

Agenda Item: 5.3.6
Prepared by: M.B. Thomas
Meeting Date: January 22, 23, 2009

Health Alliance Safety Partnership

Summary of Request:

This report includes key components of the pilot review of the Health Alliance Safety Partnership from July 1, 2005 to September 30, 2008. In addition, there is an update for the Board on the status of the pilot project.

Historical Perspective/Background Information:

Attachment A provides key information from a review of the HASP Pilot Program. Included in the report is the Eindhoven Classification Scale (pg. 3) which defines technical, organizational, human and patient factors that can contribute to errors in patient care. The frequencies of each of these categories in the pilot are provided on page 4. Note the high numbers of organizational factors that contributed to nursing errors. Page 5 entitled *Aggregate Pilot Themes* provides detailed examples of all of the factors involved in the cases.

Although there were only 13 nurses who participated in the pilot during this reporting period, the analysis of all of the factors provides themes that are lessons to be learned. Though the Board can address issues involving nursing (or human) factors, it is up to the health care industry to address the organizational and technical factors. SB 993 (80th Legislature) empowered the Board to notify Chief Nursing Officers (CNO) of any systems issues identified during the investigation of a nurse. This notification is likely to assist the CNO in making organizational changes that can reduce nursing error.

As reported in the October 2008 Board meeting, the Board is not accepting any new cases in the HASP Pilot Program until there is clarification about operational support from M.D. Anderson. Board staff will be conducting a conference call with M.D. Anderson representatives to discuss this topic on January 29.

Staff Recommendations:

None. This report is for information only.

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Annual Report

Pilot Review to Date

July 1, 2005 to September 30, 2008

The information provided in this document is part of the Quality Improvement process for the Healthcare Alliance Safety Partnership (HASP) and as such this information is confidential, privileged and protected from discovery.

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PARTICIPATING MEMBERS OF THE HEALTHCARE ALLIANCE SAFETY PARTNERSHIP

Principal Investigator: Sherry Martin

Program Director / Investigator: Debora Simmons

HASP Secretary / Investigator: Krisanne Graves

<p><u>Texas Medical Center HASP</u> St. Luke's Episcopal Hospital Roemary Luquire Karen Myers Peg Reiter Judy Ong Ho Gerry Jones</p> <p>Texas Children's Hospital Susan Distefano Francine Kingston Kim Williamson</p> <p>UT M. D. Anderson LaTasha Burns Patty Wilson Ginny Bowman Barbara Summers</p>	<p><u>Community HASP</u> Palo Pinto General Hospital Fred Danforth Ellen Murph Robin Berry</p> <p>Sid Peterson Memorial Hospital Kaeli Dressler Anne O'Brien Tammy Fisker Lori Pruitt</p> <p>Uvalde Memorial Hospital Edward Russell Cathy Alvarez Robert Garcia</p> <p>Woodlands Community Medical Center – St. Luke's Peg Reiter Liesha Davis Janet Hafeez</p>
<p><u>Seton HASP</u> Joyce Batcheller Jane Ezell Jo Keisman Collen Mullins Lynne Andrus Chris Scheer</p>	<p>Mary Viney Terri Grassau Robert Walsh Karen Burkman Cindy Krentz</p>

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Eindhoven Classification Scale / Modified for Healthcare

Category	Description
Latent Errors	Errors that result from underlying system failures
Technical	Refers to physical items, such as equipment, physical installations, software, materials, labels, and forms
	Technical failures beyond the control and responsibility of the nurse
	Failures due to poor design of equipment, software, labels, or forms
	Correct design was not followed accurately during construction
	Material effects not classified under TD or TC that contribute to a failure specifically related to their physical characteristics
Organizational	Refers to failures under the control of the organization, such as management priorities and transfer of knowledge
	Failures at an organizational level beyond the direct control and responsibility of the nurse
	Failures resulting from inadequate measures taken to ensure that situational or domain-specific knowledge or information is transferred to the nurse
	Failures related to the quality and availability of the protocols, policy and procedures or instructions within the organization or available in that situation (too complicated, inaccurate, unrealistic, absent, or poorly presented)
	Internal management decisions in which safety is relegated to an inferior position in the face of conflicting and overwhelming demands or objectives. This is a conflict between production needs and safety (e.g., decisions about staffing levels)
	Failures resulting from collective approach to risk and attendant modes of behavior in the investigating organization
Human Performance Factors	Human failures originating beyond the control of the individual
	The inability of an individual to apply existing knowledge to a novel situation
	Incorrect fit between an individual's qualifications, training, experience or education and a particular task
	Lack of task coordination within a health care team in an organization
	Failures in the correct and complete assessment of a situation or important factual information including relevant conditions of the patient and materials to be used before starting the intervention
	Failures that result from faulty task planning (selecting the wrong protocol) and/or execution (selecting the right protocol but carrying it out incorrectly)
	Failures during monitoring of process or patient status during or after intervention
	Failures in performance of fine motor skills, sequencing of actions and processing of multiple tasks
	Failures in memory of important facts
Patient-related factor	Failures related to patient characteristics or conditions that influence treatment and are beyond the control of
Unclassifiable	Failures that cannot be classified in other category

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AGGREGATE PILOT SUMMARY

(Through September 30, 2008)

Case Count Summary

Cases Accepted	13
Cases Completed and Closed	11
Cases in Resolution Phase	2
Cases in Discovery Phase	0

Contributing Factor Count Summary*

	1	2	3	4	5	6	7	8	9	10	11	12	13
Technical Factors	2	2	8	5	23	4	9	6	10	10	10	7	2
Organizational Factors	48	48	7	12	32	26	18	32	20	20	53	19	22
Human Factors	14	14	12	7	24	14	14	22	7	7	29	17	12
Patient Factors	11	11	1	6	9	8	1	3	4	4	6	0	2

* For a review of Eindhoven Contributing Factor categorization, see Page 3

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AGGREGATE PILOT THEMES

TECHNICAL FACTORS

- Issues with computer software have been contributing factors in five cases.
- Labels are not sufficient deterrents to error.
- Default settings for pharmacy systems contributed to error.
- Overload on institution infrastructure contributed to software failure.
- Similarity in equipment labeling, size, and markings of equipment.

ORGANIZATIONAL FACTORS

- Failure in communication is a contributing factor in most cases.
- Information transfer from one provider to another has been a contributing factor.
- Production pressure or an emphasis on task completion has contributed to a 'sense of hurry and business' consistently throughout the majority of cases.
- Complicated forms and policies & procedures have been contributing factors.
- Poorly displayed information has been a significant contributor in several cases.
- Inconsistent policy and procedures led to ambiguity in practice.
- High patient acuity was contributory.
- A lack of redundancy or ability for peer support with critical decisions was found in one case.
- On call policy contributed to failure in one case.
- Checklists ineffective.

HUMAN FACTORS

- High levels of experience and competency have been present in most cases.
- Distractions are present as contributing factor in almost every case.
- A lack of teamwork and availability of assistance have been consistently prevalent.
- Work related emotional stress (nurse) has been present in several cases.
- Lack of knowledge has been present in three cases.
- Fatigue has been a contributing factor in several cases.
- Visual acuity and small font sizes contributed to error in one case.
- Mis-stocked supplies were contributory.

PATIENT FACTORS

- When patient condition was appropriate, patients have not been actively involved in their own care.

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PILOT QUALITY ASSURANCE MEASURES

	Median in Days (2007 Report)	Median in Days (2008 Report)
Event to Report Received (days)	34	43.8
Event to ERC (days)	147.5	160.3
ERC to Action Plan (days)	17.5	18.4
Event to Completion (days)	310	344.7
Report to Action Plan	123.5	135.1

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