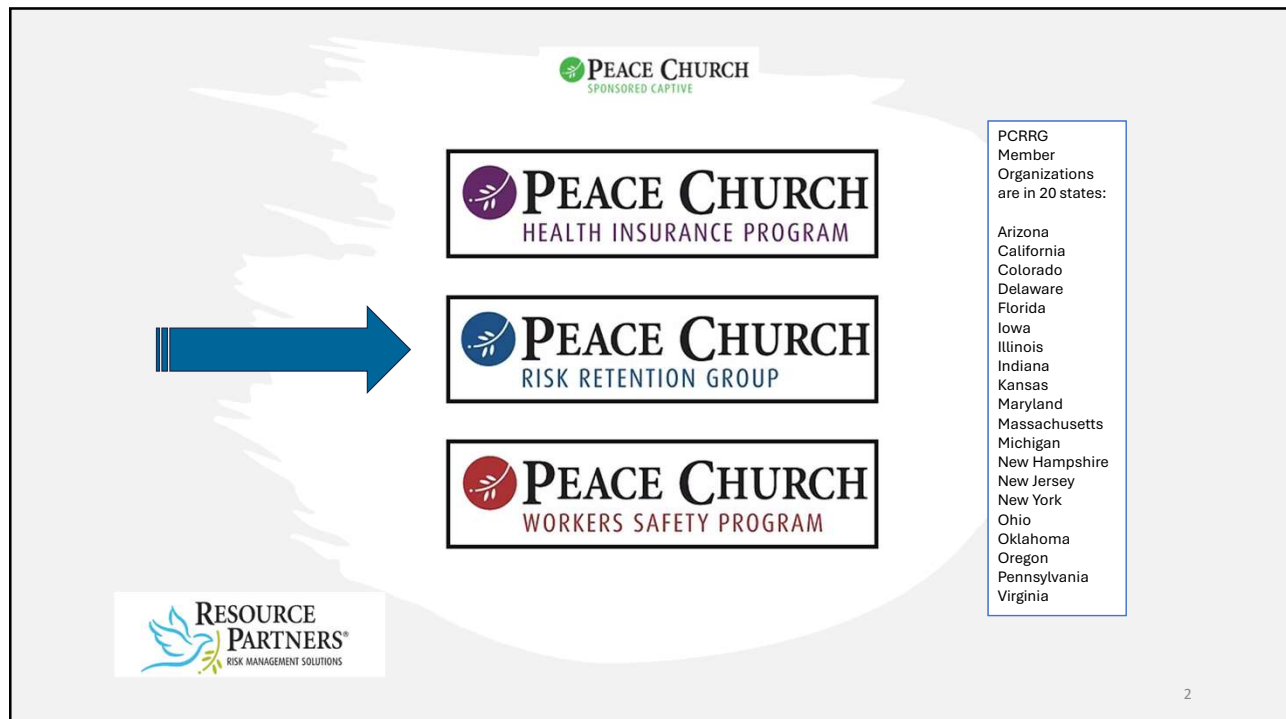# From Events to Insights: Strengthening Healthcare Safety Investigations

Jenny Sheckells, NHA, PCHA, CHC, CPASRM

Vice President of Risk Management, Resource Partners
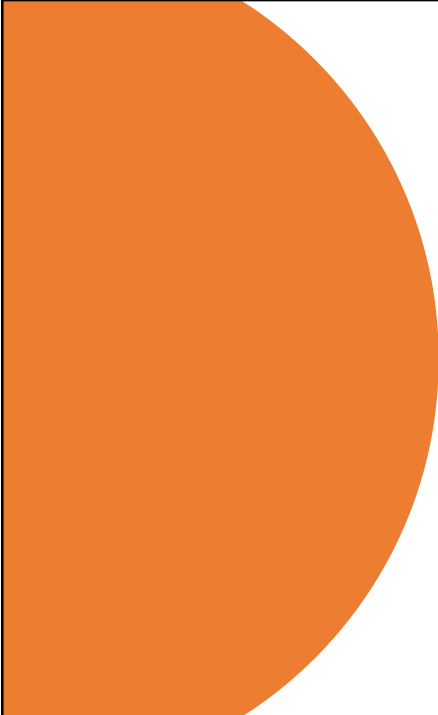
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PEACE CHURCH
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RESOURCE PARTNERS
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PCRRG Member Organizations are in 20 states:

Arizona
California
Colorado
Delaware
Florida
Iowa
Illinois
Indiana
Kansas
Maryland
Massachusetts
Michigan
New Hampshire
New Jersey
New York
Ohio
Oklahoma
Oregon
Pennsylvania
Virginia

2

2

"The world we have created is a product of our thinking; it cannot be changed without changing our thinking. If we want to change the world we have to change our thinking...**no problem can be solved from the same consciousness that created it**. We must learn to see the world anew."
– Albert Einstein

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Objectives

Build	Build a culture of safety
Use	Use root cause analysis (2)
Apply	Apply human factors engineering/consider human factors
Utilize	Utilize safety huddles and debriefings
Perform	Perform Failure Mode and Effects Analysis (FMEA)
Leverage	Leverage data analytics and reporting
Ensure	Ensure strong leadership and accountability

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Culture of Safety

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Culture of Safety

AHRQ defines a culture of safety as one "in which healthcare professionals are held accountable for unprofessional conduct yet not punished for human mistakes; errors are identified and mitigated before harm occurs; and systems are in place to enable staff to learn from errors and near-misses and prevent recurrence" (AHRQ PSNet Safety Culture 2014).

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Where is your organization on the Culture of Safety spectrum?

Gold Star	• Most, if not all, individuals feel safe reporting safety events and concerns. • We approach incidents as an opportunity to learn and change. • Leaders lead by example and reward or recognize others who foster just culture. • Resources are given to try and prevent incidents before they happen.
We're Getting There	• Some individuals feel safe reporting safety events and concerns. • We are still playing the blame game at times instead of being open to learning from incidents. • Some leaders lead by example and others don't seem to get it. • We have limits on the resources available to try and prevent incidents.
Meh	• Not many individuals report feeling safe reporting safety events and concerns. • The blame game is still our go-to response. • Our leaders are not always setting the best example. • Resources? – I'm lucky to have paper to print signs.

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Culture of Safety – Six Domains

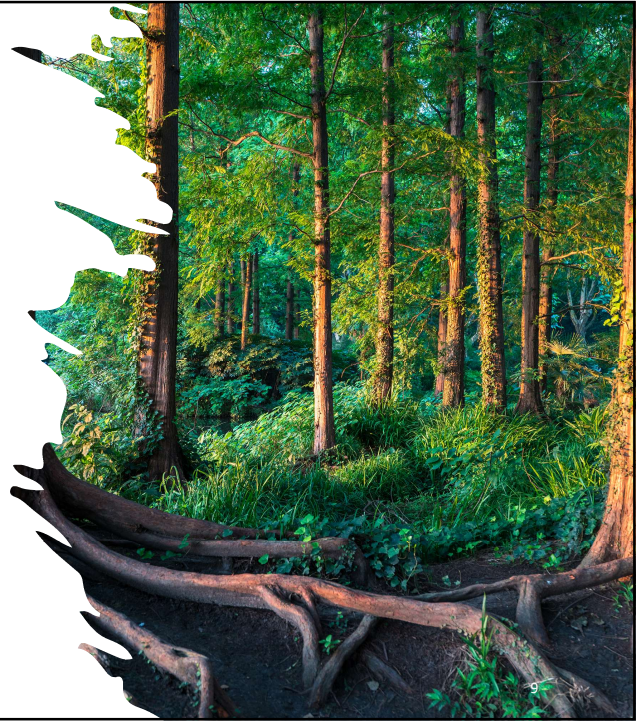Leading a Culture of Safety:
A Blueprint for Success

American College of Healthcare Executives
for leaders who care

IHI/NPSF Lucian Leape Institute

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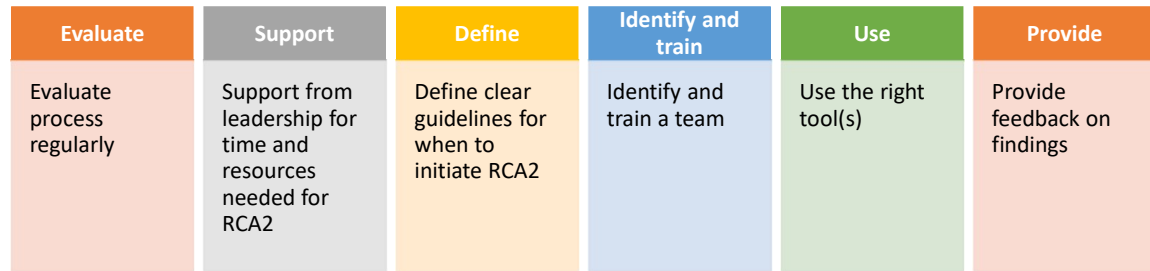# Root Cause Analysis and Action (RCA2)

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Root Cause Analysis

Root cause analysis (RCA) is a systematic process to analyze adverse events and near misses. (Rethinking Root Cause Analysis | PSNet)

Rethinking Root Cause Analysis has led AHRQ to share RCA2 – Improving Root Cause Analyses and Actions to Prevent Harm

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Root Cause Analysis 2 and Action

Evaluate	Support	Define	Identify and train	Use	Provide
Evaluate process regularly	Support from leadership for time and resources needed for RCA2	Define clear guidelines for when to initiate RCA2	Identify and train a team	Use the right tool(s)	Provide feedback on findings

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RCA2 Workbook

- Tools include
- Interview Summary
  - Multiple issues
  - Minimal issues
  - Timeline
  - Action Plan

RCA Interviews Summary
Event:

RCA Date:

RCA Attendance:

Multiple issues | minimal issues | Timeline | Action plan | +

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RCA2 Tools Download

RCA2: Improving Root Cause Analyses and Actions to Prevent Harm | Institute for Healthcare Improvement

Patient Safety Essentials Toolkit | Institute for Healthcare Improvement

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Human Factors/ Human Factors Engineering

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HUMAN FACTORS

"By considering human factors in investigations you will gain an understanding of why people behave (and think) the way they do, so that you can prevent future events. Whilst the immediate cause just before the accident occurs may often be a human failure, there will be underlying causes that influence that failure." *Martin Anderson: Creator of humanfactors101.com*

Training available on human factors includes topics such as:

- Types of human failures
- Performance influencing factors - people factors, work/job factors, organization/management factors
- Mind traps or cognitive biases and decision-making

Human Factors 101 – Introduction to human factors & work psychology

PEACE CHURCH
RISK RETENTION GROUP

Confidential and Proprietary

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Human Factors Engineering

- Systems Engineering Initiative for Patient Safety – SEIPS
  - Helps to address the systemic problems of patient/resident safety
  - Integrate human factors into design of workflows, environment, and equipment

- Think about the last time you did a renovation in your skilled nursing care area
  - Input from caregivers? Residents?
  - Height of equipment or access of supplies in bathroom and bedroom?
  - Consider ergonomics of caregiver or resident in design of room or bathroom?
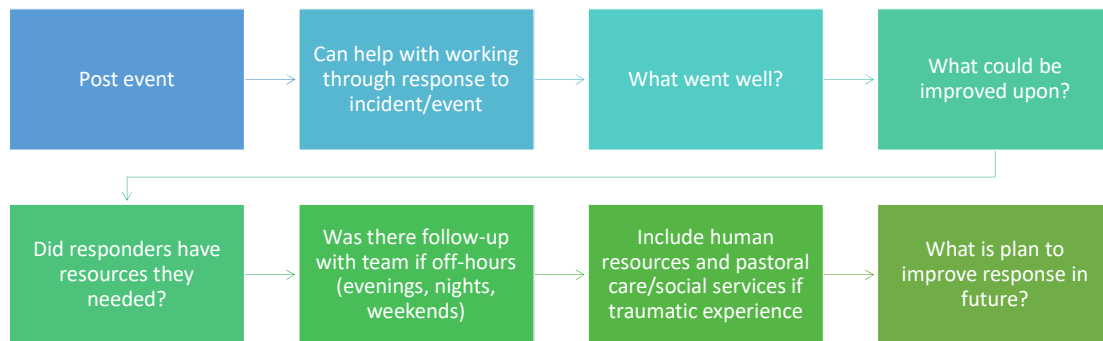
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Safety Huddles and Debriefings

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Safety huddles

- Brief focused meeting on safety concerns, risks, and strategies
- Structured – can use template to review specific areas of concern
- Can be post-incident
- Should include participation across disciplines

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Safety Debriefings

| Post event | → | Can help with working through response to incident/event | → | What went well? | → | What could be improved upon? |

| Did responders have resources they needed? | → | Was there follow-up with team if off-hours (evenings, nights, weekends) | → | Include human resources and pastoral care/social services if traumatic experience | → | What is plan to improve response in future? |

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Failure Mode and Effects Analysis (FMEA)

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Failure Modes and Effects Analysis (FMEA)

Tools available to help assess			
Steps in process	Failure modes – what could go wrong?	Failure causes – why would the failure happen?	Failure effects – what would be the consequences of each failure?

Flowcharting can be helpful!

SafetyToolkit_FailureModesandEffectsAnalysis.pdf
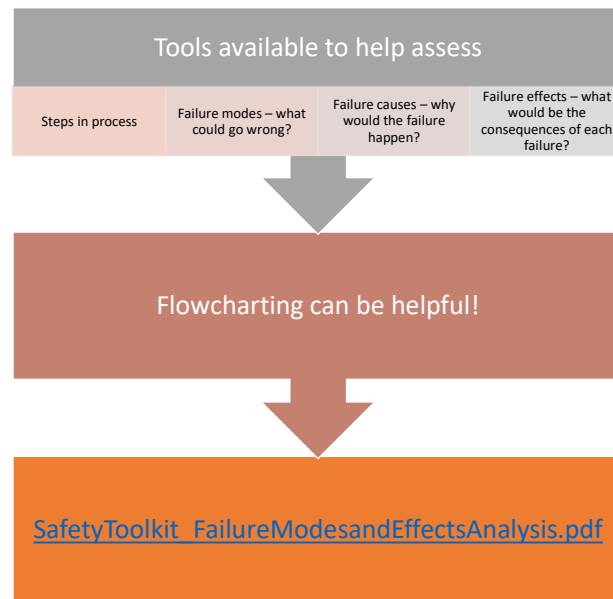
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Process not outcome

- FMEA should be used for identifiable processes
- Narrow scope
- Ask your team what processes are challenging
- Consider FMEA to evaluate new processes

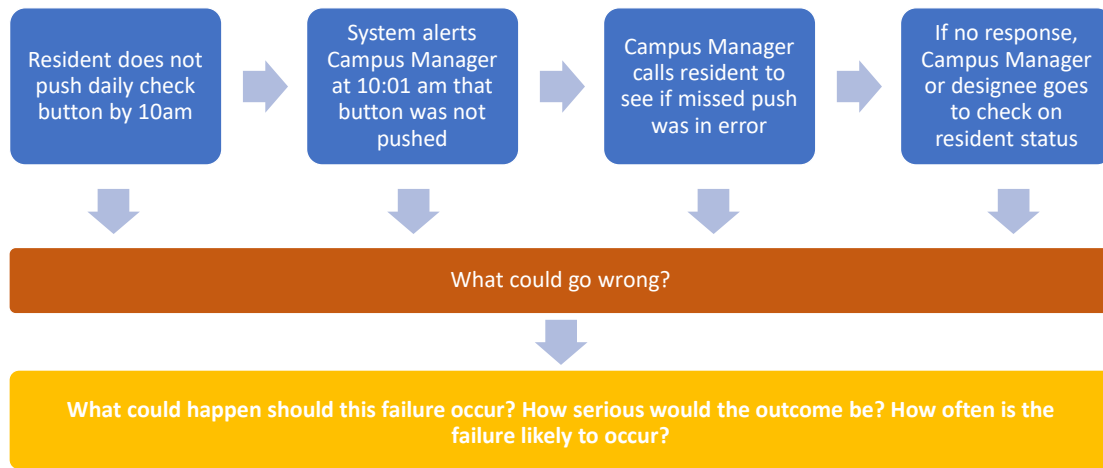Below is a quick overview of the steps of FMEA.

Steps	Explanation
1. Select a process to analyze	Choose a process that is known to be problematic in your facility or one that is known to be problematic in many facilities.
2. Charter and select team facilitator and team members	Leadership should provide a project charter to launch the team. The facilitator is appointed by leadership. Team members are people who are directly involved in the process to be analyzed.
3. Describe the process	Clearly define the process steps so that everyone on the team knows what is being analyzed.
4. Identify what could go wrong during each step of the process	Here is where the people directly involved in the process describe the problems that can or do occur.
5. Pick which problems to work on eliminating	The focus of improvements will be on those problems that happen quite often and/or have a significant impact on resident safety when they do occasionally occur.
6. Design and implement changes to reduce or prevent problems	The team determines how best to change the process to reduce the risk of residents being harmed.
7. Measure the success of process changes	Like all improvement projects, the success of improvement actions is evaluated.

Disclaimer: Use of this tool is not mandated by CMS, nor does its completion ensure regulatory compliance.

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FMEA is not just for clinical processes

| Resident does not push daily check button by 10am | System alerts Campus Manager at 10:01 am that button was not pushed | Campus Manager calls resident to see if missed push was in error | If no response, Campus Manager or designee goes to check on resident status |

What could go wrong?

What could happen should this failure occur? How serious would the outcome be? How often is the failure likely to occur?

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Data Analytics and Reporting

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Where does your data live?

|					
ELECTRONIC MEDICAL RECORD	INCIDENT REPORTING SYSTEM	CUSTOMER RELATIONSHIP MANAGEMENT DATABASE/SYSTEM	SURVEY RESULTS – FEDERAL, STATE, ACCREDITATION (CARF, JOINT COMMISSION, EAGLE)	QUALITY MEASURES	RESIDENT SURVEYS

EMPLOYEE SURVEYS

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Predictive tools

- Dashboards
- Beyond location and time of event
- Use of EMR and incident records to predict falls or risk for falls
- Improved clinical outcomes
- Extracted data
- Often 3rd party contractors
- Focus in clinical care levels

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Connect the dots

- Consider factors outside of usual patterns
- Staffing? Policy changes? New process?
- Cross-departmental review
- Analysis should feel like a shared mission
- Look at feedback
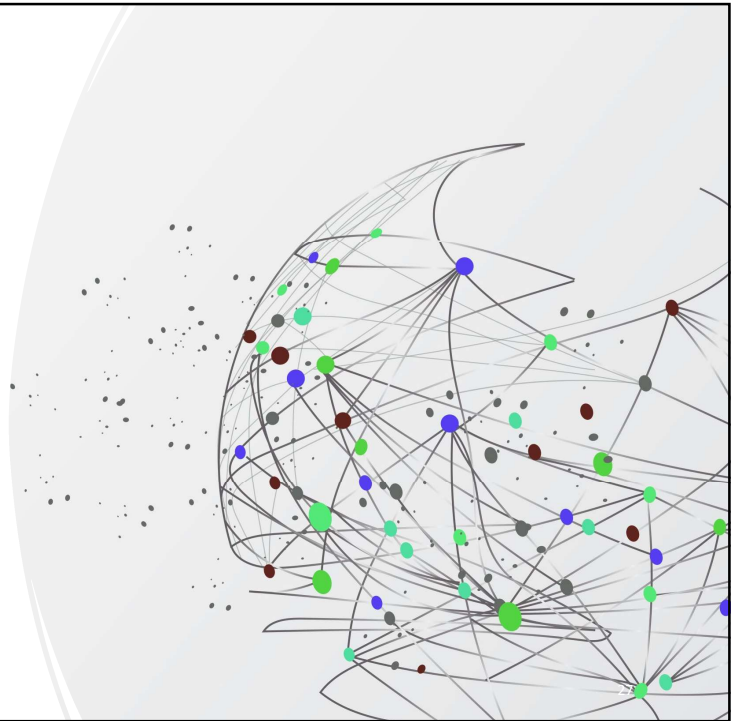
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Leadership and Accountability

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Shaping a positive culture

Leadership

Accountability

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Challenge

Culture of safety

RCA2

Human factors

Safety huddles/debriefing

FMEA

Data analytics

Leadership and accountability

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Additional Downloadable Resources

- 6 Ways to Lead a Culture of Safety | Institute for Healthcare Improvement
- What is FMEA? Failure Mode & Effects Analysis | ASQ
- Healthcare Failure Mode and Effect Analysis (HFMEA) - VHA National Center for Patient Safety
- Guidance for Performing Failure Mode and Effects Analysis with Performance Improvement Projects
- Daily Huddle Component Kit | Agency for Healthcare Research and Quality
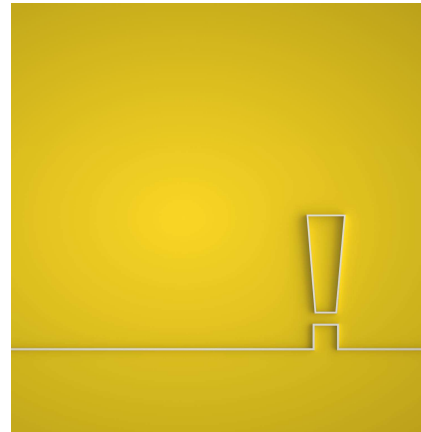
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