

HealthEast Root Cause Analysis Summary

Level of Analysis	Questions/Factors involved	Findings and Opportunities to Improve
What happened:	<i>What departments were involved?</i>	Nursing, Respiratory Therapy
Why did it happen: (Proximate cause)	<i>What was the missing or weak step in the process?</i>	62 year old female with history of CHF was admitted from the Emergency Department with Left Lower Lobe Pneumonia. She has been living independently at home with no assistance needed with cares. She was complaining of pain with inspiration, vital signs were normal, oxygen saturation was 90% on room air. On hospital day 2, she was found on the floor at 2345 in severe pain. X-rays revealed a hip fracture. The next day she was taken to surgery for repair. During surgery she had an AMI and expired while on the table.
Why did that happen?	<i>What caused the missing or weak step in the process?</i>	Inconsistency in how the falls assessment policy is carried out, lack of direction in the policy on what the staff should do related to the risk, lack of clarity regarding providing a safe environment. 1. Incomplete assessment/re-assessment of risk for falls due to the policy being vague and providing minimal direction resulted in a fractured hip 2. Obstacles in the room caused a hazard and risk for falling
Why did that happen?	<i>What is currently done to prevent failure at this step?</i>	Current policy for falls assessment/re-assessment, although found to need more clarity.
Why did it happen: (Proximate cause)	<i>What was the human error?</i>	The staff knew there was a policy on risk assessment of falls. They indicated they had been educated and had their skills validated, however they didn't think it was helpful and stated they would like more direction than what the policy provides. Risk of falls was assessed and documented on admission. The patient was found to be at very low risk with no issues. No reassessment was documented
Why did that happen?	<i>Was staff performance in the process addressed? Was staff properly qualified?</i>	Staff performance was reviewed and found to be good. Staff were felt to be qualified. There was the usual staffing levels and mix.
Why did that happen?	<i>Can orientation and inservice training be improved?</i>	None identified.

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Why did it happen: (Proximate cause)	<p><i>Was staffing appropriate to provide safe care?</i></p> <ul style="list-style-type: none"> - <i>If no, do you believe that staffing issues contributed to the event?</i> 	Staffing was felt to be good and no additional staff was considered necessary. Additional staffing would not have affected this event.
Why did that happen?	<p><i>Did actual staffing deviate from the planned staffing at the time of the event or during key times that led up to the event?</i></p>	No deviation from planned staffing was identified
Why did that happen?	<p><i>Were there any unexpected issues or incidents that occurred at the time of the event or during key times that led up to the event?</i></p> <ul style="list-style-type: none"> - <i>If yes, did the unexpected issue impact staffing or workload for staff?</i> - <i>If yes, did staff believe this change in staffing or workload contribute to the event?</i> 	No unexpected issues or incidents were identified
Why did it happen: (Proximate cause)	<p><i>Was all necessary information available:</i></p> <ul style="list-style-type: none"> -<i>when needed?</i> -<i>accurate?</i> -<i>complete?</i> 	Report communicated the patient was pleasant and cooperative, asking for help as needed, didn't attempt to get up on her own. RT had documented their adding oxygen, but not the long tubing and did not verbally pass this information on to the nurse
Why did that happen?	<p><i>Is communication among participants adequate?</i></p>	Yes. Communication is felt to be very important. Staff felt communication among them was good.
Why did that happen?	<p><i>Are there barriers to communication?</i></p> <p><i>Is prevention of adverse outcomes considered a high priority?</i></p>	None identified Yes
Why did it happen: (Proximate cause)	<p><i>How did the equipment fail?</i></p> <p><i>What broke?</i></p>	Her oxygen tubing was wrapped around her IV pump. RT had seen the patient and placed the patient on O2 at 2L for wheezing. He gave her extra long tubing as she liked to sit up in a chair. The patient had an IV pump for antibiotic administration. She was in a single room.
Why did that happen?	<p><i>What is currently being done to prevent an equipment failure?</i></p>	Equipment is checked by the department on a regular basis.
Why did that happen?	<p><i>What is currently being done to protect against a bad outcome if an equipment failure does occur?</i></p>	The equipment is taken out of service and evaluated. Equipment is checked and if appropriate reported to Med Watch.

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Why did it happen: (Proximate cause)	<i>What environmental factors directly affected the outcome?</i>	The event occurred in the evening. The room was dark, but the patient had a night light in the bathroom. The patient had been given a sleeping pill and pain medication at 10pm, the same as the previous night and the sleeping pill is the same as she takes at home. When the nurse checked the patient to do vital signs, found her dozing but easily arousable although a little confused when first awakened. The unit was busy but not chaotic. The unit became busy as they just received a fresh surgical patient post operatively. The patient had been incontinent of bed and gown, the floor was dry. They had to move furniture in the room to get at patient as there were extra chairs in the room after her family visited that evening.
Why did that happen?	<i>Was the physical environment appropriate for the process to be carried out?</i>	Yes
Why did that happen?	<i>Are systems in place to identify environmental risks? Are responses to environmental risks planned and tested?</i>	Yes Yes
Why did it happen: (Proximate cause)	<i>Were there any uncontrollable external factors?</i>	The patient was pleasant and cooperative, asking for help as needed, didn't attempt to get up on her own, used the call light.
Why did that happen?	<i>Are they truly beyond the organization's control?</i>	Patient was educated about using call light and had always used it before. Difficult to anticipate when patients will spontaneously get up without asking for assistance
Why did that happen?	<i>How can we protect against them?</i>	Continue with education
Why did it happen: (Proximate cause)	<i>Were there any other factors that directly influenced the outcome?</i>	None identified

Type of Event:

- Patient suicide
- Op/post-op or procedure complication
- Medication error
- Wrong-site surgery
- Delay in treatment
- Patient death/injury in restraints
- Patient fall
- Assault/rape/homicide
- Patient elopement
- Perinatal death/loss of function
- Transfusion error
- Fire

- Skin Integrity breakdown
- Infant abduction/wrong family
- Medical equipment – related
- Ventilator death/injury
- Maternal death
- Death associated with transfer
- Utility system failure
- Anesthesia – related
- Infection – related
- Dialysis – related
- In-patient drug overdose
- Self-inflicted injury
- Other (less frequent)

Root Cause(s) Identified by the RCA Team:

3. Incomplete assessment/re-assessment of risk for falls due to the policy being vague and providing minimal direction resulted in a fractured hip
4. Obstacles in the room caused a hazard and risk for falling

Check categories that apply:

- Behavioral assessment process
- Physical assessment process
- Patient identification process
- Patient observation procedures
- Care planning process/coordination of care
- Staffing levels
- Orientation and training of staff
- Competency assessment/credentialing
- Supervision of staff
- Access to care

- Skin Integrity
- Communication with patient/family
- Communication among care team members
- Availability of information
- Adequacy of technological support
- Equipment maintenance/management
- Physical environment
- Security systems and processes
- Control of medications: storage/access
- Labeling of medications

Patient Name/Number:

Fanny Falls

Date of incident:

1/1/11 Discovery date: 1/2/11

Participants in Root Cause Analysis:

Nancy Nurse, patient's nurse at time of fall
 Glenda Witch, Charge Nurse
 Tim Team, patient's nurse from previous shift
 Richard Aire, Respiratory therapist
 Linda Leader, Clinical Director
 Diane Diesel, Administration

Please list references of literature search:

(articles can be found in the central library)
 See attached bibliography.

Where incident occurred:

St. Elsewhere Hospital, patient room

Date Root Cause Analysis Completed:

1/5/11

Conclusions/Recommendations:

1. Implement the Morse Risk Scoring for assessment/re-assessment
2. Revise policy to include addition of Morse Risk Scoring and assessment on admission with re-assessment every shift and change in condition (which includes pain medications/sleeping pills)
3. Educate staff regarding Morse Risk Scoring
4. Create space on admission assessment form for risk scoring
5. Create space on flow sheet for reassessment/scoring every shift and PRN
6. Talk with RT about leaving shorter O2 tubing for patients to be used while they are in bed
7. Staff are to remove all but 1 chair and de-clutter room with their 10pm rounds

Please attach the associated policies:

(including any newly revised policies)