

# ACTION HIERARCHY TOOL

|  | ACTION CATEGORY  | EXAMPLE   |
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| <b>Stronger actions</b><br>(these tasks require less reliance on humans to remember to perform the task correctly) | Architectural/physical plant changes   | Replace revolving doors at the main patient entrance into the building with powered or swinging doors to reduce patient falls.  |
|  | New devices with usability testing   | Perform heuristic tests of outpatient blood glucose meters and test strips and select the most appropriate for the patient population being served  |
|  | Engineering control (forcing function)   | Eliminate use of universal adaptors and peripheral devices for medical equipment and use tubings/fitting that can only be connected the correct way (eg. IV tubing and connectors that cannot physically be connected to sequential compression devices or SCDs). |
|  | Simplify process   | Remove unnecessary steps in a process   |
|  | Standardize on equipment or process  | Standardize on the make and model of medication pumps used throughout the institution. Use bar coding for medication administration.  |
|  | Tangible involvement by leadership   | Participate in unit patient safety evaluations and interact with staff; support the RCA <sup>2</sup> process; purchase needed equipment; ensure staffing and workload are balanced.   |
| <b>Intermediate actions</b>  | Redundancy   | Use two RNs to independently calculate high-risk medication dosages   |
|  | Increase in staffing/decrease in workload  | Make float staff available to assist when workloads peak during the day.  |
|  | Software enhancements, modifications   | Use computer alerts for drug-drug interactions.   |
|  | Eliminate/reduce distractions  | Provide quiet rooms for programming PCA pumps; remove distractions for nurses when programming medication pumps.  |
|  | Education using simulation-based training, with periodic refresher sessions and observations | Conduct patient hand-offs in a simulation lab/ environment, with after action critiques and debriefing.   |
|  | Checklist/cognitive aids   | Use pre-induction and pre-incision checklists in operation rooms. Use a checklist when reprocessing flexible fiber optic endoscopes.  |
|  | Eliminate look- and sound-alikes   | Do not store look-alikes next to one another in the unit medication room.   |
|  | Standardized communication tools   | Use read-back for all critical lab values. Use red-back or repeat-back for all verbal medication orders. Use a standardized patient hand-off format.  |
|  | Enhanced documentation, communication  | Highlight medication name and doses on IV bags.   |
| <b>Weaker actions</b><br>(these tasks require more reliance on humans to remember to perform the task correctly)   | Double checks  | One person calculates dosage, another person reviews their calculation.   |
|  | Warnings   | Add audible alarms or caution labels.   |
|  | New procedure/memorandum/policy  | Remember to check IV sites every 2 hours.   |
|  | Training   | Demonstrate correct usage of hard-to-use medical equipment.   |

Action Hierarchy levels and categories are based on *Root Cause Analysis Tools*, VA National Center for Patient Safety, [http://www.patientsafety.va.gov/docs/joe/rca\\_tools\\_2\\_15.pdf](http://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf). Examples are provided here.