2016 NCSBN Discipline Case Management Conference **- Root Cause Analysis and Action: A Blueprint for Prevention of Harm**
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Event
2016 NCSBN Discipline Case Management Conference

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Presenter
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- [Patricia] It's a delight to see you here today. Thank you, Kathy, for that great introduction. It was short. That always makes it great. I want to spend a few moments just telling you... First of all, how many of you know the National Patient Safety Foundation? Raise your hand if you're familiar with us. Okay. So probably about half of the folks in the room. We're a small nonprofit. We've been in existence since 1997, and we're based out of Boston, Massachusetts. And our role is, as Kathy noted, to create a world where patients and those who care for them are free from harm. We added the "and those who care for them" in 2014, when we updated our strategic plan. Because the caregivers, whether they be professional caregivers or family caregivers, have so many issues and are not well cared for. We can't have safe patient care if our workforce, and if those who are caring for patients outside of the workforce, are not properly cared for. So there's a lot of information that we have on our website. It's www.npsf.org. A lot of resources, including the report that I'll be talking about today, which I encourage you to take a look at, and as Kathy described, it is an advance in the way that we're looking at understanding why things go wrong in the healthcare setting. How many of you who are here today are nurses? Okay, maybe I'll flip this. How many are not nurses? Oh, wow. I might be confused. I know it's early. But I didn't see the proportionate amount of hands up or down. Are some of you double-teaming this morning? Okay. That may be the case. I'm very proud to be a nurse, and I've had a lot of opportunity in my career, as you have, to take on new roles in nursing. I'm also proud to say I have a daughter who passed the NCLEX exam a few years ago. Unfortunately, she's chosen a career coaching college lacrosse instead. So I'm trying to work on getting her a job if anyone is out there looking for really good folks to join the nursing profession. But I do want to thank the National Council of State Boards of Nursing. We've been partners for many, many years. They've been a part of our Patient Safety Coalition, which is a group of organizations that come together to help us advance patient safety. We've endorsed the Multistate Licensure Compact, and likewise the National Council of State Boards of Nursing has endorsed the report that I'm going to share with you today. I will be digging into that for just a moment. So the title of our report is really kind of characterizing this new blueprint that we have on how to understand why things go wrong, and really to

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prevent them from happening again. Kathy asked about initials. You see the CPPS up there. One of the programs that we actually have is a certification program for the Certified Professional in Patient Safety. For many of you who are in tune with the safety movement, you'll see that safety is really becoming a profession in and of itself. I'd like to start off by talking to you about some important things that are going on. How many of you went to dinner last night? Most of you in the room. That was a really great dinner. Did you see the front page of the USA Today? Okay. Guess what? The Navy is banning alcohol in Japan. Banning alcohol in Japan. So not in Norfolk, thankfully, but in Japan. A couple of other things that have been going on is it's raining out. Our audio/visual man didn't know this morning that it was raining out. But I know that many of you probably looked out and saw the skies. Other interesting news, guess what happened to Mark Zuckerberg from Facebook? He got hacked. Isn't that awesome? Mark Zuckerberg did not follow the instructions from Facebook to change his password. Do you know what his password was? "Dadada," that is such a guy thing, such a parent thing. A dad has to always believe that the first thing his kid is going to say is "dadada." Most of us know that it's "mamama," and so I find that interesting. Then, the other important thing that I thought you should know, if you haven't already heard, is that we know that Twinkies came back. Right? How many of you eat Twinkies? You're so lying. So lying. Well, guess who bought the Playboy Mansion? The person who owns Hostess Cupcakes, in part because of that takeback of Twinkies. So for all of the folks who brought Twinkies back, we've been able to see the legacy of the Playboy Mansion now continue on and I'm sure that that's really meaningful for all of you. The other thing that happened this morning... Almost always when you talk and when you travel a lot, and people like Kathy know this, you almost always have great material to talk about to open up the talk. I was coming down to Norfolk, I had a relatively uneventful trip. So I actually looked at a story that came up last week I'm going to share with you. But I did have this moment this morning, and I think it's really important for case discipline people to know about it, because it has to do with a discipline that my daughter needs to receive when I get home. She's 23 years old. This is not the nurse. This is the criminal justice major. She also coaches lacrosse. I'm really glad I put both of those kids through college. But you may notice as I'm walking around, a little problem, besides the toe cleavage in my shoes. I actually don't have my black shoes. My daughter took them out of the suitcase that I packed on Saturday. So if you see me floating around with shoes that you don't think look good and that should be black, I want you to know they would have been had it not been for her. There's a little need for some case discipline when I get home. I almost thought about putting her text number up on the slide, so you could like send her nasty texts. But the material that I did prepare for you is something that really I found on the internet. I get alerts every day. Many of you probably have Google Alerts set. You might search your kids, for example, which I do. I have a Google Alert set for all three of them, and that's always interesting. But thanks to Al Gore, if something weird doesn't happen to you, you only have to go on the internet and find something that might be of relevance to your talk. So I want to tell you about something that happened last week in New Hampshire. Who's here from New Hampshire? I saw some... Okay, two people from New Hampshire. Am I missing anyone from New Hampshire? Okay, good. You may have seen this. So last week, I got a safety alert and it's a rather unusual one. The New Hampshire Department of Transportation declared that there was no one hurt in a tollbooth accident that occurred on the 31st of May, which is good because this is what the accident was. Since I know you're all into understanding why things go wrong and how things go wrong, I thought you would enjoy this. I thought you would

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mean, this is a human behavioral approach that we actually have. Here's a quote from a woman who's a business professor at Harvard. She says, "In fact, if it's sweet to be right, then let's not deny it. It is downright savory to point out when someone else is wrong." This is so true, but it has been so much of a handicap for us in being able to advance our understanding of why things go wrong, and to address those issues that are causing things to go wrong. Because boy, it's always like pointing that finger is part of the DNA, I think, of people that are educated in the healthcare arena. And we are hardwired to remember and think about the negative. We think a lot about errors we've made. How many of you've ever made an error in your clinical practice? Okay. So for the record, for those who aren't looking around the room, that's a good half of the room. I will say, the error I made... Who's from Massachusetts? Okay. All right. You don't know my name. You don't know my identity. But this was a long time ago. I actually made an error when I was supervising student nurses in a clinical setting, when I oversaw the student drawing up and administering the wrong antibiotic, a lookalike, soundalike antibiotic. I was a new graduate of the master's program, I was teaching, I was working full-time in a hospital, I was working full-time in my academic setting, and I was also taking doctoral classes. I never told this story until about two and a half months ago, when I spoke to a class that was being inducted into the National Nursing Honor Society. I had to tell them stories. We couldn't use slides. The story that I told for the very first time in my career was how terrible I felt when I made that mistake. It was an error that I know I made, and I didn't go to work that day intending to make it. I also didn't go to work that day understanding the impact of fatigue. I worked 12 hours, 7 p.m. to 7 a.m., went down the stairs to the same hospital, to the clinical setting, supervised students for seven hours. Honestly, from what I knew and what I've learned in patient safety, I really now can look back on that event and kind of do a root cause analysis on that, that I would not have been able to have done back then. What happened when we made mistakes in healthcare a couple decades ago? What would you do? What would you normally have to do? You'd fill out an incident report. Right? You'd fill out an incident report. That's what happened with me. Went in, stopped the infusion right away, and made sure that the patient was okay. Went with my tail between my legs to the nurse manager and said, "What am I going to do?" I was sure I was going to be fired from my academic job. I was sure I was going to be fired from my job, because I was teaching in the same setting I was working. I was sure that I should not belong in nursing, that I did not belong in nursing, and I was devastated for months, years. Even when I told the story a couple of months ago, I still felt

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and that again is a full report with a full set of tools, by the way, which you can use, it's freely available. In order to help understand, how we can make accident investigation or adverse events analysis go more smoothly. We did receive a grant from the Doctors Company Foundation, they're a malpractice insurer. And I do want to just clarify that they had no bias. They had no influence or content over the report. And by the way, they have continued to fund this next phase of the report that Kathy mentioned earlier today. Where, we're working on a

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organizations that don't use Just Culture Models to determine whether or not there was intentional egregious reckless behavior that was going on, as compared to something that happened because of a human error that quite frankly was probably propagated in many ways by a lot of the environmental factors that are going on in this system. The RCA2 report takes a really firm stance on getting the analysis and the investigation going, immediately. And, obviously, the first thing that we need to do when something goes wrong, is to take care of the patient and the family. And ensure that their immediate needs are met. But we do strongly suggest that the review process being started within 72-hours, using the risk-based prioritization matrix as a first step. And that it be completed within 30 to 45 days. And some people complete it within 30 to 45 days, as many organizations require. But the quality of their completion isn't always quite so strong. We're going to talk about the team in a minute. But I just want to mention here, in terms of timing, again, that this is not something that you just randomly pull a team together to investigate. Organizations, really, should have plans in place for deciding who's on that team, and ensuring that there is protected time, and that there are scheduled meetings that are in place if those meetings don't need to be held. If there have not been any events, that's fine. If an event does occur there are several meetings that are likely necessary to take place for the core team to do their work. And the team membership, overall, is a core team in the view of our RCA2 recommendations with fairly dedicated people. There can be some transition to this core team that does the actual review, depending upon the nature of what the event was that happened. We encourage that these team members have a fundamental knowledge of the subject area, and root cause analysis process. Not everyone needs to have the same skill set. You don't want everyone having the same skill set coming to the table. Conflicts of interest need to be minimized. So lots of times people will say, "Should the staff member or the manager of the staff member be involved in the RCA2 process?" And our advice is: No, because...inherently they should be interviewed, but not involved on the core team because of the inherent bias, which is very, very real. We encourage the teams to be capped to about six or so team members. The team lead needs to be experienced and skilled. And, again, this is something that needs to be designated and developed as part of the real work that needs to go on within an organization. There's a lot of questions that we get about patients and family members. And whether or not patients and family members should be involved in the RCA2 process? And we do believe, as this publication notes, that when properly handled involving patients and family members in RCA2 or post event analysis can, in fact, be very helpful. And it really is an important part of the RCA team and those who are involved in caring for the patient and family, to determine whether or not the patient and family member is willing and able to provide information. Because, it's so important. They see so many things that we don't normally see in the course of care, that can contribute to us making improvements, and addressing fracture lines and fault lines that exist within the organization. We do emphasize and we do believe that, whenever possible a patient representative should be included on the RCA2 team. So I don't know how many of you have ever worked with someone, for example, who's on a Patient and Family Advisory Council. But as we look at the sophistication, and the vision, and the capabilities of what patients and family members bring to our ability to improve the safety of care, they can be massive contributors. How many of you know of the Betsy Lehmann story that occurred in the state of Massachusetts? Massachusetts

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this is public information at the Dana-Farber Institute, which is as many of you know, is just a premier cancer center. Today, the Dana-Farber Institute has over 100 committees. And every single one of their committee's has a patient and a family member on those committees. They are phenomenal contributors. If a patient and family member hasn't shown up for the meeting, the meeting doesn't start without them. They're considered to be that vital. And many other organizations like the Dana-Farber have figured out ways to really meaningfully include patients and family members into the work of improving safety and quality of care. And that doesn't count: Where do we put the flowers in the lobby? That's not a meaningful contribution for a patient and family member. The report includes examples of different types of team members, and what their role could and should be in either the interview process or in serving on the core team. And you will see that we do in fact note that families and the patients who are involved in the event can and should be interviewed to the extent possible. But they really should be on the core team. But the patient representative, if at all possible within organizations, should be. How many of you have public members on your boards? Okay. Yeah. So you know what I'm talking about, when I talk about patients, and family members, and the public. However, when I go back to that survey...and the cartoon on the right says, "I have metal fillings in my teeth. My refrigerator magnets keep pulling me into the kitchen, and that is why I'm overweight." Do you guys have fridge magnets in you? So really, we do know that patients and family members can contribute a lot. But in the survey that we just did, when we ask people, which components of the RCA2 process are you likely to implement? Nearly all of them were rated very high, in terms and the likelihood of implementation. But look at the numbers. Engaging patients and family members in process: only 18%. And providing feedback to patients and family members after completion of the process where a patient has been harmed: only at 27%. You feel good about those numbers? We've got some good work to do on that. This can be one of the import elements of our next webcast series. We have an interviewing secession going on, I know, after this section. The, I-know-a-guy team, over here, for you guys going will spend a lot of time on interviewing, best practice, and successful practices. And we do outline tips for interviewing in our report in appendix three. The goal,

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acknowledgment that anything was wrong. And they don't receive an explanation of how it's going to be prevented in the future. And this is critical work for the learning of an organization. And it's critical work for ensuring that, as we look at things that go wrong, that we're thinking about all of the players that are involved in these situations, and treating them with the respect and the engagement that they deserve. And other things include, and you'll hear about this in the interview session if you're going to it. You've got to be a good interviewer. If someone's going to be in scrubs and you're going and interview them, you don't go in with a black tie suit. And you don't call people into the carpeted areas of the hospital, because you have to interview...am I right on this I-know-a-guy people? Okay. You want to interview them in environments that are safe and comfortable for them. And you want to ensure that the tone of the questions that you're asking is balanced and is focused on understanding. And that you thank people for being a part of that investigation. Causation is something that sometimes is short-circuited, I would say to put it nicely, when we have accident investigations. Lots of times people will say... I'm going to show you an example on this. "I found out the reason why it went wrong..." And then the whole investigation stops there. There are a lot of tools and resources in the report to help improve...and I believe, even in your roles, although you're not doing root cause analyses in the clinical care environment. I think there's some good things that you can take back into practice. Because, they can really improve the way we understand how things go wrong. There are causal diagrams that are shown in the report. And there is always the

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