What Worked and What Didn’t

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Disclosures

• I have no disclosures.....
“Those that fail to learn from history are doomed to repeat it”
Winston Churchill
Sentinal Event

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof.
CAUSE MAPPING

Problem Solving • Incident Investigation • Root Cause Analysis

Step 1 Define
Goals

What's the Problem?

Step 2 Analyze
Causes

Why did it happen?

Step 3 Prevent
Solutions

What will be done?
Root Cause Analysis

- Failure (sentinal event)
- Evidence
- Investigation
- Analysis
- Corrective Action
- Implementation
Failure (Sentinal Event)

- A record is created that something happened
- Risk management system activated at the earliest possible time
- Keep thorough records
- Do not alter records
Evidence

• Gather and record all relative information about the case and event
• Be prepared to discuss all issues of the event with your risk management dept
• Follow their directions, this is what they do!
• Root cause analysis committee will be designated by the risk manager assigned the case
Investigation

• What failed?
• Why did it fail?
• Who and what is involved?
• Patient harm?
• Were actions appropriate?
Analysis

- Human error?
- Equipment failure?
- Process/system error?
- Avoidable/unavoidable?
Corrective Action

- Results of the root cause analysis committee discussed
- Equipment repair?
- Employee training?
- Policy revision?
- Systems revision?
Implementation

- The plan is put into place to prevent future events
- Must be audited to make sure the action plan was effective
Barriers to Full Disclosure

- Embarrassment
- Fear of discipline
- Loss of job
- Shame
- Psychological
- Having no clue there was even a problem!!
Why is This Important?

- The obvious answer is for patient safety
- The JCAH mandates that a sentinel event policy must exist!!
Panel Discussion