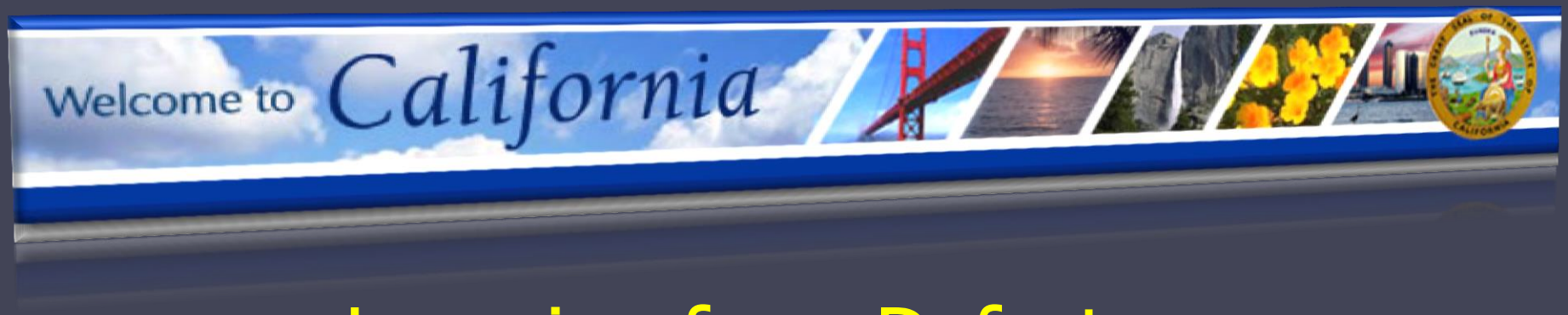


Learning from Defects

Sustaining Safe Care ~ The Penguin Project

Mary E. Nennig, BSN, RN
Healthcare-Associated Infections Program
Center for Health Care Quality

Adapted from "On the CUSP: Stop HAI"

Lessons Learned from the Field ~ Why Learning from Defects Is Important

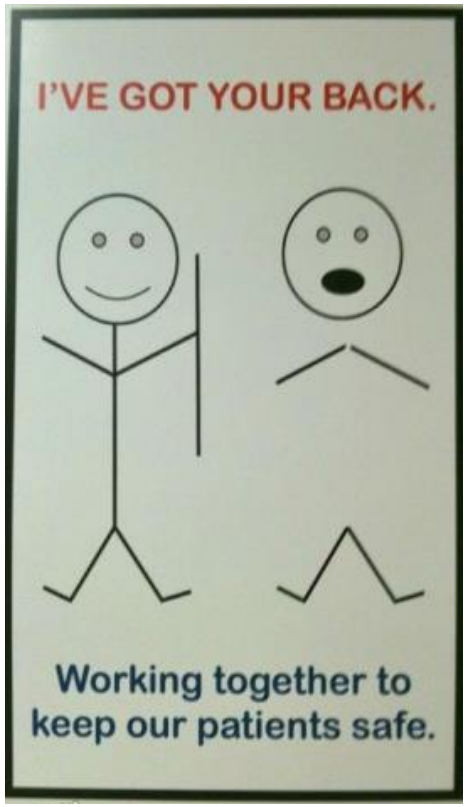
- In order to incorporate improvements into clinical practice it is necessary to perform a systematic review of areas of potential patient harm and to take action
- Shared accountability by all staff must be operative on all units
- It is wise to know the value and efficacy of various risk reduction strategies to sustain improvements

Key Concepts

- Focus on systems not people
- Prioritize
- Use Safe Design principles
- Go mile deep and inch wide rather than mile wide and inch deep
- Pilot test
- Learn form one defect a quarter
- Answer the 4 questions

What is wrong with this picture…

…and how can we learn from it?



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Healthcare-associated Infections HAI Elimination

Defects Defined

A defect is any clinical or operational event or situation that you would not want to happen again.

Examples:

- Unstable oxygen tanks on beds
- Medication look-alike
- Inconsistent use of agreed upon resource tools
- Inaccurate information by residents during rounds

Sources of Defects

- Adverse event reporting systems
- Sentinel events
- Claims data
- Infection rates
- Complications
- Where is the next patient going to be harmed?

Learning From Defects: Four Questions

1. What happened?
2. Why did it happen?
3. What will you do to reduce the risk of recurrence?
4. How will you know the risk is reduced?

What Happened?

- Reconstruct the timeline and explain what happened
- Put yourself in the place of those involved, in the middle of the event as it was unfolding
- Try to understand what they were thinking and the reasoning behind their actions/decisions
- Try to view the world as they did when the event occurred

Why Did It Happen?

- Develop lenses to see the system factors that lead to the event
- May result from production pressures
- Damaging consequences may not be evident until a “triggering event” occurs

What will you do to reduce the risk of it happening again?

- Prioritize most important contributing factors and most beneficial interventions
- Employ Safe Design principles:
  - Standardize what we do
  - Eliminate defect
  - Create independent check
  - Make it visible
- Safe Design applies to technical and socio-adaptive work

What will you do to reduce risk?

- Develop list of interventions
- For each intervention rate:
  - How well the intervention solves the problem or mitigates the contributing factors for the accident
  - The team's belief that the intervention will be implemented and executed as intended
- Select top interventions (2 to 5) and develop intervention plan
  - Assign person, task follow up date

How do you know risks were reduced?

- Did you create a policy or procedure (weak)
- Do staff know about policy or procedure
- Are staff using the procedure as intended
  - Behavior observations, audits
- Do staff believe risks were reduced

Risk or Error Reduction Strategies

Listed from most effective to least effective

Forcing functions and constraints

Automation and computerization

Standardization and protocols

Checklists and double check systems

Rules and policies

Education and information

"Be more careful. Be vigilant."

Just Culture and Learning from Defects

A system of ***shared accountability***

- ***Healthcare institutions*** are accountable for the systems they have designed and for supporting the safe choices of the patients, visitors and staff

- ***Staff*** are accountable for the quality of their choices, knowing that they may not be perfect, but can strive to make the best possible choices available

Staff Safety Assessment

- Step 1 – What are clinical or operational problems that have or could have jeopardized patient safety?
- Step 2 – How might the next patient be harmed on your unit?
- Step 3 – What can be done to minimize harm or prevent safety hazards?

Next Steps

- List all defects submitted by staff
- Prioritize defects by the potential level of risk to one or more patients
- Select one defect to address with the support of senior executive
- Develop a plan for the selected defect

Using the Learning from Defects Tool

- Assemble team with staff appropriate to define resolution
- Minimum requirement: physician, nurse, administrator and others as appropriate
- Complete the Learn from Defects Tool
- Implement the plan
- Evaluate the plan to determine if risk was reduced

Safety Issue Worksheet for Senior Executive

- Engage the senior leadership in addressing the safety issues identified

- Use the form to:
  - Document issues
  - Identify potential solutions
  - Record resources needed

There is no routine work in healthcare

Learning from Defects = Professional Development

Summary

1. Create a one-page summary answering the four Learning from Defects questions

2. Share the summary within your organization
   - Engage staff in face-to-face conversations to provide opportunities to learn from defects

3. Share de-identified information with others (pending institutional approval)

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Questions?

Mary Nennig
California Department of Public Health
Healthcare-Associated Infections Program
mary.nennig@cdph.ca.gov