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Staff Leadership Key to Enhancing the Root Cause Analysis Process

By Elizabeth Vinton, B.S.N., R.N., patient safety manager, Charles George VA Medical Center

The Charles George VA Medical Center,[1] Asheville, N.C., is committed to becoming a high-reliability organization. Non-punitive event reporting is encouraged so that processes and systems can be evaluated to improve patient care.

A high-reliability organization is one that uses a systems approach to problem solving in an environment where problems can be expected due to risk factors and complexity, such as the aviation industry. The focus is on prevention, not punishment.

In the "name and blame" culture of the past, the focus was on individuals and their mistakes, rather than on system level vulnerabilities and events that had combined in an unfortunate sequence to cause an incident to occur. By shifting the goal from eliminating errors to reducing or eliminating harm to patients — through investigating system level vulnerabilities, rather than focusing on individuals — our entire way of looking at close calls and adverse events has changed.

Staff Development

Because we have worked hard to institute a culture of safety that encourages staff to report, our facility has conducted 19 Root Cause Analyses (RCAs) [2] in fiscal year 2012 and 18 in fisca year 2013. Conducting this number of RCAs, many concurrently, can be daunting when trying to find sta f to participate and serve on the teams, but that has not been my experience as patient safety manager (PSM).

In 2011, while I was developing my role as a PSM, I was fortunate enough to be given a "peer mentor PSM" at another facility in our VISN. Michelle Ernzen, now in quality management at the Grand Junction, Colo., VA Medical Center, had extensive experience. Her motivation, leadership and guidance propelled me forward. I soon found when organizing RCA teams that our facility had several previously "untapped" staff interested in actively promoting patient safety.

"It's important to engage staff from all levels and areas in understanding that patient safety is everyone's concern," said Ernzen, M.S.N., R.N., CPHQ. "One way to engage staff is by having them participate on RCA teams. Front-line staff, in particular, can provide unique insights into processes that can lead the team to finding the key to improving the quality of care."

I encouraged RCA team members to talk with their peers about what they were experiencing, having been on a team, and their impression of subsequent outcomes. As a result, I found several staff either volunteering to be on RCA teams or suggesting possible team members for future RCAs. I have been fortunate to have other staff members who would help spread the word about the importance of conducting RCAs.

All of our RCA teams are made up of a diverse group of members that include those from non-clinical as well as clinical areas. In fact, many of the team members had never met before becoming a team member.

As our PSMs are well aware, each RCA team develops its own "personality." I've found some members to be natural leaders and champions for patient safety, which has really propelled the teams forward. I also approach staff members to determine their interest in learning to lead RCA team processes. Many indicated interest, though some were hesitant because they felt unsettled by the responsibility of taking on a team lead position, but we were lucky to have an RCA training course conducted on-site.

In July 2013, during an NCPS site visit, Amanda Fore, M.S., R.N., NCPS nurse coordinator, conducted an "RCA 101" course for seven team leaders who had indicated interest in learning to lead RCA team processes.

"RCA team leaders can be a wonderful asset and the on-site RCA leader training is invaluable," said Amanda Fore. "The hands-on training provides participants with the tools they need to successfully lead an RCA."

"The patient safety manager continues to provide guidance during the process; however, each also gains time to focus on many other safety-related responsibilities," she added.

Amanda's site visit was very helpful. Within a month of the training, I began to assign participants to lead RCA teams. Each had completed leadership of at least one RCA by December 2013. The following are comments they made when asked about their experiences.

Continued on page 4

A "Lean" Way to Improve Patient Event Reporting

By Maria O'Toole M.S.N., R.N., patient safety manager, Jennifer Cowart, M.D., chief resident, quality management and patient safety, and Lisa Johnson, Ed.D., RRT, patient safety coordinator, Michael E. DeBakey VA Medical Center, Houston, Texas

Background

Effective July 1, 2013, our medical center[1] transitioned from a voluntary paper-only incident reporting process to an electronic patient event reporting system, known as "ePER."

Though ePER can be an excellent method to gather a wide range of information, it is *not* a replacement for the Patient Safety Information System, an internal, confidential, non-punitive system, commonly known as "SPOT." Developed by NCPS, SPOT is the only official VA-wide reporting system for near misses and adverse medical events. It allows users to electronically document patient safety information from across the VA so that "lessons learned" can benefit the entire system [2]

Our Approach

To implement the ePER system, our team used Lean methodology to map the previous process of incident reporting in paper form, which identified significan areas of waste and delay. Overall incident reporting increased significantly after implementation of the new system, while reducing delays in reports reaching the patient safety team.

Lean thinking begins with driving out waste so that all work adds value and serves the customer's needs. Although health care differs in many ways from manufacturing, where the Lean concept began, there are also surprising similarities: Whether building a car or providing health care for a patient, workers must rely on multiple, complex processes to accomplish their tasks and provide value to the customer or patient. Wasted time, supplies, or good will — decreases value.[3]

Voluntary incident reporting is recommended by the Institute of Medicine in its seminal 1999 report *To Err is Human*. Under-reporting of adverse patient events is a widespread problem: It is estimated that fewer than 2 percent of all sentinel events are reported to The Joint Commission.[4]

Methods

Our facility charted a "Black Belt Lean" team to improve incident reporting and eliminate significant reporting delays in early 2013. The team, (led by Maria O'Toole) included nurses, a clinical application coordinator, a physician, laboratory staff, a patient safety coordinator, and a pharmacist. The team used "Value-Stream Mapping" to identify areas of waste in the current paper-based process, which included: lack of availability of the paper forms, "batching" of reports and lost reports. These problems created critical delays in the ability to act on, or even in some cases, receive reports.

The team was tasked from senior leadership to implement the ePER reporting system. Our aim was that all incident reports would be electronically entered and available for review within 24 hours of report entry by July 1, 2013.

We created educational resources to "train the trainer" in the use of ePER, including slide sets and brochures. Training was provided to resident physicians, medical students, physicians, nurses, and other clinical and non-clinical staff. To enhance accessibility, an ePER icon was added to the facility's computer desktops, the tools menu of the electronic medical record system, and our Intranet website.

The system was introduced in a pilot on one inpatient nursing unit and in the Department of Radiology in May 2013. We met the facility-wide "go-live" date of July 1, 2013, and paper reporting was discontinued two weeks later.

Results

Staff began using the ePER site as soon as the desktop icon became available, even before the "pilot" was completed. After the go-live date, only a few paper reports were submitted. A comparison of the third quarter of fiscal year 2012 (paper) to third quarter fiscal year 2013 revealed a 245 percent increase in patient event reporting! And the time between reporting and receipt was reduced from 16.9 to 0 days. Per staff feedback, ePER is "easy to use," one of many reasons for our success. Other factors include the medical center director's support, ePER availability of several access locations, facility-wide marketing during implementation, staff's ability to report anonymously, and senior management's support.

Lessons Learned

Increasing accessibility and anonymity of incident reporting with an electronic system, combined with a facility-wide education campaign, increased incident reporting at our facility while reducing delays. Senior leadership support and interdisciplinary involvement were crucial to the successful completion of this project. Lean methodology helped the team identify areas of waste and delays in the previous process.

Looking Ahead

Continued sustainability will require strategies for managing the increased workload while improving the completion of follow-up documentation.

Team Members

Maria O'Toole, M.S.N., R.N. CNOR VHA-CM, black belt team leader
Donna Richardson, systems redesign, black belt team advisor
Lisa V. Johnson, Ed. D., patient safety coordinator
Jennifer B. Cowart, M.D., chief resident for quality and safety
Vy Nguyen, R.Ph., quality pharmacist
Susan Dierker, R.N., nursing executive
Shirley Koshy, R.N., assistant nurse manager perioperative
Roxie Pierce, clinical applications coordinator
Kimberly Kulig, M.T. (ASCP), quality laboratory manager

References

1. Learn more about the Michael E. DeBakey VA Medical Center: *http://www.houston.va.gov/*
2. Learn more about SPOT: *http://www.patientsafety.va.gov/media/reporting.asp*
3. IHA, Going Lean in Healthcare: *http://www.entnet.org/Practice/qualityimprovement/upload/GoingLeaninHealthCareWhitePaper-3.pdf*
4. Joint Commission: *http://mail.tcrespite.com/TJCNewsletters/Perspectives/Perspectives-10.pdf*

Further Reading

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Improving Communications by "Training the Trainer"

By Amanda Fore, R.N., M.S., NCPS nurse coordinator

Staff members from 25 areas at the VA Greater Los Angeles Healthcare System (GLA) were selected as trainers and came together January 14-15, 2014 for a Clinical Team Training (CTT) train-the-trainer session. The course, a train-the-trainer version of the CTT program which began in January 2013, was designed to facilitate unlimited training opportunities and implementation of crew resource management based projects system-wide.

The 43 trainers, nominated by Donna Beiter, R.N., M.S.N., facility director, comprise a multidisciplinary team responsible for training and leading change projects in the areas they work. For a facility as large as Greater Los Angeles (GLA), serving 1.4 million Veterans in their service area, the train-the-trainer program provides an excellent opportunity to implement and disseminate patient safety concepts related to effective communication and teamwork.

"This training was important to our facility because it not only demonstrated our commitment to fostering a culture of safety, but also displayed our staff's focused intent to deliver safe, quality, patient-centered care to our Veterans," said Ms. Beiter.

Support for the program has been unprecedented. Led by Patient Safety Officer Joann Wortham, M.S.N., C.N.E., CPHQ, and strongly supported by leadership, the program was conducted seamlessly. Through outreach and individualized letters to potential trainers, which included a personal nomination from the director, the selection process was thorough. Trainers came to the session energized and ready to learn and improve the facility's patient safety program. During the next several months, as the trainers work to develop area-specific training sessions and prepare unit-based projects, the opportunity for major transformation is limitless.

"I think this will make a difference for us because our staff is ready to put into practice the many principles they've learned, including how to teach others about the life-saving tenets taught during the training," said Wortham. "This initiative has sparked a tidal wave of discussion and movement toward progressing our patient safety culture to new heights of innovation. All in all, we have certainly reaped double for our efforts."

The extended course was led by NCPS staff. Gary Sculli, R.N., M.S.N., A.T.P., director of the NCPS CTT program, conducted a full day of the interactive module-based curriculum. Day two consisted of a question and answer period followed by a discussion that I led, which concerned project options and implementation.

Lori DeLeeuw, R.N., M.S.N., C.A.P.A., NCPS nurse educator, also had the opportunity to meet with Femi Faminu, R.N., BLS/ACLS training center coordinator, providing expert guidance on inserting the key concepts in simulation.

"This is a very exciting project for the NCPS and the CTT Team," said Sculli. "To have a facility contact us and follow through with such a large project is truly a testament to the commitment that GLA leadership demonstrates when it comes to creating high-reliability teams."

"What makes this so amazing is that they were able to send staff champions to the training from so many areas, each personally selected by the director," he continued. "This training model allows our curriculum to achieve greater saturation than if we trained just one or two units. We'll be guiding GLA through the next year, but there is no question this is a motivated facility well ahead of the curve. GLA doesn't just talk safety — they live it."

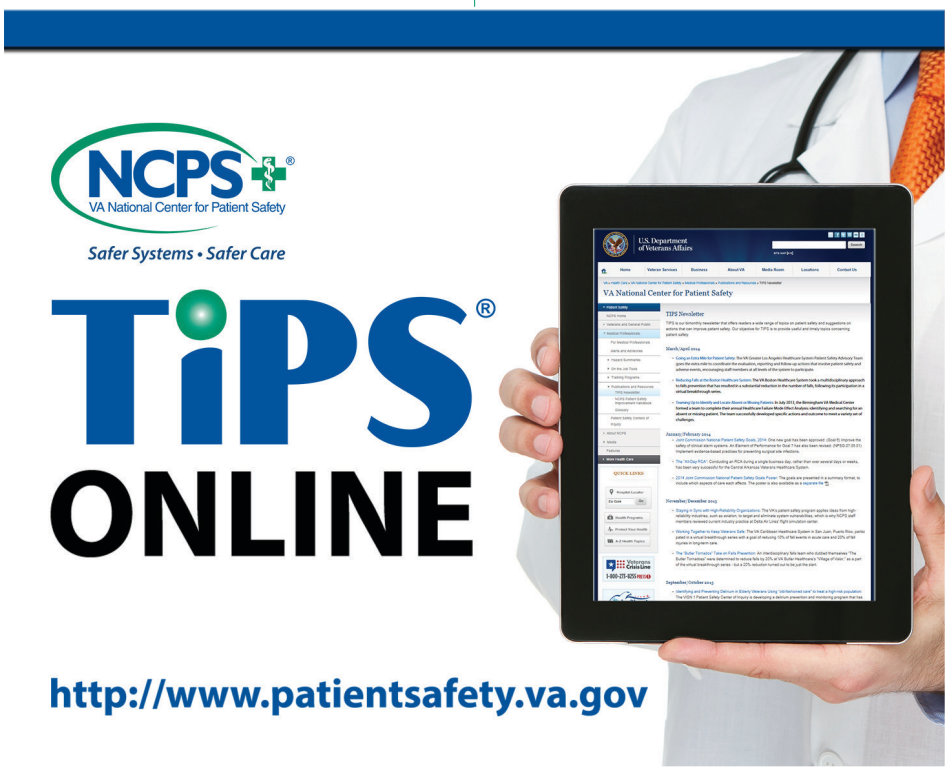
The CTT program creates an opportunity to improve patient safety and reduce the risk of patient harm by facilitating clear and timely communication through collaborative teamwork in the clinical workplace.

Aimed at a multi-disciplinary group of front-line health care providers, this NCPS program is based on techniques used in aviation's Crew Resource Management (CRM) training.

CRM was implemented by the airline industry in the early 1980s after a series of highly publicized accidents resulted not from mechanical malfunctions, but from poor communication and team decision making. Today, the airlines enjoy an exemplary safety record, due in large part to the implementation and sustainment of CRM methodologies.

Note

Learn more about CTT: *http://www.patientsafety.va.gov/professionals/training/team.asp*



Staff Leadership Key to Enhancing the Root Cause Analysis Process

(Continued from page 1)

"Being on a team gave me the opportunity to work collaboratively with other members to determine the root cause of the specific adverse event and, as a result, provide the opportunity to help minimize the chance of inadvertent harm to patients," said Kristy Barlow, M.A., a facility psychometrist.

"Becoming a team leader shifted my focus. Team members looked to me for leadership and guidance on how to identify and, in some cases, look differently at a situation when identifying contributing causal factors," she said. "Many times team members get 'stuck' in the process and tend to look for human error or want to use negative descriptions in the statements."

"Being a leader allowed me the opportunity to help guide the team and get them to look at the whole picture," Barlow continued. "I wanted them to see that our main goal was to find how a care system's problems affected our staff and ultimately make things better by repairing a broken system."

"We take a lot of pride in promoting patient safety within our organization," she concluded. "And, for me, one of the most rewarding things about being a team leader is to be able to see how action plans are being implemented and can create positive change."

Josh Douglass, a member of the health administrative service, has also been a team leader.

"When I first was asked to serve on an RCA team, I was still quite new to the organization. I quickly discovered that our facility values patient safety because it is invested in learning and bettering itself when adverse incidents do occur. I saw how the RCA process brings together into a team individuals that may never otherwise interact during their normal duties," he said. "As a clinic clerk at the time, being able to delve into an issue with people from a clinical background gave me the opportunity to gain a new perspective on the interworking of our hospital and grasp a bigger picture of what we do as an organization."

"When I was approached to take the RCA leadership training, I really felt that our organization valued my ideas and was invested helping me develop professionally," Douglass continued. "Given the task of leading a team comprised of experienced clinicians, I was apprehensive to say the least! Though I was still relatively new to our organization compared to my team, I felt like we had built a cohesive unit in a short amount of time."

"Coupling that with great support and advice from our PSM, we were able to deliver to executive leadership with what I feel were very strong proposed actions and relevant lessons learned. I am very proud of my team and organization for supporting the RCA process — and that I was given a leadership position," Douglass concluded.

Elizabeth Lima, Ph.D., the facility's health behavior coordinator and clinical psychologist, noted, "The transition from being an RCA team member to an RCA team leader was significantly facilitated by the on-site training received and the continuous support from our PSM."

"During staff interviews, it was remarkable to see how the RCA process, when done well, really helps to assuage staff concerns about findings being used in a punitive manner," she continued. "Overtime, they become more comfortable, in part due to our approach and style during interviews, and are able to provide their insights into the event that allows the team to gain much more information and then be able to make meaningful and accurate conclusions."

"On a personal level, I have appreciation for the opportunity to meet and interact with individuals from areas of the hospital I normally don't have much contact with. This has afforded me the opportunity to begin gaining a more global understanding of the facility and how the different systems affect each other," added Dr. Lima.

Dianne Warney, B.S.N, R.N., Surgical Intensive Care Unit, said: "Being a participant for the first time, gave me a strong sense that our leaders put safety first. It was an opportunity to a fect real change. The RCA process is effective and not cumbersome. And participation allows different levels of staff to know that they can make a difference, as well as function in a collaborative manner, regardless of their backgrounds or titles."

"Being a member of an RCA team showed me the possibilities of being able to influence change that would improve patient safety and outcomes," noted Julie Azar, B.S.N., R.N., also a member of the Surgical Intensive Care Unit staff.

"And having an opportunity to be a team leader and enhance the RCA process has allowed me to realize the commitment our organization has to achieving a higher level of patient safety," she added. "Our leadership is committed to front-line involvement and it's great to have an opportunity to work collaboratively with other staff."

"In addition to developing action plans which improve patient safety, I have been able to develop ongoing professional relationships with the other members," Azar continued. "This collaborative effort has carried over into our daily work interactions and has ultimately had a positive impact on patient care. As a staff nurse, I feel empowered to be a catalyst for change, which has not been the case in other organizations."

Conclusion

Discovering and training active, involved RCA team leaders has resulted in strengthening our patient safety program; but without the support from leadership at all levels, we would not have been able to do so.

People who have participated on RCA teams have also been able to see the results of their work, passed the positive experiences on to others, and engendered wider and wider interest in participating on an RCA team — strengthening our organization's culture of safety.

Notes

1. Learn more about the medical center: *http://www.asheville.va.gov/*
2. Learn more about the RCA process: *http://www.patientsafety.va.gov/professionals/onthejob/rca.asp*