Root Cause Analysis and Action (RCAA)

Kentucky Hospital Association

Who we are:

Billie Delauder, DNP, MSN,RN

- 37 years of nursing experience
- 17 years in quality as a PI Supervisor & Clinical Abstraction Specialist

Adam Isaacs, BSN, RN, HACP-CMS

- 9 years of nursing experience
- 2 years in quality as a Clinical Quality Nurse

What to Expect:

- Type in your question(s) in the chat as we go, and we will address them at the end of the presentation.
- We may ask for a show of hands at times, and feel free to use the reaction icons and emojis!

The RCAA:

- A Root Cause Analysis is a method of determining the core cause(s) of problem(s) to appropriately identify solutions for those problem(s).
- The RCA looks beyond the superficial “cause and effect” and will show where processes or systems failed or caused an issue in the first place.
- The 2nd “A” in RCAA is an **Action plan** that shows what strategies an organization intends to implement to reduce the risk of similar events from occurring in the future.

Reference-IHI Website. (2023). RCA2: Improving root cause analyses and actions to prevent harm. Institute for Healthcare Improvement. https://www.ihi.org/resources/tools/rca2-improving-root-cause-analyses-and-actions-prevent-harm

Electronic Safety Report:

This pharmacist received a call from an inpatient nurse on 1/23/24 at 00:45 on Unit 2B. She had found out that her patient, Juan Ramirez, had an allergy that was not in the patient's existing chart and that the antibiotic was due in an hour. The nurse was calling to ask how to proceed. The pharmacist indicated that the patient's prior chart needed to be referenced and merged. The pharmacist then contacted the admitting doctor to obtain a discontinue order for that antibiotic and placed a new order for a different antibiotic suitable for pneumonia that the patient was not allergic to.

Do you have what you need?

What do you want to do first?

Interview List of involved parties

- Take detailed notes of all interviews
  - PSWP

Record available

- Patient's chart
- Original merged chart

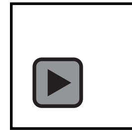
Baseline:

What tools are needed to assist you?

- History Review
- Completed Interviews
- Vet out all the contributing factors making sure you clarify and understand what you hear.

Alex

Pharmacist



WHEN

When and where did this happen?

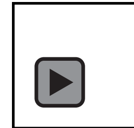
- ED registration
- ED
- Observation Unit
- Radiology

WHO

- Pharmacist- Alex
- Registration- Paula
- Floor RN- Angela
- Patient- Juan
- Radiology Tech-?
- ED RN- ?
- ED MD- ?
- Admitting Hospitalist- Dr. Little

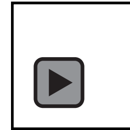
Angela, RN

Observation Unit
Floor Nurse



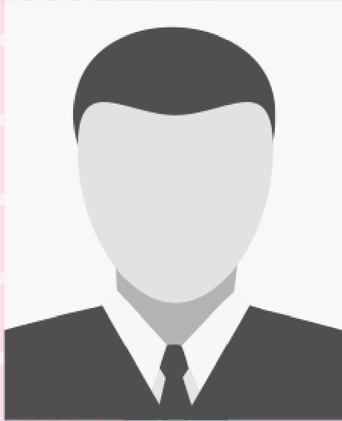
Paula

ED Registration Clerk



PERMISO DE CONDUCCIÓN REINO DE ESPAÑA

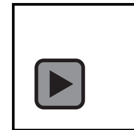
1. Ramirez
2. Juan
3. Birth: 03/07/1967 Place: Madrid
4. Issued: 11/05/22
5. Expires: 30/05/24
6. Lic.#: 3356890021



9. Category: B, C1, C

Danni, RN

ED Nurse



ED Doctor

Let’s Talk!

In the chat, please put

1. What do you think went well?
2. What did not go well?
3. What questions do you have now?

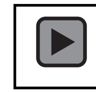
OCR’s Final Rule: 1557

The Office for Civil Rights or OCR’s Final Rule 1557 is part of the Affordable Care Act. It helps the improvement of Health Equity while reducing health disparities.

Reference- (OCR), O. for C. R. (2021, August 10). *Summary final rule implementing SEC 1557 of the ACA*. HHS.gov. https://www.hhs.gov/civil-rights/for-individuals/section-1557/summary-of-final-rule/index.html

Bob

ED Tech



Radiology Tech

Admitting Hospitalist

Juan

What can you all tell me about Juan?

1/22/24 18:20
Registration: New chart created for Mr. Ramirez with transposed birthday MM/DD/YYYY vs. DD/MM/YYYY

1/22/24 18:35
Triage: Patient identifiers and questions asked before interpreter available. Allergies not clarified to medication when patient reported Allergy medicine.

1/22/24 19:45
ER Doctor: used interpreter only used name as identifier.

1/22/24 20:50
Radiology tech took patient for x-ray only asked for patient name.

1/22/24 21:04
Blood draw: No interpreter asked name and used patient wrist band

1/22/24 21:20
Medication administration: Used understanding of "Spanish numbers" to figure out DOB.

1/22/24 21:40
Reaction to medication patient recieved,
0.5mg EPINEPHrine IM, 50mg Diphenhydramine IV, and 2,400 ml Normal Saline over 90 min.

1/22/24 21:50
Blood draw: Mr. Ramirez was sleeping tech just used wrist band

1/22/24 22:10 Admitting doctor: used interpreter asked patient name and verified address as second identifier.

1/22/24 22:50
Transferred from ED to Inpatient

1/23/24 0:00 Admission to inpatient:
Used interpreter, Only incomplete admission information was medications and allergies when left room.

1/23/24 0:20 Called outpatient pharmacy: DOB and allergy discrepancy.

1/23/24 0:45 Nurse spoke to inpatient pharmacy to inform of allergy to Penicillin next antibiotic.

1/23/24 0:56
Registration marked charts to be merged

Mr. Ramirez spent 3 days in hosptial due to swelling after allergic reaction.

CMS and TJC:

- IMPROVING CARE FOR PEOPLE WITH LIMITED ENGLISH PROFICIENCY (cms.gov)
- https://www.jointcommission.org/-/media/tjc/newsletters/quick-safety-issue-13-lep-update-10-5-21.pdf
- Summary Final Rule Implementing Sec 1557 of the ACA | HHS.gov
- Patient Safety Organizations Program | Agency for Healthcare Research and Quality (ahrq.gov)
- https://pso.ahrq.gov/faq/what-is-patient-safety-work-product

THANK YOU

KHA Voice Performers!

End of Part 1

Questions