INCIDENT REPORTING & ROOT CAUSE ANALYSIS (RCA)

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INCIDENT REPORTING

Why bother reporting incidents?

- .....It only wastes time and money that could have been used to do something better

There are several reasons why people tend not to report incidents;

- Fear that they might get into trouble or even be fined, suspended or fired from their position or that they might be demoted.
- Feeling that it is waste of the time, money and resources.
- There is also a lack of decent investigations, sometimes just done, because it is a legal or procedural requirement.
- Nothing ever changes when they do
- They don’t have the time

SOME COMMON LAB INCIDENTS

Patient ID error

Lost sample

Sample delayed in transit

Contaminated samples

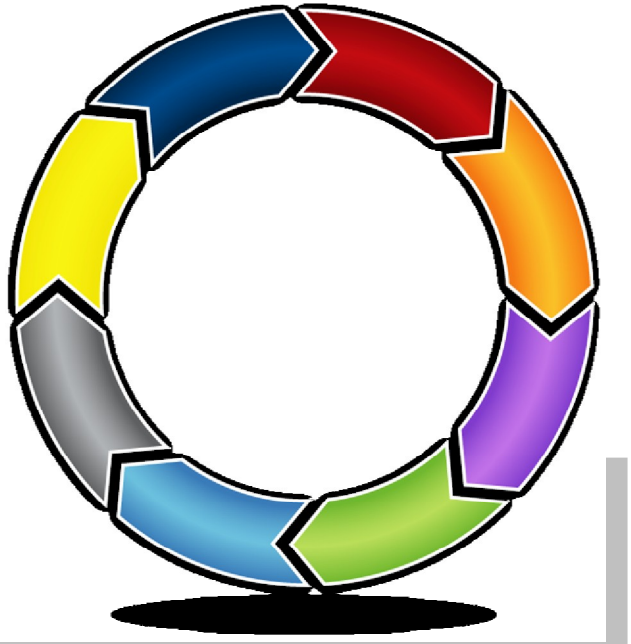
Wrong test performed

Test performed inconsistent with the written procedure

- Proficiency testing error
- No action on out of range controls
- False negative result
- Late reports
- Missing reports
- Complaints
- Laboratory accident
- “Near miss”

SO WHY BOTHER REPORTING...

Lack of reporting and investigating incidents forms a vicious cycle that can add up to great amounts of money lost, loss of life, loss of abilities, loss of knowledge and wastage of valuable tir[illegible]



One can start at an incident itself. If the incident is not reported it will not undergo an investigation, therefore there will be no root causes found, therefore no new risks/ hazards or deficiency in the system will be identified, therefore no corrective actions will take place, leading to the re- occurrence of these hazards or risks, leading to another incident.

Failure to do proper investigations will lead to the same result.

Incidents will re- occur until the cycle is broken by reporting the incidents and doing a formal investigation.

WHEN SHOULD AN INCIDENT BE REPORTED...

Each Trust will have different guidelines, set out in the incident reporting policy; but some guidelines

When harm has come to a person (including patients and staff)

When the problem keeps occurring

When the problem has “escaped” the department

SYMPTOM APPROACH VS. ROOT CAUSE

SYMPTOM APPROACH

Errors are often a result of worker carelessness (human error)

We need to train and make them be more careful

We don't have the time or resources to waste time getting to the bottom of the problem

We know why it happens, because it has happened before

ROOT CAUSE

Errors are result of defects in the system – people are only part of the process

We need to find out why this is happening and implement mistake proofs so it wont happen again

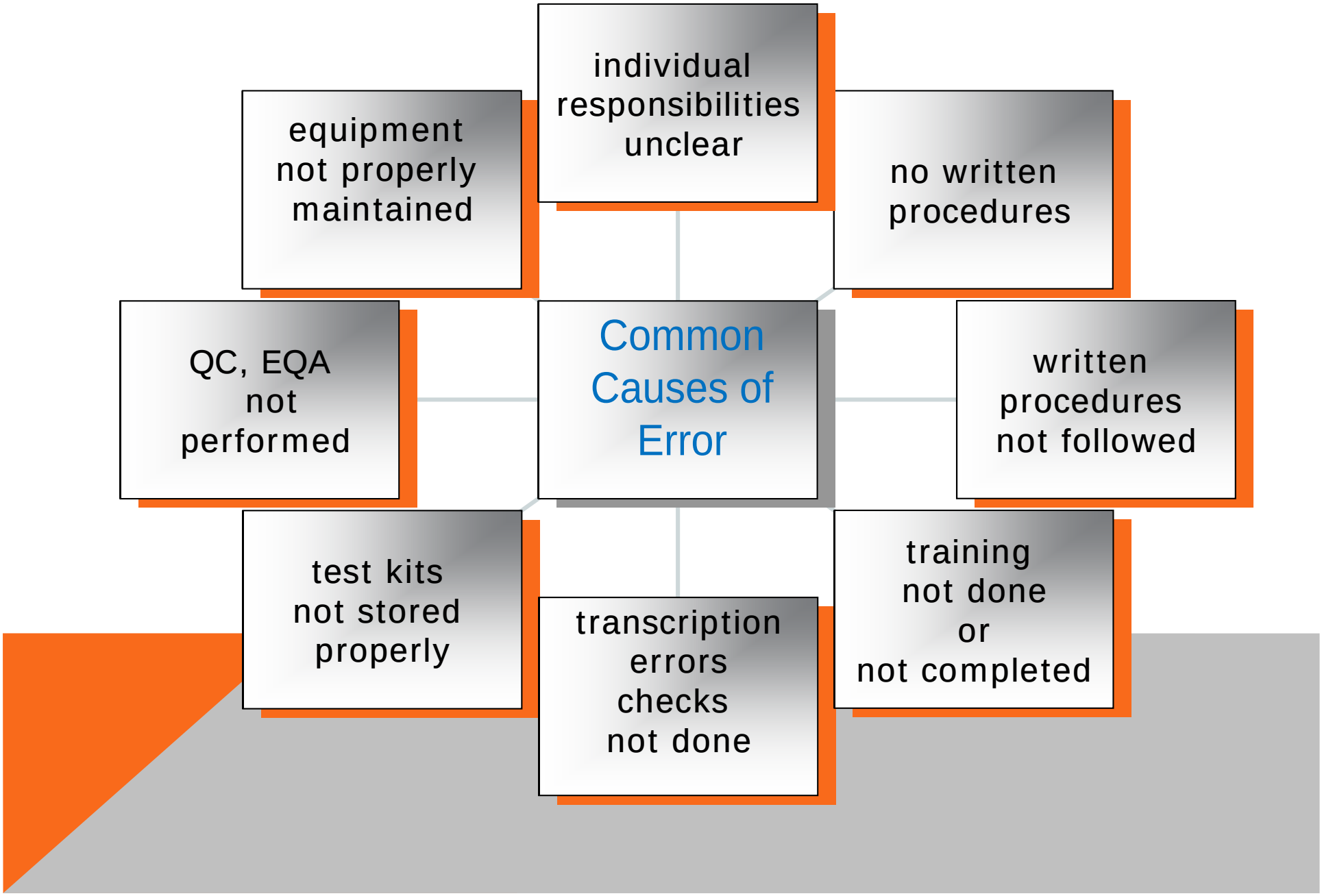
This is critical, we need to fix it for good, otherwise it will come back and burn us.

ROOT CAUSE ANALYSIS

The move to conduct root cause analysis is largely motivated by a growing recognition that the complexity of health care and health care delivery drives the incidence of adverse events uncomfortably and unacceptably high (Brennan et al, 1991)

‘Root cause analysis is a structured investigation that aims to identify the true cause of a problem, and the actions necessary to eliminate it.’

Anderson and Fagerhaug, 2000


individual responsibilities unclear
equipment not properly maintained
no written procedures
QC, EQA not performed
Common Causes of Error
written procedures not followed
test kits not stored properly
transcription errors checks not done
training not done or not completed

WHEN A PROBLEM OCCURS .....

1) Need to understand the problem
2) We need to contain the problem (containment action)
3) We need to identify the root cause
4) We need to correct the problem (corrective action)
5) We need to prevent the problem happening again (sometimes referred to as permanent corrective action, sometimes referred to as preventive action)

UNDERSTANDING THE PROBLEM

If we do not understand the problem fully – how can we understand what caused it

What is the problem, When did it happen , How large is the problem, is it still occurring, What is the effect of the problem

Then .....

Why did it happen

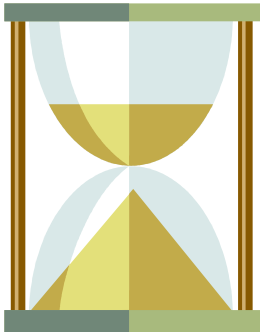
CONTAINING THE PROBLEM

Halting the examination process if needed

Stopping any more results being sent out if necessary

Putting extra steps in to check everything is ok (100% inspection)

Containment almost always costs money (and time)



IDENTIFYING THE ROOT CAUSE

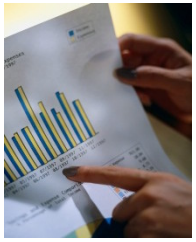
There will normally be at least 2 root causes . The first being the cause of the error, the 2nd being the failure of the escape point. The escape point is usually the next step after the error has occurred

For example Phlebotomist identifies the patients blood with the wrong name as the wrist band was incorrect.

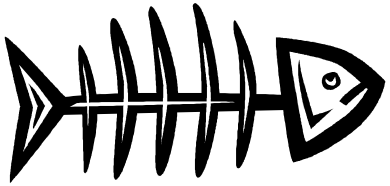
1) Why was the wristband incorrect?
2) Why did the phlebotomist not notice the wristband incorrect when asking the patient to confirm their details?

TOOLS FOR CONDUCTING RCA

Brainstorming



Charts
Pareto, Scatter Diagram,
Histogram, Control Charts



Fishbone Diagram

5 Why's

IS	IS NOT

Is / Is not Table

Interviews

Gembutsu

THE POPULAR HUMAN ERROR

Human error can be considered as a symptom but not the true root cause of a failure.

It is almost always the process and not the person

CORRECTIVE & PREVENTIVE ACTION

Corrective Action

Eliminates the need for the costly containment action, puts in a solution to the problem once the root cause is known.

Preventive Action

Stops the problem re-occurring, a popular method is mistake proofing (Poka-Yoke)

Be careful not to add waste to your process

IN SUMMARY ROOT CAUSE ANALYSIS

A systematic approach to finding the real root cause(s)

Dealing with the problems ... not just the symptoms

When you permanently fix the real root cause(s) the problem goes away

Not every error / incident needs a full root cause

Solutions should, save you money and time in the long run

Thank you

Any Questions