

Adverse Events

Learning

- Frankel A, Federico F, Ogrinc G, Huber S. *PS 105: Responding to Adverse Events* [IHI Open School online course]. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2009. Updated 2016.
 - Available at <http://app.ihi.org/lmsspa/#/6cb1c614-884b-43ef-9abd-d90849f183d4/614af4d5-09ed-4c08-b495-59673b0a581a>
 - Appendix B: redesigning health care with insights from the science of complex adaptive systems. In: Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: National Academy Press; 2001: 309–322.
 - Available at <https://www.nap.edu/read/10027/chapter/13>
 - Baum K. Advanced case study. IHI Open School website. Accessed November 6, 2015.
 - Available at http://www.ihl.org/education/IHIOpenSchool/resources/Documents/Participant_AdvancedCaseStudy.pdf
 - Cause-and-effect diagram. In: *QI Essentials Toolkit*. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017:3–5.
 - Available at <http://www.ihl.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx>
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Reflection

- Identify contributing factors to the major adverse event in the advanced case study. Draw a cause-and-effect diagram to help you. (see *QI Essentials Toolkit*).
- Make a list of all the people involved in Carla's case. Describe each person's role in the events that caused long-term harm. Imagine how each person might feel after the event, and what they each might need.
- Referring to *PS 105*, craft an apology to Carla and her family. Who do you think should deliver the apology, and under what circumstances?

- Based on the Institute of Medicine report, create one or more simple rules that might guide the development and evolution of Carla's ideal health care system.
- What changes in the current system of care would you recommend testing? (i.e., are there small-scale, incremental changes that would be beneficial? Are there new care processes that need to be designed and implemented?)