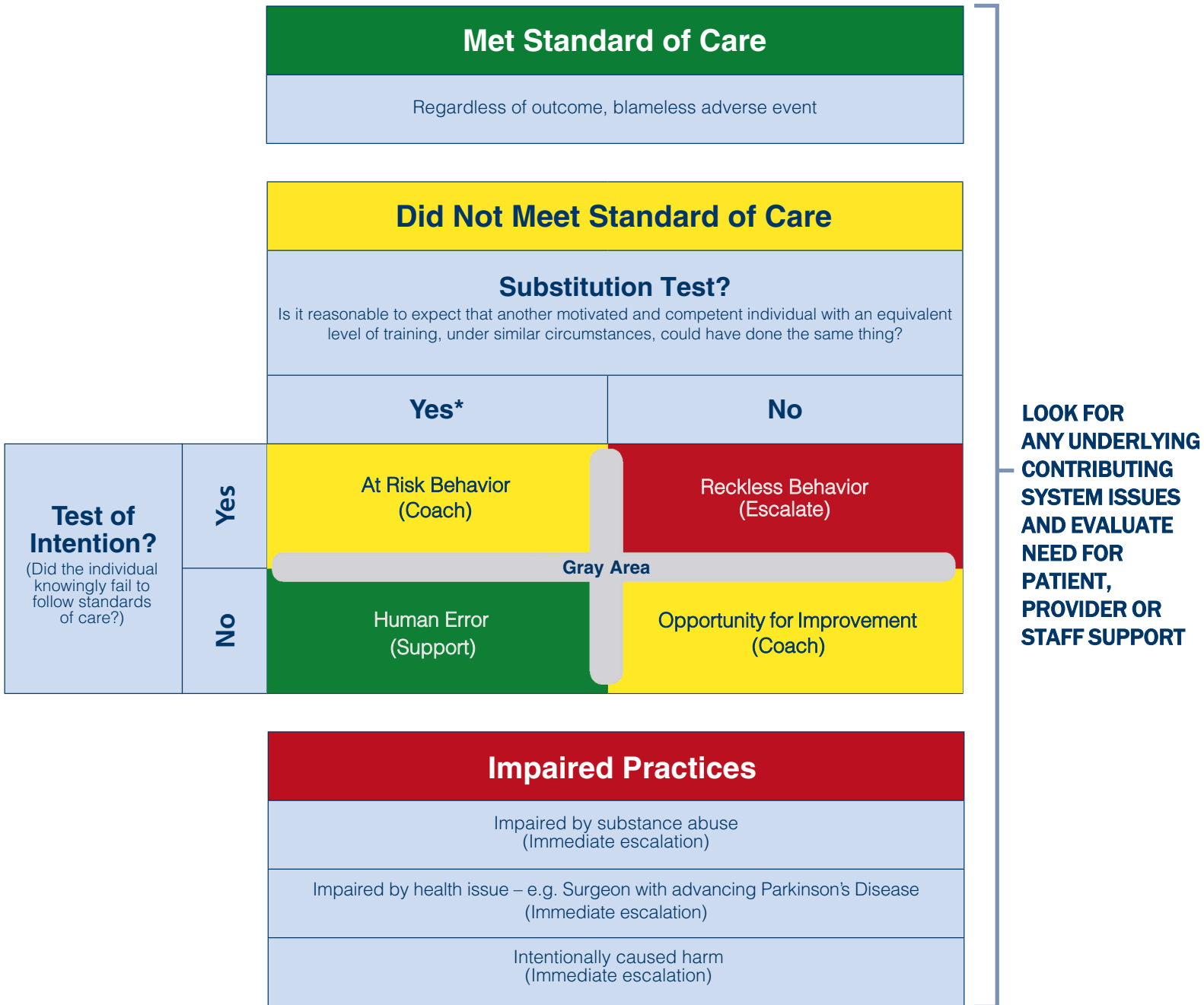


# Safety Event Review Tool

Guiding fair and respectful reviews of individuals working in complex systems.



\* If the answer to the substitution test is yes, question the effectiveness of current practice and evaluate for "Normalization of Deviance." Normalization of Deviance is defined as the gradual drift away from best practices until a deviant behavior is commonplace (e.g. ignoring an alarm, bypassing a safety check, etc.).

"The common initial reaction when an error occurs is to find and blame someone. However, even apparently single events or errors are due most often to the convergence of multiple contributing factors. Blaming an individual does not change these factors and the same error is likely to recur. Preventing errors and improving safety for patients requires a systems approach in order to modify the conditions that contribute to errors. People working in health care are among the most educated and dedicated workforce in any industry. The problem is not bad people; the problem is that the system needs to be safer." —To Err is Human, Institute of Medicine, 1999

"Most serious errors are committed by competent, caring people doing what other competent, caring people would do." —Dr. Don Berwick, former founder and CEO of IHI, and former Administrator of the Centers for Medicare and Medicaid Services

## BACKGROUND

When evaluating an individual involved in a medical error, reviewers should keep in mind that we are all human and will occasionally make mistakes. Dr. Lucian Leape, a professor at Harvard School of Public Health and a Patient Safety expert, has argued that we need to dispel two myths:

**The perfection myth:** *if people try hard enough, they will not make any errors.*

**The punishment myth:** *if we punish people when they make errors, they will make fewer of them.*

The Safety Event Review Tool was created to help evaluate colleagues or employees involved in a medical error and to better understand the relative contribution of human and system factors in an error, near miss or unsafe condition. The goal is to evaluate errors without bias or judgment, and to learn from the errors and fix the underlying system issues in order to provide the safest environment for our patients.

It is important to note that when reviewing a medical error and determining an individual's culpability, there is no perfect algorithm that can automatically determine an individual's degree of responsibility. Applying the Safety Event Review Tool requires careful thought and consideration of the individual's intent, and consideration of what a competent individual with similar training would do in the same situation. The tool should be used as a guide in evaluation but there may be "gray" areas which can make categorization difficult.

Below are simple instructions for how to use the tool and best navigate these "gray areas".

## INSTRUCTIONS


**A. GREEN - Determine if the individual met the standard of care:** Regardless of patient outcome, if an associate clearly met the standard of care, he/she should be consoled.

**For example,** *a pediatrician gives a child with strep throat amoxicillin, and subsequently the child becomes anaphylactic and dies. The child was not previously exposed to the medication and had no known allergies. The associate followed best practices and should be consoled.*


**B. YELLOW - Determine if the individual did NOT meet the standard of care:** When an associate does not meet the standard of care, the following two tests should be applied:

- 1. The test of intention:** After investigation including review of the chart and interviewing the individual, determine if the act of not following the standard of care was intentional (i.e. knowingly failed to follow the standard of care).
- 2. The substitution test:** Determine if other competent individuals with an equivalent level of training, faced with the same situation, could have done the same thing.


The result of these 2 tests will categorize the provider's action in 1 of 4 quadrants in the 2x2 table.

 **Human Error** - If the answer to the substitution test is YES and the answer to the test of intention is NO, consider the individual made a human error and should be supported.


**For example,** *a physician intends to order hydroxyzine but instead accidentally orders hydralazine. The patient's blood pressure drops, and he becomes light headed and falls, fracturing his hip. The error was largely due to the fact that the two medication names sound alike and were in close proximity to each other on the electronic order screen.*

 **At-risk behavior** - If the answer to the substitution test is YES and the answer to the test of intention is YES, consider there was at risk behavior.

**For example,** *to save time a nurse knowingly failed to follow a policy and best practice and prepares medications for three patients at once. In doing this, she almost mixes up two patients' medications. This individual demonstrated risky behavior and should be coached.*

 **Opportunity for Improvement** - If the answer to the substitution test is NO and the answer to the test of intention is NO, question the individual's competency and coach as needed.

**For example,** *a physician assistant with 5 years of experience misreads an EKG and misses classic "tombstone" ST elevations indicative of an acute myocardial infarction.*

 **Reckless Behavior** - If the answer to the substitution test is YES and the answer to the test of intention is YES, consider the individual acted recklessly and escalate to a supervisor.

**For example,** *a surgical resident is called to place a femoral central line in a morbidly obese patient. The patient's fat pannus obstructed the femoral insertion site. Instead of requesting an assistant to facilitate performing the line insertion within known safety practice standards, the resident used his left hand to push the fat pannus out of the way while attempting to insert the central line by using just his right hand. The guide wire slipped out of his hand and was accidentally pushed into the patient.*

**C. RED - Determine if the individual demonstrated impaired practices:** If an individual was impaired due to substance abuse or disease or intentionally caused harm, escalation is indicated. Consult with Human Resources and Employee Health in coordination with the Associate Chief Medical Officer.

**For example,** *a surgeon is out having drinks with his wife and is called to the hospital because one of his patients has appendicitis. He comes to the hospital and operates while under the influence of alcohol. The individual should be disciplined and the issue escalated.*

## NOTE ABOUT THE SUBSTITUTION TEST

When determining whether you or a comparable individual would have acted in the same manner as the individual being evaluated, there may not be a simple yes/no answer. The substitution test can be viewed as a continuum, subject to interpretation and

amenable to discussion and debate which the tool is intended to encourage. The gray area represents this area of uncertainty that can distinguish at-risk from reckless behavior (when an individual knowingly violated standards of care) and human error from opportunity for improvement (when an individual did not knowingly fail to follow standards of care).

## SYSTEM ERRORS & NORMALIZATION OF DEVIANCE

When evaluating errors, there will often be times where the true root cause of the mishap is an underlying system failure. In these cases, when best practice is not followed, regardless of whether the cause was a human error, risky behavior, incompetence or reckless behavior, healthcare leaders must strive to better understand the system in which the event occurred. Even in situations where there is a human component contributing to the error or near miss, often there is also a major system contribution. By focusing through this fairer lens, we can identify vulnerable points in processes, improve the underlying systems and prevent future harm. Examples of steps that can be taken to safeguard systems include safety checks, forcing functions, and culture change. Many more system improvements are needed before healthcare can be classified as a "high reliable" system.

One type of system error often found in healthcare is known as Normalization of Deviance, a concept in which there is a gradual drift away from best practices until a deviant behavior is commonplace (e.g. ignoring an alarm, bypassing a safety check, etc.).

## SUPPORTING OUR PROVIDERS & STAFF

Some individuals who make a human error that results in an adverse event will take personal responsibility for the bad outcomes, even if the "true cause" was a poor system design in which the individual was set up to fail. In the most extreme cases, individuals involved in medical errors are challenged with intense emotional turmoil, have quit their jobs, and may even impose physical harm on themselves. In order to avoid this, it is important to communicate to individuals involved in a human error that we all make mistakes from time-to-time and that we are not looking to blame. Rather, we need to learn from the errors and build our systems to be robust enough to prevent these errors from reaching patients. These individuals should be supported as soon as possible after the error is made and the focus on system improvement, instead of individual blame, should be reinforced.

*"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes." — Dr. Lucian Leape, Professor Harvard School of Public Health, from his testimony before Congress in 2000.*

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