

WHY ARE WE FAILING TO PREVENT SENTINEL EVENTS?

BY MARK PARADIES

DEATH TOLL ↑

What kills more people in the US than industrial accidents, highway accidents, and airline accidents combined? Mistakes in hospitals. The technical term for these mistakes is “**Sentinel Events.**”

Estimates of the deaths caused vary. We use estimates because there are no accurate statistics on the total number of deaths caused by mistakes in hospitals. There is no national reporting requirement.

Even though there is no national reporting requirement, studies show that despite over a decade of effort to stop sentinel events, no progress is being made. Some studies actually show the problem getting **worse**. And this problem isn't unique to the USA. It is a worldwide phenomenon.

WHY NO IMPROVEMENT

Why can't we improve? There are a number of factors that make improvement difficult:

1. Healthcare Complexity
2. Poor Root Cause Analysis (RCA)
3. Inadequate Corrective Actions
4. Not Enough Management Attention

We will review all of these factors and what we can do about them in the following sections.

HEALTHCARE COMPLEXITY

Medical practice keeps getting more complex. More complex technology. More drugs with more interactions. More pressure to work faster and be more efficient. The result? More chances to make errors with catastrophic consequences. At the same time, downsizing means less staff to catch errors.

Healthcare complexity calls for increased, proactive application of system reliability and human factors solutions to improve healthcare delivery. Intelligent, resilient design can make complex systems reliable. Plus, staffing needs to be assessed to ensure adequate coverage to apply error-catching activities.

POOR RCA

After a decade of using RCA to analyze sentinel events, the lack of progress indicates a failure of healthcare root cause analysis.

What's wrong? A majority of healthcare facilities use inadequate RCA systems including fishbone diagrams, 5-Whys, and healthcare derived root cause checklists. These “simple” techniques are inadequate to analyze complex healthcare sentinel events.

Not only are the RCA systems inadequate, the RCA training is also inadequate. People are assigned to investigate healthcare sentinel events with little or no training. They are lucky to attend a free one to eight hour session provided at a professional society meeting or sponsored by an insurance provider.

But healthcare investigators face another factor that makes root cause analysis even more difficult: **BLAME**. More than your everyday blame that comes with every accident. Medical malpractice seems designed to make people less open - less willing to cooperate wholeheartedly with investigators.

Furthermore, doctors who are independent contractors are naturally suspicious of investigators who seem to question their judgment and put their credentials at risk. Is it any wonder that we haven't made progress?

Despite some of the factors that are difficult to address, picking an advanced root cause analysis system and getting people trained shouldn't be hard. After all, there is TapRooT®!

The TapRooT® System was designed to be used for simple and complex investigations. It has been applied successfully in healthcare settings and has improved performance of complex systems. The 2-Day and 5-Day TapRooT® Courses have been customized for on-site training of healthcare investigators to help them with demanding investigations. Problems solved!

POOR CORRECTIVE ACTIONS

Inadequate root cause analysis is just the start. Typically, we see the weakest corrective actions applied to prevent repeat sentinel events.

Those familiar with the terminology “hierarchy of controls” applied in industrial and process safety may know what I am pointing out. Healthcare corrective actions often include the application of new standards that depend on human reliability. When these fail, investigators recommend some of the “re” corrective actions, including: re-train, re-mind, and re-emphasize (discipline).

But these are the weakest possible corrective actions (see pages 127 -129 in your 2008 *TapRooT® Book*.) More effective corrective actions include another type of “re” corrective action. Removing the hazard or the target. Or, re-engineering the process to improve system reliability and decrease human error without adding additional tasks for people to cope with.

These types of corrective actions and more are the result of a TapRooT® investigation when investigators apply the suggestions in the Corrective Action Helper® and apply Safeguards Analysis as part of the development of their solutions.

MANAGEMENT ATTENTION

One might say that the cause of all the previous problems is inadequate management attention to performance improvement at healthcare facilities. Part of this inattention can probably be attributed to the fact that most healthcare administrators aren't trained in advanced performance improvement techniques. Even the few who have had Six Sigma training don't know about advanced root cause analysis and, therefore, don't know about the action they could take to make performance improvement happen.

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WHY ARE WE FAILING TO PREVENT SENTINEL EVENTS? (CONTINUED)

Plus, hospital administrators need to become more involved in the analysis, review, and approval of sentinel event investigations. Involvement can bring them face-to-face with the challenges people are experiencing in the field. Trained managers reviewing a SnapCharT® can see beyond blame to real action to improve performance. They can see their contribution to errors that come from understaffing and fatigue. They can become a knowledgeable part of the team fighting sentinel events.

SIMPLE PLAN TO IMPROVE

Each day, hundreds of lives are lost because we haven't won the battle to defeat sentinel events. Don't wait for the entire healthcare industry to wake up to the problems and solutions. Don't wait for regulatory requirements to force your facility into action. Start today with the tools that are at hand.

1. Bring the message to management. Get them involved. They should feel that EVERY sentinel event at their facility is a personal failure to address the causes!

2. Adopt an advanced root cause analysis system – TapRoot® – including the latest root cause analysis software and database to help you learn from small incidents to prevent major sentinel events.

3. Get the training that your facility needs in root cause analysis. This includes training for hospital administrators, staff, and your performance improvement experts.

Start with a customized 2-Day TapRoot® Course for senior management. Follow that with a 2-Day TapRoot® Course for those who are frequently involved in sentinel event investigations and a 5-Day TapRoot® Course for those who facilitate sentinel event investigations.

4. Once you complete steps 1-3, you are ready to start continuous improvement efforts. Start by attending the TapRoot® Summit healthcare track to find out what other leaders in the field of healthcare are doing to continue improvement efforts.

Don't wait. People are dying waiting for improvement to occur. **Start today!**

Last Chance

Register NOW for the
TapRoot® Summit
Feb 29 – Mar 2, 2012
Las Vegas, Nevada, USA



If you act when you get this Newsletter, you still have time to register. See:

www.TapRoot.com/Summit.

SPECIAL PRE-SUMMIT COURSES

Las Vegas, Nevada, USA
February 27-28, 2012

Still Time to Register!

Don't miss this chance for learn advanced root cause analysis and performance improvement skills.

[TapRoot® Incident Investigation & RCA](#)

[2-Day TapRoot®/Equifactor®](#)

[TapRoot® Quality Root Cause Analysis](#)

[Basic Investigation Skills](#)

[Fatigue Risk Management Program](#)

[TapRoot® Advanced Trending Techniques](#)

[How To Find & Fix Culture Problems](#)

[Stopping Human Error](#)

[Advanced TapRoot® Skills](#)

[Risk Management](#)

[TapRoot® Software Admin/Super-User](#)

With 11 excellent courses to choose from, you know there is at least one course you need to attend. See the Summit web site to register:

www.taproot.com/summit

STOPPING HUMAN ERROR

Recently, I read an article by a human factors expert that said human error can't be eliminated but that errors could be managed. The article covered the common information about Skill-Rule-Knowledge based behaviors and preventing slips and rule-based errors.

Just a couple of days later, I heard a talk about a method to "self-trigger" and recognize when a mistake was just about to be made so that you could stop yourself in the nick of time and not make a mistake.

The theory was that people are more error prone when they are rushing, fatigued, frustrated, or complacent. And when this is true, they are more likely to take their eyes and mind off a task, put themselves in the line of fire, or lose balance, traction, or grip. All you need to do is to constantly observe your own state of mind, and if you become complacent, frustrated, rushed, or fatigued, you alert yourself to be careful and watch/think about what you are doing. Take a break to reduce fatigue. Stop rushing and realize that your frustration is counter-productive.

You can also work on habits to self-check for errors when you might be in an error likely situation (like being distracted).

What's wrong with this? It requires people to exhibit behaviors that aren't "human." People are really bad at self-monitoring. It's unlikely that if you are hurried, fatigued, frustrated, or complacent that you will notice it "just in the nick of time." However, afterwards if you admit you were hurried, fatigued, frustrated, or complacent, then the condition seems like an obvious pre-condition and you failed to notice. Thus, your failure is the "cause" of the accident.

A better idea would be to use human factors tools to improve the human reliability of the tasks and use mistake proofing to trap or prevent errors that can't be tolerated.

Whenever your performance improvement initiative requires people to be like machines, my bet is that the program will fail. Instead, use humans where their skills are needed and use automation where unvarying performance is needed.

FUNNY SUMMIT PICS

Don't take things too seriously. Having fun can make learning and improving fun. That's why we have fun at the Global TapRoot® Summit. We even laugh at ourselves.

We don't always look this funny, but cameras have a unique way of capturing people when they have a silly look on their face (or their eyes shut!). Add a caption ... and it's funny! Here are some examples from previous TapRoot® Summits...



Newest fashion ... a headlamp!

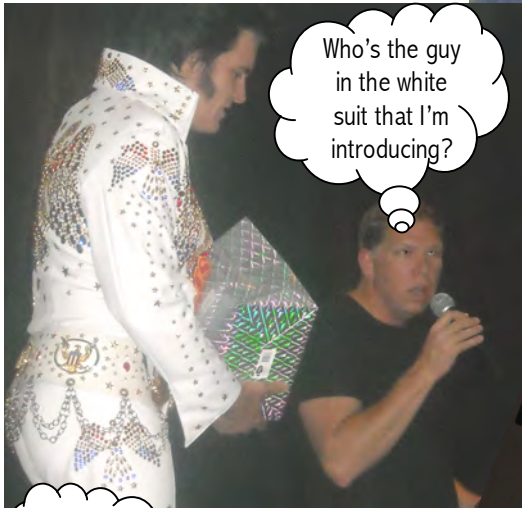


With shades, no one can tell when you're sleeping!



I need more sleep at these Summits!

Me too!



Who's the guy in the white suit that I'm introducing?



Hea, hea, hea



If only this was the Masters!



Isn't the ball supposed to move?



Who dat?

What happens in Vegas, stays in Vegas (3-5 years!)



I knew I shouldn't have volunteered to drive to the Summit! Now, how'm I gonna get the truck out'ta this crater?



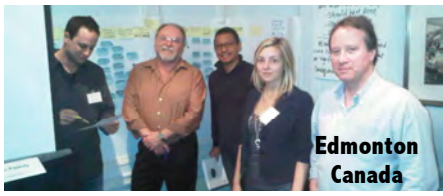
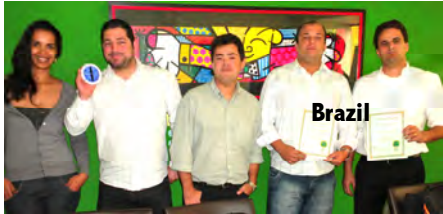
I can fly!

INTERNATIONAL ROOT CAUSE NEWS



TAPROOT® COURSES AROUND THE WORLD

Why do industry leaders around the world use TapRoot® to find root causes? Find out at a TapRoot® Course. For a worldwide list, see: www.taproot.com/courses
Photos from recent TapRoot® Courses...



GOOD EXAMPLE OF POSTED PROCEDURE FROM IRELAND

This photo came from my tour of the Baileys Irish Crème Factory in Dublin.



UK ON-LINE ACCIDENT REPORTING

The UK HSE now requires accidents to be reported on-line at the UK HSE web site:

www.hse.gov.uk/forms/incident

The only incidents that can be reported by phone are fatalities and serious injuries.

This is part of efforts to cut expenses at the UK HSE after budget reductions to meet new austerity measures.

Could you save money with an on-line incident reporting and processing system? Your Enterprise TapRoot® Software can serve this function. It can be set up for anonymous incident reporting.

Investigators will save time by using the on-line software and reporting functions. And reports can be customized by your staff or during implementation by having SI develop custom reports.

Want more information about the Enterprise TapRoot® Software? Call us at 865-539-2139 or e-mail info@taproot.com to set up a web demonstration.

DONALD GANNON

Where facts are few,
experts are many.

INTERNATIONAL TAPROOT® COURSE SCHEDULE

Have you planned your TapRoot® Training for 2012? You can schedule courses at your sites around the world or you can send people to our public TapRoot® Courses.

Where do you see the worldwide schedule? At www.taproot.com/courses.

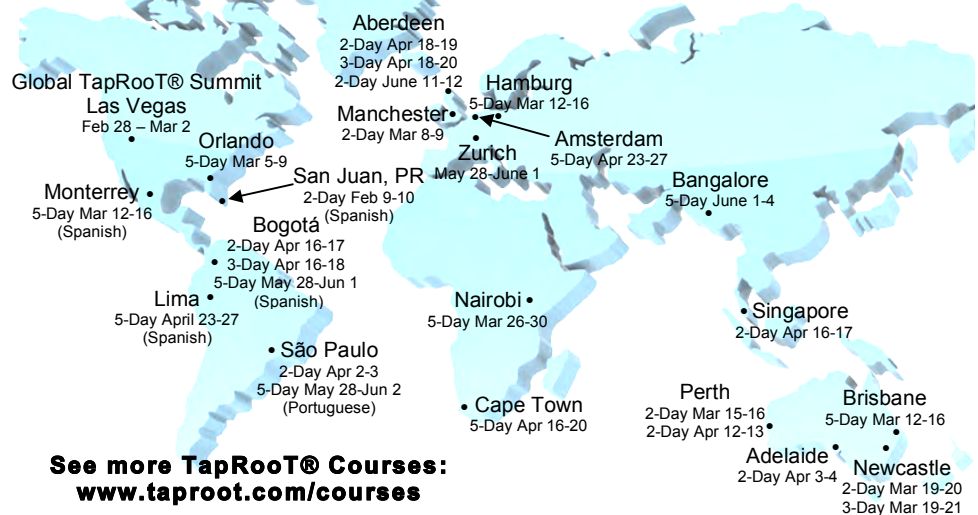
Just click on the continent that you are interested in and see the upcoming schedule.

Here are a few of the new places where we are holding courses in 2012:

- 2-Day - Antwerp, Belgium - Feb 8-7
- 2-Day - Mumbai, India - Feb 13-14
- 5-Day - Hamburg, Germany - Mar 12-18
- 2-Day - Oklahoma City, OK - Apr 11-12
- 2-Day - Wilmington, NC - Apr 12-13
- 5-Day - Halifax, Canada - April 16-20
- 5-Day - Lima, Peru - Apr 23-27
- 5-Day - Anchorage, AK - May 14-18
- 5-Day - Zurich, Switzerland - May 28-Jun 1
- 5-Day - Bangalore, India - Jun 4-8
- 2-Day - Rio de Janeiro, Brazil - Jul 5-6

Sign up now!

UPCOMING TAPROOT® COURSES AROUND THE WORLD ...



See more TapRoot® Courses:
www.taproot.com/courses

TAPROOT® COURSES
CANADA/USA/MEXICO

Sign up 3 or more at once and SAVE \$100 per person! See the full TapRoot® Course schedule at www.taproot.com/courses.

**3-Day TapRoot® / Equifactor®
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2.4 CEUs 4 CIH CM Points **\$1895 USD**

3-Day Includes TapRoot® Software!

LAS VEGAS (Special 2-Day)	Feb 27-28
CALGARY , AB, Canada	Mar 7-9
HOUSTON	Mar 19-21
HOUSTON	May 8-10
PITTSBURGH	May 15-17

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 Root Cause Analysis Training**

1.6 CEUs 2 CIH CM Points **\$1095 USD**

LAS VEGAS , (Pre-Summit)	Feb 27-28
CALGARY , AB, Canada	Mar 7-8
TORONTO , ON, Canada	Mar 14-15
HOUSTON	Mar 19-20
EDMONTON , AB, Canada	Mar 27-28
INDIANAPOLIS	Apr 2-3
DENVER (Golden, CO)	Apr 3-4
OAKLAHOMA CITY	Apr 11-12
WILMINGTON , NC	Apr 12-13
ALBUQUERQUE	May 3-4

**5-Day TapRoot®
 Advanced Root Cause Analysis
 Team Leader Training**

4 CEUs 7.5 CIH CM Points **\$2395 USD**

Includes TapRoot® Software!

Prior 2-Day students/licensed sites save **\$500**

ORLANDO	Mar 5-9
MONTERREY , Mexico (Spanish)	Mar 12-16
KNOXVILLE , TN	Mar 12-16
VANCOUVER , BC, Canada	Mar 19-23
BALTIMORE	Mar 26-30
HOUSTON	Apr 16-20
HALIFAX , NS, Canada	Apr 16-20
PORTLAND	Apr 23-27



For TapRoot® Courses in Africa, Asia, Australia, Europe, Middle East, South America, see: www.taproot.com/courses

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**Why Are We Failing
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 Events?**

(See Page 1)

Funny Summit Pics

(See Page 3)



ROOT CAUSE NETWORK™ NEWSLETTER

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Good Reading...

- Why Are We Failing to Prevent Sentinel Events?** (Page 1)
- Last Chance** (Page 2)
- Stopping Human Error** (Page 2)
- Pre-Summit Courses** (Page 2)
- Funny Summit Pics** (Page 3)
- Good Example of a Posted Procedure** (P. 4Int)

(Note: Page 4Int Only in PDF Version – e-mail: info@taproot.com to get yours!)

Go to the **BEST** Root Cause Training - TapRoot®
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