Agenda Item:6.2
Meeting Date: October 19 - 20, 2006
Prepared by: M.B. Thomas

Report of the Health Alliance Safety Partnership

Summary of Request:

This report is to update the Board on the current status of the Patient Safety Pilot - Health Alliance Safety Partnership as authorized under the Texas Occupation Code Section 301.1606.

Background Information:

Attachment “A” is the Error Review Action Plan for two incidents that have been reviewed by the Event Review Committee (ERC) since the last written board report. Both action plans outline multiple factors that the committee believes contributed to the error events.

The Health Alliance Safety Partnership conducted its first ERC meeting in August, 2006. Attachment “B” provides a descriptive analysis of the cases that have been reviewed in the first year of the program. As more data from the pilot is collected, methodologies to investigate the relationship and significance of these factors will be explored.

Staff Recommendations:

None. This report is for information only.

Event Review Action Plan for HASP Report 20060517

Agenda Item: 6.2
Attachment A
Prepared By: M.B. Thomas

Institution – 200600517			
Theme / Issue	**Evidence from HASP review**	**Action Plan Suggestion**	**Action Plan Return Date**
1. Blood retrieval, verification, and administration process	Retrieval, verification, and administration of blood products is a high risk, complex procedure.	a. The Committee recommends that the Institution examine the hand off process between blood bank and nursing and consider requiring a formal verbal and written verification process to ensure correct unit is obtained. b. The Committee commends the institution for the changes already made to the infusion record. c. The Committee recommends that the Institution consider adding a checklist to the blood verification process and infusion form. For example, there are outlined process steps at the top of the form. Would making these a checklist facilitate compliance with the steps? d. The Committee recognizes that the policy was altered to require that the verification process be restarted from the beginning when interrupted. It recommends that the Institution also considered adding a similar statement to the infusion record. e. The Committee suggests that the administration of blood products can carry the potential for significant adverse outcome and recommends that the Institution consider the benefits or drawbacks of incorporating a “three-way, two-person check” as described in H. Kaplan article, “Getting the right blood to the right patient: the contribution of near-miss event reporting and barrier analysis.” (Kaplan, 2005) A copy of the article is included with this action plan. f. The Committee asks, if would it be helpful to consider using the face sheet, armband and transfusion request form (triple side by side) at the same time?	12/11/2006

Institution – 200600517			
Theme / Issue	**Evidence from HASP review**	**Action Plan Suggestion**	**Action Plan Return Date**
		g. The Committee notes that having blood product requisition forms prestamped with patient identifiers in the unit may contribute to the possibility that the incorrect form is pulled or filed in the wrong record.. a. Should the form be stamped prior to need? b. Should it be hand labeled?	
2. Staffing	Complex, critical patients with the potential for sudden changes in condition.	A. The Committee recommends that the institution examine allocation of staff resources. What provisions are in place to ensure staff resources can be modified to address patient complexity and changes in patient condition, especially in the case of immediate issues? a. Who would have intervened if both patients were trying to get out of bed? b. Has the institution looked at the staffing model is applied? Is an adequate skill mix available? c. Where can a staff member get help if colleagues are busy?	12/11/2006
3. Culture / Climate	The Committee questions the appropriateness of a 90 day suspension in a situation that resulted from multiple systems and human factors issues.	A. The Committee recommends that the Unit's nursing leader complete David Marx's Just Culture training. a. After completion of the training, please consult with the Institution's HASP representative to consider the appropriateness of punishing unintentional acts and the consequences of hard rule discipline on safety. B. The Committee recommends that a summary of the Just Culture training concepts be presented to nursing leaders and management. C. The Committee also recommends that an analysis of practice environment, specifically related to disciplinary action, surrounding this event be completed, shared with staff and, as appropriate, action plans be developed to address any issues identified.	12/11/2006

Event Review Action Plan for HASP Report 20060517

Institution – 200600517			
Theme / Issue	**Evidence from HASP review**	**Action Plan Suggestion**	**Action Plan Return Date**
4. Distractions / Interruptions	The patient care unit is open, noisy and does not facilitate limiting distractions and interruptions during critical care processes.	A. The Committee recommends that an environmental assessment be conducted in the patient care unit to determine if there are cost effective actions that could limit the distractions and interruptions that occur during critical tasks in this unit? B. The Committee asks if there is a method of filtering or screening patient requests/needs through personnel other than the registered nurse that could be employed in this unit in order to decrease non-scheduled demands?	12/11/2006
5. Proactive Intuitional response	The Institution has taken several steps to address the systemic issues related to this event.	A. The Committee commends the Institution for taking steps to empower staff to by including red rules and process modifications in policy to encourage staff to take an active role in ensuring patient safety. B. In addition to those process steps, the Committee suggests the Institution may consider additional activities and policies be changed to empower staff to stop a process when an unsafe situation is detected.	12/11/2006

Kaplan, H. S. (2005). Getting the right blood to the right patient: the contribution of near-miss event reporting and barrier analysis. *Transfus Clin Biol, 12*(5), 380-384.

Event Review Action Plan for HASP Report 20060517

Nurse - 20060517

Theme / Issue	Evidence from HASP review	Actions to be taken / Changes to be made	Action Plan Return Date
1. Human Error	In addition to other failures noted in the system, a breakdown occurred when the patient's armband was not checked with the face sheet..	A. The institution is encouraged to allow the reporting RN to actively participate in operationalizing the "three-way, two-person check" (Kaplan, 2005) into the Institution's policy on Transfusion of blood products or other quality/safety improvements in this patient care area. The article is included with this action plan. B. The reporting RN is encouraged to complete the David Marx Just Culture training to provide a framework about Human Error for incorporation in staff inserviceing/story telling that is already planned.	12/11/2006
2. Active participation in the resolution of this event.	Your report and willingness to discuss this event with your peers.	A. You are to be commended for your willingness to report, to participate in the HASP program to identify lessons to assist other nurses in the future and for initiating peer training surrounding this event. B. The Committee notes that this event may present emotional / psychological issues that need to be addressed. You may wish to seek EAP / other assistance to resolve any outstanding issues related to this event, if desired C. Please note that members of the Event Review Committee would be happy to meet with you at any time to discuss this event and the systems and human factors that lead to its occurrence. If this is of interest at any time, please notify the HASP team.	None Required

Kaplan, H. S. (2005). Getting the right blood to the right patient: the contribution of near-miss event reporting and barrier analysis. *Transfus Clin Biol, 12*(5), 380-384.

Event Review Action Plan for HASP Report 20060323

Institution – 20060323			
Theme / Issue	**Evidence from HASP review**	**Action Plan Suggestion**	**Action Plan Return Date**
1. Busy, crowded unit contributes to environmental distractions	- Observation and Interviews - Please note photographs provided.	A. Conduct an environmental assessment to assist in balancing the pediatric social and developmental needs of patients and the needs of staff to care for patients without interruption or and distraction that can decrease concentration. B. Examine/evaluate the amount of displayed information and clutter on the walls to see if a decrease can assist in information retrieval and decrease overload.	11/1/2006
2. Documentation	Tremendous volume of information included in the chronic patient's chart.	A. Reassess medical record structure – seeking "best of practice" in hospital based outpatient hemodialysis unit documentation structure. The amount of information and the inaccessibility of necessary information may be a contributing factor. B. Develop systematic review/renewal of orders with physician (monthly/weekly/quarterly) • Consider reliability and visibility of standing orders in an outpatient unit.	11/1/2006
3. Illegible handwriting	Note orders dated 1/30/06, 2/6/06	A. Is there are requirement in medical staff bylaws requiring legible handwriting? The ERC recommends this be reviewed.	11/1/2006

Event Review Action Plan for HASP Report 20060323

Institution – 20060323			
Theme / Issue	**Evidence from HASP review**	**Action Plan Suggestion**	**Action Plan Return Date**
4. Continuity of Care	- There are 3 attending physicians listed in this medical record. - Patients do not always have the same nurse or physician.	A. Please review the medical responsibility for this patient to consider continuity of care. B. Is there a way to cue staff that there is a variation from the normal patient care activities involved in dialysis? For instance, is giving blood outside of the normal care process and if so, should there be some sort of alert to notify the nurse? C. What is your process for hand off communication – Is this an opportunity to require a 'team huddle' / rounds to prepare for each set of patients? D. Please review National Patient Safety Goals for 'Time Out' requirements. Should there be a time out with a physician at the beginning of this procedure? Should the patient be involved based on developmental capability?	11/1/2006
5. Work hours – Fatigue	- Interview • Many nurses work 2 jobs. • No float pool to call on when census is high.	A. Please evaluate the frequency of nurses in this unit working more than 40 hours per week. B. Please examine creative methods to staff the unit to eliminate nurses working more than 40 hours. C. Assess patient load assigned to per diem nurse.	11/1/2006

Event Review Action Plan for HASP Report 20060323

Institution – 20060323			
Theme / Issue	**Evidence from HASP review**	**Action Plan Suggestion**	**Action Plan Return Date**
6. High Risk / Low Frequency Procedures	Interviews • Hemodialysis and transfusion of blood products are both high risk procedures	A. What is the frequency of competency assessment of staff for transfusions and other high risk/low frequency procedures? • Is premedication included in the transfusion competency checklist?	11/1/2006
7. Age Appropriate Care	Record review _ • Patient is 16 years old and in 9th grade per 1/2006 history and physical.	A. Work with this patient to educate her on speaking up about her healthcare. B. Do the nurses adequately assess the developmental level of the patient to assess the ability of the patient to be included in their own care?	11/1/2006
8. Proactive Actions	Interview • Funds have been budgeted for EMR in hemodialysis.	A. The ERC acknowledges the difficulty of maintaining records in this area and commends the institution has made an effort to implement for an electronic medical record for the Hemodialysis unit. The ERC encourages the institution to move ahead after adequate analysis of current infrastructure.	na

Event Review Action Plan for HASP Report 20060323

Nurse - 20060323			
Theme / Issue	**Evidence from HASP review**	**Actions to be taken / Changes to be made**	**Action Plan Return Date**
1. Professional Development	Interview • Patient was apparently not active in her own care. • Very complex patient with significant variation from usual patient/diagnosis/treatment.	A. Please develop a case study with the unit CNS based on this case, in order to share what you have learned. This will help others who face similar problems. B. Ask the CNS to incorporate this into the orientation of nurses for this unit	11/1/2006
2. Professional Accountability	Your report.	A. The ERC commends you for bringing this case to the Healthcare Alliance Safety Partnership. B. The ERC acknowledges and commends you for efforts to collaborate with your supervisor and team members to seek assistance when care is in question. We encourage you to continue that seek assistance when faced with an uncertain situation. C. The ERC acknowledges that you recognize the value of a routine in patient care. We encourage you to continue with your routine even when you collaborate with your peers.	na

Healthcare Alliance Safety Partnership

Attachment Two

Annual Report -2006

In the calendar year 10 cases have been submitted to the HASP pilot from the Texas Medical Center Hospital program.

- Five cases were accepted to the program and undergone review by the ERC.
- Others excluded, did not meeting criteria for the program.
- Cases have been reviewed by the Board's liaison and staff.

Case	**20050721**	**20050722**
Date of Event	6/13/05	6/13/05
Date of ERC	8/29/05	8/29/05
Final Review	Pending completion of monitored practice	

Contributing Factors Identified:

Technical Factors	2
Organizational Factors	48
Human Factors	14
Patient Factors	11

Case	**20050818**
Date of Event	8/3/05
Date of ERC	10/24/05 rescheduled from 10/13
Final Review	cased closed 02/06

Contributing Factors Identified:

Technical Factors	8
Organizational Factors	7
Human Factors	12
Patient Factors	1

Case	20051128
Date of Event	8/3/05
Date of ERC	1/27/06
Final Review	05/06 case closed

Contributing Factors Identified:

Technical Factors	5
Organizational Factors	12
Human Factors	7
Patient Factors	6

Case	20060323
Date of Event	2/06
Date of ERC	7/06 rescheduled from 6/22
Final Review	Pending (nurse completed , institution pending 11/11/06)

Contributing Factors Identified:

Technical Factors	23
Organizational Factors	32
Human Factors	24
Patient Factors	9

Case	20060517A
Date of Event	3/06
Date of ERC	8/24/06 rescheduled from 7/24
Final Review	Pending (nurse 12/11/06 and institution 11/11/06)

Contributing Factors Identified:

Technical Factors	4
Organizational Factors	26
Human Factors	14
Patient Factors	08

Significant Program changes during first year:

1. Simplified the institution response form to help categorize action plans
2. Standardized the interview questions
3. Condensed the literature search and gave relevant quotes
4. Added 2 executive advisory members :
    a. David Marx, Just Culture Community
    b. Capt Bruce Tessmer , Continental Airlines