1 Problem

ONLY 1 IN 7 MEDICAL ERRORS REPORTED

Cause Mapping is a Root Cause Analysis method that captures basic cause-and-effect relationships supported with evidence.

CAUSE MAPPING
Problem Solving • Incident Investigation • Root Cause Analysis

Step 1	Problem	What's the Problem?
Step 2	Analysis	Why did it happen?
Step 3	Solutions	What will be done?

Step 1. Define the Problem

What	Problem(s)	Only 14% of medical errors reported
When	Date	Report released Jan. 2012
	Different, unusual, unique	Study reviewed only Medicare beneficiaries
Where	State, city	USA
	Facility, site	Hospitals
	Task being performed	Treatment of a variety of health issues
Impact to the Goals		
	Safety	Potential harm to patients
	Cust. Service	Negative publicity
		This incident ??
	Frequency	Estimated that more than 130,000 Medicare beneficiaries experienced one or more adverse events in hospitals in a single month.
		??

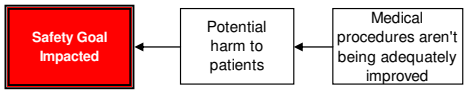
Cause Map

A study by the Department of Health and Human Services found that only 14 percent of medical errors are being reported by hospitals.

"Today's report confirms what many other studies have already documented. Hospitals are doing a poor job of tracking preventable infections and medical errors and making the changes necessary to keep patients safe. It's time that hospitals make patient safety a higher priority"
- Lisa McGiffert, Director of Consumers Union's Safe Patient Project

2 Analysis

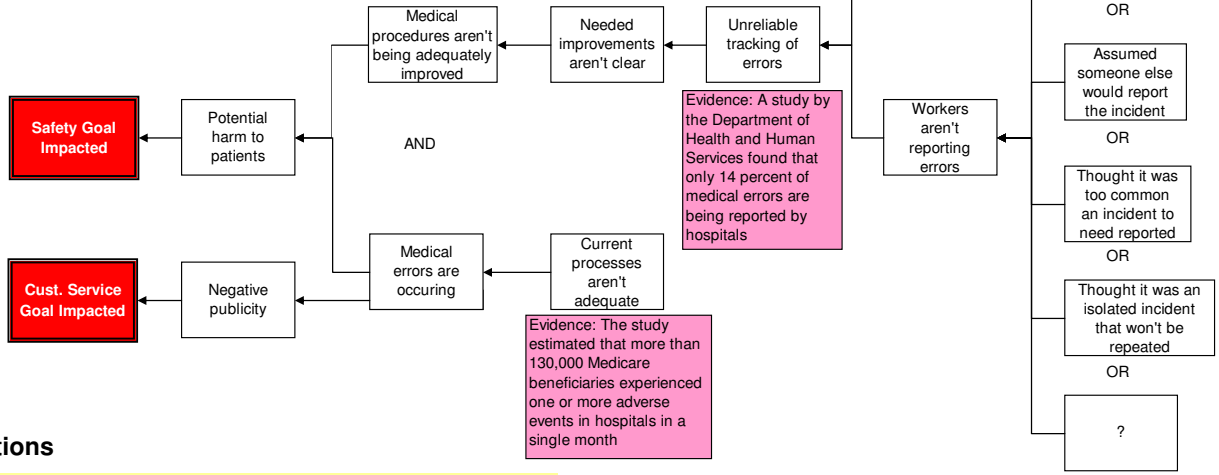
Basic Level Cause Map - Start with simple Why questions.



Basic Cause-and-Effect

In this example, patients may suffer harm because medical errors aren't being reported. Without information on what needs to be improved, hospitals are unable to improve their procedures to help prevent errors from occurring again in the future.

More Detailed Cause Map - Add detail as information becomes available.



Effect ← Cause
Evidence:

More Detailed Cause-and-Effect

The study was conducted by reviewing the medical records of Medicare patients. As a condition of participating in the Medicare program, hospitals are required by federal regulations to track medical errors that harm patients and to implement solutions to protect patients from similar mistakes in the future. All hospitals involved in the study had a method to collect information on medical errors, but all adverse events were not being efficiently captured by the systems in place.

The study found that out of 293 cases reviewed, only 40 were reported, 28 led to investigations and only five resulted in changes in the hospital's processes. Additionally, the inspector general estimated that more than 130,000 Medicare beneficiaries experience at least one adverse event in a hospital in one month so there is a plenty of room for improvement in patient care.

The study found a number of reasons that adverse events and medical errors were not being reported. Confusion over requirements was one cause of the under reporting because hospital employees did not always recognize that a particular event harmed a patient and was required to be reported. Also, there were cases where employees assumed someone else would report the incident or they considered the incident to be so common that it didn't need to be reported. There was also a tendency to not report things that were considered to be isolated events that were unlikely to recur.

3 Solutions

The final step of the Cause Mapping process is to come up with potential solutions that could be used to prevent the problem from reoccurring. To help combat these causes, the OIG report recommends the development of a standard list of medical errors that should be tracked and reported. The OIG also recommends that guidance be developed and provided for the accreditors of hospitals since they do not typically investigate adverse event collection methods. Additionally, some consumer groups are pushing for public reporting of medical errors to help pressure hospitals to improve their policies and practices.

For a free copy of our Root Cause Analysis Template in Microsoft Excel, used to create this page, visit our web site.

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