St. Pandelver's Hospital / 18 Jul 2019 / Dr. Jonathan Barnes

8D Report Template

Complete

Inspection score	Failed items	Created actions
81.25%	0	0

Site Sydney
Company St. Pandelver's Hospital
Location 417 6th Ave S, Ellendale, ND, 58436
8D Team Leader Dr. Jonathan Barnes
Conducted on 18th Jul, 2019 12:35 PM +08

Inspection

81.25%

8D Report

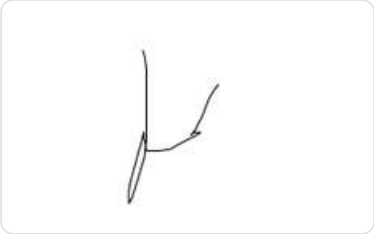
D1

List 8D Team Members

MEMBER

MEMBER 1

Full Name, Role and Signature



Jonathan Barnes - Surgeon

18th Jul, 2019 2:08 PM +08

MEMBER 2

Full Name, Role and Signature

Larkin Sparrow - Anesthesiologist

18th Jul, 2019 2:12 PM +08

MEMBER 3

Full Name, Role and Signature

Bethanny Maye - CRNA

18th Jul, 2019 2:14 PM +08

MEMBER 4

Full Name, Role and Signature

Steve Rankin - Operating Room Nurse

18th Jul, 2019 2:16 PM +08

MEMBER 5

Full Name, Role and Signature

Rica Forte - Surgical Tech

18th Jul, 2019 2:17 PM +08

MEMBER 6

Full Name, Role and Signature

Danielle Carmen - Physician Assistant

18th Jul, 2019 2:42 PM +08

D2

Briefly describe the problem

Reports of IV line errors have risen by 7% since the previous quarter.

What will be done? (Action steps, description)
In-house seminars will be held to retrain hospital personnel on safe and proper preparation of IV lines, pre-insertion guidelines, labelling of IV lines, placement, monitoring, as well as complete and proper documentation.

Why will it be done? (Justification, reason)
The seminars will serve to clarify SOPs regarding the preparation, utility, and monitoring of IV lines. It is also intended to reinforce our standards to improve safety and lower rates of preventable errors.

Where will it be done? (Location, area)
Providence Conference Room

When will it be done? (Time, dates, deadlines)
7 seminars will be held for 30 minutes each to cover all shifts and personnel without adversely affecting staffing:

July 19
9:00am
11:00am
3:00pm
5:30pm
8:00pm
11:00pm

July 20
3:00a

Who will do it? (Who's responsible?)
Doctor Barnes for July 19 (9am,11am,3pm)
Doctor Sparrow for July 19 (5:30pm, 8:00pm)
Doctor Maye for July 19 (11pm) and July 20 (3am)

How will it be done? (Method, process)
Doctor Barnes, Doctor Sparrow, and Doctor Maye will convene and create a 30-minute presentation on the proper proper preparation of IV lines, pre-insertion guidelines, labelling of IV lines, placement, and monitoring to be presented at intervals stated above.

How much? (What will it cost to do/make?)
No extra expenses.

Does the problem statement contain the 5W2H? (Who, What, When, Where, Why, How, How much/often)	Yes

D3

Are there interim containment actions for this problem?	Yes

Briefly describe current interim containment actions	
1. Had on-shift staff confirm that the IV lines in the stock room are uncontaminated and safe for use. 2. Advised nurses and other staff personnel concerned with documentation to double-check the information on patient forms and ensure that the information is complete and accurate before passing it on to the surgical team. 3. An email and text was sent to all hospital staff advising them to pick up their copy of a read-do checklist and a do-confirm checklist regarding IV line prep and utility.	
Rate effectiveness (1 = low, 10 = high)	7 From 0 to 10

D4

Identify the root cause of the problem	
Omissions and discrepancies in pre-surgery patient documentation accounted for 82% of all IV line errors	
Take/attach relevant photos as verification of the root cause	
Unanswered	
Does the root cause of the problem reveal flaws in business processes?	Yes
Why was the problem not detected and resolved at the time it occurred?	
The hectic schedule of the staff made it difficult to set time aside for calibration.	

D5

What permanent corrective actions can be developed to solve the problem?
1. Hiring additional staff to reduce workload and in turn improve safety and quality standards and compliance. 2. Introducing read-do and do-confirm pre-surgery checklists to ensure that safety protocols are followed at all times. 3. Impose stricter penalties to staff committing documentation errors. 4. Assign staff to regularly monitor and compile data regarding IV line errors and have a monthly huddle so everyone stays vigilant.
Take/attach relevant photos as proof of effectiveness of corrective actions
Unanswered

D6

Implementation date of corrective actions	
29th Jul, 2019	
Did we communicate the changes to all stakeholders?	Yes

D7

Are additional measures needed to prevent similar problems?	No

What lessons are learned and can be applied to other problems?

Sometimes simple protocols and SOPs are taken for granted which can result in dire consequences. We need to come up with control measures to ensure SOPs and protocols for other processes, not just IV use, are continuously implemented.

Were procedures and work instructions updated?	Yes

D8

How can the team be rewarded to boost motivation?

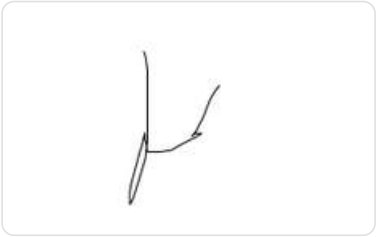
An incentive program that will give monetary awards to staff who champion the new protocols.

Completion

Additional Recommendations

Review and compile data for other hospital processes to identify recurring errors so an 8D Report can be made to rectify them.

Full Name and Signature of 8D Team Leader



Dr. Jonathan Barnes

19th Jul, 2019 11:35 AM +08