Yale New Haven Hospital
Facilitator Competence Assessment

Root Cause Analysis

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Objectives

- Describe Yale New Haven Hospital RCA process including the identification of variations in RCA facilitator work product.

- Explain the development and implementation of the RCA facilitator competency evaluation process.

- Practice use of the evaluation tool
“To address this mistake we must use root-cause analysis. I will begin by saying it’s not my fault.”

Source: adapted from the original cartoon by Royston Robertson on www.cartoonstock.com.
High Reliability Implementation

- **2012**: Daily Morning Safety Report
- **2013**: Leadership Training
  - “Train the Trainers”
- **2014**: Initial Training (Frontline Staff, Medical Staff & Residents)
  - RCA Facilitator Training
- **2015**: Sustainability Planning
  - Safety Coach Program Implementation
  - Event Management Standardization
- **2016**: RCA Facilitator Evaluation
- **2017**: Health System Standardization
Yale New Haven Hospital Event Management Structure

Organizational Oversight
- Legal & Risk Services
- Hospital Quality Improvement

Decentralized Safety & Quality
- 13 Service Lines & Departments

Serious Event Review Committee (SERC)
- Review & approval of RCA action plans
Addressing RCA Variation

- 2014 Facilitator Training
- Variable RCAs
- Four Expert Facilitators
- Evaluate Facilitator Competency
What Makes an Ineffective RCA?

- **Culture**
  - Operational Leadership
  - Non-Collaboration
  - Inadequate Mission
  - Competency
  - Compliance

- **Structure**
  - Inadequate Structure
  - Collaboration Mechanisms
  - Inadequate Job Function

- **Process**
  - Excessive Actions

- **Policy & Protocol**
  - Lacking or informal

Ineffective RCA

Courtesy of Jeffrey Cotton, Quality Performance and Safety Lead, YNHH
Addressing RCA Variation

- 2014 Facilitator Training
- Variable RCAs
- Four Expert Facilitators
- Evaluate Facilitator Competency
Development and Implementation

1. Creating evaluation tool & process
2. Testing
3. Implementation
4. Results
RCA Evaluation Categories

1. Initiation of Root Cause Analysis
2. Identification of RCA Team
3. Interview Skills
4. Meeting Facilitation*  
5. Process Mapping
6. Writing Inappropriate Act Statements
7. Identification of Root Causes
8. Corrective Action Planning
9. Administrative Activities

* Not directly observed
## Evaluation Tool

### Quality Improvement Support Services
#### Root Cause Analysis Facilitator Evaluation

<table>
<thead>
<tr>
<th>Process Step 1</th>
<th>Initiation of RCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Completes timely Safety Event Classification (within 2 business days)</td>
<td></td>
</tr>
<tr>
<td>Met</td>
<td>5</td>
</tr>
<tr>
<td>Partially Met</td>
<td>3</td>
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<tr>
<td>Not Met</td>
<td>0</td>
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<tr>
<td>2. Identifies deviations from acceptable practice standards and/or policy</td>
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<tr>
<td>Met</td>
<td>5</td>
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<tr>
<td>Partially Met</td>
<td>3</td>
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<tr>
<td>Not Met</td>
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<tr>
<td>3. Accurately classifies event as a Serious safety Event</td>
<td></td>
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<tr>
<td>Met</td>
<td>5</td>
</tr>
<tr>
<td>Partially Met</td>
<td>3</td>
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<tr>
<td>Not Met</td>
<td>0</td>
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<tr>
<td>4. Able to identify if other units, department, service line or delivery networks with YNHHS at risk and escalates as appropriate</td>
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<tr>
<td>Met</td>
<td>5</td>
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<tr>
<td>Partially Met</td>
<td>3</td>
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<tr>
<td>Not Met</td>
<td>0</td>
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<tr>
<td>5. Confirms disclosure of event to patient/family within 72 hours</td>
<td></td>
</tr>
<tr>
<td>MET</td>
<td>5</td>
</tr>
<tr>
<td>Partially Met</td>
<td>3</td>
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<tr>
<td>Not Met</td>
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<tr>
<td>6. Shares information as appropriate with other departments/service lines or delivery networks for situational awareness</td>
<td></td>
</tr>
<tr>
<td>Met</td>
<td>5</td>
</tr>
<tr>
<td>Partially Met</td>
<td>3</td>
</tr>
</tbody>
</table>
Evaluation Process

Meeting One:
Presentation of simulated event

Meeting Two:
Interviews with 2 Staff RNs

Meeting Three
Discussion related to criteria not directly observable

Meeting Four:
Feedback to facilitators
Development and Implementation

1. Creating evaluation tool & process
2. Testing
3. Implementation
4. Results
Face Validity Testing

**Multiple RCA**
- Met – 87%
- Partially Met – 9%
- Not Met 1%

**One RCA**
- Met 63%
- Partially Met - 9%
- Not Met- 29%
Development and Implementation

1. Creating evaluation tool & process
2. Testing
3. Implementation
4. Results
Implementation

- November 2016
  - Group A
    - (n=4)

- January 2017
  - Group B
    - (n=5)

- February 2017
  - Group C
    - (n=5)
FACILITATOR EVALUATION PRACTICE
Healthcare Performance Improvement
Safety Event Classification

A deviation from Generally Accepted Performance Standards (GAPS)

- **Near Miss Safety Event**: A deviation in GAPS that does not reach the patient (the error is caught by detection barrier or by chance).
- **Precursor Safety Event**: A deviation from GAPS that reaches the patient and results in minimal harm or no detectable harm.
- **Serious Safety Event**: A deviation from GAPS that reaches the patient and results in moderate to severe harm or death.

Safety Event Classification Pyramid
Adapted from: Healthcare Performance Improvement, LLC. Copyright 2010
Date:  May 30, 2018
Patient Name:  Rhonda Jones     Date of Birth:  4/22/41     Age:  77

Unit:  5-5 (General Medical Floor)

Narrative:
Patient received medications intended for another patient (Sarah Johnson).  RRT called. Patient intubated and transferred to MICU.
Preliminary Investigation

From the patient record:

• Patient was being admitted for changes in mental status and rule out sepsis from urinary tract infection.

• Shortly after arrival from the emergency department, R. Jones received 2mg of IV dilaudid. No order for this medication was in place for this patient at the time.

• Approximately 20 minutes after the documented dose; the patient was found by the RN, unresponsive to verbal stimuli, hypotensive with shallow respirations.

• Vital signs: HR 110 RR 12 BP 82/40. RRT was called.
• The patient was intubated; started on neosynephrine for blood pressure control and transferred to ICU.

• 24 hours after the event, the patient is extubated and the neo has been discontinued.
Preliminary Investigation

From the unit manager:

• Sally, the nurse who administered the medication to the incorrect patient was covering her peer, Karen.
• Karen had to leave the unit to administer a medication to another patient in CT Scan.
• The medication was intended for patient Sarah Johnson who was in the next room.
• Sally said she scanned the medication and the patient’s bracelet at the computer in the hall. She walked into the incorrect room and asked the patient “Are you Sarah Johnson”. The patient (R. Jones) answered yes and the medication was administered.
• The error was discovered when Sarah Johnson called to request her pain medication for the second time.
• Sally was hired as a new grad and has been on the unit for 9 months; off orientation for 6. There has not been any concern related to her performance to date.
• Karen is a senior nurse who orients the majority of new staff and is seen as the informal leader on the unit.
PRACTICE: Initiation of a Root Cause HPI Safety Event Classification

Did the deviation reach the patient?

- YES: Did the deviation cause moderate to severe harm or death?
  - YES: Serious Safety Event
  - NO: Near Miss Event
- NO: Not a Safety Event

- NO: Was there a deviation from generally accepted performance standards?
  - YES: Serious Safety Event
  - NO: Near Miss Event
Evaluation
Initiation of RCA
Volunteers?
Evaluation: Interview Skills
Evaluation

Interview Skills
Mock Interview & Feedback
Development and Implementation

1. Creating evaluation tool & process
2. Testing
3. Implementation
4. Results
Aggregate scores: 63% - 96%

Top four areas for improvement:

- Writing inappropriate act statements
- Corrective Action Planning
- Creating a process map
- Interview Skills
Top Challenges & Next Steps

- **Inappropriate Act Statements**
  - Review criteria
  - Practice sessions
  - Direct feedback r/t CCA coding

- **Corrective Action Planning**
  - Continued through SERC

- **Process Mapping**
  - Review required elements
  - Format template
  - Small group practice sessions

- **Interview Skills**
  - Formalize Second Victim Assessment & Referral
  - Interview Training
“Every problem is really an opportunity. Every system defect, a treasure.”

Kitchiro Toyoda
Toyota Founder
Questions?
thank you!