

1 Problem

| | |
|----------------------------|---------------------------------------|
| Problem(s) | Patient death, excessive blood loss |
| Date | 2010 |
| Time | See timeline |
| Different, unusual, unique | Patient blood loss exceeded 1500 cc's |
| Where | California |
| State, city | Medical Center |
| Facility, site | Labor & Delivery |
| Unit, area, equipment | Normal full term vaginal delivery |
| Task being performed | |

Where

Impact to the Goals

| | | |
|-----------------------|--------------------------------|----------|
| Patient Safety | Patient death | |
| Employee Impact | Second victim | |
| Compliance | "Never event"/ "Adverse event" | |
| Organization | Fined \$50,000 | \$50,000 |
| Patient Services | Delay in life saving measures | |
| Environmental | N/A | |
| Property, Equip, Mtls | N/A | |
| Labor, Time | ? | |

| | | |
|-----------|-----------------|----------|
| Frequency | This incident | \$50,000 |
| | Annualized Cost | ? |

MATERNITY DEATH

Cause Map

Blood Loss after Normal Delivery

After a normal delivery, excessive blood loss caused the death of a new mother in a California medical center.

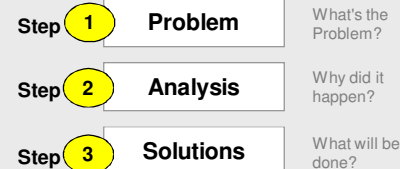
"We have reviewed these situations with everyone involved . . . to learn from them, improve patient care, update our policies and make sure nothing like these incidents can happen again."

- Medical Center CEO

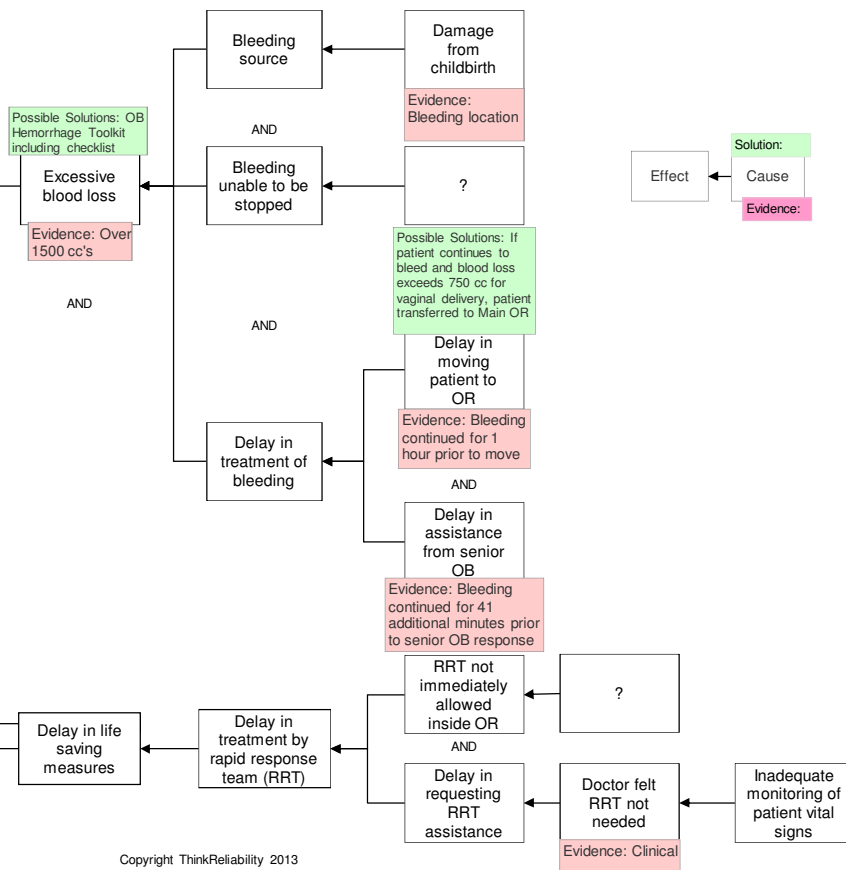
Cause Mapping is a Root Cause Analysis method that captures basic cause-and-effect relationships supported with evidence.

CAUSE MAPPING

Problem Solving • Incident Investigation • Root Cause Analysis

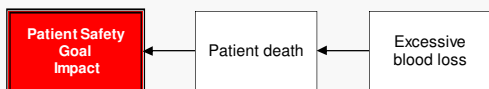


More Detailed Cause Map - Add detail as information becomes available.



2 Analysis

Basic Level Cause Map - Start with simple Why questions.



Basic Cause-and-Effect

Excessive blood loss caused the death of a woman after a normal full term vaginal delivery. Maternal death associated with labor or delivery in a low-risk pregnancy while being cared for in a facility is considered an "adverse event" by the California Department of Public Health, and a "never event" by the National Quality Forum.

Timeline

| Time | Description |
|----------|--|
| 2:10 AM | Patient arrives at hospital |
| 11:26 AM | Membranes ruptured artificially |
| 3:18 PM | Baby delivered |
| 4:20 PM | Patient moved to Operating Room (OR) |
| 5:00 PM | Senior obstetrician called to OR |
| | Unsuccessful attempts to stop bleeding |
| 5:25 PM | Nurse asks if another physician or rapid response team (RRT) is needed; doctor says no |
| 5:30 PM | RRT arrives at OR, not allowed inside |
| 5:35 PM | Doctor places breathing tube |
| | RRT allowed inside |
| | Code Blue resuscitative measures begun |
| 6:47 PM | Patient death |

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.
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Patient Services Goal Impacted

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