MOCK RCA
SUMMARY HANDOUT

Types of Error

- Errors in judgment
  - Commonly occur when relying on heuristics (mental shortcuts)
  - Heuristics subject to individual biases
    - Common biases include
      - Framing effect
        - React to particular choice in different ways depending upon how it is presented
      - Confirmation bias
        - Tendency to accept or encode events which confirm one's belief, and reject those that are contrary
      - Anchoring bias
        - Overly influenced by first piece of information that we hear
      - Availability bias
        - Judging likelihood of a diagnosis based on ease with which examples can be retrieved (more familiar or recent).
- Errors in execution
  - Systems errors
    - Relate to policy, procedure, equipment, environmental or human resources, information, communication or organizational sources
  - Human error
    - Provider means to do something but doesn't
    - Typically a symptom of deeper trouble, systematically connected to operating environment

Quality Review Process

- Routes by which concern comes to attention of department
  - Hospital error reporting mechanism
  - Clinical concern raised by provider/RN
  - Legal
- Steps of quality review process
  - Fact finding
    - Review of HER
    - Interviews with involves staff
      - One individual at a time
      - Goal is to identify system issues

                - Progressively probe and rebuild how the world looked to people on the inside of the situation at each juncture
    - Construction of timeline
        - Use information from fact finding
        - Focus on facts only (no opinions or blame)
    - Review of applicable policies, clinical pathways or evidence
    - Identification of contributing factors
    - Identification of root cause
        - 5 why's
        - fishbone diagram
    - Provisional error determination
        - Error in judgment
        - Error in execution
            - Systems error
            - Human error
                - Information about how people learn to cope (successfully or not) with complexities and contradictions of real work
    - Provisional standard of care (SOC) determination
        - SOC is defined as the level and type of care that a reasonably competent and skilled health care professional with a similar background and in the same medical community would have provided under the circumstances
        - Options for SOC determination
            - SOC met
            - SOC met with room for improvement
            - SOC not met due to systems
            - SOC not met due to practitioner
    - Provisional harm determination
        - Harm – death
        - Harm – severe permanent harm
        - Harm – permanent harm
        - Harm – temporary harm
        - Harm – additional treatment
        - Harm – emotional distress or inconvenience
        - No harm
        - Unknown
    - Presentation at local quality committee
        - Rework as needed based on committee input
        - Final error determination
        - Final SOC determination
        - Final Harm determination
    - Local plan of correction defined

        - Risk reduction strategies to prevent the event from recurring
        - Measures of effectiveness to ensure that risk reduction strategies have been implemented and are successful
    - Case reviewed by hospital quality, which can
        - Agree with local formulation/plan
        - Send additional requests for review
        - Send case to formal RCA

RCA Structure

- Moderator introduces the purpose of the RCA and its participants
- Moderator briefly defines event
- Representatives from each department/service provide details relevant to their department/service, including errors identified and their root causes/contributing factors
- Committee makes a standard of care determination
- Representatives from each department/service outline risk reduction strategies and measures of effectiveness they will undertake
- Moderator summarizes the findings, consensus and next steps