A Framework for a Root Cause Analysis and Action Plan
In Response to a Sentinel Event

Sentinel Event # 2012-001

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why?"	Take Action
What happened?	Sentinel Event	What are the details of the event? (Brief description)	Patient alleged she was sexually assaulted by another patient.			
		When did the event occur? (Date, day of week, time)	Monday, April 30, 2012 between 14:24-14:35 (video documentation of the hallways shows male patient entered the patient's room at 14:24 and exited at 14:35)			
		What area/service was impacted?	Unit A			
Why did it happen?	The process or activity in which the event occurred.	What are the steps in the process, as designed? (A flow diagram may be helpful here)	Current processes require that patient room doors be locked during specified hours and that patient movement be observed and monitored. Staff assignments are made at the beginning of the shift to observe the hallways and monitor patient movement. In this event, the following events were noted: 1. On the day of the event, the female patient stated she was ill and remained in her room with the door unlocked. For this female patient, it was not uncommon that she would remain in her room and not participate in unit activities. It is the unit standard to leave the door unlocked when the patient is in the room as locking the door would constitute prohibited seclusion. The female patient was in a room on a female-only designated hall. Entry by patients was to be observed and access to rooms controlled through staff escort of patient to unlock rooms. 2. At 14:24 the male patient walked down the hallway unobserved and entered the female patient's room. 3. At 14:33:50, another patient walked by the room and informed a Social Worker (who was leading a group of patients to the day room at the end of that hallway) of a man in the room exposing his penis. According to the Social Worker, he instructed the patient to tell a staff member of the male patient's activities. 4. At 14:34:28, the male patient was seen on video leaving the female patient's room, followed immediately by the female patient. Approximately twenty minutes later, the female patient reported she had been sexually assaulted.			

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What were the most proximate factors?		What steps were involved in (contributed to) the event?	1. On the day of the event, the male patient had been observed on the female hall earlier in the day and was redirected and warned by the Unit Safety Officer (USO) that male patients were not allowed on that hallway. There was no communication of this interaction by the USO to other staff members. 2. Staff members reported they were unaware of information present in the nursing shift report stating the male and female patients had attempted to interact on the previous Friday. 3. The male patient was admitted to the unit in transfer from a coed geriatric psychiatric unit at the VA upon court order. The patient was admitted with a diagnosis of [illegible] Placement of the patient on this unit was based in part upon the fact that the male patient [illegible] and required [illegible] [illegible] ASH admission history (seven months [illegible]) showed the patient had a history of non-sexual touching of other male patients, exposing genitals and being on 1:1 observation for his own protection until discharge. Based upon the physician's assessment of the patient upon admission and the patient's past history, no special precautions were initiated for this patient upon admission to the coed unit. 4. The female patient was admitted i[illegible]011 and had demonstrated [illegible] 5. The hallway leading to the female patient's room was unmonitored due to staff members being on unauthorized break in the dining hall or in other hallways. 6. Video shows one staff person was at nursing desk for most of the time period during the event with her back to hallways, engaged in charting and then phone texting. 7. Supervisors did not ensure staff carried out assigned patient monitoring duties.	X	X	X
(Typically "special cause" variation)	Human factors	What human factors were relevant to the outcome?	1. The male patient was observant of the opportunity to enter patient room unnoticed. 2. There was unapproved / prohibited use of a cell phone by a staff member. 3. There was a lack of staff knowledge of the patients' recent behavior. 4. Multiple staff members were away from their assigned duty in the dining hall area or on break elsewhere without authorization.	X	X	X

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			5. Supervisors did not provide adequate oversight of staff. 6. There was a lack of understanding of or disregard for the unit chain of command regarding leaving a duty assignment. 7. Multiple diversions distracted staff from duties with little or no coordination for how these events were to be managed. 8. There was a lack of documentation in the record of events that had occurred the previous Friday. 9. There was a lack of sensitivity to risk behaviors evident by patient history and actions in decision-making regarding potential adjustments in assignments to meet patient safety needs.	X	X	X
	Equipment factors	How did the equipment performance affect the outcome?	No direct effect currently identified.			
	Controllable environmental factors	What factors directly affected the outcome?	None identified.			
	Uncontrollable external factors	Are they truly beyond the organization's control?	N/A			
	Other	Are there any other factors that have directly influenced this outcome?	1. Inadequate organizational focus on strategies to prevent inappropriate patient interaction. 2. Team concept not evident.			
		What other areas or services are impacted	None.			
Why did that happen? What systems and processes underlie those proximate factors? (Common cause variation here may lead to special cause variation in	Human Resources issues	To what degree are staff properly qualified and currently competent for their responsibilities?	All involved staff were qualified for their position and determined to be competent to fulfill their responsibilities.			
		How did actual staffing compare with ideal levels?	Staffing was adequate as confirmed by the Nurse Manager; however, minimum staffing levels for the management of groups have not been established.			

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dependent processes)						
		What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?	1. Staff are called in or floated from another unit to meet required staffing levels. 2. There were no defined contingency plans to address staff responding to emergencies or other diversions.			
		To what degree is staff performance in the operant process(es) addressed?	1. Staff members failed to carry out their assigned observation duties, hand off their duties to other staff members when going on break, and obtain authorization for going on break. 2. Supervisors did not provide adequate supervision. 3. Staff did not operate as a team.	X X X	X X X	X X X
		How can orientation and in-service training be improved?	1. Mandatory training could be reinforced to include on-going validation of patient observation by the person in charge, team concepts, and expectations related to communication. 2. The organization needs to develop and educate staff on recognition of potential risk factors that may be present on admission or may present during a shift or change from shift-to-shift. 3. The organization needs to develop a policy and procedure on the prevention of sexual harassment and assault in the behavioral health setting.			
	Information management issues	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?	1. Medical record documentation as a communication tool was not utilized. 2. Nursing documentation practices maintain a focus on the treatment plan problem list and do not emphasize documentation of immediate shift issues and considerations.			
		To what degree is communication among participants adequate?	Communication throughout the shift and from shift-to-shift was not consistent and does not support the team concept. • The USO did not provide information about redirecting the male patient to the person in charge. • The Social Worker did not take immediate action and communicate with other team members when informed by a patient of inappropriate activity. The programming therapy staff members were unsupervised and did not communicate with the person in charge when leaving their assignment to go on break.	X	X	X

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			• Behavioral Health Assistant (BHA) staff gathered in the dining hall area and other support staff left the unit and observation assignments were not "handed off."			
	Environmental management issues	To what degree was the physical environment appropriate for the processes being carried out?	1. The "X" design of hallways lends itself to observation from a central vantage point. 2. There is reliance on camera monitors as a concurrent monitoring tool which can lead to inattentiveness and a false sense of security. 3. There were no additional observation strategies implemented when a patient remained in an unlocked patient room.			
		What systems are in place to identify environmental risks?	Members of the Safety Committee conduct routine environmental safety rounds to identify environmental hazards.			
		What emergency and failure-mode responses have been planned and tested?	None noted.			
	Leadership issues: - Corporate culture	To what degree is the culture conducive to risk identification and reduction?	The culture is reactive rather than proactive with a focus on personal actions rather than systems failures. The processes for debriefing and documentation need to be improved.			
	- Encouragement of communication	What are the barriers to communication of potential risk factors?	Punitive approach and focus on personal performance restricts staff openness to discuss potential risk factors, causes, and solutions.			
	- Clear communication of priorities	To what degree is the prevention of adverse outcomes communicated as a high priority? How?	While prevention of adverse events is not an obvious priority of culture at this time, culture change is in process pursuant to the Systems Improvement Agreement withCenters for Medicare and Medicaid (CMS) . The CEO regularly holds Town Hall meetings with frontline staff to emphasize the message of "patients first – we are a team". The CEO also meets regularly with the leadership team to emphasize messages related to patient safety and teamwork. The Performance Improvement Plan established Patient Safety as the first priority of the organization and patient-safety related measures are reviewed and discussed regularly during performance improvement meetings.			

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	Uncontrollable factors	What can be done to protect against the effects of these uncontrollable factors?	There were none identified.			

Action Plan	Risk Reduction Strategies	Measures of Effectiveness
Action Item #1: ***Observation***	**Immediate Strategies** *(completed within seven days following the event)* 1. Revised protocol for continuous hall observation by the monitor station staff to require continuous attendance at the station with appropriate handoffs and informed affected staff of the requirement. 2. Every 15 minute patient monitoring was instituted. 3. BHAs were instructed to remain at their assigned duty station until an appropriate handoff was completed. **Short Term Strategies** 1. Uniform enforcement of ban on cell phone usage during work hours. 2. Establish staffing requirements for groups to ensure sufficient support in patient observation during group meetings and transitions. 3. Develop minimum staffing expectations for observation coverage to be applied at initial assignment and throughout the shift including groups. 4. Nurse Manager Rounds Checklist modified to include findings related to compliance with expected observations. 5. Implement the Team Nursing Model, which includes a dedicated Nurse Manager for each unit who is responsible for supervision of patient care, and reduce the nurse-patient ratio by increasing the number of licensed staff assigned to the unit. 6. Education of staff on Team Nursing concept. 7. "Safe and Therapeutic Milieu" Education module (20 hours) for clinical leaders (completed on 5/22/12); and made a requirement for all staff with patient care responsibilities to be completed within the next two months.	**Responsibility:** The Nurse Manager, in conjunction with the Director and Assistant Director of Nursing **Short Term Strategies Implementation Dates:** 1. 5/24/12 2. 6/15/12 3. 6/15/12 4. 6/4/12 5. 6/15/12 for involved unit; expansion to other units in a phased sequence 6. 5/22/12 7. 5/22/12 **Measures:** Ongoing monitoring of observation procedures by the Nurse Manager through in-person and video review and rounds. Ongoing monitoring of staffing requirements for groups through random observations and review of group attendance rosters. Ongoing monitoring of compliance with the ban on cell phone usage during work. Completion of required education (numerator:

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		number of staff completing required education/total number of staff required to complete education). **Reporting:** Results reported in staff meetings and communicated to the Performance Improvement & Quality Committees.
Action Item #2: ***Communication***	**Immediate Strategies** *(completed within seven days following the event)* 1. Review of video and discussion of event with involved staff. 2. Added handoff procedure to floor duties. 3. Added a protocol to hall duties the requirement for handoff. 4. Revised monitor station duties to include continuous hall monitoring. 5. Nurse Managers implemented "spot" checks on units to look for evidence of active observation. **Short Term Strategies** 1. Implement "huddle" communication practices. 2. Provide training to staff on structured handoff method, such as SBAR. 3. Establish criteria and expectation for communication of potentially problematic patient behaviors or circumstances. 4. Define "never ignore" conditions / "red flag" circumstances and expectations for communication and documentation related to these. 5. Require authorization for breaks by person in charge and educate staff on this requirement.	**Responsibility:** The Nurse Manager, in conjunction with the Director and Assistant Director of Nursing **Short Term Strategies Implementation Dates:** 1. 6/25/12 2. 6/25/12 3. 6/4/12 4. 6/4/12 5. 6/4/12 **Measures:** Ongoing monitoring of huddles conducted to validate the effectiveness of communication in response to identified criteria ("never ignore" and "red flag" criteria). Ongoing monitoring of handoffs and authorization for breaks through shift assignment documentation. Completion of "never ignore" and "red flag" criteria. Completion of required education (numerator: number of staff completing required education/total number of staff required to complete education).

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		Reporting: Results reported in staff meetings and communicated to the Performance Improvement & Quality Committees.
Action Item #3: ***Teamwork***	**Immediate Strategies** *(completed within seven days following the event)* 1. Review of video and discussion of event with involved staff with a focus on teamwork failures. **Short Term Strategies** 1. Implement the Team Nursing Model, which includes a dedicated Nurse Manager for each unit who is responsible for supervision of patient care, and reduce the nurse-patient ratio by increasing the number of licensed staff assigned to the unit. 2. Education of staff on Team Nursing concept. 3. "Safe and Therapeutic Milieu" Education module (20 hours) for clinical leaders (completed on 5/22/12); and made a requirement for all staff with patient care responsibilities to be completed within the next two months. 4. Implement "huddle" communication practices. 5. Establish criteria and expectation for communication of potentially problematic patient behaviors. 6. Develop a policy on the prevention of sexual harassment and assault on the inpatient units and educate clinical staff on prevention.	**Responsibility:** The Medical Director and Clinical Direction in conjunctions with the Director of Nursing **Short Term Strategies Implementation Dates:** 1. 6/15/12 for involved unit; expansion to other units in a phased sequence 2. 5/22/12 3. 5/22/12 4. 6/25/12 5. 6/4/12 6. 7/2/12 **Measures:** Ongoing monitoring of staffing assignments and observation procedures to support the team nursing model. Completion of required education (numerator: number of staff completing required education/total number of staff required to complete education). Ongoing monitoring of huddles conducted to validate the effectiveness of communication in response to identified criteria ("never ignore" and "red flag" criteria). Completion of policy and criteria and

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		expectations for communication of potentially problematic patient behaviors . **Reporting:** Results reported in staff meetings and communicated to the Performance Improvement & Quality Committees.
Action item #4: ***Supervision***	**Immediate Strategies** *(completed within 7 days following the event)* 1. Review of video and discussion of event with involved charge nurse. 2. Nurse Managers were instructed to implement "spot" checks on units to look for evidence of active observation and compliance with assigned duties. **Short term strategies** 1. Implement the Team Nursing Model, which includes a dedicated Nurse Manager for each unit who is responsible for supervision of patient care, and reduce the nurse-patient ratio by increasing the number of licensed staff assigned to the unit. 2. Education of staff on Team Nursing concept. 3. "Safe and Therapeutic Milieu" Education module (20 hours) for clinical leaders (completed on 5/22/12). 4. Provide education to Nurse Managers and charge nurses regarding supervision expectations to maintain a safe and therapeutic environment.	**Responsibility:** The Nurse Manager, in conjunction with the Director and Assistant Director of Nursing **Short Term Strategies Implementation Dates:** 1. 6/15/12 for involved unit; expansion to other units in a phased sequence 2. 5/22/12 3. 5/22/12 4. 6/4/12 **Measures:** Ongoing monitoring of observation procedures by the Nurse Manager through in-person and video review and rounds. Ongoing monitoring of staffing requirements for groups through random observations and review of group attendance rosters. Ongoing monitoring of compliance with the ban on cell phone usage during work. **Reporting:** Results reported in staff meetings and communicated to the Performance Improvement & Quality Committees.

Cite any books or journal articles that were considered in developing this analysis and action plan:

Cole, M. (2003) Sexual assaults in psychiatric in-patient units: The importance of a consistent approach. Psychiatric Bulletin, 27, 25-28.

Manna, M. (2010) Effectiveness of formal observation in inpatient psychiatry in preventing adverse outcomes: The state of science. Journal of Psychiatric and Mental Health Nursing, 17(3) 268-273.

Page, M. (2006) Methods of observation in mental health inpatient units. Nursing Times, 102 (22), 34.

Wallace, B. (2007) Increased levels of observation in a mental health setting: challenge or chore? Advancing Practice in Bedfordshire, 4(2), 52-57.