Sharing in the Name of Patient Safety

ProMedica makes communicating the results of its serious safety event investigations a necessary step in its root cause analysis process.

By Audrey Doyle

Despite the best efforts of medical professionals, errors in the delivery of health care are an everyday occurrence. Most errors are near misses—the error was caught by a detection barrier or by chance before it reached the patient. And many are precursor safety events—although the error reached the patient, it caused minimal or no harm. However, an increasing number of errors today are serious safety events, in which the patient suffered moderate to severe harm or death as a result of one or more preventable errors made in the delivery of their care.

In the wake of a serious safety event, health systems should make root cause analysis (RCA) a requirement to better understand why the event occurred and how to prevent a recurrence, according to safety experts with HPI, now part of Press Ganey. HPI advises health systems to adopt a “three-meeting” RCA model to provide structure to the process.

- **Meeting 1:** Understand what happened.
- **Meeting 2:** Determine why the existing system or process allowed the event to happen.
- **Meeting 3:** Identify and implement changes that can be made to the system or process to keep the event from happening again.

Earlier this year, ProMedica Toledo Hospital, a Press Ganey HPI client, embarked on a six-month pilot project in which it added a fourth meeting to its RCA process.

- **Meeting 4:** Communicate findings not just to the people involved in the event, but to other departments in the hospital as well.

By sharing information on serious safety events and their root causes, ProMedica Toledo helped employees elsewhere in the facility understand how to prevent similar events from occurring in their own systems and processes. By making this fourth meeting an expected part of its RCA process, the hospital reassured staff that they could safely share details regarding serious safety events without fear of recrimination, and encouraged as well as reiterated the importance of a hospital-wide atmosphere of transparency.

The Roots of RCA and the Three-Meeting Model

A method of comprehensive systemic analysis, root cause analysis has its roots in the automotive industry. Credited to Toyota Industries founder Sakichi Toyoda, the method, which focuses on systems and processes as opposed to individuals’ performance, was first used in 1958 to prevent or solve problems in Toyota’s manufacturing procedures. Over the years, different approaches to RCA were developed to meet the needs of a variety of fields, including occupational safety, engineering, business, nuclear power, aerospace and aviation.
Health care organizations became interested in RCA in 1999 when the Institute of Medicine published its landmark report, *To Err Is Human: Building a Safer Health System*, which stated that up to 98,000 Americans die each year from medical errors and that errors can be prevented “by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing.” Shortly after the report was published, The Joint Commission began requiring accredited health care facilities to conduct a comprehensive systemic analysis, such as an RCA, after the occurrence of a serious safety event. Today, RCA of serious safety events is fairly common among Joint Commission–accredited facilities.

To conduct an RCA, within three days of the event’s occurrence the facility should form an interdisciplinary team comprising an executive sponsor, a risk analyst, an operational leader from the department where the event occurred, and, if the type of event warrants it, one or more subject matter experts and additional risk analysts, all of whom have been trained in RCA. “We also believe it’s a good practice to have a physician on the team in cases where the event involved a physician or requires someone with clinical knowledge,” said Craig Clapper, partner and Chief Knowledge Officer at Press Ganey HPI.

The goal of the RCA is always the same: Determine what happened, why it happened and what to do to prevent it from happening again. The three-meeting model is a best practice for achieving that goal. The model consists of five steps.

### Meeting 1
**Step 1: Organize the team and gather data.**
Determine the scope of the analysis and each team member’s role, and then conduct one-on-one interviews with those who were involved in and/or present at the event.

The interviews shouldn’t be accusatory, nor should they be so much historical as forward-looking. As such, the team should ask what happened, when it happened and what or who was affected, but not who they think was at fault. Instead, the questions should focus on what systems/processes they think caused the event and what changes they think should be made to prevent recurrence. “For example,” Clapper offered, “who/what was affected by the event? What steps led to the event? Which of those steps do you think contributed to the event? Why did those steps make sense at the time? What human and/or equipment factors played a role in the event?”

### Meeting 2
**Step 2: Identify the causal factors.**
From the gathered data, determine what events caused the serious safety event to occur and what conditions surrounded those events. Organizations should avoid approaching this task with preconceived ideas as to why the event occurred, Clapper cautioned, adding, “If they don’t go into this with an open mind, they may not uncover the causal factors that are key to avoiding recurrence.”

**Step 3: Identify the root causes.**
Dig deep and ascertain the specific root cause of each causal factor. “The more specific you are, the easier it will be to determine how to prevent the event from recurring,” said Clapper.

**Step 4: Identify hidden deficiencies.**
Reflect on why it took a serious safety event to reveal the problem. “The root causes were already there, so what prevented the staff from identifying them through a near miss or other opportunity?” asked Clapper. The deficiencies could be one or more of the causal factors. “Or they could be latent weaknesses: present, but undetected,” Clapper said; in this case, the team needs to uncover each deficiency that allowed or caused the root cause to result in the serious safety event.

### Meeting 3
**Step 5: Recommend and implement an action plan, and assess its success.**
Draft a detailed plan that includes people’s responsibilities and deadlines, and gain stakeholders’ approval. Then, follow through with the recommended system/process changes, and follow up to ensure that the changes were implemented and that they’ll prevent recurrence.

The RCA and action plan should be completed within a month, plan implementation should be completed within six months, and monitoring and review of the implementation should continue on a quarterly basis for up to a year in order to assess whether the recommendations were followed and were successful. If they weren’t, the team should ask questions such as “Did we misidentify the root cause? Did we come up with the wrong action plan? Did we implement the plan incorrectly?” Then the team should reassess what could be done differently to effect change. “Change is hard, but if you correctly change your processes so they eliminate identified gaps and errors, the event shouldn’t happen again,” Clapper said.
Meeting 4: Taking RCA a Step Further

ProMedica Toledo Hospital is the largest of ProMedica Health System’s 12 acute care facilities. Although the fourth meeting in ProMedica Toledo’s RCA process is new, the practice of conducting an RCA after a serious safety event had been in place throughout the ProMedica system for several years.

In 2012, ProMedica enhanced its existing RCA process by adopting the Press Ganey HPI three-meeting model. At that time, ProMedica also rolled out an error prevention curriculum to its entire staff; provided staff with 10 error prevention techniques, including Speak Up for Safety Using ARCC (Ask a question, make a Request, voice a Concern, and if not successful, use the Chain of Command) and STAR (Stop, Think, Act and Review); assigned at least one Safety Coach to each department in the organization; and educated its leadership on their role in safety and error prevention.

Earlier this year, with help from ProMedica’s quality, safety, risk and legal departments, ProMedica Toledo added the fourth meeting to its RCA process, dubbing it “Toledo Talks.”

According to Nicole Justus, MSN, RN, ProMedica safety coordinator, the idea to add this fourth meeting stemmed from Press Ganey HPI education, which recommends transparency and sharing of lessons learned facility-wide. Where ProMedica Toledo is unique is that it added these best practices as an actual step in its RCA process. This allowed the facility to share information it otherwise might not share, since the information remains protected under its risk/quality umbrella as part of an RCA; and it makes the sharing of the event a necessary and expected part of a structured process, driving home the importance of transparency.

As Justus explained, historically at ProMedica and in health care in general, people tend to keep information about serious safety events to themselves. “They’re afraid they’ll be looked down on, blamed or punished if they stand up at a hospital leadership meeting, for example, and admit that a serious safety event occurred in their unit.

“We wanted to encourage the opposite atmosphere, where people know it’s OK to share when bad things happen so that others can learn from them,” she continued. “We wanted people to see that the RCA doesn’t point fingers at individuals; it seeks to uncover the system errors behind an event. And once people saw this, they realized sharing is a good thing.”

The one-hour meetings, which were held monthly, were open to everyone in the hospital. For the first 15 minutes, details regarding the serious safety event were provided and lessons learned from the RCA were shared; for the remaining 45 minutes, the participants explored how similar events could occur in their own departments. Following the meeting, details of the discussions were given to department leaders so that they could determine how best to prevent those events from ever occurring in their own areas.

According to Justus, results of the pilot were positive. On post-meeting evaluation forms, more than 95% of the meeting attendees strongly agreed that sharing information about serious safety events and their causes is important to improving safety throughout the facility.

Perhaps more importantly, more than 95% of the attendees also strongly agreed that root causes discussed in the meetings do exist in other areas of the hospital. As Justus explained, there’s a lot of similarity in health care; certain safety procedures followed in an intensive care unit, for example, may also be followed in an operating room. When the RCA team shared what they discovered about systemic problems that led to a particular serious safety event, “people’s eyes would light up and they’d say, ‘We have a similar situation in our area, so this event could happen to us too,’” Justus said.

“Staff used to hide their mistakes—they’d think, if anybody in another unit or department finds out about them that’s it, I’m done for,” she continued. “Now they want to tell you about mistakes that happened so that others don’t make them too. The fourth meeting was very successful in this regard.”

Because data collected thus far has focused on the content of the fourth meetings and ways to improve delivery of the information, Justus couldn’t say with certainty that adding the fourth meeting to ProMedica Toledo’s RCA process has had a direct effect on the prevention of similar events elsewhere in the hospital. “But I can foresee this being the next step in our thought process—how can we measure the actual impact of the fourth meeting,” she said.

The hospital also plans to expand its four-meeting model to the other 11 hospitals in the ProMedica system. “All of these are smaller than Toledo Hospital, and some of them achieved zero serious safety events some time ago and are starting to do RCAs on precursor safety events,” Justus said. The plan, she said, is for those hospitals to adopt the four-meeting model, as well.
“Mistakes Are the Portals of Discovery”

Irish poet James Joyce once said, “Mistakes are the portals of discovery.” And according to Justus, that sentiment rings true throughout ProMedica Health System, where continually analyzing system and process errors reveals improvements that reduce the level of harm to which patients are exposed.

“As of July 1, our Serious Safety Event Rate (SSER) was 0.99. The data for the first six months of 2016 represents a 55% decrease in our number of serious safety events when compared to the first six months of 2015,” Justus said, adding that July marks the organization’s 10th consecutive month of improvement.

“There’s no such thing as no error, but there can be no error that reaches a patient,” Justus concluded. “That’s our ultimate goal at ProMedica—zero harm to patients—and it’s one we’re well on our way to achieving.”