i-Sight Investigations

Using the Just Culture Method

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Just Culture

- A system of Shared Accountability
  - Everyone in the organization is responsible for maintaining a safe and reliable system
- Core Beliefs
  - To err is human
  - To drift is human
  - Risk is EVERYWHERE
  - We must manage around our values
  - We are ALL accountable
- CVMC has adopted the Just Culture method of investigation

When investigating an event, ask…

- What happened?
  - Don't assume you already know. **Listen** to feedback from all involved.
- What should have happened? What does procedure say to do?
  - Walk through the "norm"
  - How was the system designed to work?
- Why did it happen?
- How was the organization managing the risk?

When investigating an event, ask…

- What can we do to fix this and prevent it from happening again?

- Follow the Just Culture Algorithm to complete investigation once these initial questions have been answered (department Managers should have copies of the Algorithm, if not contact Adina Andreu, ext 3020)

Look at the System

- How is the system designed?
  - Is it robust?
  - Does the design of the system allow employees to succeed, or does it set them up for failure (bad system design)?
- Was there adequate knowledge and skill level available?
  - Did everyone involved have proper training/orientation?

Look at the System First

- Does the system design decrease the probability of employees making mistakes or engaging in behavioral drift?
- Was there an accurate perception of risk ?
- Is there a barrier (administrative or physical) in place to prevent human error ?
  - Examples: needleless systems, passwords on computers to prevent privacy breaches, green and yellow connectors to distinguish oxygen from air

Look at the System First

- Was a recovery system in place?
  - Catching a mistake before it leads to an adverse event/outcome through feedback or system checks
- Are redundant paths in place?
  - Multiple ways to achieve a positive outcome
  - Is the patient 1 or more errors away from harm?
  - Example: Key equipment connected to emergency generators in case of a power failure of main electrical system.

Look at Individual Behavior Second

- Human Error
- At-Risk Behavior
- Reckless Behavior

Algorithm

- 3 ways to enter Algorithm
  - Duty to produce an outcome
    - System that the employee is in control of
    - Example: arriving to work on time, having identification badge
  - Duty to follow a procedural rule
    - The organization (CVMC) is in control of the system
    - The employee is not accountable for the action, only to follow the rule
  - Duty to avoid harm
    - Takes precedence over all other duties

Algorithm

- When looking at the Duty to Produce an Outcome, ask yourself how many times is too many for the error to occur
  - If 1 time is too many, then you must enter the Algorithm at the Duty to avoid Harm entrance.
- Once you have determined what entrance point to start the Algorithm, follow the boxes and answer the questions to determine if the error was caused with a system problem or an employee problem

Results

- Your investigation should reveal 1 of 3 results either at the system level or the individual level
  - Human Error- an honest mistake
    - Modify the system if needed
    - Console the employee for making a mistake
  - At-Risk Behavior- employee made a bad choice because he didn't recognize the risk involved
    - Modify the system if needed
    - Coach employee to make better choices
    - Counsel Repetitive At-Risk Behaviors; Counseling is putting the employee on notice that his actions are not appropriate and a change must be made, it is the start of the disciplinary process
  - Reckless Behavior- employee knew risks and disregarded them
    - Punitive action, also part of the disciplinary process

Results

- Once you have completed your investigation:
  - Enter all findings into the Supervisor Investigation section of i-Sight
  - Provide enough information so that someone unfamiliar with the event can read your investigation and see clearly what was done
  - The purpose of Risk Management reporting is to investigate incidents with the goal of reducing/eliminating events that can cause harm. It is not sufficient to just explain the events as they took place. The expectation is to find permanent solutions to problems and to consistently improve our systems.

Example #1

A nurse is going to administer Phenergan 25mg IV to her patient. The unit she works on has a Pyxis machine that will automatically dispense the prescribed medication. When the Pyxis drawer opens, there are 8 numbered bins with different medications present in each bin. Phenergan 25mg is always in bin number 3 and has an orange top, so the RN reaches into bin 3 and retrieves a vial of Phenergan after seeing the orange top is present. The RN goes into the patient room and administers the medication after having the patient verify his name and date of birth. As the RN is disposing of trash and placing sharps in the sharps container, she notices that the vial of medication she is holding does not say Phenergan 25mg, it says Phenergan 50mg.

Example #1

- What happened?
  - The RN administered the wrong dose of medication. The patient should have received Phenergan 25mg, but instead received 50mg.
- What should have happened?
  - The RN should have looked to verify the name and dosage of medication when it was removed from the Pyxis. She also should have verified the name and dosage against the patient's MAR prior to drawing up the medication.

Example #1

- Why did this happen?
  - The RN did not look at the medication clearly when she removed it. She knew Phenergan had an orange cap and was always in bin 3. When she saw the orange cap in bin 3, she assumed it was the correct medication.
  - When withdrawing the medication from the vial, the RN did not look at the vial, she just continued to assume it was the appropriate medication because it looked the way it always did.
  - After talking with pharmacy, it was found out that a new tech was filling the pyxis machines and had inadvertently stocked the Pyxis with the incorrect dosage of Phenergan.

Example #1

- Is the system of using a Pyxis machine a robust system?
  - Yes, it is designed to allow anyone who uses it to succeed and administer medications appropriately, if all steps are followed.
- Did staff have adequate knowledge and skill about using the Pyxis?
  - Yes, she used it everyday and was comfortable enough with the process that she had developed drift. The new pharmacy tech may have not been as familiar with the system and may have benefitted from further training.

Example #1

- Was there an accurate perception of risk?
  - No, the RN assumed that the correct medication would always be in the same bin and developed drift about double checking the name and dosage of the medication prior to removing it from the Pyxis.
- Was there a barrier in place to prevent human error?
  - There was an administrative policy in place that should have caught the error, but because the RN had drifted away from proper practice, this barrier was bypassed.
- Was a recovery system in place?
  - Yes, the RN had several points where she should have verified the proper medication and dosage, but because of drift she did not.

Example #1

- Were there redundant paths in place to prevent this error?
  - Yes, the RN should have verified the name and dosage prior to removing the med from Pyxis. She should have again verified it prior to withdrawing the med from the vial. As a final check, she should have verified the medication against the vial and the MAR prior to administering to the patient when she was reviewing the 5 patient rights.
- Did the RN or the pharmacy tech knowingly harm the patient?
  - No, this was an honest mistake on both parts. A Human Error.

Example #1

- In the Supervisor Investigation box, your review of the incident should look something like this:
  - After talking with the RN involved and pharmacy, it was discovered that a new tech unfamiliar with the Pyxis system had loaded the wrong dosage of Phenergan into the pyxis bin. The RN involved went to remove the medication as she normally has done and did not verify the correct dosage by looking at the vial. She saw the orange top and assumed it was the right medication. Because she has given this medication so many times, she didn't stop to verify the dosage on the vial against the MAR prior to administering it. She assumed she had the correct medication, so she only verified 2 patient identifiers prior to administering it to the patient. Policy and procedure were available to inform the RN of the proper technique for giving medication, but she felt rushed because she had several other patients calling out that she cut out a few of her normal steps which resulted in this error. The RN and the pharmacy tech have both been consoled about the error and methods of decreasing the chance of this type of error occurring again have been discussed.

Example #2

Ms. Smith comes to Day Surgery for a Left Total Knee replacement. Unbeknownst to the Day Surgery RN, Ms. Smith is also scheduled for a Right Total Knee replacement next week. The DS RN verifies with the pt and against the OR schedule that patient is to have a LTK, she marks the correct knee on the patient. During pre-op preparation, the DS RN checks the chart for a consent for operation, consent for anesthesia, consent for blood, recent H&P, and a SBAR sheet- all are present. Ms. Smith leaves the DS area and goes to PACU to have an epidural placed. While in PACU, the CRNA interviews the patient and verifies procedure to be done with patient against OR schedule. CRNA checks chart for presence of operative consent, anesthesia consent, and anesthesia questionnaire- all are present. After epidural is placed, Ms. Smith is taken to the OR. While the pre-op time out is being done with the OR team and surgeon, it is discovered that the operative consent on the chart is not for a LTK, but for a RTK. The surgery is delayed while the surgeon's office is contacted to obtain the correct consent.

Example #2

- What happened?
  - Ms. Smith went to surgery with the incorrect operative consent on the chart.
- What should have happened?
  - When Ms. Smith arrived to Day Surgery, the admitting RN should have looked at chart and verified that proper consent was present. CRNA should have verified that correct consent was present on chart prior to going to PACU for epidural placement. Circulating RN should have verified correct consent was on chart prior to leaving PACU and entering OR with the patient.

Example #2

- Why did this happen?
  - The Day Surgery RN had verified the procedure with the OR schedule and verbally with the patient. When she checked the chart, she only checked for the presence of an operative consent. She never read the consent to verify if said Left Total Knee.
  - The CRNA assumed that the DS RN had verified the correct operative consent, so when he took patient to PACU, he too only looked for the presence of an operative consent and never read what was on the consent.
  - When the circulating RN took the patient from PACU to the OR, she too assumed that the correct consent had already been verified and only looked for the presence of an operative consent on the chart without reading it.
  - Everyone involved in the care of this patient had drifted away from the established policy that is meant to protect the patient.

Example #2

- Was the system in place designed for employees to fail or succeed?
  - The system was designed for employees to succeed, if they follow the policy
- Did staff have adequate knowledge and skill to complete the process of checking the patient's chart?
  - Yes, all involved had been properly oriented to checking and verifying procedures listed in the chart against posted OR schedules, consents, and verbally with patients.

Example #2

- Was there an accurate perception of risk?
  - No, after speaking with the DS RN involved, she had no idea that there was the possibility the patient could be scheduled for 2 procedures, which is why she didn't read the consent form. She just looked to make sure an operative consent was on the chart
  - The CRNA assumed that the DS RN had verified the consent already, so he also did not read it, just checked to make sure an operative consent was on the chart.
  - Circulating RN did not have patient chart available when she took patient to the OR, so she only verbally verified the procedure with the patient and against the OR schedule. Those 2 matched, so she assumed the consent matched also and that it had been verified twice already.

Example #2

- Was there a barrier in place to prevent human error?
  - Yes, there was an administrative policy in place that should have caught the error, but because several of the staff involved had drifted away from the policy, the error was not caught.
- Were there redundant paths in place to prevent an error?
  - Yes, there were several double checks along the way to the OR. However, it wasn't until the Time Out was being performed that someone finally read the consent and caught the error before any harm came to the patient.

Example #2

- Your review in the Supervisor investigation box should look something like this:
  - A round table discussion was had with everyone involved in the wrong surgical site near miss. It was determined that everyone had drifted away from the required process of checking and reading the surgical consent for accuracy. A new process has been developed where the DS RN, CRNA, and Circulating RN all verify the consent with the patient and the DS RN and patient both initial the consent to show that it has been checked and verified.

Questions

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References

- Engineering, L. (2008). *Just culture training for healthcare managers* (Rev. 4. ed.). Plano, TX: Outcome Engineering, LLC.