Post Event Debrief
An Integral Part of Our Patient Safety Culture

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American College of Medical Quality December 2014
Many to thank

but

no financial disclosures
When patient care is delivered as a series of independent, rather than interdependent actions of expert professionals, quality of care and patient safety is likely to be negatively impacted.

A team of experts is not an expert team...

-AHRQ TeamSTEPPS
Complex sociotechnical system

- Relationships
- Interactions
- Local rationality

- Complicated patients

- Dynamic
- Evolving
Challenge: Manage Systems

- Interrelationships between all components
- Generate and enhance positive interactions between components
- Change negative interactions into positive
- Foster understanding and communication of what the object is

NO MIND READING
NEVER WORRY ALONE
Traditional approach

The ABC’s (Good old days…)

Assess

Blame

Crucify
Post Event Debrief

an integral component of our Immediate Event Management and the initial analysis of our RCA process
Debrief
Backbone of Our Patient Safety Culture

Purpose
• examine existing processes and systems, not individuals

Intent
• improve patient care quality, system performance improvement, and utilization of resources

Protection
• Confidential Patient Safety Work Product, Protected under the Patient Safety and Quality Improvement Act
## Debrief Checklist

### ACTION ITEMS

- **Prompts for Discussion**
  - Describe what happened.
  - What normally happens?
  - What went well, what should we change, what can we improve?
  - Do you have any other concerns?

- **Other Considerations for Discussion**
  - Any staff not present for *Debrief*, need ongoing support, defusing or should be recognized? (1-877-595-5284 staff support)
  - Any patient or family ongoing support needed?
  - Is there a need for disclosure? Identify patient/family spokesperson
  - Is there a need to secure equipment?

- **Feedback**
  - Summarize and share any Actions Plans as a result of this Debrief

*Thank you for your efforts to improve Patient Safety*
Patient
A 35 year old chronically ill male who resided at a long term care facility presented to Emergency Department with altered mental status, lethargy, and vomiting.

Past Medical History
- Insulin Dependent Diabetes
- Congestive Heart Failure
- Hypertension
- End Stage Renal Disease – Dialysis
- Chronic Pain
- Multiple CVAs
Lab Tests

Metabolic panel
- Creatinine 8.7
- BUN 52
- Glucose 132
- K+ 4.7
- Bicarb 22
Course in ED

- Altered mental status possibly secondary to pain medication side effects
- Observation
- Monitored in ED overnight
- Returned to baseline clinical status

- Vomiting recurred
- Hematest positive
- Possible gastritis

- Repeat labs ordered, drawn by phlebotomist and sent to the lab
Laboratory Process

- Requested *redraw*
- Documented as “canceled”
- EMR (Powerchart)
Patient Course

- Multiple attempts by clinical providers to re-collect labs were unsuccessful due to poor venous access
- Patient refusal
- Further attempts at venipuncture abandoned
- No further vomiting
- Condition stabilized, mental status returned to baseline
- Admission considered
- Hospitalist (who knew patient from multiple prior admissions) advised discharge
- Discharged to long term care facility
Return to ED within Two Hours

- Increased lethargy
- Hypotension
- Transport to ED initiated
- Glucose (POCT) > 500
- → DKA

Labs

Interosseous line

- Glucose 664
- Potassium 6.6
- pH 6.9
• The patient decompensated rapidly, resulting in code

• Resuscitation successful

• 7 liters of fluid

• Vasopressors continued

• Transferred to an intensive care unit

• Ventilator support required -- tracheostomy

• Ongoing hemodynamic and metabolic support
Safety First Learning Report

• Initiated -- lab quality director
• His task: Review critical lab results
  • Investigate events
  • Obtain information
    • Readmit to ED
    • Interosseous line
    • Code
• Inference: worry and concern
• Debrief: Gaps in information
• Facts as known
Debrief Process
Interprofessional Participants identified

- Participants invited - individual who initiated the report, patient care team(s), involved departments with leadership representation

- In this case, participants included:
  - Laboratory Director, VP, Chair Pathology, Lab Scientist
  - ED physicians, Chair, Vice Chair, Attending MD, Nurses, Residents
  - PI Staff
  - Risk Management
  - Facilitator
Debrief

• Tension and polarization

• Defensive Posturing

• Protectionism - “support”
  • Why are we here? Just don’t let it happen again…

"Two monologues do not make a dialogue." - Jeff Daly
Framework

- Individual Objectives
  - ED-safe efficient care
  - Lab-required to observe patterns that suggest compromise in integrity of sample affecting accuracy of test results

- Positions
  - Territories of experts
  - Frame of reference
  - Culture/ context embedded

- Assumptions
  - Design and communicate
  - Communication challenges
Debrief

- Everyone was right and provided appropriate care
- Something went wrong
- Construction vs authentic Reconstruction
- Inside corners of complex systems not generally known
First story—Hindsight
outcome based

- No redraw, no dialysis catheter invasion, no central line
- Discharge, not admission
- Clinician attribution of error—human error, negligent, reckless, irresponsible
- Human closest to accident is source or cause of failure
- “But for”, “if only”, “my bad”
2\textsuperscript{nd} Story—Insight
path to constructive learning and change

- BUT...if this is the conclusion, wrong frame of reference for understanding the behavior

- Easy to stop at individual attribution of error—need to look up and out, not down and in....

- Systems thinking....health care errors are rarely caused solely by an individual

- This error was a symptom of an embedded systems problem
  - Multiple conditions created conditions that led to errors
Deeper Dive into Lab Process

- **What did canceled mean?**
  - To clinicians it meant
    - no testing was done
    - no sample arrived
    - specimen lost
    - could not obtain result
    - clotted
    - hemolyzed
    - machine broke down
    - someone else canceled
    - specimen destroyed
    - no results available
    - any or all of the above
Communication of Canceled

• What did canceled mean to Lab?
  • Met criteria for suspected contamination
  • Basis - delta checks to assess contamination
  
  + criteria + contamination \rightarrow canceled

• Conclusion:
  • Unreliable and invalid, therefore results unreportable
  • Based on experience, anecdotes, policy and culture
Local rationality -- LAB

- Determine compromise in integrity of specimen affecting accuracy of test results
- Contaminated = unreliable
  - unreportable
  - Redraw necessary
- Expectation: redraw (not discharge)
Debrief led to Wicked Question

• Were results from initial lab draw reported as “canceled” actually processed and available?

Yes

Initial Lab values: Prior Lab values:
• Potassium 7.0 mmol/ L Potassium 4.7
• Bicarb 8 mmol/ L Bicarb 22
• Glucose 610 mg/ dl Glucose 132
Realization = Discovery

• Actual specimen results had been generated and interpreted by medical laboratory scientist for “specimen validity” and determined to be unreliable

• Need for redraw communicated to ED clerk, but

• No communication to clinician required

• Local rationality: harm could result if treatment initiated based on erroneous contaminated result
Knowledge of “canceled” results by clinician(s) would have

- Led the provider to diagnose DKA
- Prompted a more aggressive attempt to redraw blood or point of care testing
- Prompted the administration of insulin and IV fluids
- Resulted in patient admission to the hospital, NOT discharge
Lessons Learned from Debrief

“Canceled”

- Clinician--Results not available
- Lab- Unreliable, therefore unreportable

- Lab Process not known or understood by those outside of laboratory

- Lack of awareness by laboratory professionals of impact of current policy/ process on clinical decision-making

- Profound system vulnerability initially identified through debrief process
Value of Debriefs

- Analysis of unintended clinical outcomes is retrospective by definition but does allow for thorough, systematic review of all elements of care from a perspective that is not always feasible in the midst of real time care delivery.

- A timely multidisciplinary debrief with clinicians and staff involved in care maximizes initial appreciation of what happened and the impact on patient and staff.

- Teams engaged in further analysis can delve more deeply into systems issues identified during debriefs.

- Immediate actions can be taken to provide the safest possible care and mitigate harm to our patients.
Summary—Debrief

• Diversity—safety, value
  • Perspectives
  • Narratives
  • Minority Opinions
  • Dissent encouraged
  • Level the hierarchy
  • Decentralization
  • Voluntary and protected

• Authenticity
  • Vitality of everyday life in a system

• Insider accounts
  • Process of sensemaking
  • Local rationality
  • Trade-offs in a system
Example of Debrief Discoveries: Variation in Interpretation of Canceled notation

- “Canceled” lab label in EHR did not have the same meaning to the bedside clinician as it did to laboratory staff
Use of PI tools leveraging Debrief information
Post-Event Debrief and RCA Results

Root Cause

“The process for handling highly abnormal laboratory results presumed to be secondary to contamination allowed the option for a redraw request from lab -- without direct communication of the suspected invalid results to the provider for clinical correlation.”
Revised Process

Lab Test Result

Perceived contamination

Report result in EMR

No  Yes

Call clinician and share result

Clinician confirms potential contamination?

--result entered into EMR

Test canceled

New sample collected

ALERT* initiated

Result posted in EMR as ALERT*

Redrawn sample result confirms “contamination”?

Result reflects patient condition

No  Yes

“true” contamination
New View in EMR

**Results**

**10/04/2011 15:27**

**Chemistry**

- **Electrolytes Status**: See Below
- **NA**: ALERT *
- **K**: ALERT *
- **CL**: ALERT *
- **Total CO2**: ALERT *
- **ANION GAP**: ALERT *

**Lab Reports**

**Lab Reports**: LABRPT

**Result**

**Sodium Serum**: ALERT MMOL/L

- **Normal Low**: 136
- **Normal High**: 146
- **Date/Time**: 04 October 2011 15:27
- **Contributor System**: LIS
- **Accession Number**: 340400445:82
- **Status**: Auth (Verified)

**Comments**

1. (Medium Importance) Result Comment by Contributor_system, LIS on 04 October 2011 15:28

Test Sodium = 136 Possible specimen contamination or hemodilution /hemoconcentration affecting results. Interpret results with caution. If clinically indicated, consider repeat of this test.

Results verbally communicated to Dr Witkin at 10/04/2011 15:29.
Success of changed process

- Greater communication with clinicians
- Enhanced documentation of suspected contaminated results
- Increased interdepartmental understanding and cooperation
- Concurrent review by lab staff and clinicians likely to result in
  - Improved patient care and improved patient safety

Supports value of debrief process
Best Practice for Debriefs

- Debrief immediately following or soon after harm event
- Willingness to question assumptions about systems and processes
- Openness does not last long if debrief discussion not initiated in timely way
- Critical to discovery that goes beyond initial perception that only some people or parts are unreliable
- Unsettles the reassurance of safety of systems
- Diversity of participants and viewpoints
- Leveling of hierarchy
Just Culture
not “who” but “what” was responsible

Leaders are responsible for designing and implementing systems that support the safe choices of healthcare workers.

Healthcare workers are responsible for the quality of their choices.
CANDOR

Communication and Optimal Resolution
The Christiana Care Way

We serve our neighbors as respectful, expert, caring partners in their health. We do this by creating innovative, effective, affordable systems of care that our neighbors value.

Debriefs
An integral part of our Patient Safety Culture