Case Review vs Root Cause Analysis: How to Determine Best Approach

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Disclosure

- I do not have any disclosures.

Objectives

- Identify specific instances in which either case review or root cause analysis methodologies is appropriate approach to investigate patient safety or adverse events.

CMS Guideline 482.96(b)2

"A thorough analysis is a planned, systematic investigative process that considers all of the phases of transplantation/living donation in identifying the causes of and factors contributing to an adverse event. The scope and depth of analysis, as well as the extent of multi-disciplinary involvement, may be scaled in proportion to the scope and severity of the harm experienced and/or the risk of harm involved."

2020 Interpretive Guidelines

CMS Guideline 482.96(b)2

Thorough analysis to include but not limited to:

- Description of key factors
- Review of similar events in the past
- All info needed to identify factors may have caused or contributed to outcome
- Analysis of info to identify actual or potential vulnerabilities and opportunities to reduce risks and improve care
- Use results to design improvement actions
- Specific plan for implementation, evaluation and monitoring

Institutional Patient Safety Policy/Plan

"High priority/high risk events are investigated using:

- root cause analysis (RCA)
- apparent cause analysis (ACA)
- risk review or a
- peer review process

to identify causes for the event."

Emory Healthcare Quality Plan 2020

Case Reviews

- Focus on the individual
- Death and/or graft failure within 1st year
  - Peer protected
  - Addresses all phases of transplant
  - Multidisciplinary attendance
  - Presented by surgeon and/or physician
  - Engagement
  - Educational (literature)
  - Patient & quality improvement focus
- Complaint investigation begins with a medical record review (patient or regulatory agency)

Root Cause Analyses

- Focus on system and processes, rather than the individual
- Structured, systematic analysis
- When adverse event, sentinel event, or a cluster of less serious incidents of near misses has occurred
- Multi-disciplinary, often interdepartmental tea
- Identify root causes, contributing factors, and interrelationship of those factors

Root Cause Analysis in Health Care: Tools & Techniques, Fifth Edition, TJC

Root Cause Analyses

- Interpret analysis results
- Use results to develop and implement action plan for improvement
- Assess effectiveness
- Integrate root cause analysis with other programs

Root Cause Analysis in Health Care: Tools & Techniques, Fifth Edition, TJC

Case Review -> Root Cause Analysis

Potential donor derived disease transmission (Hep B)

- Recipient Hep B negative baseline, 1 and 3 months
- Hep B positive at 1 year with no known exposures
- 24 hours to notify OPTN/UNOS via UNet patient portal
- Began with review of the documented story within the patient's medical record with timeline and laboratory data

Primary Findings

- Handoff communication issue post surgery to inpatient and subsequently outpatient care teams
- Inconsistencies between program protocol and Center policy regarding surveillance monitoring
- Need for incorporation of treatment protocol, surveillance monitoring, and tracking into EeMR

Major Initiatives

- Policy and Protocol Revisions with Staff Re-Training
- Patient Education Materials Revised
- Education begins at Evaluation; again at Organ Offer with Verbal Consent
- Consent for Organ Transplant includes PHS Risk –> Written Consent

Major Initiatives (*cont*)

- IT Solutions

  EeMR transplant page summary includes all donor serologies

  Any/all donor PHR risks on transplant page in red font for 1st year

  Post-transplant Notes have PHR status, monitoring, and treatment section

  Electronic report in email on Friday of PHS risk recipients scheduled for Clinic the following week with date of last surveillance testing

Major Initiatives *(cont)*

- Initiatives Center-wide across all transplant programs
- Weekly audits and report outs at monthly quality meetings
- Sustainable for last 3 years with rollout for NAT positive program as well

Resources

Agency for Healthcare Research and Quality (AHRQ) https://www.AHRQ.gov

CMS Transplant Program Interpretive Guidelines, 2020

Institute for Healthcare Improvement (IHI), IHI.org

Root Cause Analysis in Health Care: Tools and Techniques, Fifth Edition, The Joint Commission

Thank You ….
Comments, Questions?