



WPSC Teleconference Avoiding Never Events

Linda Furkay, PhD, RN
Patient Safety Adverse Event Officer

WPSC Teleconference Avoiding Never Events

Share—

- Findings from adverse events—surgical errors, pressure ulcers, & falls
- Successful patient safety strategies here in Washington & from other states

WPSC Teleconference

Avoiding Never Events

- **Medical mistakes are a big deal and are getting bigger**
 - IOM Report *To Err is Human* (1999)
 - Increasing press coverage
 - Growing public awareness
 - Trend to deny payment for never events

WPSC Teleconference

Avoiding Never Events

- Adverse Events are preventable medical errors that result in patient death or serious disability
- Adverse Event Reporting Systems
 - Promote quality improvement in facilities
 - Enhances open and honest conversations
 - Support learning, sharing information, and identifying best practices

WPSC Teleconference

Avoiding Never Events

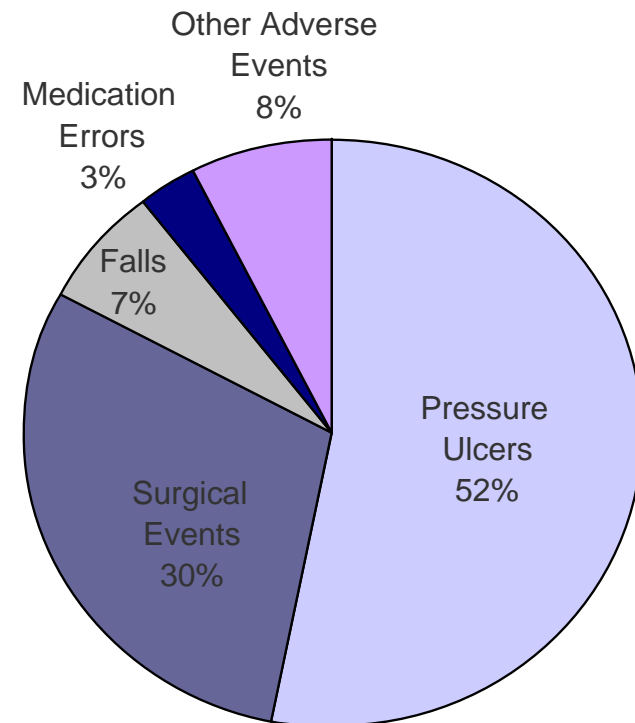
- Never Events
 - 2001 National Quality Forum (NQF) in reference to shocking medical errors that should never occur
 - Adverse events are usually preventable and result in death or disability
 - 28 NQF Serious Reportable Events
 - Never events are now known as adverse events, serious reportable events, adverse health events, and patient safety work products



WPSC Teleconference Avoiding Never Events

Notification of Adverse Events

- Total of **603** events reported from June 2006 to June 2009
 - 315 – Pressure Ulcers
 - 182 – Surgical Events
 - 40 – Falls
 - 18 – Medication Errors
 - 48 – Other Adverse Event Types



WPSC Teleconference Avoiding Never Events

- Current Work of Adverse Event Program
 - Evaluate Root Cause Analyses & Action Plans
 - Provide Consultations & Training

WSPC Teleconference Avoiding Never Events

- 450+ Root cause analysis and action plans have been reviewed
- The Root Cause Evaluation Tool ¹ completed each time

Reference:

1. Adapted from Joint Commission Sentinel Event Methodology and Maryland Department of Health & Mental Hygiene, Office of Health Care Quality



WPSC Teleconference Avoiding Never Events

What Have We Learned from Adverse Event
Reporting?



WPSC Teleconference Avoiding Never Events

General Findings

WPSC Teleconference Avoiding Never Events

■ Findings

■ Composition of RCA Team

- Team often developed by Nursing Department
- Lack representation from physicians, biomedical, pharmacy, operations
- RCA teams provide an opportunity to create a “culture of safety”
- Organization endorsements for RCA team inconsistent

WPSC Teleconference Avoiding Never Events

- Findings
 - Developing Action Plan
 - Findings are often vague and are not recorded as root cause/contributing factors
 - Findings must be very specific in order to plan an effective action plan
 - Actions proposed vary in effectiveness—often memo's, changes in policies & procedures are planned which are activities that are generally weakest or intermediate strength
 - Correction plans often do not assign responsibility to a specific person
 - Completion dates for correction plans often missing
 - Monitoring schedule indeterminate

WPSC Teleconference Avoiding Never Events

Surgical Events



WPSC Teleconference Avoiding Never Events

- **Key Findings & Strategies from RCA's**
 - Wrong Sites
 - Time-Outs
 - Other
 - Retained Foreign Objects

WPSC Teleconference

Avoiding Never Events

- **Corrective Strategies from RCA's—from WA & MN**
 - Wrong Sites, TO's & Other Causes
 - Medical staff protocols re: establishing site location
 - Staff in all procedure areas follow TO protocol
 - Assign accountability to one staff position description
 - Mandatory check lists for different procedures

WPSC Teleconference

Avoiding Never Events

- **Corrective Strategies from RCA's—from WA & MN**
 - Wrong Sites, TO's & Other Causes
 - Briefing all staff about procedure
 - Cover instrument tray prior to procedure until TO completed
 - Clear guidelines for pre-operative documentation

WPSC Teleconference

Avoiding Never Events

■ Corrective Strategies from RCA's

■ Retained Objects

- Implementing policies to measure guide wires pre & post procedure
- Manage distractions by limiting OR personnel in room to essential staff
- Provide staff training re: new devices
- Clarify policy re: items required to be counted

WPSC Teleconference

Avoiding Never Events

■ Corrective Strategies from RCA's

■ Retained Objects

- Replace policy with clear guidelines for pre-operative documentation
- Replace devices with tips that break or when it is hard to differentiate tip from the device
- Counting policy requires that each sponge be counted individually
- All instruments and equipment counted and accounted for

WPSC Teleconference Avoiding Never Events

Pressure Ulcers



WPSC Teleconference

Avoiding Never Events

■ Corrective Strategies from RCA's

■ Pressure Ulcers

- Establishing pressure ulcer prevention groups to review all cases looking for common causes
- New standardized documentation strategies developed
- New training plans developed

WPSC Teleconference

Avoiding Never Events

■ Corrective Strategies from RCA's

■ Pressure Ulcers

- Communication plans for safe hand-offs
- Decision making algorithms developed to guide choices about treatment and equipment
- Implementation of processes for toileting, positioning and pain relief for patients every two hours

WPSC Teleconference Avoiding Never Events

- **Corrective Strategies from RCA's**
 - Aggregate Reviews for Pressure Ulcers, Falls, and Surgical Events

WPSC Teleconference

Avoiding Never Events

■ Minnesota

- In 2007, the Minnesota Hospital Association launched The SAFE SKIN Campaign against pressure ulcers
- Website:
<http://www.health.state.mn.us/patientsafety/>

WPSC Teleconference Avoiding Never Events

Falls



WPSC Teleconference

Avoiding Never Events

- **Adverse Event Causes-Key Findings from RCA's**
 - **Falls**
 - Communication about fall risk not reported across shifts & units
 - No procedure in place to document which fall prevention elements were in place
 - No decision tools to guide choices of fall prevention interventions to use

WPSC Teleconference

Avoiding Never Events

- **Adverse Event Causes-Key Findings from RCA's**
 - **Falls**
 - No protocol available to guide interventions after a fall
 - Revisions in fall prevention protocol not adequately communicated to staff
 - Fall risk assessments and/or interventions not adjusted with change in patient status
 - Equipment shortages such as gait belts

WPSC Teleconference Avoiding Never Events

■ Adverse Event Causes-Key Findings from MN

■ Falls

- Patients were not appropriately placed at high risk, the risk was not adequately documented or communicated, or the risk reduction interventions weren't match to the patient's individual risk factors or were not consistently applied
- Majority of falls happened enroute to the bathroom or when patients were in the bathroom
- Slightly higher percentage occurred at night suggesting that sleep meds, drowsiness/disorientation, or lighting were factors

WPSC Teleconference

Avoiding Never Events

■ Minnesota

- In 2007, the Minnesota Hospital Association launched The SAFE FALLS Campaign against patient falls
- Website:
<http://www.health.state.mn.us/patientsafety/>



Thank You!

Linda Furkay, PhD, RN
Patient Safety Adverse Event Officer
Adverse Event Reporting Program
Office of Community Health Systems
WA Department of Health
360-236-2875



linda.furkay@doh.wa.gov