

**1 Problem**

<b>What</b>	Problem(s)	Patient death, septic crisis
	When	See timeline
	Different, unusual, unique	Initially sepsis can look like less serious ailments; every hour delay in giving antibiotics after low blood pressure sets in decreases survival rate by 7.6%
<b>Where</b>	State, city	New York
	Facility, site	University Medical Center
	Unit, area, equipment	Emergency room
	Task being performed	Treating patient for vomiting, fever, pain

<b>Impact to the Goals</b>	<b>Patient Safety</b>	Patient (child) death
	<b>Employee Impact</b>	Emotional impact to providers
	<b>Compliance</b>	?
	<b>Organization</b>	Potential for lawsuit
	<b>Patient Services</b>	Initial misdiagnosis
	<b>Environmental</b>	N/A
	<b>Property, Equip, Mtls</b>	?
	<b>Labor, Time</b>	?

Frequency	750,000 cases of sepsis annually; nearly 40% mortality rate
	National annual estimated cost \$16.7 B

# SEPSIS DEATH

## Delay in treatment results in death of a child

Sepsis is very difficult to diagnose even in the best case and can depend on information from multiple diagnostic tools. When information from those tools is not shared between a patient's caregivers, diagnosis can be delayed . . . sometimes with fatal results.

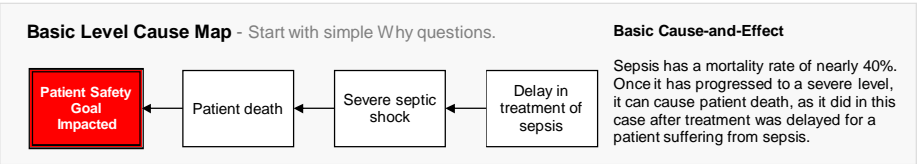
"I never knew that testing was done."  
-Patient's pediatrician

### Cause Map

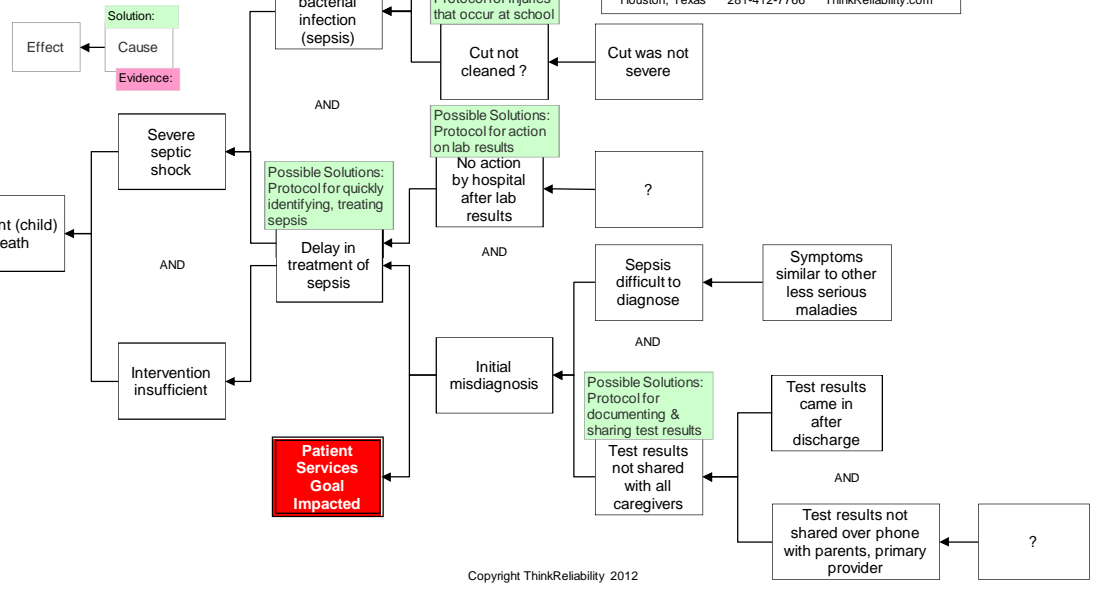
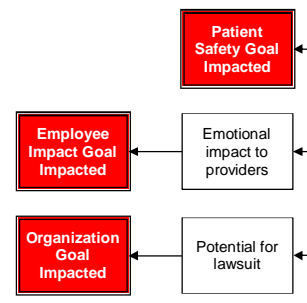
### Timeline

Date	Time	Description
March 28, 2012		Patient cuts arm
		Cut bandaged at school
	~Midnight	Patient begins vomiting, complaining of leg pain
March 29, 2012	Morning	Patient is weak, has leg pain, and a fever of 104F
	Evening	Patient went to pediatrician's office with fever, pain in leg and vomiting
		Rapid strep swab test negative
		Patient sent to emergency room for rehydration
	7:14 p.m.	Patient arrives at medical center
		Patient diagnosed with upset stomach and dehydration
		Patient given fluids
	9:12 p.m.	Orders for patient's discharge given
	9:26 p.m.	Patient vital signs suggest he may still be seriously ill
	~9:30 p.m.	Patient discharged with instructions to take Tylenol
	~Midnight	Lab results printed - showing that patient is producing neutrophils and bands at "abnormal" rates that would "suggest a serious bacterial infection"
March 30, 2012	10:00 a.m.	Pediatrician phoned, tells parents to return to ER
		Patient enters intensive care unit
		Patient sedated, put on ventilator
April 1, 2012	evening	Patient dies after he is unable to be resuscitated

**2 Analysis**



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



For a free copy of our Root Cause Analysis Template in Microsoft Excel, used to create this page, visit our web site.

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**3 Solutions**

No.	Action Item	Cause
1	Protocol for injuries that occur at school	Cut not cleaned ?
2	Protocol for action on lab results	No action by hospital after lab results
3	Protocol for quickly identifying, treating sepsis	Delay in treatment of sepsis
4	Protocol for documenting & sharing test results	Test results not shared with all caregivers