Where do FMEA and RCA opportunities fit in the budget?

Editor's note: The following is the second in an occasional series regarding human error and its role in medical error. This month, author ***Robert J. Latino,*** *executive vice president of the Reliability Center, Inc., defines human error as it relates to healthcare.*

Where do proactive technologies such as root cause analysis (RCA) and Failure Modes and Effects Analysis (FMEA) stand when it comes to budget time? It is common knowledge that patient safety and patient care are key buzzwords in the healthcare environment today, but are RCA and FMEA considered integral to patient safety and patient care?

Budgets are often seen as a necessary evil to control costs and manage business processes. They are needed to accommodate our accounting requirements for internal and external reporting. Budgets, unfortunately, can also stifle an organization's creativity and be organized so that they steer clear of any purchases that may seem too risky. When an organization is risk aversive, it tends to be rigid in its decision-making and discourages people from seeking opportunities.

A case study

A risk manager has properly researched various RCA and FMEA tools on the market and decided on a specific tool that will best fit her organization's culture. The tool chosen incorporates both training in the methodologies and software to help expedite documentation and communication. Based on the hospital's research, the tool costs about $5,000 for education and the software.

The risk manager prepares the information to take to her supervisor for obtaining funds to attend a scheduled public workshop for the tool selected. But the hospital operates fiscally on a calendar year. This request is being made in February after the new budget has been applied.

Before submitting the request, the risk manager receives a memorandum from the chief financial officer stating that a moratorium has been placed on any purchase over $500 that isn't required for patient care.

The vendor for the selected tool calls the risk manager to routinely follow up on the proposal that was submitted to the hospital for the RCA and FMEA tool.

The risk manager mentions the moratorium and adds, "Because this is RCA/FMEA training, the finance department would never go for it."

The following assumptions can be read into such a statement:

- Technologies such as RCA and FMEA are not directly linked to patient care
- RCA and FMEA are basically interpreted as education or a generic line item in a budget, just as diversity training or communication skills might be perceived
- RCA and FMEA do not have a software component, which would simply mean, in such an organization,

that they might be categorized in the budget in a generic software line item (just as Microsoft Word and PowerPoint might be classed)

- Those who make the determinations about what monies can be spent on patient care think they understand what RCA and FMEA actually mean and can accomplish
- There is no need to even present the opportunity because those reviewing it would not be open-minded enough to evaluate the submittal based on its proposed value to the organization

When reviewing RCA methods, approaches, and software, we must ask ourselves, "How will the utilization of this product produce results for the organization's bottom line?" The first concern should be return on investment (ROI), and the second should be initial cost.

When industry commissions engineering projects, capital projects, etc., the organization typically requires that a cost/benefit analysis be performed and a quantitative ROI be determined. Why should education be any different?

The Reliability Center has come across only a handful of companies that measure ROI of training. This is unfortunate because more than $60 billion is spent annually on occupational training and only about 20% of the training is ever implemented. This is an unbelievable waste of money.[1]

In the above scenario, this organization would expense the opportunities that such tools could bring to the table because of an imposed paradigm restricting expenditures on certain categories. Therefore, it is up to the determination of whoever is seeking funds to persuade the finance department to view his or her request as "required for patient care."

If this is the case, rather than get shot down for such a request, often the risk manager will simply ignore it because it is viewed as too difficult and time-consuming to fight for, and such time is scarce. However, the patient loses out!

Among those purchases that the information services department traditionally views as "required for patient care" are supplies such as needles and gauze. For example, let's say all of a sudden there is an urgent need for 20% more needles when the patient load has been at a consistent level. The finance people are approached and the request is made to spend x amount of money on 20% more needles, which are "required for patient care." The likely response from finance? Approved!

What if the increase in the need for additional needles was due to an increase in blood redraws? What if this increase in blood redraws was due to a lack of education of newly hired nursing staff members to properly draw blood on the first attempt?

Questions such as these are asked every day. What often happens from this point is that the needle expenditures are entered into the budgetary numbers and "become a cost of doing business." This is because when the next budget development period arrives, those making the budget will most likely look at the historical expenditures on needles, add a cost of living hike to the budget, and move on to the next item.

The lost opportunity

What would not have been uncovered is the fact that the hospital was redrawing blood 10,000 times per year at an annual cost of $3 million (includes ER time, nurse time, lab technician time, gauze, syringes, etc.). The hospital would have continued to pay for extra needles with no questions about the budget, but the requests for RCA and FMEA software would have been denied.

The irony here is that the RCA and FMEA tool would have detected this $3 million loss, determined why it was occurring, implemented corrective actions to eliminate or mitigate the loss, and demonstrated a phenomenal ROI to the hospital in the current fiscal period. However, because RCA and FMEA were seen as "education" and/or "software" line items in the budget and not "required for patient care," these ROIs will never be realized.

Is this scenario really fictional? Could this scenario be happening at hospitals across the country as we speak?

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FMEA and RCA

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The solution

Although this scenario may hit home with many, the solutions often appear out of our reach. This is because any solutions would involve changes in the "way that we do business." This may mean that the hospital's finance and accounting systems need to go under the microscope because they affect patient safety.

Often when the term "patient safety" is used, we automatically think of the errors of those closest to the patients. The effect of decisions made regarding patients from those far removed from them is what is often forgotten. All clinical processes in the organization are part of larger systems.[2]

The above scenario demonstrates the effect that decisions made regarding larger systems can have on the patients. In the scenario, the budgetary process is just another one of the "larger processes" in our organization. Budget process deficiencies, such as those stated in this article, have been identified as organizational system root causes in numerous RCAs.

Educate budget approvers and procurement personnel to understand the direct relationship between soft technologies such as education and software to patient care and safety. "Technology is more effective than humans in enhancing process consistency and in receiving, storing, and processing information. Technology does not take shortcuts. It is not influenced by emotion. And it has the advantage of being a long-term improvement in contrast to risk reduction strategies."[3]

Also, be sure to review guidelines for evaluating and accepting budgetary items. Ask yourself the following:

- Do standard guidelines exist for the evaluation of such budgetary items?
- Do these guidelines restrict/discourage the inclusion of potential opportunities integral to patient safety efforts?
- Do these guidelines encourage short-term cost reduction paradigms at the expense of long-term patient safety goals?
- Do these guidelines provide for the demonstration of value of line items in the form of potential ROI calculations?
- Is there a standard ROI for the corporation in which, if the case is made, the budget item will be accepted?
- Is there a standard ROI for the corporation for training monies expended?
- Do these guidelines require the submitter's specific reasons for why submittals were rejected to improve future submittal attempts?

Many of these are commonsense questions. However, the point to be made and internalized is that organizational processes such as budgeting can be significant contributors to overall patient safety. Decisions made to include or not include items in the budget, to change vendors in purchasing based on low cost, and to limit formularies in response to cost-reduction mandates are all examples of how daily decisions can either contribute to patient safety or detract from it. How is it handled in your organization?

The last word

If you don't get the budget to do it right, you will get the budget to do it over![4] ■

Editor's note: To visit The Reliability Center's Web Site, go to www.proactforhealthcare.com

Sources

1. Latino, R.J., Latino, Kenneth C. (2002). *Root Cause Analysis: Improving Performance for Bottom-Line Results.* Boca Raton, FL: CRC Press.
2. Croteau, Richard J., Schyve, Paul M. (2000). *Proactively Error-Proofing Health Care Processes. Error Reduction in Health Care.* San Francisco: Jossey-Bass Publishers.
3. Croteau, Richard J., Schyve, Paul M. (2000). *Proactively Error-Proofing Health Care Processes. Error Reduction in Health Care.* San Francisco: Jossey-Bass Publishers.
4. Corcoran, Bill (2004). *Root Cause Analysis Conference Statement.*