*Please note - all information contained is fictional, used for example purposes only.

CONFIDENTIAL
Protected under Minnesota Statute §§ 145.61 et seq.

HealthEast Root Cause Analysis Summary

Level of Analysis	Questions/Factors involved	Findings and Opportunities to Improve
What happened:	*What departments were involved?*	Nursing, Pharmacy, Administration, Quality Management
		56 year old female, Laurel Johnson was admitted after having a new onset seizure. She was pleasant but worried about the seizure and what it could mean. She had never been on medication before and now was to be started on a medication, Klonipin 1mg. The medication was not up from pharmacy yet, but her nurse had just spent time with her providing education about the medication. The nurse took telephone order from a physician for another patient, Lara Johnstone. The order was for Clonidine 0.1mg. The medication was then ordered. After giving the medication, the nurse returned to the medication room to set up the medications for another patient. When she arrived at the medication room, she found another nurse searching through the medication bins. When asked what she was doing, the nurse said she was looking for her patient's dose of Clonidine. It was a new dose and she knew it came up from pharmacy as she put it in the patient's bin herself. The nurse for Laurel Johnson had a sick feeling in her stomach and checked the medication wrapper in her hand from the dose she just gave Laurel Johnson. She saw that it was the Clonidine with the name Lara Johnstone and birth date November 18, 1952 clearly stamped on it. The physician for Laurel Johnson was called and informed of the error. The patient's vital signs were ordered to be monitored q hour for 2 hours then every 2 hours for 4 hours. She had a slight drop in her blood pressure, however she recovered well.
Why did it happen: (Proximate cause)	*What was the missing or weak step in the process?*	The names of the patients involved were very similar, the names of the medications were very similar, the birthdates were very similar, the name band was not checked and matched with the medication wrapper prior to giving the medication.
Why did that happen?	*What caused the missing or weak step in the process?*	1. The nurse's familiarity with the patient and belief she had the correct patient for the medication led to failure to match the patient's identification band with the medication wrapper as indicated in the policy resulted in the medication error 2. Physical set up of the medication room with location of bins led to similar names being close together resulted in placing the wrong medication into a patient's bin resulting in the medication error
Why did that happen?	*What is currently done to prevent failure at this step?*	Policy on patient identification, bins in medication room currently set up by room number, tall man lettering on medication labels

Level of Analysis	Questions/Factors involved	Findings and Opportunities to Improve
Why did it happen: (Proximate cause)	*What was the human error?*	The nurse of Laurel Johnson indicated she had been working there 27 years and this had never happened to her before. She recognizes now that she should have checked the package labeling more carefully when setting up the patient's medication as the information was clearly stamped on it. She thought she had compared the label information to the kardex, but obviously not carefully enough. She remembers thinking there was an extra dose in her patient's medication bin, but it has happened before so she didn't question it further. She had just taken the verbal order for the Clonidine and perhaps that was on her mind when she was setting up the medications for her patient, the names do sound alike. The nurse carefully wrote down the order and then read it back to the physician. She did not check the patient's arm band as she had the patient for the last 2 days and knew her well. She did ask for the patient's name and date of birth and it sounded right so she didn't think any more about it. Laurel Johnson's date of birth is October 18, 1952 and Lara Johnstone's date of birth is November 18, 1952. The nurse for Laurel Johnson went into the medication room to set up her medication. She noted what she thought was an extra dose of Klonipin in the bin. She thought because it was a new medication, pharmacy had mistakenly sent it up twice, once for the initial dose and again for the dose for that day. She didn't think anything more about it and continued to set up the patient's medications according to the MAR. She then went into Laurel Johnson's room to give her medication. As she stepped into the room, she asked the patient to state her name and date of birth, October 18, 1952. The nurse then removed the medication from the packaging and gave it to the patient.
Why did that happen?	*Was staff performance in the process addressed?* *Was staff properly qualified?*	Nurse did not check the patient's identification band as per policy. It was indicated that other staff feel they do not always check the ID band each time as they know the patient. Staff were felt to be qualified. There was the usual staffing levels and mix.
Why did that happen?	*Can orientation and inservice training be improved?*	The hospital procedure for verification of patient identification information is according to the Joint Commission National Patient Safety Goals which states there must be two unique patient identifiers and staff must match the treatment to the individual patient. The two unique identifiers the hospital chose were patient name and date of birth.
Why did it happen: (Proximate cause)	*Was staffing appropriate to provide safe care?* – *If no, do you believe that staffing issues contributed to the event?*	Staffing was felt to be good and no additional staff was considered necessary. Additional staffing would not have affected this event.
Why did that happen?	*Did actual staffing deviate from the planned staffing at the time of the event or during key times that led up to the event?*	No deviation from planned staffing was identified
Why did that happen?	*Were there any unexpected issues or incidents that occurred at the time of the event or during key times that led up to the event?* – *If yes, did the unexpected issue impact staffing or workload for staff?* – *If yes, did staff believe this change in staffing or workload contribute to the event?*	No unexpected issues or incidents were identified

Level of Analysis	Questions/Factors involved	Findings and Opportunities to Improve
Why did it happen: (Proximate cause)	*Was all necessary information available:* *-when needed?* *-accurate?* *-complete?*	The order was clearly and correctly written. The order was correctly transcribed onto the Medication Administration Record (MAR). The nurse is responsible for checking for new orders, there is no defined method of communication regarding new orders.
Why did that happen?	*Is communication among participants adequate?*	Yes. Communication is felt to be very important. Staff felt communication among them was good.
Why did that happen?	*Are there barriers to communication?* *Is prevention of adverse outcomes considered a high priority?*	None identified Yes
Why did it happen: (Proximate cause)	*How did the equipment fail? What broke?*	The information on the identification band was already faded and hard to read. The bins in the medication room for these two patients were on top of each other and there was nothing to separate them or warn of the like names. They are set up by room number and although the patient rooms are not close to each other, it just happened that they fell one on top of the other in the cart.
Why did that happen?	*What is currently being done to prevent an equipment failure?*	The policy on patient identification includes a segment on when the current band becomes un-readable. It directs the staff to replace it.
Why did that happen?	*What is currently being done to protect against a bad outcome if an equipment failure does occur?*	The equipment is taken out of service and evaluated. Equipment is checked and if appropriate reported to Med Watch.
Why did it happen: (Proximate cause)	*What environmental factors directly affected the outcome?*	The unit was very busy. When the medication came up from pharmacy via the dummy, the Health Unit Coordinator took that medication, along with several others, off the dummy and placed them on the counter in the medication room. Another nurse came in to the medication room and saw the medications on the counter and placed them in the bins for the patients. Sending 2 doses often happened with newly ordered medications which were ordered for once a day.
Why did that happen?	*Was the physical environment appropriate for the process to be carried out?*	Yes
Why did that happen?	*Are systems in place to identify environmental risks?* *Are responses to environmental risks planned and tested?*	Yes Yes
Why did it happen: (Proximate cause)	*Were there any uncontrollable external factors?*	None identified
Why did that happen?	*Are they truly beyond the organization's control?*	
Why did that happen?	*How can we protect against them?*	
Why did it happen: (Proximate cause)	*Were there any other factors that directly influenced the outcome?*	None identified

*Please note - all information contained is fictional, used for example purposes only.

CONFIDENTIAL
Protected under Minnesota Statute §§ 145.61 et seq.

Type of Event:

- ☐ Patient suicide
- ☐ Op/post-op or procedure complication
- ☒ Medication error
- ☐ Wrong-site surgery
- ☐ Delay in treatment
- ☐ Patient death/injury in restraints
- ☐ Patient fall
- ☐ Assault/rape/homicide
- ☐ Patient elopement
- ☐ Perinatal death/loss of function
- ☐ Transfusion error
- ☐ Fire
- ☐ Skin Integrity breakdown
- ☐ Infant abduction/wrong family
- ☐ Medical equipment – related
- ☐ Ventilator death/injury
- ☐ Maternal death
- ☐ Death associated with transfer
- ☐ Utility system failure
- ☐ Anesthesia – related
- ☐ Infection – related
- ☐ Dialysis – related
- ☐ In-patient drug overdose
- ☐ Self-inflicted injury
- ☐ Other (less frequent)

Root Cause(s) Identified by the RCA Team:

1. The nurse's familiarity with the patient and belief she had the correct patient for the medication led to failure to match the patient's identification band with the medication wrapper as indicated in the policy resulted in the medication error
2. Physical set up of the medication room with location of bins led to similar names being close together resulted in placing the wrong medication into a patient's bin resulting in the medication error

Check categories that apply:

- ☐ Behavioral assessment process
- ☐ Physical assessment process
- ☒ Patient identification process
- ☐ Patient observation procedures
- ☐ Care planning process/coordination of care
- ☐ Staffing levels
- ☐ Orientation and training of staff
- ☐ Competency assessment/credentialing
- ☐ Supervision of staff
- ☐ Access to care
- ☐ Skin Integrity
- ☐ Communication with patient/family
- ☒ Communication among care team members
- ☐ Availability of information
- ☐ Adequacy of technological support
- ☒ Equipment maintenance/management
- ☒ Physical environment
- ☐ Security systems and processes
- ☐ Control of medications: storage/access
- ☐ Labeling of medications

Patient Name/Number:
Melinda MedError

Date of incident:
11/1/10 Discovery date: 11/1/10

Participants in Root Cause Analysis:
Nancy Nurse, patient's nurse at time of error
Glenda Witch, Charge Nurse
Tim Team, patient's nurse from previous shift
Michael Med, Pharmacist
Linda Leader, Clinical Director
Diane Diesel, Administration

Where incident occurred:
St. Elsewhere Hospital, patient room

Date Root Cause Analysis Completed:
11/7/10

Conclusions/Recommendations:

1. Reinforce the need to match the patient's ID band with the mediation label prior to giving meds
    a. Staff meetings
    b. Newsletters
    c. Validation
2. Investigate and implement a bar-code process where medications and ID bands are scanned prior to giving medications
3. Create a process to change how bins are labeled to clearly identify similar name patients

*Please note - all information contained is fictional, used for example purposes only.

CONFIDENTIAL
Protected under Minnesota Statute §§ 145.61 et seq.

Please list references of literature search:
(articles can be found in the central library)
See attached bibliography.

Please attach the associated policies:
(including any newly revised policies)