Critical Event Review
A Facilitated Process for Allina

Facility	
Medical Record #	
Patient Name	
Patient DOB	
PVSR #	**REQUIRED**
Following to be completed by Allina System Safety Staff	
Event ID#	
Date Event Entered	
RCA Due Date	
RCA Submitted Date	

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ITEMS MARKED WITH A RED ASTERISK (*) ARE REQUIRED ITEMS FOR REPORTING TO THE MN PATIENT SAFETY REGISTRY

*Facility:		*Event Date:	
*Event Discovery Date:		*Event Time:	
RCA/CAP Due Date:		*Patient Type:	
Patient Initials:		*Patient Age:	
Date of Review:	*Information Consulted: (Cite references)		
*Pre-Event Condition:			
*Event Location:	*AHE Type	*Severity of Injury Use PVSR Definitions	
*Describe the Event in Detail (Pertinent information based on type of event)			
*Immediate Action Taken:			

▪ Confidentiality Statement

- The sole purpose of this meeting is to further quality improvement and all data and information acquired through this process shall be held in confidence.

- This information is protected under Minnesota Statute 145.61, et. seq., commonly known as the peer review statute. In other words, what is discussed in this room must not be shared outside this room.

- Limited disclosure of some of this information is permissible only when necessary to carry out the quality improvement plan and should be coordinated through Risk Management and Patient Safety.

- The information you learn from others or the discussion and conclusions of the group must not be disclosed to the patient, your insurance company, the media or an attorney who is handling a malpractice case as this would breech confidentiality under the statute.

- Your signature on the sign-in indicates your attendance as well as your understanding and acknowledgement of your responsibility and legal obligation to maintain this level of confidentiality.

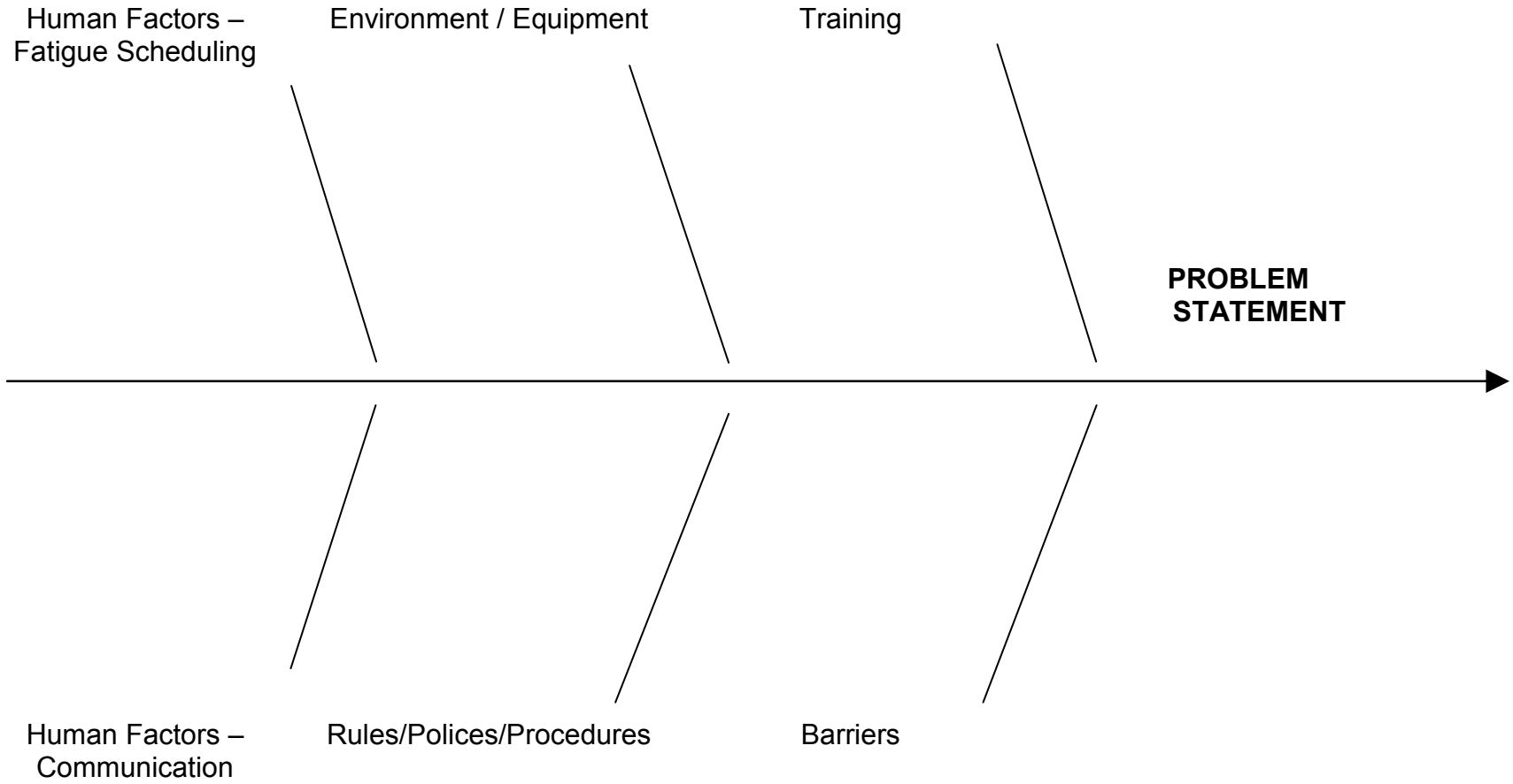
- **Facilitator(s) and *Title(s):**
- **Participants:**

Name	**Title**
	*
	*
	*
	*
	*
	*
	*
	*
	*
	*

Time Line

Multi – Causal Analysis

This chart is set up in a table format – To use, ***left click*** *anywhere on the chart to get a* ***BOX*** *to form around it. Then with the box in place,* ***right click*** *the mouse and select* ***"Document Object"*** *and then select* ***"Open".*** *The table will then open in another sheet. Go ahead and make your entries to that document. When finished, click on the "x" in the right upper corner to* ***"Close Window"****. Your entries will then be saved in this chart.*



***What are the Key Learnings from this event to share with other facilities to enhance safety?**

Are there other areas that might benefit from what was learned related to this event? (*List*)

Might other sites benefit from what was learned related to this event? (*List*)

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Categories: (*Select One)* **Human Factors – Fatigue/Scheduling** **Rules/Policies/Procedures** **Human Factors – Training** **Environment/Equipment** **Human Factors – Communication** **Barriers**			***SELECTED CATEGORY:** ***Is this category a contributing factor OR root cause?** *Must have at least 1 root cause reported*	
***Briefly describe the Root Cause Finding**:* *---See Tip Sheet (p. 13)*				
***Corrective Action Plan**/Risk Reduction Strategy—describe the action that will be taken to reduce the risk of reoccurrence*				
Measurement Strategy ***Measure the effectiveness of action, not the completion of the action*** ▪ What is the goal ▪ Define sampling plan and time frame ▪ Define numerator / denominator ▪ What is the threshold ▪ Plan for when initial measure did not meet threshold				
**How will effectiveness of action be monitored over time*				
**How will CAP be communicated within and across departments*				
**Implementation Date*				
**Staff Position(s) Responsible for Implementation*				
**What is the measure for MOS (measure & goal)?*				
****MOS –** Met at 4 months?* *__ Yes __* ***No*** ****Actual Performance Achieved?*** %	**If no, what are the barriers**?***	*What changes will be made to meet threshold at 8 months?	****MOS –** Met at 8 months?* *__ Yes __* ***No*** ****Actual Performance Achieved?*** %	**If no, what are the barriers**?***

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ALL QUESTIONS MUST BE ANSWERED FOR WRONG SITE SURGERY EVENTS – REQUIRED INFORMATION BY THE REGISTRY

Wrong Site Surgery

#	Question	Yes	No	NA
1	Did the OR schedule, and informed consent match?			
2	Did the surgeon sign the patient site in Pre-op?			
3	Did the surgeon sign the patient site with his/her initials?			
4	Was there active, verbal participation in a time out or pause before the procedure or incision?			
	• If not, why not?			
5	If the procedure site had internal laterality, was there a second pause that occurred?			
6	Was this a spinal procedure?			
	If so, answer questions below:			
	a. Was there a pre=op -x-ray available for the surgeon?			
	b. Was there an intra-op x-ray taken and comparison to the pre-op x-ray?			
	c. Was the level marked on the outside of the patient body with the surgeon's initials			

ALL QUESTIONS MUST BE ANSWERED FOR PRESSURE ULCER EVENTS – REQUIRED INFORMATION BY THE REGISTRY

Pressure Ulcer Prevention Best Practices

#	Question	Yes	No	NA
1	Pressure ulcer risk assessment (Braden) was documented on admission.			
2	Pressure ulcer risk assessment (Braden) was documented daily.			
3	Skin inspection was documented on admission.			
4	Skin inspection was documented at minimum daily.			
5	At a minimum, removable devices such as stockings and splints were removed each shift.			
6	At a minimum, non-removable devices such as tubes were repositioned at least daily.			
7	The care plan linked risk assessment findings to specific preventive interventions.			
8	Patients with impaired sensory perception, mobility, and activity as defined by the Braden sensory perception score of 1-3 had the following interventions documented:			
	• Repositioning every 2 hours			
	• Heels off of bed			
	• Appropriate support surfaces (mattresses, chair cushions) for pressure redistribution was in place prior to the wound being identified			
9	Patients with friction/shear risk as defined by the Braden friction/shear score of 1-2 had HOB 30 degrees or less documented (if medically contraindicated, there was an MD order and an alternative plan was documented to prevent shear injury)			
10	Patients with nutritional deficits as defined by the Braden nutrition score of 1-2 were followed by dietary services once the deficit was identified			
11	Patients with incontinence had documentation of (*does not apply if not age appropriate – i.e. infant, young child):*			
	• Barrier use			
	• Collection device use			
	• Underlying etiology of incontinence addressed			
12	Patient/family skin safety education and patient response was documented			

13	Standard skin safety interventions that were determined to be medically contraindicated or inconsistent with the patient's overall goals were documented or ordered by an MD and re-evaluated routinely			
14	Inability to adhere to standard skin safety interventions (i.e., noncompliance) was documented with evidence of patient/family education and ongoing efforts to reeducate or modify care plan.			

Additional Required Pressure Ulcer Data

#	√	Data Element
Patient Characteristics (check all that apply)		
1a		Dialysis
1b		Morbid obesity (BMI ≥ 40)
1c		Clinically malnourished
1d		Incontinent
1e		Diabetic
1f		Smoker
1g		Kidney failure
1h		Heart failure
1i		Respiratory failure
1j		Neurological/neuromuscular condition
1k		Sepsis
1l		Peripheral vascular disease
1m		Receiving palliative or comfort care
1n		History of previous pressure ulcer
Pressure Ulcer Development		
2a	Date of admission:	
2b	Date pressure ulcer first identified for (indicate date for all applicable)	
	Stage I: Stage II: Stage III: Stage IV: Unstageable:	
Additional Patient Questions		
3a	Did patient have a long ambulance or other transport time? Yes No	
3b		# of surgeries during this hospitalization (prior to wound development)
3c	Was the patient able to shift without assistance? Yes No	
3d	Did patient refuse repositioning? Yes No	
	If yes, why?	
3e		Did patient have an unstable condition that prohibited repositioning? Yes No

#	√	Data Element
Device-related pressure ulcers		
4	Was this a device-related pressure ulcer? Yes No	
	If yes, complete question 4a.	
4a	√	Check category of device below:
		Immobilizer
		Tube
		Restraint
		Respiratory equipment
		Anti-embolism
		Orthotic
		Transfer
		Transport
		Other (specify):
4b	What was the type of device (i.e. NG tube):	
Surgery/procedure related pressure ulcers		
5	Was the pressure ulcer possibly related to a surgery/procedure? Yes No If yes complete the following:	
5a	Date of surgery:	
5b	Length of procedure: hrs. mins.	
5c	Length of time in PACU (level 1 recovery): hrs. mins	
5d	√	Type of procedure (check as appropriate)
		Spine
		Vascular
		Cardiac
		Trauma
		Other (describe):
5e	Type of surface used during procedure:	

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ALL QUESTIONS MUST BE ANSWERED FOR ALL FALL EVENTS – REQUIRED INFORMATION BY THE REGISTRY

#	Question	Yes	No	NA or Unknown
1	Does your facility have a falls team that regularly evaluates your falls program?			
2	Was a fall risk screening documented at admission?			
3	Was a validated, reliable fall risk screening tool used?			
4.	Did the screening tool indicate patient was at risk for falls?			
If screening tool did not indicate patient was at risk for falls				
5a.	Was patient still placed at risk due to clinical judgment?			
5b.	If yes, what were the additional factors that placed the patient at risk?			
5c.	Were universal fall precautions in pace (e.g. items placed within patient's reach, room free of clutter)?			
If patient was determined to be at risk for falling				
6a.	Was screening documented every 24 hours minimum (within the 48 hrs prior to the fall)?			
6b.	Was screening documented upon transfer between units?			
6c.	Was screening documented upon change of status?			
6d.	Was screening documented post fall?			
7.	Was there a visual indication alerting staff to patient's at risk status?			
7a.	If there was a visual indication, what type?			
8.	Was a fall prevention intervention plan documented?			
9.	Did the intervention plan focus on the patient's specific risk factors?			
10.	Was patient/family education completed?			
11.	When was patient rounding last conducted for this patient to check for pain, positioning, and potty			
	a. ≤ 30" prior to fall b. ≤ 60" prior to fall c. ≤ 2 hrs prior to fall d. >2 hrs prior to fall e. Unknown			
12.	Was equipment to reduce risk for fall/injury in place?			
12a.	If yes, what type of equipment?			
13.	Was patient on culprit meds within 24 hours of fall?			
13a.	If yes, what were the medications?			

Story of Event: *(Optional)*

Determining the Root Cause* – *Tip Sheet

5 Rules of Causation

- ✓ Causal statements must clearly show the "cause and effect" relationship
- ✓ Negative descriptors are not used in a causal statement
- ✓ Each human error must have a preceding cause
- ✓ Each procedural deviation must have a preceding cause
- ✓ Failure to act is only causal when there was a pre-existing duty to act

Examples:

1. Lack of coordination between staff development and unit directors resulted in inconsistent skin assessment training for new staff causing incomplete skin assessments which lead to the PU

2. Staff workload results in hurried reading of algorithm causing inappropriate choice of pressure reducing mattress resulting in PU.

3. No "owner" to regularly review and update skin care policies caused delay in skin consultation leading to the PU.

Corrective Action Plan* – *Tip Sheet

- ✓ **Do the actions meet the following**:
  - Address the root cause and contributing factors
  - Specific
  - Easily understood and implemented
  - Developed by process owners
  - Measurable

Strong Actions	Intermediate Actions	Weak Actions
*Physical plant changes *New device with usability testing prior to purchase *Forcing functions *Simplifying process – remove unnecessary steps *Standardize process/equipment *Leadership is actively involved	*Decrease workload *Software enhancements/modifications *Eliminate/reduce distraction *Checklists/cognitive aids/triggers/prompts *Eliminate look alike and sound alike *Read back *Enhanced documentation/communication *Redundancy	*Double checks *Warnings/labels *New policies/procedures/memorandums *Training/education *Additional study