Partnering to Identify Trends

Take Aways

Riley Hospital for Children
Indiana University Health

Partnering Training

- Target audience: front line leaders who respond to incident reports
- Purpose: teach them to think about incidents differently… process vs. person
- System and individual failure modes
- Discussed how trended failure modes direct organization safety resources – the "why"

Your role

- Use the error modes tool when investigating an incident
- Ask team members probing questions when investigating
- Challenge team members to think about system error modes
- Seek to understand what led to the incident
- No assumptions

Human Error – A Symptom, Not Cause

Human error is not the cause of failure, but a *symptom of failure*

Human error – by any other name or by any other human – should be the *starting point* of our investigations, NOT the conclusion

BEST CHILDREN'S HOSPITALS
U.S.News
RANKED IN 10 SPECIALTIES
2017-18

But to understand failure

- Questions are <u>not</u>
  - Where did they screw up?
  - Why didn't they notice what we find important now?
- Question is:
  - Why did it make sense for them to do what they did?

Why did it make sense?

- To understand why people did what they did…
- Reconstruct the world in which they found themselves at the time

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1. Investigate the event

- What events led to the incident?
- Was the normal process, policy, or standard followed? Is it known?
- Look at documentation if necessary
- What else was going on at the time?
- Chain of command utilized?
- Experience level of team member involved
- Was there a deviation in generally accepted practice?

Deviations from GAP’s

- Are determined by comparing actual performance to expected performance (include internal and external standards)

-Internal **AND** external policies, procedures, protocols

-Nationally recognized best practices and standards of care

-Industry imposed practices and standards

-Professional practice standards

-Objective review of other experts

-Organizations obligation to best protect the patient from harm (*if there isn't a process or protocol should there have been)*

Source: HPI

Good Questions to Ask

- Do you remember what you were thinking or doing when this occurred?
- Do you recall anything unusual about the shift or event?
- Are there any barriers that keep you from doing this a different way (distraction, staffing, competency, etc.)?
- Can you think of anything we could do to make completing this task easier?
- Is there anyone else I should talk to about this incident?

Effectiveness of Prevention Strategies

1. Design process for minimum error "mistake proof"
   - Ex: forcing functions
2. Control errors with active safety devices
   - Ex: checklists
3. Provide warning devices for manual action
   - Ex: electronic alert, visual aid
4. Use procedures for reduction of error and control
   - Ex: write a policy
5. Use administrative controls for reduction of error
   - Ex: performance management, compliance monitoring
6. Rely on knowledge and skill of staff
   - Ex: awareness – put in lessons learned or newsletter

MOST EFFECTIVE

LEAST EFFECTIVE

2. Think about failure modes

- System failure modes?
- Individual failure modes?

REMINDER:
No deviation
=
no failure
modes

80% of errors involve both system and individual modes

Examples of good loop closure

- *“I have reached out to x to collaborate and develop a plan for XXX”*
- *“The equipment has been tagged and CE notified”*
- *“Reviewed with staff involved-information will be shared in staff huddle-no harm to patient”*

What not to say

- *“Tell the NICU manager that I said….”*
- *“Noted”*
- *“I think this needs to be sent to Clinical Engineering”*
- *“Someone needs to work on a process for…”*
- Simply repeat the description of the event

What to say

- *"Spoke with the RN. She was interrupted while hanging the medication by a phone call. We discussed the need to validate and verify the correct medication is hanging at the correct rate at the end of the process"*
- *"This RN is still on orientation. She has been educated on cervical exams in orientation, however she says she is not comfortable yet with them. I have requested her preceptor to focus on cervical exams this week in orientation. Will follow up on progress at next orientation check in."*

Bringing it all together

Key Takeaways

- Tell a story, from beginning to end
- Discuss the event both from the human error and the system contributing factors or causes
- Capture what, if anything is being done to fix the problem
- Provide meaningful information for cause trending

Take-Aways

- Encourage team members to fill out incident reports
- Investigate incident reports impacting your area (keeping failure modes in mind)
- Follow up on any action plans stemming from incident reports