevent future events.
  - The purpose of an RCA is to find out
    - 1) what happened, 2) why it happened, and 3) determine what changes need to be made.
    - It can be an early step in a Performance Improvement Project (PIP), that helps to identify what needs to be changed to improve performance.
    - Once you identify what changes need to be made, you follow the steps you would use in any type of PIP.

**Root Cause**

- The most fundamental reason for the failure or inefficiency of a process.
- A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk.

![Image](https://via.placeholder.com/150)

*Image by Flickr user Paul Cross/Creative Commons licensed*

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**Contributing Factor**

- Additional reasons, not necessarily the most basic reason an event has occurred.
Root Cause Analysis

- Tool for identifying prevention strategies
- Part process for building a “culture of safety” beyond blame

Root Cause Analysis is

- Interdisciplinary
- Involves those familiar with the situation
- Digs deeper and asks why at each level of cause and effect
- A process that identifies changes needed in a system
- A process as impartial as possible
**Root Cause Analysis**

- Determines human and other factors
- Determines related processes and systems
- Analysis of underlying cause and effect systems by asking “why?” “why?” “why?”
- Identifies risks and their potential contributions
- Determines potential improvement in processes or systems

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**To be Credible, a Root Cause Analysis must:**

- Include participation by leadership and those most closely involved in processes & systems
- Be internally consistent
- Include consideration of relevant literature = evidence-based
**Performance Improvement Project**

- Outcome of the root cause analysis
- Addresses
  - system and process deficiencies
  - Improvement strategies development & implementation
- Includes outcome measures to change

---

### Steps for a RCA to develop a PIP

<table>
<thead>
<tr>
<th>Steps</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>1. Identify the event to be investigated and gather preliminary information</td>
<td>Events and issues can come from many sources (e.g., incident report, risk management referral, resident or family complaint, health department citation). The facility should have a process for selecting events that will undergo an RCA.</td>
</tr>
<tr>
<td>2. Charter and select team facilitator and team members</td>
<td>Leadership should provide a project charter to launch the team. The facilitator is appointed by leadership. Team members are people with personal knowledge of the processes and systems involved in the event to be investigated.</td>
</tr>
<tr>
<td>3. Describe what happened</td>
<td>Collect and organize the facts surrounding the event to understand what happened.</td>
</tr>
<tr>
<td>4. Identify the contributing factors</td>
<td>The situations, circumstances or conditions that increased the likelihood of the event are identified.</td>
</tr>
<tr>
<td>5. Identify the root causes</td>
<td>A thorough analysis of contributing factors leads to identification of the underlying process and system issues (root causes) of the event.</td>
</tr>
<tr>
<td>6. Design and implement changes to eliminate the root causes</td>
<td>The team determines how best to change processes and systems to reduce the likelihood of another similar event.</td>
</tr>
<tr>
<td>7. Measure the success of changes</td>
<td>Like all improvement projects, the success of improvement actions is evaluated.</td>
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</table>

RCA – Tool The 5 Whys

<table>
<thead>
<tr>
<th>Problem statement</th>
<th>One sentence description of event or problem</th>
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<tbody>
<tr>
<td>Why?</td>
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<th>Root Cause(s)</th>
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<td>3.</td>
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To validate root causes, ask the following: If you removed this root cause, would this event or problem have been prevented?

Five Why’s Example

1. **Why** did the patient’s end up with a burn on his hand?
   - The therapist put a hot pack on the patient’s hand

2. **Why** did the hot pack burn the patient’s hand?
   - The patient had peripheral neuropathy

3. Why did the therapist put a hot pack on a patient who had peripheral neuropathy?
   - The therapist didn’t read the chart
   - ROOT CAUSE=The therapist didn’t read the chart
Root Cause Analysis

- **Step 1:** Select the event to be investigated and gather preliminary information
  - Start with a problem – not a solution – what went wrong?


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Root Cause Analysis

- **Step 2:** Charter and select team facilitator and team members
  - Include people who can discuss and review what happened during the event in an objective and unbiased manner
  - Want staff members who know the process and systems under study
  - Process confidential

Step 3 – Describe What Happened

- Example: A resident suffered a serious injury during his transfer from a wheelchair back to his bed.
  - 300 pound man placed in a Hoyer lift and elevated into the air.
  - As the CNAs turned the lift toward the bed it began to sink because of the weight.
  - The CNAs swung the lift quickly toward the bed to complete the transfer.
  - The lift tilted dangerously to the side and the legs started to move together, narrowing the base of support. The resident dropped to the ground and the lift fell on top of the CNA.

Create a Timeline

- Step 4 continued:
  - Flip chart or sticky notes
  - Everyone must agree with the facts first.
  - Timeline should give just the facts

Facilitator finalizes the timeline by asking if the timeline tells an adequate story and if each step logically derives from the previous step.

Step 4- Identify the contributing factors

- Knowledge gained during step 3 is used by the team to dig deeper into what happened to discover why it happened.
- Must have people here who are involved in the process and the perspective of those involved in the event
- This step the team looking at each step of time line and asking, “What was going on at this point in time that increased the likelihood the event would occur?”
  - These are the contributing factors

Step 5: Identify the Root Causes

- Direct cause: the occurrence or condition that directly produced the incident
  - the tilting and collapsing Hoyer lift is the direct cause of the accident
- Root cause: underlying faulty process or system issues that lead to the harmful event
  - Often more than one
  - 5 Why’s help find the root cause

Contributing factors are not root causes. The team needs to examine the contributing factors to find the root causes. This can be done by digging deeper—asking repeated “why” questions of the contributing factors. This is called the “five why’s” technique, which is illustrated below.

1. CHAs didn’t have the equipment needed to care for the resident
2. Needed equipment is sometimes hard to find
3. Not enough specialized equipment to care for residents with unique needs
4. The anticipated number of residents with unique needs and their equipment requirements are not known
5. The strategic planning and budgeting process does not include projections of the equipment needs of residents with unique physical and psychological needs


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**Test the Root Cause**

- Ask 2 questions to make sure it is the root cause:
  1. Would the event have occurred if this cause had not been present?
  2. Will the problem recur if this cause is corrected or eliminated?
- The team should not make judgments about whether an individual did the right thing
- Alternative method is the “fishbone” or cause and effect diagram to determine root cause

Fishbone Alternative To Find the Root Cause

- Helps with brainstorming causes with a more structured visual cause and effect tool.
  - The problem or effect is displayed at the head or mouth of the fish.
  - Possible contributing causes are listed on the smaller “bones” under various cause categories.
  - Helpful to identify possible causes for a problem not otherwise considered by directing the team to look at the categories and think of alternative causes.
  - What does the best available evidence show????

CMS. (2014). How to Use the Fishbone Tool for Root Cause Analysis

[Diagram of a fishbone diagram with categories such as Equipment/Supplies, Environmental, Standards or compliance with standards, Communication, Lack of knowledge, information, Scheduling, Rules/Policies/Procedures, and Staff/People.]


continued
**Fishbone Example Scenario**

- Facts gathered:
  - Time of fall: change of shift from days to evenings
  - Location of fall: resident’s bathroom
  - Witnesses: resident and aide
  - Background: the plan of care stipulated that the resident was to be transferred with two staff members, or with one staff member using a sit-to-stand lift.

CMS. (2014). How to Use the Fishbone Tool for Root Cause Analysis

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**Fishbone Too**

- Information from interviews: the resident was anxious and needing to use the bathroom urgently. The aide was helping the resident transfer from her wheelchair to the toilet, without using a lift, and the resident fell, sustaining an injury. The aide stated she did not use the lift because the battery was being recharged, and there was no extra battery available. The aide stated she understood that the resident could be transferred with assist of one.

CMS. (2014). How to Use the Fishbone Tool for Root Cause Analysis
Step 6: Design and Implement Changes to Eliminate the Root Causes

- For corrective actions consider:
  - What safeguards are needed to prevent this root cause from happening again?
  - What contributing factors might trigger this root cause to reoccur? How can we prevent this from happening?
  - How could we change the way we do things to make sure that this root cause never happens?
  - If an event like this happened again, how could we stop the accident trajectory (quickly catch and correct the problem) before a resident was harmed?
  - If a resident were harmed by this root cause, how could we minimize the effect of the failure on the resident?

Corrective Action

- System changes that do not allow the errors to occur are the strongest
- “Stronger Actions:
  - Change physical surroundings
  - Usability testing of devices before purchasing
  - Engineering controls into system (forcing functions which force the user to complete an action)
  - Simplify process and remove unnecessary steps
  - Standardize equipment or process”

Corrective Actions

- “Intermediate Actions
  - Increase staffing/decrease in workload
  - Software enhancements/modifications
  - Eliminate/reduce distractions
  - Checklist/cognitive aid
  - Eliminate look alike and sound alike terms
  - “Read back” to assure clear communication
  - Enhanced documentation/communication”

Corrective Actions

- “Weaker Actions
  - Double checks
  - Warnings and labels
  - New procedure/memorandum/policy
  - Training
  - Additional study/analysis”

Examples of Corrective Actions

- The strongest action to prevent another accident would be to keep all equipment designed for larger residents in just one storage area (change physical surroundings)
- The weakest would be to place a sign on the lift equipment – “DO NOT USE FOR RESIDENTS OVER 250 LBS. (warning label)
RCA PIP Template

This template can be used to document the completed RCA PIP process, including follow-up actions and measures. Revise it as necessary to meet your needs.

Team Facilitator: Date RCA Started: ___________________________ Date Ended: ___________________________

Team Members:

<table>
<thead>
<tr>
<th>Name</th>
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Brief Narrative Description of Event (include time line if available):


Corrective Action Plans

For each root cause identified, enter the corrective action plans intended to prevent the root cause from causing another harmful event. There can be more than one action plan for each root cause. Some action plans may be short-term interventions which can be accomplished quickly and some action plans require more long-term implementation steps. For each action plan designate the individual or group responsible for completing the action and the time frame for completion.

<table>
<thead>
<tr>
<th>Root Cause</th>
<th>Corrective Action</th>
<th>Responsible Individual/Group</th>
<th>Completion Deadline</th>
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<tbody>
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**Step 7: Measure the Success of Changes**

- Measure whether root cause is minimized or eliminated by answering 3 questions:
  - “Did the recommended corrective actions actually get done? (e.g., Did the warning signs get put on the Hoyer lifts? Did a formal equipment evaluation step get added to the annual budgeting process?)
  - Are people complying with the recommended changes (e.g., How often is the wrong type of Hoyer lift used for residents weighing over a predetermined weight? Is staff provided an opportunity to participate in an equipment needs assessment during the budgeting process?)
  - Have the changes made a difference? (Has another resident been harmed by equipment unsuited for their physical condition?)”


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**Measuring success of the PIP:**

- “Ideally, all of the following criteria should be met to conclude a PIP has been successful:
  - Measures of success were monitored over time.
  - The goal was attained (process changes were made and sustained, no recurrent events).
  - You are confident that the change is permanent.”

### Measures of Success

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measures of Success (How we will know if this action is successful)</th>
<th>Reporting Schedule and Individual or Group Responsible for Reviewing Results</th>
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<tr>
<td></td>
<td>Consider measures of how often recommended processes are not followed and the incidence of similar adverse events.</td>
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</table>

Signature of RCA team leader: ____________________________ Date ______________________________________


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**Joint Commission**

- explicitly defines circumstances under which facilities must perform a root cause analysis.
**Occurrences Reviewable under JC’s Never Event Policy**

- Any occurrence that meets any of the following criteria:
  - The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or

**The event is one of the following**

- (even if the outcome was not death or major permanent loss of function):
  - Suicide of a patient in a setting where the patient receives around-the-clock care
  - Unanticipated death of a full-term infant
  - Abduction of any individual receiving care, treatment or services
  - Rape
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
  - Surgery on the wrong patient or wrong body part
**Fl. Stat. Reporting Requirements**

- Adverse events & sentinel events are reported to the Florida Agency for Health Care Administration
- Three types of reports
  - Annual
  - Code 15
  - Code 30

**Other reporting requirements for Sentinel event**

- Joint Commission Never Events Database
- Appear to be related to nosocomial (hospital acquired infections).
- Home care services, reportable to federal and state agencies as part of the OASIS requirements.
- Long term care services, reportable to federal and state agencies as part of the Minimum Data Set (MDS).
Joint’s 4 Alternatives for Reporting Never Events

- Range from delivering the root cause analysis & related documents to the Joint Commission to requesting an onsite review by the Joint Commission of its processes for reviewing sentinel events

Joint Commission Framework

- A Framework for a Root Cause Analysis & Action Plan In Response to a Sentinel Event
  - Joint Commission downloadable from http://www.jointcommission.org/Framework_for_Conducting_a_Root_Cause_Analysis_and_Action_Plan/
  - an aid in organizing the steps in a root cause analysis.
**Reporting: Legal & Ethical Issues**

- Fear of civil suits
  - Malpractice
  - Criminal actions
- Ethical obligations to report incompetent practitioners
- Legal obligation to report under the licensure law

*_Image by Flickr user PRSA-NY/Creative Commons licensed._
https://www.flickr.com/photos/prsany/16666571547/

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**Medication errors**

- Taking medications is an IADL…. Part of Medical Management and Maintenance
- Our Role:
  - We spend more time with patients than other team members
  - What do you see

Engaged Patients

- Our Role Medical Management and Maintenance – to help patients become engaged, and empowered patients because:
  - Research shows patient engagement
    - Improves health outcomes,
    - lowers costs,
    - Improves patient care, and
    - Decreases medical errors (James, 2013)


Internet Resources

- Campaign zero: Download their checklists http://www.campaignzero.org
- The Empowered Patient Coalition
  - “The Empowered Patient® Hospital Guide For Patients and Families”
  - in a checklist format, explains many procedures that occur in the hospital & what to do to prevent them.
References & Resources


References & Resources

- Campaign zero http://www.campaignzero.org
References & Resources

- Empowered Patient Coalition, The Empowered Patient® Hospital Guide For Patients and Families. 

References

  http://www.jointcommission.org/Framework_for_Conducting_a_Root_Cause_Analysis_and_Action_Plan/
References & Resources


References & Resources

Questions?

- Email: barbarakornblau@gmail.com