

RCA Team PBL Session



11:55 am-12:00 pm	Introduction to team work
12:00-1:00 pm	Lunch and team work Teams can decide to eat lunch and work or divide up the time how they wish
1:00-1:15 pm	Group review using poll everywhere
1:15-1:30 pm	Root Cause Statement Review
1:30-2:20 pm	Team work on case Faculty will walk around and provide support in rooms starting at 1:30 pm latest
2:20-2:30 pm	Peer feedback
2:30-2:40 pm	Faculty report out of observations

Cases/Teams



Case 2 (A Catheter Gone too Far): Table 1, 3, 5

Case 1 (Culture, what culture): Table 2, 4

Rooms:

Table 1 113

Table 3 114

Table 5 112N

Table 2 112N

Table 4 111N

The Fundamentals of Root Cause Analysis (RCA)

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GREATER NEW YORK HOSPITAL ASSOCIATION & UNITED HOSPITAL FUND

CLINICAL QUALITY FELLOWSHIP PROGRAM

Conflict of Interest



- Lorraine Ryan, Esq. has no conflicts to report.
- Brijen Shah, MD is on the Data and Safety Monitoring Boards (DSMB): Takeda



Learning Objectives

At the conclusion of this session and the RCA exercise in March fellows will be able to:

- Describe the core concepts of a team-based RCA
- Identify root causes using safety tools

Overview



Part I: Fundamentals of RCA

- Core Patient Safety Concepts
- Types of Quality/Safety Reviews
- Features of an Effective RCA
- Tools for an Effective RCA
- Writing a Root Cause Statement

Part II: RCA team-based learning exercise at May 2023 retreat

REVIEW

Root Cause Statements

Example 1



A practitioner's failure to assess and document a change in clinical status with new complaints of back pain, weakness and progressive drop in hemoglobin resulted in delay in obtaining CTA which lead to a delay in diagnosis of RP bleed.

The practitioner's cognitive anchoring on the patient's chronic back pain and frailty led to a decision to provide verbal orders for Tylenol (instead of assess the patient at bedside) which resulted in a delay in obtaining a CTA leading to a delay in diagnosis on an RP bleed.

Example 2



Suboptimal process in the identification and removal of expired products from inventory led to an expired graft being opened on the surgical field.

A manual and variable process in the identification and removal of expired products from inventory led to an expired graft being brought into the room for the case and then opened on the surgical field.

Example 3



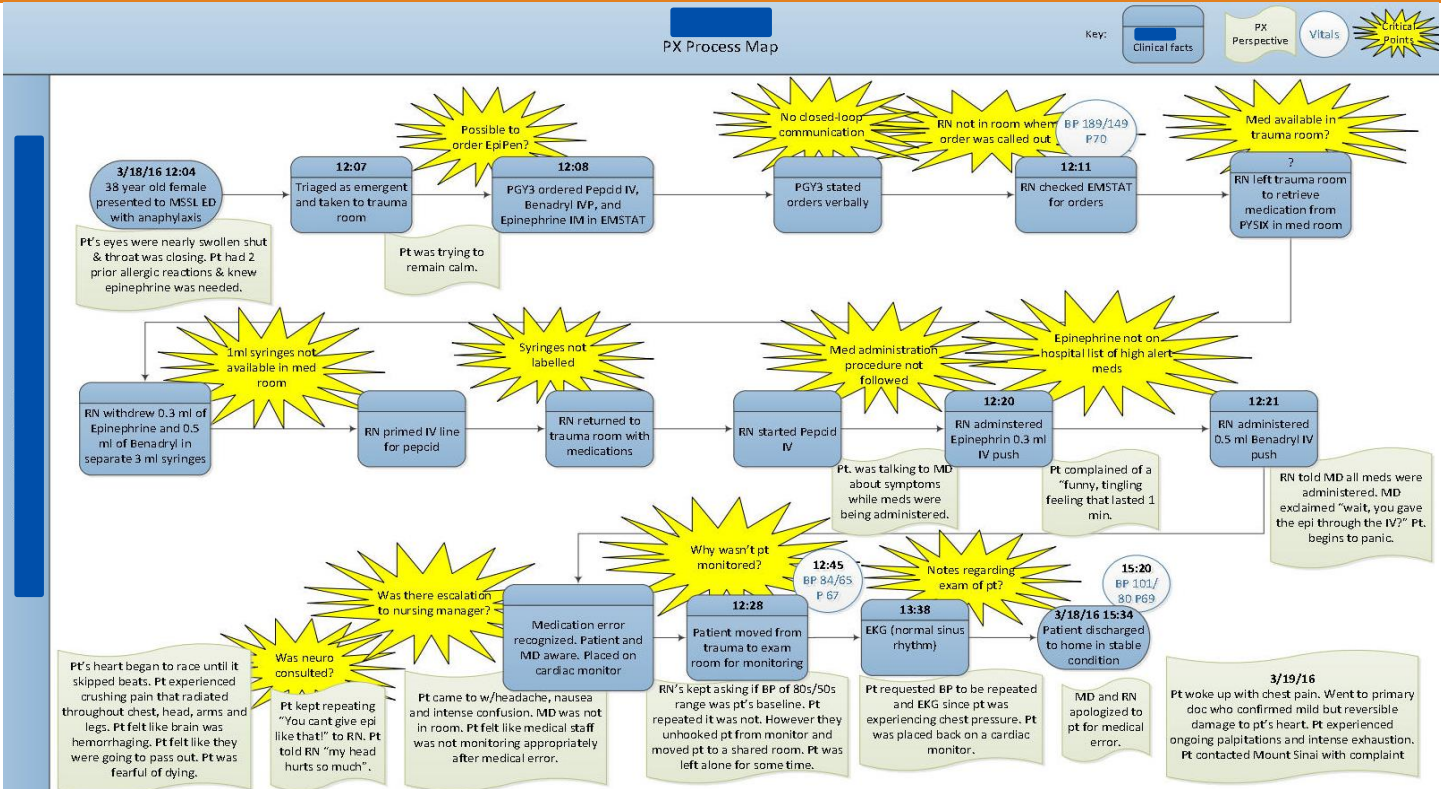
Electronic medical record settings that permit PA and lateral chest radiographs to be ordered as portable studies on ICU patients too unstable to travel or stand for imaging, led health care team members to select the incorrect imaging order, populate the device with the incorrect anatomic orientation creating the left-right inversion of the radiograph.

Electronic medical record settings that permit PA and lateral chest radiographs to be ordered as portable studies on unstable ICU patients led the ordering physician to select the incorrect imaging order, and the radiology tech populate the device with the incorrect anatomic orientation, resulting in the left-right inversion of the radiograph.

CASE

38-year-old female presents to the emergency room with anaphylaxis. Pt received 0.3 ml IV of epinephrine and 0.5 mL of diphenhydramine IV. Pt given wrong dose and route of medication. Pt required further monitoring.

Process Map



Root Cause Statements



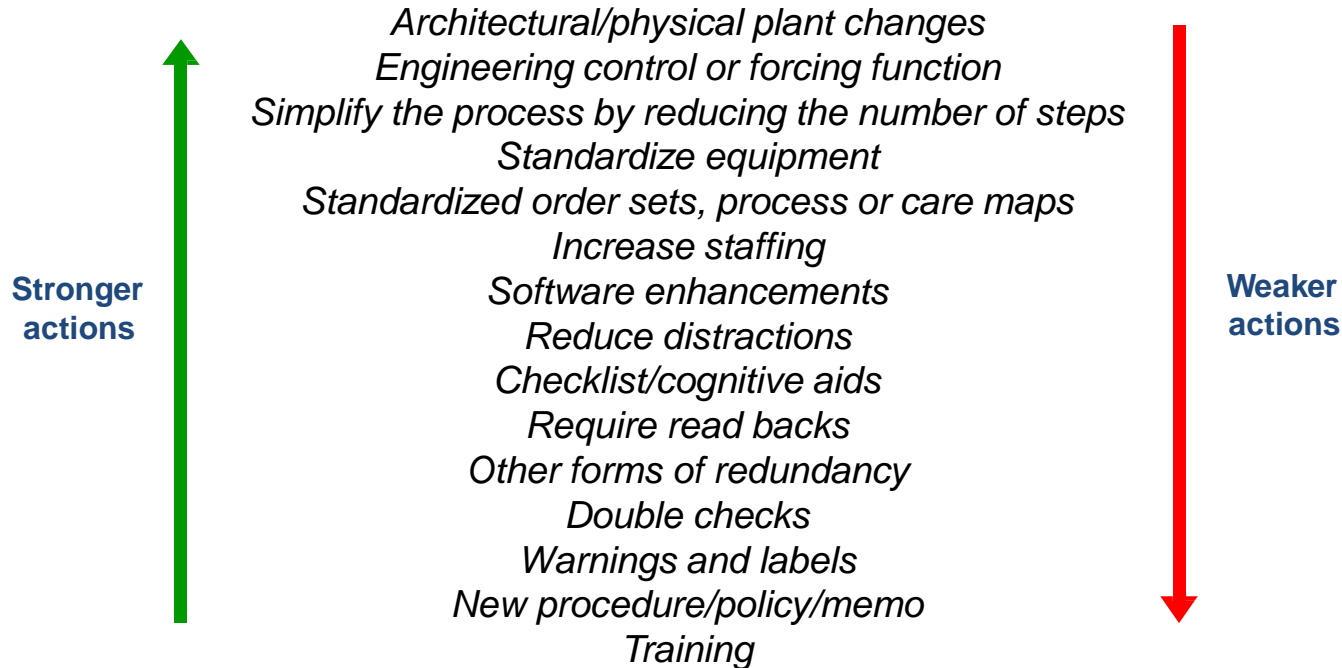
1. Due to under recognition by the clinical staff of the consequence of IV epi administration resulted in a low level of monitoring of the patient in the ER.
2. Due to a lack of verbal and non-verbal communication including eliminating the patient from the care team led to the patient feeling neglected.
3. Under appreciation of the importance of empathy and disclosure communication after a medical event led to the patient questioning the quality of care.

Rule 2- more clear descriptor

Rule 2- more specific, Rule 1- cause/effect

PLAN FOR IMPROVEMENT

Hierarchy of Corrective Actions Taken in Response to an Adverse Event



Sources:

- -Department of Veterans Affairs National Center for Patient Safety, Available at www.va.gov/ncps/CogAids/RCA/index.html
- -RCA² Improving Root Cause Analyses and Actions to Prevent Harm, National Patient Safety Foundation, 2015

CONFIDENTIALITY

NYS's QI/QA Confidentiality Protections



- **Public and Education Laws protect confidentiality of quality reviews**
 - **EXCEPT** statements (written/oral) made at a QA/QI/ RCA/MM review committee by a party to an action or future action

“The party statement exception”

- **Siegel v. Snyder (2d Dept 12/22/2021) a recent challenge to the confidentiality protections afforded by NY laws**
 - Party asserting QA protection must demonstrate statements made during review were made by a non-party
 - Meeting minutes attributed statements about the case to “the Committee” or unidentified speaker and did not distinguish who said what
- **Court held all such statements made were discoverable**

Organizational Approach to Serious Adverse Events



- Huddle
- Escalate
- Respond to patient/family following an adverse event
- Organize a team
- Investigate
- Conduct Root Cause Analysis
- Develop corrective action plan with leadership support
- Plan implementation
- Measure progress
- Share what you've learned
- Spread to other units as appropriate

- Analyze the event to uncover all underlying root causes/contributing factors
- Uncover “latent failures” that persist in the organization
- Each human error must have a preceding cause
- Failure to act is only a root cause when there is a pre-existing duty to act