

IMPROPERLY STERILIZED EQUIPMENT RISKS DISEASE

27 men being tested for HIV, hepatitis after third step of sterilization procedure skipped for prostate ultrasound probes

Cause Map

"It was human error, and we've done an investigation across our institution to make sure it isn't happening anywhere else."

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

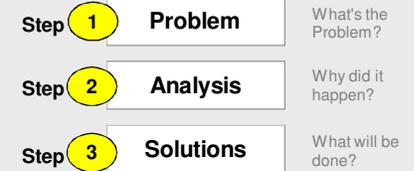
- Chief Medical Officer Dr. John Vassall

Timeline

Date	Description
September 19, 2013	Beginning of risk of transmissible disease
December 10, 2013	Last use of improperly sterilized probe
December 17, 2013	Clinical staff informs hospital officials of sterilization issues
December 21, 2013	Affected patients notified

CAUSE MAPPING

Problem Solving • Incident Investigation • Root Cause Analysis



1 Problem

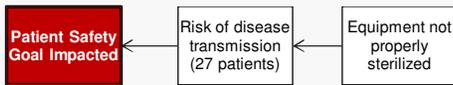
What	Problem(s)	Incorrect sterilization of equipment, risk of disease
When	Date	September 19 - December 10, 2013
Where	Different, unusual, unique	Problem discovered December 17, 2013
	Facility, site	Step in sterilization process not completed
	Unit, area, equipment	Seattle, WA Medical Center
	Task being performed	Ultrasound probe
Impact to the Goals		Prostate procedures

Patient Safety	Risk of disease transmission for 27 patients
Employee Safety	?
Environmental	?
Compliance	Equipment not properly sterilized
Patient Services	Risk of disease transmission
Schedule/ Operations	?
Property/ Equipment	?
Labor/ Time	HIV, hepatitis testing provided by medical center

2 Analysis

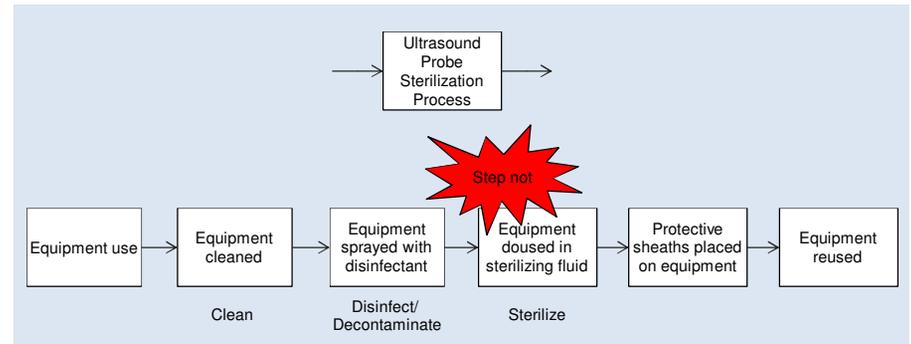
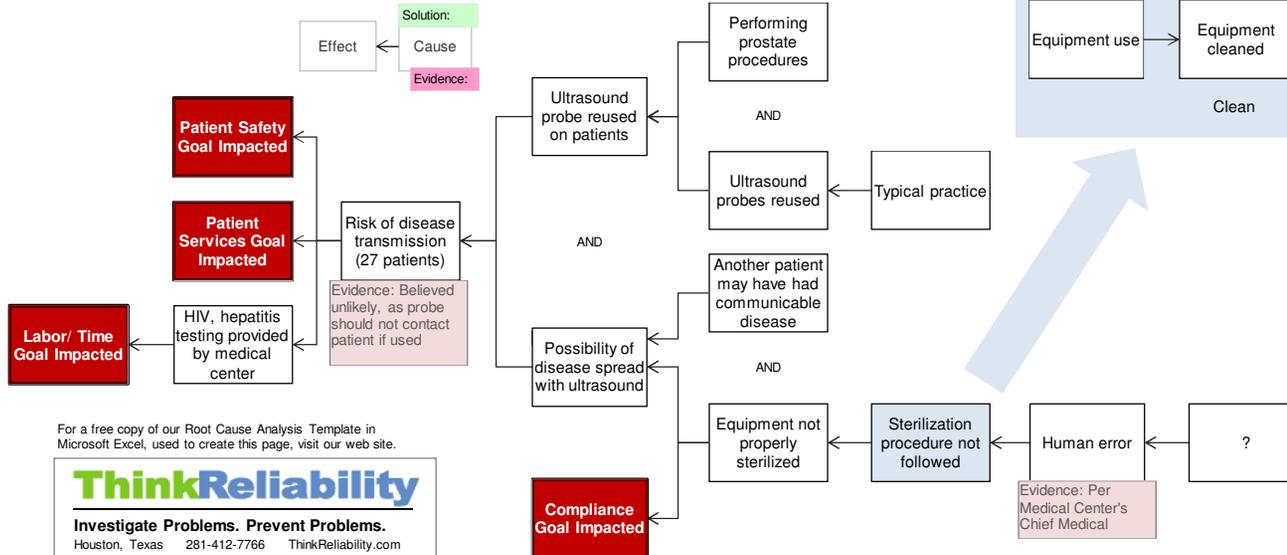
Basic Level Cause Map - Start with simple Why questions.

Basic Cause-and-Effect



In this case, the patient safety goal was impacted due to the risk of disease. The disease risk resulted from the reuse of prostate probes that had the possibility to spread disease. The disease risk occurred because the probes were not

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



3 Solutions

In order to determine effective solutions to prevent the issue from recurring, more detail needs to be obtained about the expectations for the process being performed, as well as the verification (if any) that took place to ensure that the procedure was being performed correctly. Once it's possible to determine what allowed the process to break down, safeguards that will reduce the risk of it happening again can be implemented.

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

ThinkReliability

Investigate Problems. Prevent Problems.
Houston, Texas 281-412-7766 ThinkReliability.com

Copyright ThinkReliability 2013