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

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