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HealthEast Root Cause Analysis Summary

Level of Analysis	Questions/Factors involved	Findings and Opportunities to Improve
What happened:	*What departments were involved?*	Nursing, WOC Nurse, Administration, Quality Management
		83 year old female was admitted from nursing home to the Surgery Admission Unit (SAU) for a 2 vessel CAB. Patient history includes Coronary Artery Disease, Atrial Fibrillation and a previous hip replacement surgery 1 year ago. Recent symptoms include shortness of breath with activity, increased lethargy and decreased appetite. The surgery was successful with no complications. Post surgery, the patient was admitted to the ICU in stable condition. During the night, she developed atrial fibrillation which was difficult to manage despite multiple pressors. For the next several days she was hypotensive and would drop her blood pressure every time she was moved. She also developed pulmonary insufficiency making it difficult to extubate. By Post Operative Day (POD) 5, she became more stable and was able to be extubated. On POD 6 she was transferred to Telemetry. She seemed to be slowly improving. On POD 8 the physical therapist was assisting her with walking when her gown slipped open and he noted an open wound on her sacrum. After he returned her to her room, he stopped at the nurses station to let them know about the wound. There were no nurses available so he left the message with the unit coordinator. The unit coordinator made a note of this and placed a post-it on the medical record. The next day, the nurse caring for her saw the note and went to check the wound. The wound was noted to be very small, about the size of an eraser with purple coloring around it. The WOC nurse was consulted and described it as unstageable. The patient continued to improve and was transferred to TCU for further care.
Why did it happen: (Proximate cause)	*What was the missing or weak step in the process?*	The patient's unstable condition did not allow for frequent turning. Her nutritional status was not optimal and needed additional support. The unit had turning options, however they were not available. Information between Surgery and the nursing unit is inconsistent.
Why did that happen?	*What caused the missing or weak step in the process?*	1. The patient's unstable condition and failure to optimize equipment led to lack of turning which resulted in an unstageable pressure ulcer 2. Inconsistent transfer of information between Surgery and the nursing unit resulted in lack of clarity about the patient's skin condition on admission.
Why did that happen?	*What is currently done to prevent failure at this step?*	Surgery is supposed to print out a copy of the admission assessment and send to the nursing unit with patient's who are admitted from Surgery

Level of Analysis	Questions/Factors involved	Findings and Opportunities to Improve
Why did it happen: (Proximate cause)	*What was the human error?*	Nursing indicated their main concern initially was stabilizing the patient. There are so many things for staff to monitor when she was so unstable, skin may not have been as complete as they should have been. The dietician was called in to assess the patient while in the ICU. She made several recommendations which were carried out as the patient's nutritional status was low.
Why did that happen?	*Was staff performance in the process addressed?* *Was staff properly qualified?*	Staff performance was reviewed and found to be good. Staff were felt to be qualified
Why did that happen?	*Can orientation and inservice training be improved?*	Regular, yearly education on skin assessment and inspection is provided for the staff.
Why did it happen: (Proximate cause)	*Was staffing appropriate to provide safe care?* – *If no, do you believe that staffing issues contributed to the event?*	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?	*Did actual staffing deviate from the planned staffing at the time of the event or during key times that led up to the event?*	No deviation from planned staffing was identified
Why did that happen?	*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?* – *If yes, did the unexpected issue impact staffing or workload for staff?* – *If yes, did staff believe this change in staffing or workload contribute to the event?*	No unexpected issues or incidents were identified

Level of Analysis	Questions/Factors involved	Findings and Opportunities to Improve
Why did it happen: (Proximate cause)	*Was all necessary information available:* *-when needed?* *-accurate?* *-complete?*	While gathering information for the RCA, it was noted that her admission assessment was done electronically in the SAU computer system. That system (SIS) does not interface with the inpatient electronic medical record. The ICU Clinical Director was asked how they review the admission information they receive from surgery. She explained SAU is responsible to complete a full assessment on admission and their process is not to repeat that assessment. They expect the full assessment is complete unless SAU indicates they were unable to complete a section. She informed us that sometimes SAU will print out a copy of the admission assessment, but not always. When they have printed it out, the assessment seemed complete. The SAU did not indicate there was any incomplete section on this patient. Skin assessments were documented, however not consistently as the patient was unstable. It was unclear exactly when the skin began to break down as documentation was inconsistent. At one entry, a nurse noted a reddened area on the sacrum and for several shifts after that the nurses noted no skin problems. The electronic medical record has fields for documenting skin assessment and inspection and there is the capability to type in comments for that section. It is difficult for the nurse to see what was previously documented in the electronic medical record. The nurse is required to go through several steps in order to review what was previously documented. When the patient was transferred to Telemetry, the usual report was given which included the patient's latest vitals, medications, any order changes and current activity status but nothing on skin condition.
Why did that happen?	*Is communication among participants adequate?*	Yes. Communication is felt to be very important. Staff felt communication among them was good.
Why did that happen?	*Are there barriers to communication?* *Is prevention of adverse outcomes considered a high priority?*	The electronic medical record in surgery does not interface with the inpatient medical record. Staff may not see issues prior to or in surgery that could affect the patient's skin. Yes
Why did it happen: (Proximate cause)	*How did the equipment fail?* *What broke?*	The ICU has a rotation bed to assist with turning a patient, however another patient was in that bed. That patient in the rotation bed did not need it for rotation, however the unit was full and they couldn't switch beds. Besides, the rotation bed was new and the staff were unfamiliar with how to use it so it wasn't used at this point. There is no written procedure on how to use this bed and after initial demonstration by the manufacturer when the equipment was purchased, there has been little education other than hand outs. Electronic documentation is new in the ICU in the past 2 months and staff are still becoming accustomed to documenting electronically.
Why did that happen?	*What is currently being done to prevent an equipment failure?*	Education is done regarding the rotation bed and the electronic medical record
Why did that happen?	*What is currently being done to protect against a bad outcome if an equipment failure does occur?*	The equipment is taken out of service and evaluated. Equipment is checked and if appropriate reported to Med Watch.

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Level of Analysis	Questions/Factors involved	Findings and Opportunities to Improve
Why did it happen: (Proximate cause)	*What environmental factors directly affected the outcome?*	The unit was very busy.
Why did that happen?	*Was the physical environment appropriate for the process to be carried out?*	Yes
Why did that happen?	*Are systems in place to identify environmental risks?* *Are responses to environmental risks planned and tested?*	Yes Yes
Why did it happen: (Proximate cause)	*Were there any uncontrollable external factors?*	ICU nurses stated the patient's unstable condition made it difficult to regularly turn the patient as the blood pressure would drop significantly. The patient's daughter is an ICU nurse at another local hospital and visited the patient daily. She assisted with caring for the patient and never mentioned a wound developing. She was very concerned about the patient's pain status and would stop staff from moving her if the patient moaned or cried out in pain.
Why did that happen?	*Are they truly beyond the organization's control?*	The patient's unstable condition is hard to control. Effort was done to stabilize the patient, but this takes time. The daughter was anxious about her Mother's condition, protective.
Why did that happen?	*How can we protect against them?*	Support and education for the daughter on the need to perform cares even though the patient is very ill. Cares prevent further issues from developing.
Why did it happen: (Proximate cause)	*Were there any other factors that directly influenced the outcome?*	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:

1. The patient's unstable condition and failure to optimize equipment led to lack of turning which resulted in an unstageable pressure ulcer
2. Inconsistent transfer of information between Surgery and the nursing unit resulted in lack of clarity about the patient's skin condition on admission.

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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
- ☒ 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:
Polly Pressure

Date of incident:
2/1/11 Discovery date: 2/5/11

Participants in Root Cause Analysis:
Nancy Nurse, patient's nurse at time of error
Glenda Witch, Charge Nurse
Tim Team, patient's nurse from previous shift
Wanda Skinz, WOC nurse
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:
2/10/11

Conclusions/Recommendations:

1. Create education program for staff on use of the rotation bed
   - Request manufacturer assist with development of this education
   - Utilized electronic education program to make this readily available to staff as they need
2. Work with IT to make surgical documentation visible to nursing unit staff
   - Request information be pushed out to permanent medical record after patient leaves surgery
   - Request a report be created to be printed out which reflects documentation in the surgery area and can be sent to the nursing unit.
3. Explore with WOC nurses to determine if WOC can be called in to assess patients who are considered critically unstable with limited ability to move patients

Please attach the associated policies:
(including any newly revised policies)