IMPROVED SEPSIS RESPONSE

Cause Map

1 Problem

What	Problem(s)	Child's death, sepsis
When	Date	April 1, 2012
	Different, unusual, unique	Resembles normal responses to infection
Where	Facility, site	New York
	Unit, area, equipment	University Medical Center
	Task being performed	Treating patient for vomiting, fever, pain

Impact to the Goals

Patient Safety	Child's death
Patient Services	Initial misdiagnosis

Foundation fights for country-wide adoption

New York state has become a leader in identifying and treating sepsis since it adopted "Rory's Regulations" on December 31, 2013. The regulations are named after a twelve-year-old boy named Rory Staunton who died from sepsis in a New York hospital on April 1, 2012. These regulations require "health care providers to develop and implement protocols to rapidly diagnose and treat sepsis infections". In addition, the state adopted hospital pediatric care regulations which specifically addressed many of the causes identified in Rory's case.

"Early detection of sepsis is a vital tool to treat this potentially life-threatening condition and save lives. Using evidence-based standards, we have identified key protocols to improve patient outcomes for sepsis. Further, we are taking additional steps to ensure that children's vital health information, including lab and test results, is communicated effectively to both parents and primary care providers. Thanks to Governor Cuomo, New York is a leader in implementing these critical measures."

- New York State Health Commissioner Nirav R. Shah, M.D., M.P.H.

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

CAUSE MAPPING

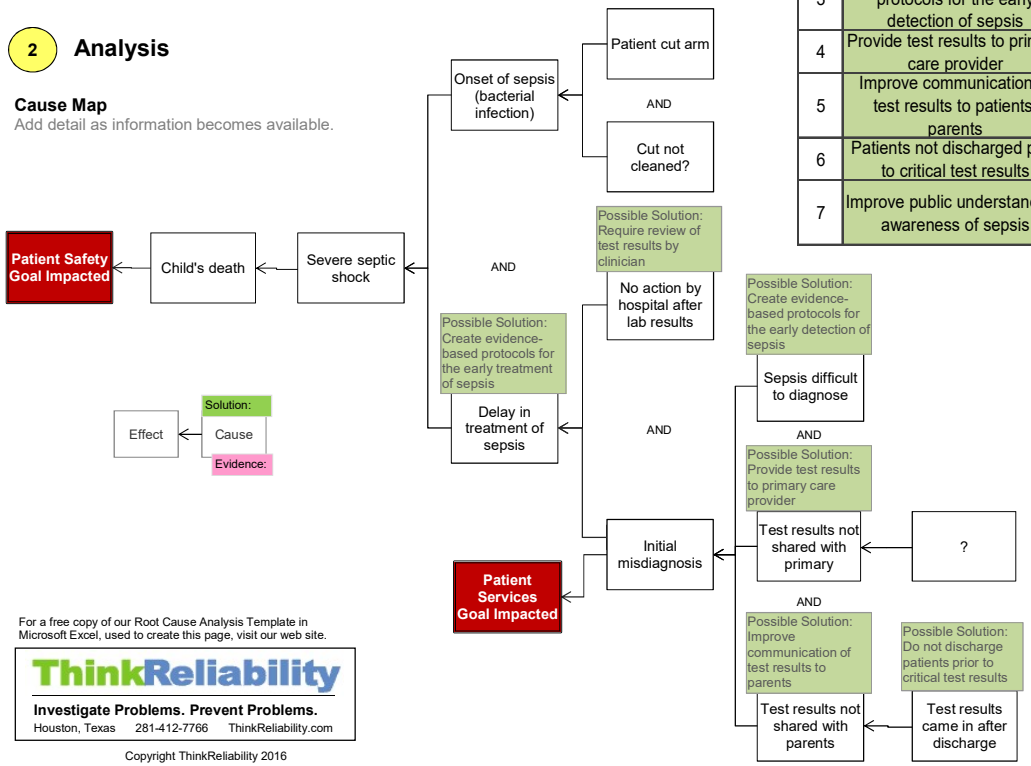
Problem Solving • Incident Investigation • Root Cause Analysis

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

2 Analysis

Cause Map

Add detail as information becomes available.



3 Solutions

No.	Action Item	Cause	Owner(s) (Names)	Status-Completed	Notes
1	Require review of test results by clinician	No action by hospital after lab results	New York hospitals	Adopted 12/31/2013	Amendment to Part 405 of Title 10 NYCRR
2	Create evidence-based protocols for the early treatment of sepsis	Delay in treatment of sepsis	New York hospitals/ International Task Force	12/31/13	NY requires hospitals to adopt protocols
3	Create evidence-based protocols for the early detection of sepsis	Sepsis difficult to diagnose		2/22/2016	Task force releases definitions/ guidance
4	Provide test results to primary care provider	Test results not shared with primary provider	New York State	Adopted 12/31/2013	Amendment to Part 405 of Title 10 NYCRR
5	Improve communication of test results to patients/ parents	Test results not shared with parents	New York State	Adopted 12/31/2013	Amendment to Part 405 of Title 10 NYCRR
6	Patients not discharged prior to critical test results	Test results came in after discharge	New York State	Adopted 12/31/2013	Amendment to Part 405 of Title 10 NYCRR
7	Improve public understanding/ awareness of sepsis	N/A	CDC	Website updated 5/29/2014	Available at: http://www.cdc.gov/sepsis/

Selections from the amendment to Part 405 of Title 10 NYCRR, adopted 12/31/2013

All test results completed during the patient's admission or emergency room visit will be reviewed by a physician, physician assistant, or nurse practitioner who is familiar with the patient's presenting condition.

Patients may not be discharged from the hospital or the emergency room until any tests that could reasonably be expected to yield "critical value" results - results that suggest a life-threatening or otherwise significant condition such that it requires immediate medical attention - are reviewed by a physician, physician assistant (PA) and/or nurse practitioner (NP) and are communicated to the patient, his or her parents or other decision-makers, as appropriate.

Patients may not be discharged until they receive a written discharge plan, which will also be verbally communicated to patients, their parents or other medical decision-makers, which will identify critical value results of laboratory or other diagnostic tests ordered during the patient's stay and identify any other tests that have not yet been concluded.

The communication of critical value results and the discussion of the discharge plan must be accomplished in a manner that reasonably assures that the patient, their parents or other medical decision makers understand the health information provided in order to make appropriate health decisions.

Hospitals shall provide all lab results to the patient's primary care provider, if known.

A patient, his or her parent or other medical decision maker has the right to request information about the diagnosis, possible diagnoses that were considered and complications that could develop as well as information about any contact that was made with the patient's primary care provider.

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