Medical Incident Investigations

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Overview

- Medical Incident Investigations
  - Process Overview
  - Lessons Learned

Medical Incident Investigation (MII)

"Human error is not the conclusion of the investigation, it is the starting point."

"A safety culture is one that allows the boss to hear bad news."

Sidney Dekker, "The Field Guide to Human Error Investigations"

MII

- Air Force Instruction 44-119, *Medical Quality Operations*
- The primary purpose of a MII is to find out how the system contributed to the adverse outcome by thoroughly investigating the facts in a non-punitive way.
- The ultimate goal is to learn from the event, recommend system changes to reduce the risk of recurrence, thereby decreasing harm to patients and improve health care.
- Protected from disclosure under Title 10 U.S.C., Section 1102

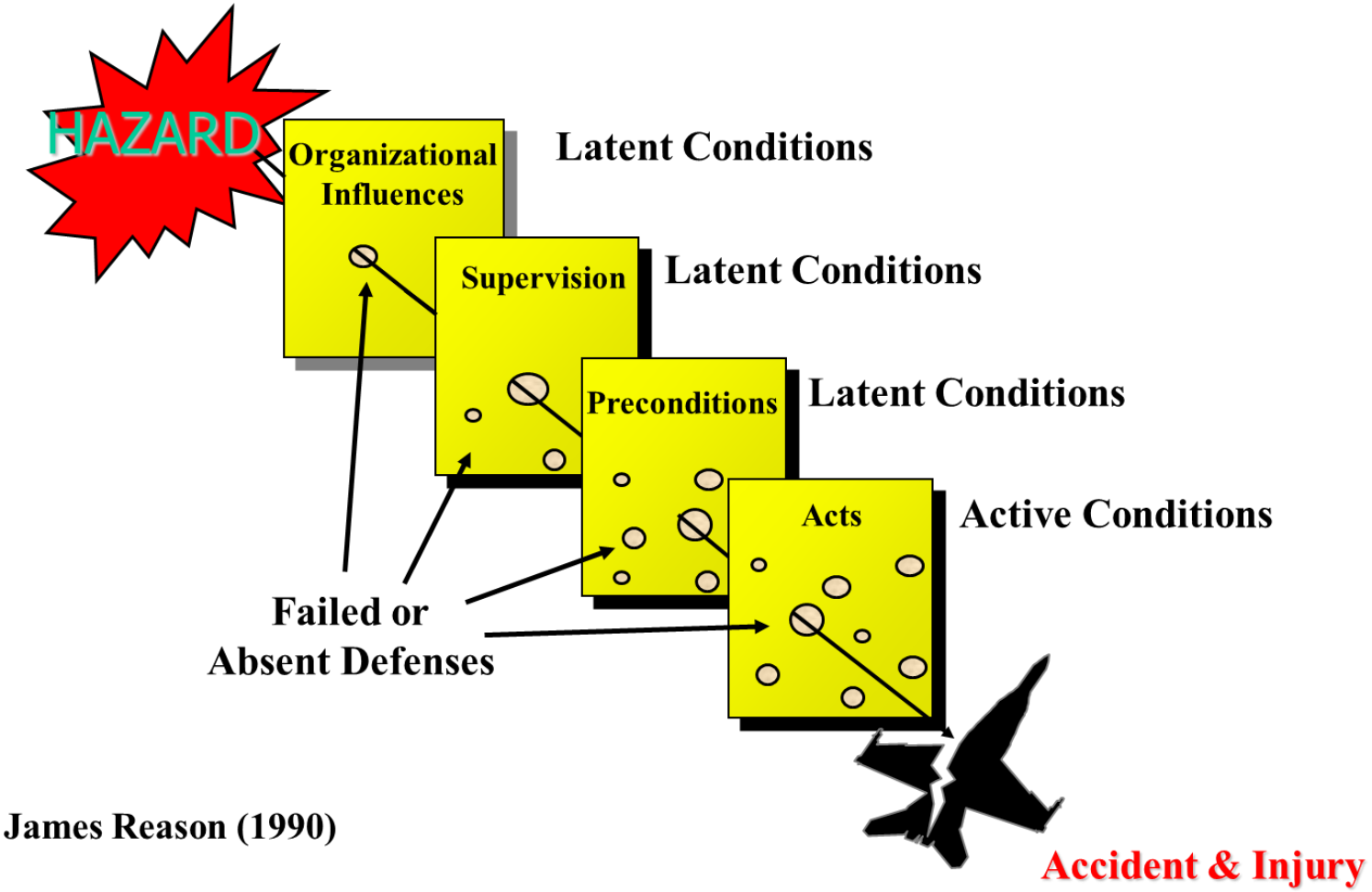
MII Process

- *EXTERNAL* investigation
- Objective and thorough
- Analogous to Flight Mishap and Ground Safety Investigations
- Medical Group Commander consults with MAJCOM/SG to initiate
- Investigation to start within 30 days of incident
- Team selected by Air Force Medical Operations Agency, Clinical Quality Division (AFMOA/SGHQ)
  - Team members approved / appointed by MAJCOM/SG
  - AFMOA/SGHQ conducts team training
- MTF supports MII team with evidence, witnesses, logistics

MII Process

- MII Team Chief leads investigative team and facilitates process
  - Determines contributing factors and key findings
  - Recommendations for risk mitigation and performance improvement
  - Incorporates DoD Human Factors Analysis and Classification System
- MII team briefs
  - MTF commander
  - Wing Commander (if requested)
  - AFMOA commander, MAJCOM/SG, AFMS CMO
- Lessons learned and SG NOTAMs shared with AFMS and DoD

Swiss Cheese Model



DoD Human Factors (HFACS)

Organizational Influences

- Resource Management
- Organizational Culture
- Organizational Processes

Supervision

- Inadequate Supervision
- Planned Inappropriate Operations
- Failure to Correct Known Problems
- Supervisory Violations

Preconditions

- Environmental Factors
- Condition of Individuals
- Personnel Factors

Acts

- Errors
- Violations

Incidents Suggesting an MII

- Sentinel events as defined by The Joint Commission
  - Event has resulted in an unanticipated death or major permanent loss of function not related to underlying illness
- Unanticipated / preventable death
- Significant injury resulting from medical care
  - Wrong site surgeries
  - Unintended retained foreign bodies
- All inpatient suicides or active duty attempted or actual suicide while under medical care
- Outside evaluation requested by MTF
- Upon request by Inspector General, installation commander, MAJCOM/SG, or Air Force Surgeon General

Alternate Review Processes

- Root Cause Analysis
  - Required for sentinel events
  - Standardized review process to determine root causal factors
- Potential Compensable Event
  - Formal facility and individual standard of care review for events
- Command Directed Investigation
  - Address particular questions surrounding an incident
  - Not protected by Title 10 U.S.C., Section 1102

MII Tool Kit

- Reference: AFI 44-119
- MII Tool Kit on AFMS Knowledge Exchange website
  - Flowchart, Process talker, Helpful Hints, briefing process, templates, etc.
- Resources: AFMOA/SGHQ, Clinical Quality Division
  - Col Lorna Westfall, Chief, Clinical Quality
  - Col Thomas Harrell, Deputy Dir, Medical Services
  - Col Paul Hogue, Chief, Inpatient Clinical Operations
  - Lt Col Bret Burton, Chief, Outpatient Clinical Operations
  - Ms. Meghan Snide, Risk Management Operations

MII Lessons Learned

- Strong cultural stigma
  - Inhibits seeking care for mental health problems
- Over-reliance on self-reporting of mental health problems
- Disparate information / documentation systems
- Inconsistent follow-up
- Human resource management
  - High turnover rate, deployment tempo
- Policy and clinical guidance compliance

MII Lessons Learned

- Resident supervision
  - Confusing chain of command and “who is in charge”
- Lack of coordination and case management of patients referred to network or other facilities
  - Failure to follow-up / lack of continuity of care
  - Transitions of care were not adequate
- Inadequate policy / procedures regarding high-risk, high-interest patients, including clinical criteria thresholds for inclusion

MII Lessons Learned

- Inadequate documentation
  - Intake history, clinical info, treatment plan, and follow-up
- Use templates from Air Force Guide to Managing Suicidal Behavior to formally assess risk level
- Standardize a thorough orientation and training for all Mental Health personnel

Questions?