12-2017

Critical Event Review Team (CERT)

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Critical Event Review Team (CERT)

Core Project Team: Jeffrey Kuhlman, MD (Chief Medical Officer/Executive Sponsor) ; Thomas Looke, MD (Anesthesiologist) ; Louis Barr, MD (Surgeon) ; Jeanette Bartos, RN (Surgical Services Patient Safety Officer) ; Gengie Nail (Risk Management) ; Brittany Almon (Project Coordinator) in partnership with Embry Riddle Aeronautical University Human Factors Advisors: Joseph Keebler, PhD, Elizabeth Lazzara, PhD and Elizabeth Blickensderfer, PhD.

BACKGROUND

The culture of medicine is shifting from placing blame on providers to a systems-minded culture of trying to understand human error as a symptom of deeper rooted systemic issues. The goal is to reduce harm by redesigning the systems in which humans work.

AIM

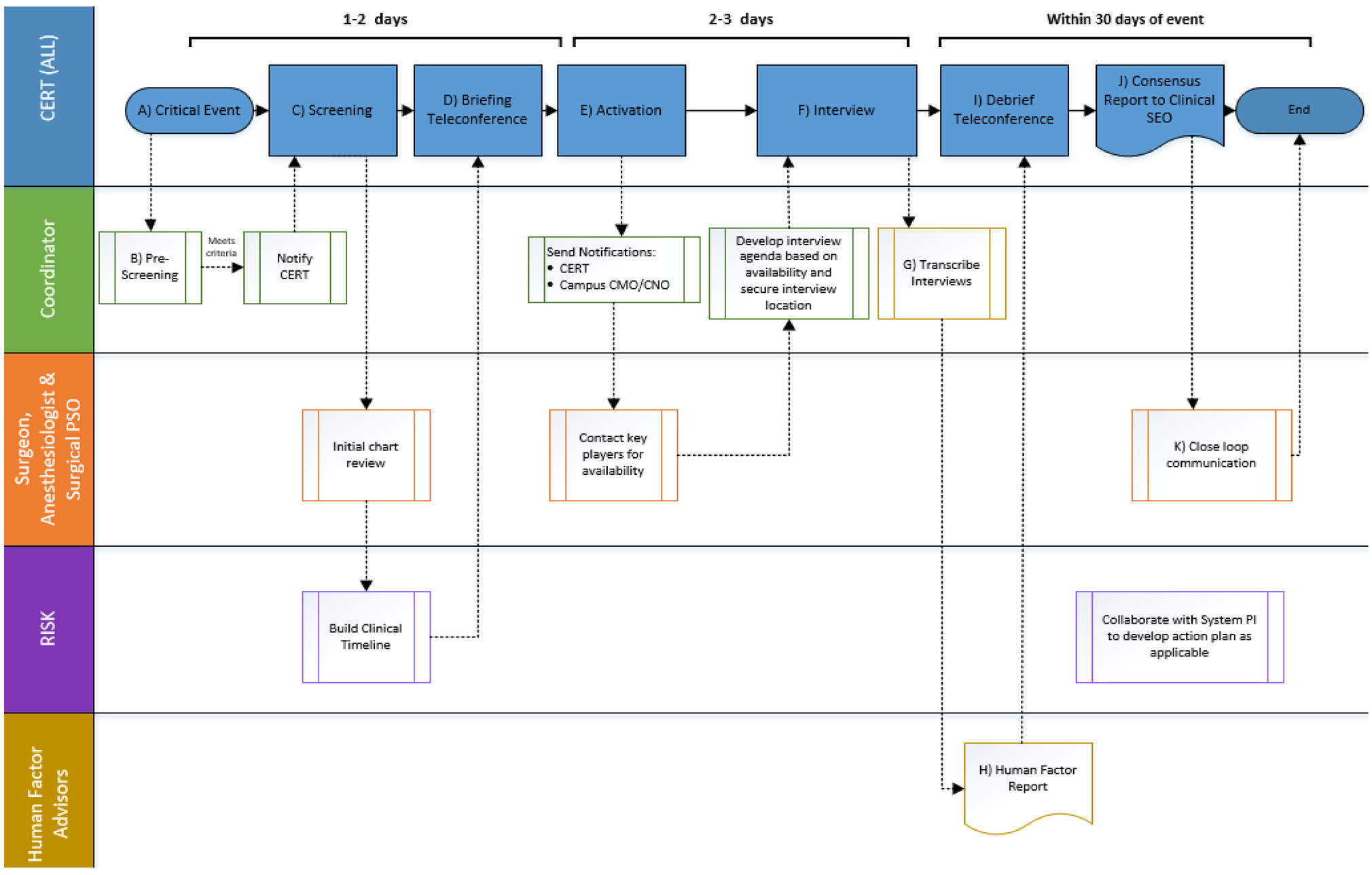
To develop and pilot a Critical Event Review Team for the analysis of the ***human factors*** contributing to an operating room death in order to minimize the opportunity for recurrence of any systemic errors, improve quality and increase patient safety in a non-punitive just culture.

- Conduct semi-structured interviews with providers within 2-3 days of a critical event using a “National Transportation and Safety Board like” approach to investigation.

PROJECT DESIGN / STRATEGY

- Designated an interdisciplinary team and back-up members:
  - *Content Experts:* Anesthesiologist, Surgeon, Surgical Services RN, Human Factors Advisors
  - *Core*: Risk Management and Coordinator
- Trained the team in Human Factors: Human Factors Analysis and Interviewing
- Established screening criteria to ensure appropriate utilization:
  - *Inclusion*: American Society of Anesthesiologist (ASA) < 5 and Pre-Operative Score to Predict Post-Operative Mortality (POSPOM) <38
  - *Exclusion*: Outpatient or bedside procedure, CPR on arrival to OR, procedure done outside of the 8 hospitals within the Central Region of Florida Hospital
- Developed a validated scoring system to stratify cases
- Built an electronic notification (CERT Alert) associated with EMR
- Formalized standard operating procedure
- Spread awareness across all forums
- Began reviewing cases

PROCESS



NEXT STEPS

Aggregate findings for one year to determine trends in systemic errors across individuals, teams, technology, and/or the organization.

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