



**Are systems reviews including QARs, PSRs
and ABCs confusing? Not anymore!**

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Disclosure

Dr. Amir Ginzburg, Carroll Thorowsky and Paula Beard have no disclosures.



Learning Objectives

- Outline the principals of incident analysis and steps in immediate management
- Describe the analysis process and range of methods / tools, including the importance of patient/family interviews
- Explore the intersection between individual and system accountability



Linda Kenney

<https://www.youtube.com/watch?v=bfzAfZZ8JHg>



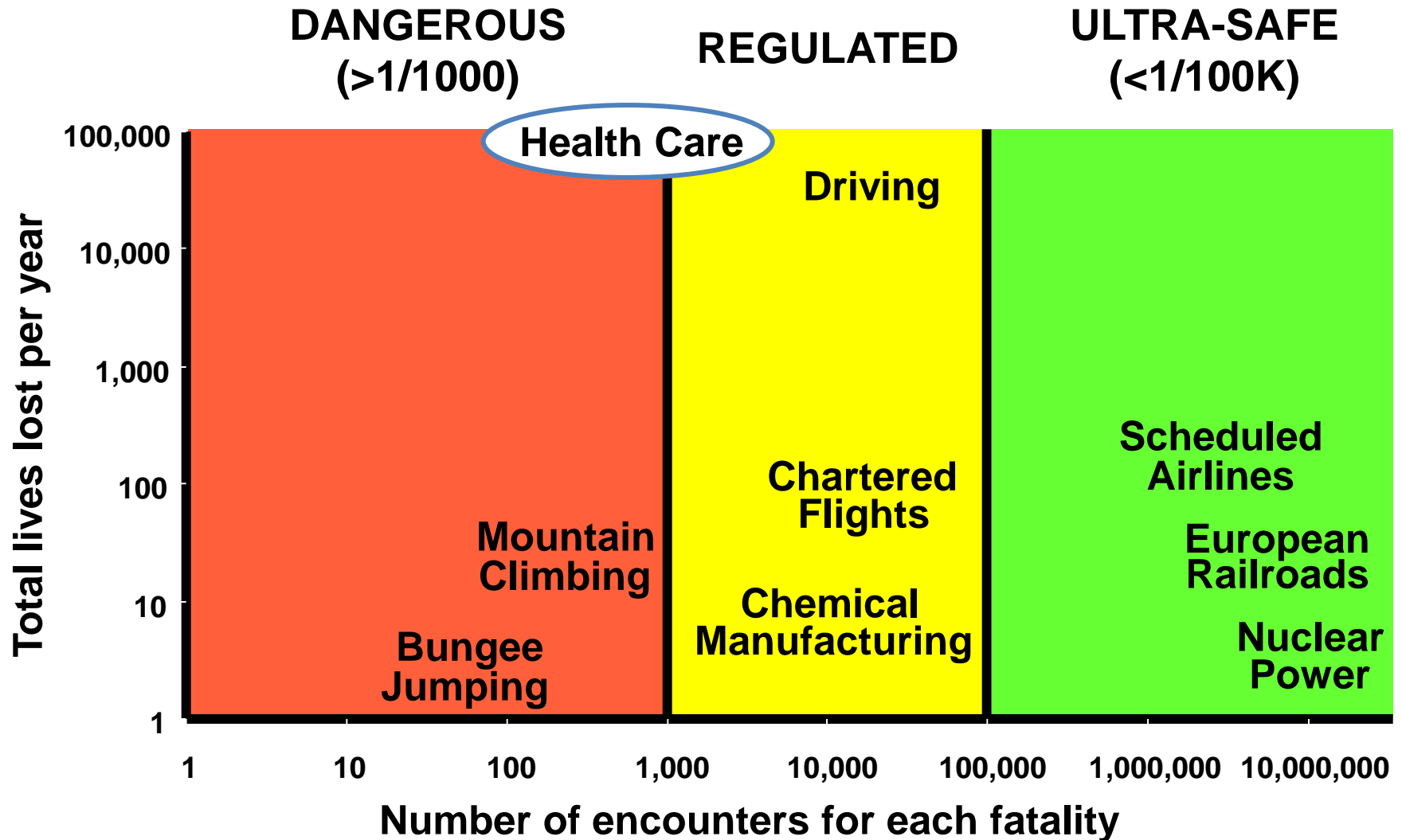
Linda Kenney – Group Debrief

- Reflections
- What do providers want?
- What does the public want?





How Hazardous is Health Care?





The Canadian Experience

Likelihood of an adverse event (CIHI, 2007)

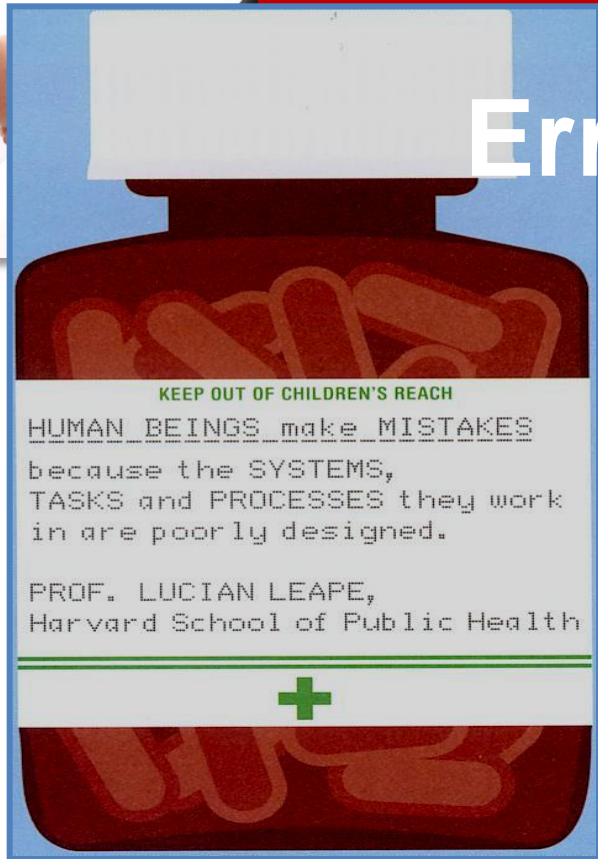
Contracting hospital acquired infection	Adults: 1 in 10 Children: 1 in 12
Receive wrong medication or dose	1 in 10
Acute care hospital medical / surgical patient experiencing an adverse event	Non-fatal: 1 in 13 Fatal (Preventable): 1 in 150
Obstetrical trauma (vaginal delivery)	1 in 21
Retained foreign body after procedure	1 in 3,000



Blame and Accountability

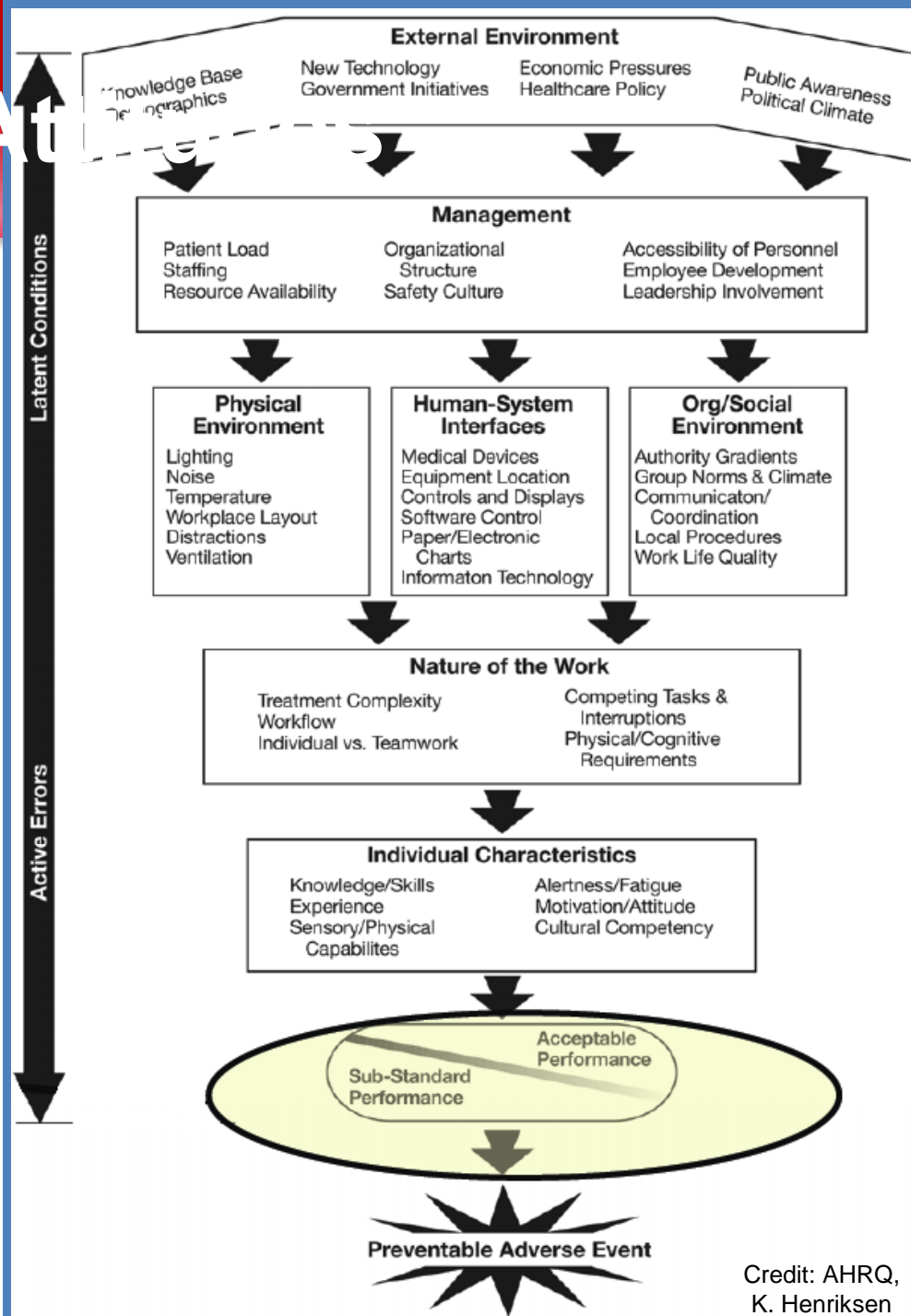
https://www.youtube.com/watch?v=RZWf2_2L2v8

Error Attribution



“The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes”

Prof. Lucian Leape, Harvard School of Public Health





Definitions (WHO / CPSI)

Patient Safety Incident:

An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient.

Reached the patient

Did not reach the patient

HARMFUL INCIDENT

NO HARM INCIDENT

NEAR MISS



Definitions (Alberta)

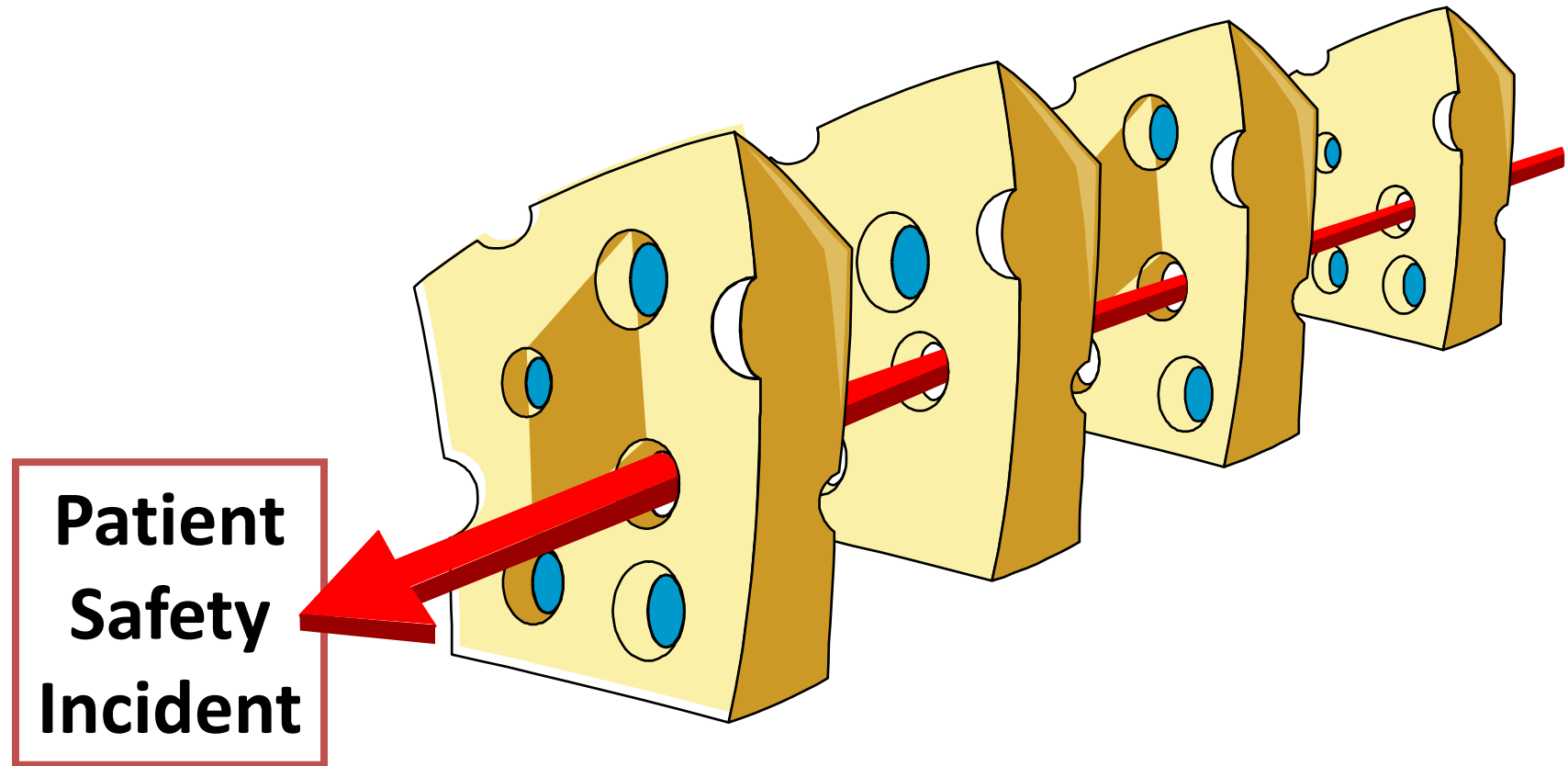
Clinical Adverse Event

An event that could or does result in an unintended injury or complications arising from healthcare management, with outcomes that may range from (but are not limited to) deaths or disability to dissatisfaction or require a change in patient care.



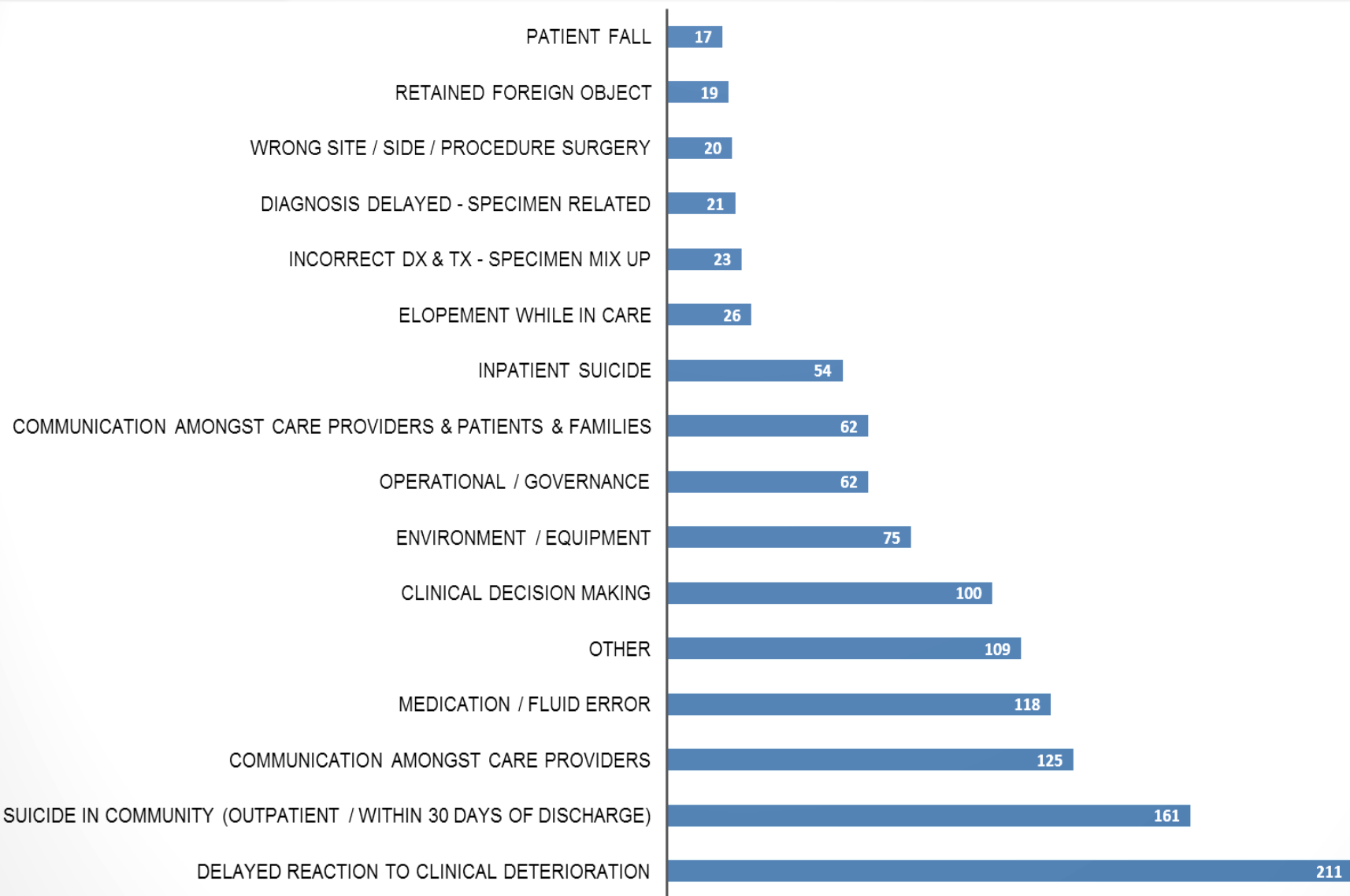


Safeguards and Latent Hazards





AHS Review Themes n=1203





Communication

<https://www.youtube.com/watch?v=gmOTpIVxji8>



Incident Analysis – Why?

- Uphold our commitment to value safety for patients, families and healthcare providers.
- To learn, improve care, and share our learning
- Minimize risk of future similar harm



Canadian Incident Management Continuum





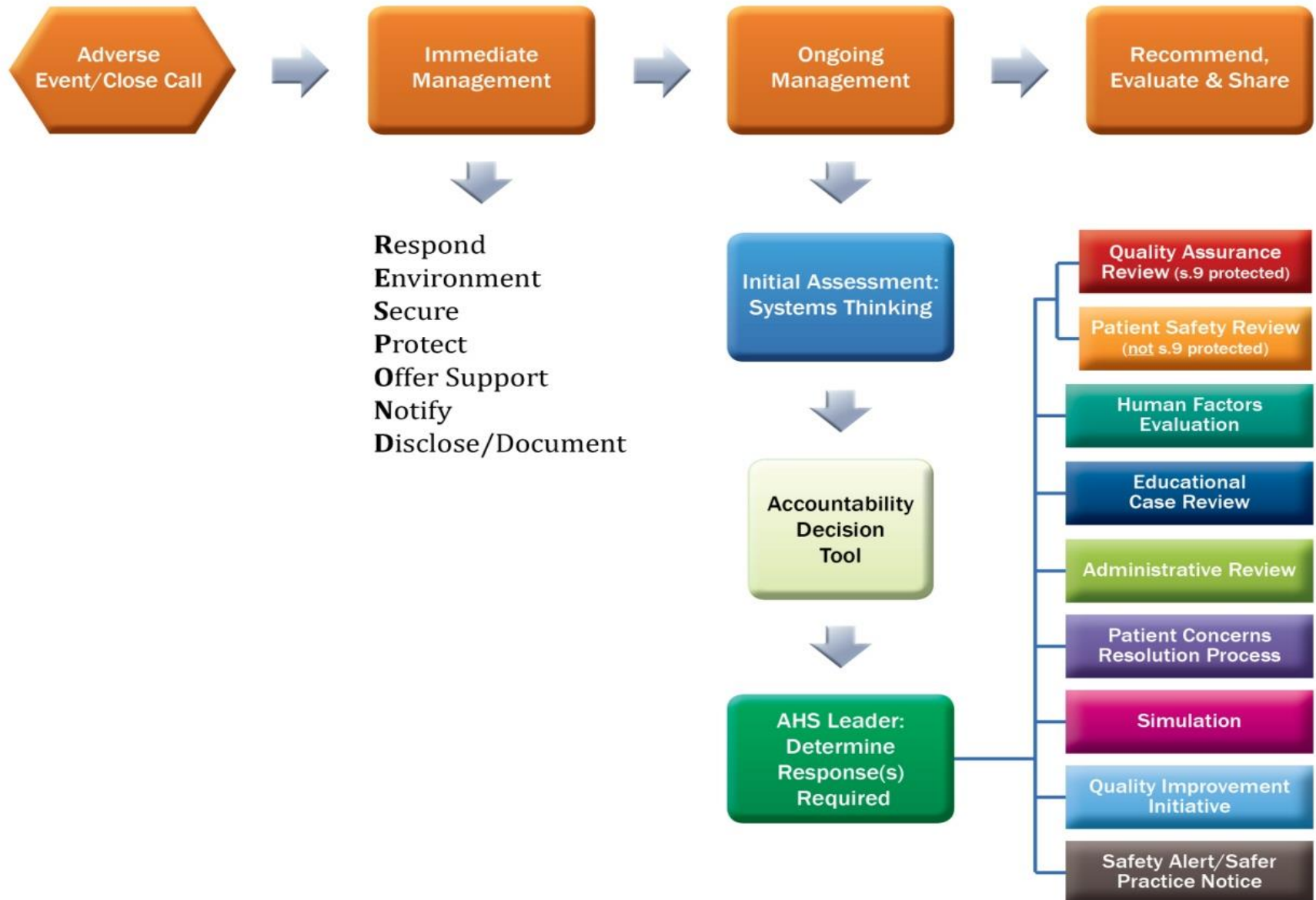
Before an Incident

- Cultivate a safe and just culture
- Leadership support
- Develop a plan including resources





Systems Analysis Methodology (AHS, 2017)





Patient Safety Incident: Mr. I.O.

Table Exercise:

You are a patient safety / QI practitioner and the ICU manager call you to assist in the immediate management of this incident

- ***Provide guidance to the ICU team on next steps***





Immediate Response



Respond
Environment
Secure
Protect
Offer Support
Notify
Disclose/Document

Quality Assurance Reviews

Quality Assurance Reviews (QARs) are one way in which we can learn from adverse events (or close calls) in healthcare. The objective of these reviews is to identify system issues that contributed to this event and to generate recommendations that will reduce the risk of a similar type of situation from occurring in the future.

The review team consists of individuals that are knowledgeable about the care processes relevant to the incident and does not evaluate the performance of individuals. The focus is on how to improve systems of care, not the actions of individuals. If you are a community physician participating in this review, AHI is disclosing this information to you under Section 55 of the Health Information Act. Your obligations to maintain the confidentiality of this information remain in place. Should you receive a request for this information we can assist you as this QAR is protected from disclosure.

QARs are conducted under section 9 of the *Alberta Evidence Act*. Section 9 protection is intended to provide a safe environment for sharing opinions so that the members of the review team can obtain the best possible understanding of the event and contributing factors. This information is confidential and cannot be subpoenaed or entered into evidence in a court of law, and is not subject to a request for information under Alberta's access to information legislation. Participants in a QAR are not permitted to answer any questions or share any documentation that is produced in this review. It is important to highlight that the facts, such as clinical records, are not protected by section 9 and a patient or their authorized representative can request access to these records under the *Health Information Act*.

What can I expect if asked to participate in an interview or analysis meeting related to the event?

- QARs are a collaborative and consultative process used to understand the limitations of our healthcare system, learn and make recommendations for improvement aimed at preventing this type of event from reoccurring.
- Participants will be treated with care, compassion, support, respect and dignity.
- All discussions within a QAR and documents produced by a QAR are protected by section 9 and confidential. Any discussions that occur during this review cannot be subpoenaed and you cannot answer any questions as to the discussions before the QAR in a court of law. Your name is not used anywhere in the final report that is submitted to a Quality Assurance Committee for approval.
- QARs have two parts:
 - Investigation Phase: Interviews with staff, physicians, patients and families understand:
 - What happened?
 - What may have contributed to the event?
 - What can be done to improve safety for future patients?
 - Analysis Phase: Identify hazards & develop recommendations:
 - What system issues can be changed to make patients safer?
- At the conclusion, the only information released is a brief de-identified factual case description as well as any recommendations and lessons learned:
 - QAR Summary is shared with the QAC for operational assignment
 - Patient Safety Learning Summary is shared with staff and physicians who may benefit from lessons learned, and affected patients/families for sharing lessons learned.

If you have questions about the QAR process you are encouraged to call



Disclosure

Barriers	Facilitators
Culture of minimal discussion of error	Patient safety training (how to identify and disclose incidents)
Lack of confidence in organizational support	High safety culture
Social fears	Perceived support
Fear of litigation	Routine open discussions of incidents
Hierarchy	



Disclosure Checklist

Patient Safety Policy Suite: **Disclosure** Quick reference guide



What is this procedure?

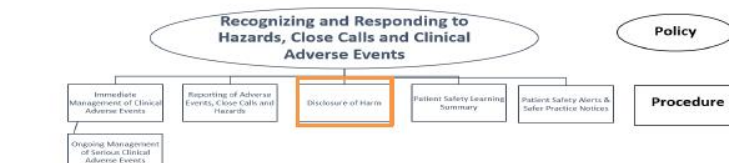
Despite our best efforts to provide safe care, patients may occasionally experience harm while in our care.

When harm occurs to a patient, we must communicate what happened to the patient/family in an empathetic, timely and transparent manner.

This is called **DISCLOSURE OF HARM**, and is one of six procedures in the patient safety policy suite.

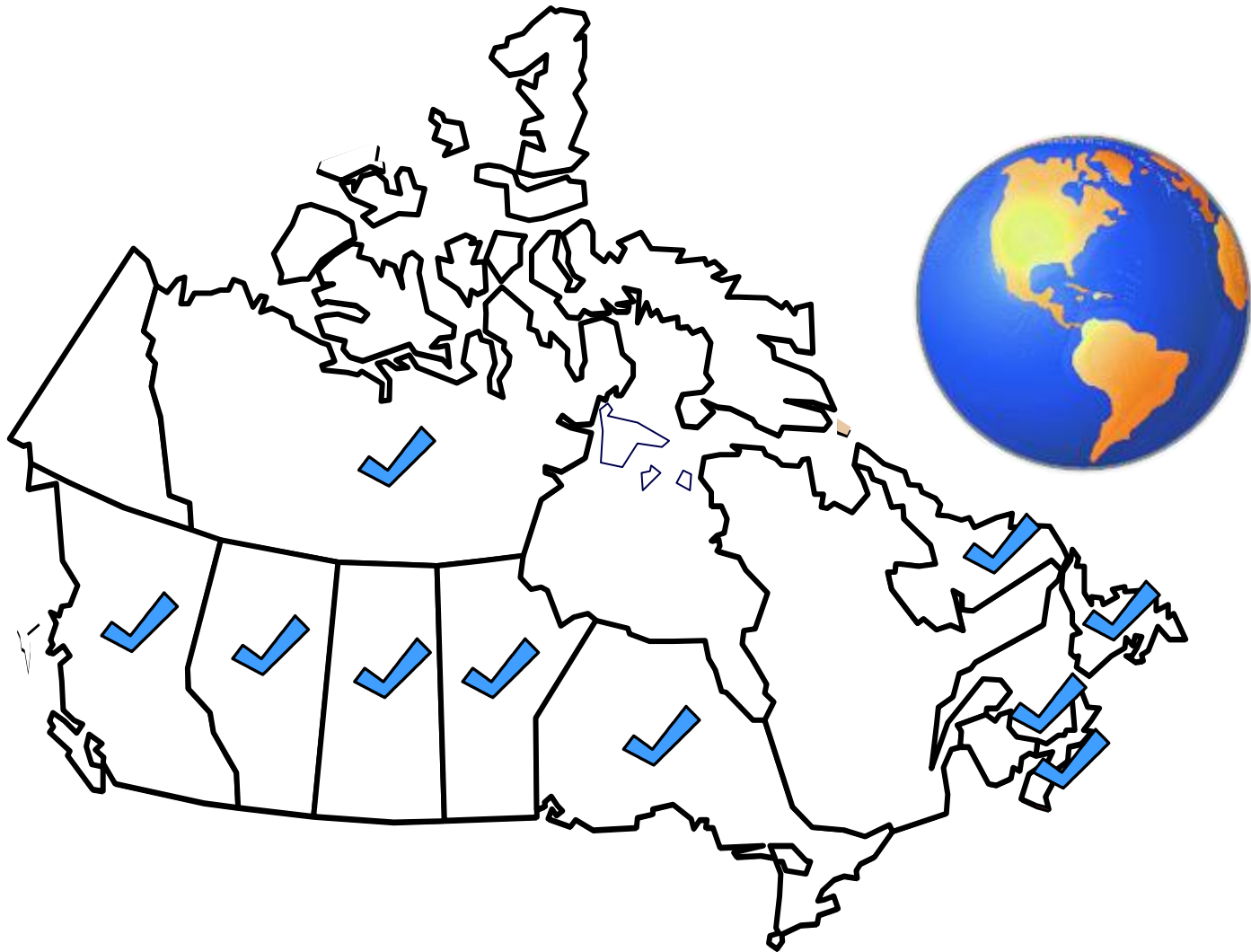
What you need to know

Disclosure	When any harm occurs, a risk of future harm exists or if a change in care or monitoring is made because of something occurring in care we provide, we must disclose to the patient/family.
Close calls	In the event of a close call, disclose if it's in the best interest to the patient/family to know or if they would wish to know. If you aren't sure, disclose the close call to the patient/family.
How do I disclose?	<ol style="list-style-type: none"> 1. Acknowledge that harm has occurred to the patient and apologize on behalf of AHS. 2. Explain the future impact the harm could have on the patient. 3. Explain how the harm occurred. If unsure, don't speculate, but commit to investigate and follow up with the patient/family to discuss what we learned and why the harm occurred.
When is disclosure complete?	Disclosure is complete when the patient receives an accurate understanding of what happened, the impact it will have on them and how AHS will respond. In complex cases, the disclosure process may involve several conversations.





Apology Legislation





Support for Providers

- Also known as “second victims”
- Health care providers involved in a patient safety incident often experience emotional and sometimes physical distress

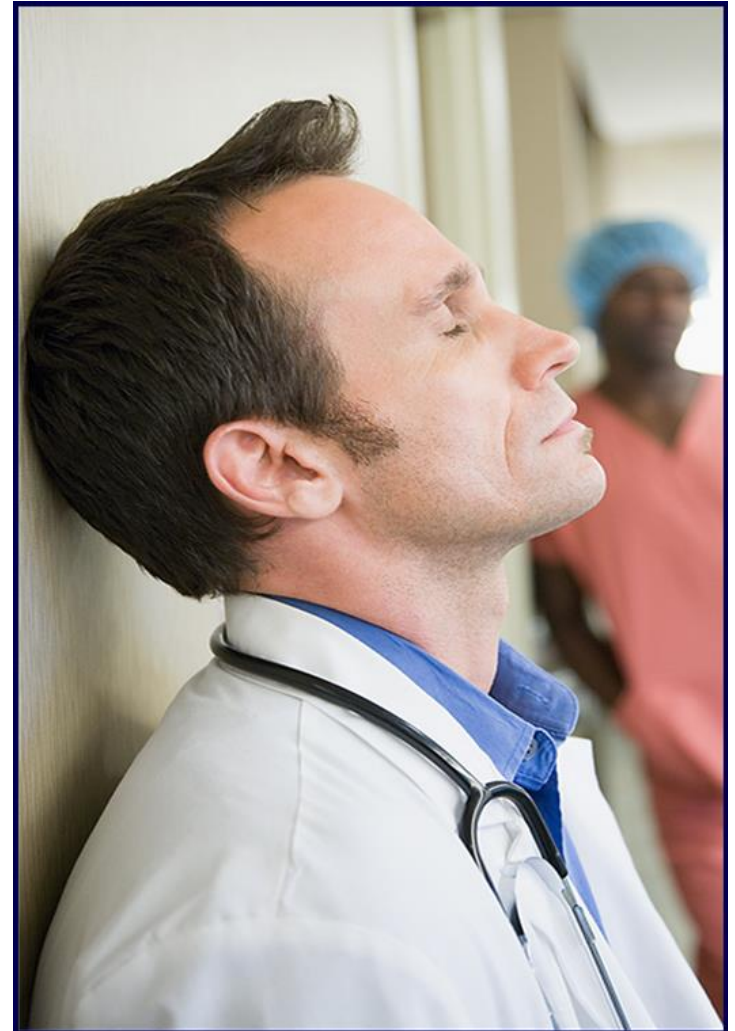




Support for Providers

What is needed:

- Professional re-affirmation
- Personal reassurance





Support for Providers (AHS)

Tips for Supporting Staff Involved in Clinically Serious Adverse Events

- The mental wellness of our staff and physicians is a big component of the safety of our environment and it is prudent for the sake of both the staff involved and patients to assess whether staff might need to be replaced on a short term basis to ensure safety while they have a chance to recover.
- Consider the need to bring functional teams together (e.g., lab staff who work together in one area) to open the lines of communication. During the meeting general information is shared (e.g., a clinically serious adverse event has occurred and a process is underway to understand what happened and how we can make care safer). This information is provided by the local leader and is intended to open dialogue, avoid secrecy, isolation, and shame. Recounting details of the event during this type of meeting is not recommended and may, in some cases, be harmful.
- During a general information session or one to one interactions with staff and physicians send clear messages of support to all staff involved: "We'll figure this out together."
- Provide information about how the organization is going to respond to prevent future harm to patients and better support staff to do their work. Include any relevant policies, procedures or guidance documents.
- Help staff and physicians understand that it may be helpful to seek support from family, friends and peers and that this is encouraged however, individuals should not provide patient identifying information or specific details about the event. This type of detail is provided within approved organizational processes for learning such as a quality assurance review or a patient safety review.
- Remind staff that if they need additional support they are encouraged to obtain assistance through Employee Assistance Programs (EAP) and other professionals. Managers can also call for advice on the best way to support their teams.
 - 24 hour contact number for confidential EAP help for AHS employees is 1-877-273-3134
 - 24 hour contact number for confidential support for physicians and residents is the Physician and Family Support Program of the AMA 1-877-SOS-4MDs (767-4637).
- Occasionally staff want to speak with an individual who has experience with clinically serious adverse events but are not administratively involved in their particular event. Currently there is one such informed and objective individual willing to be available to staff on an as needed basis:
 - Dr. Bruce MacLeod can be contacted at Bruce.macleod@albertahealthservices.ca

Please contact Michael.siro@albertahealthservices.ca for additional information regarding the development of program materials for the support of individuals involved in clinically serious adverse events in AHS.

The Second Victim

Fatal errors and those that cause harm are known to haunt health-care practitioners throughout their lives. The impact of the error is felt in their private lives, interactions with professional colleagues, and in the context of their social lives.

Immediately after the error is recognized, practitioners typically experience stress-related psychological and physical reactions related to sadness, fear, anger, and shame.

They are immediately panicked, horrified, and apprehensive, which is manifested by disbelief, shock, an increased blood pressure and heart rate, muscle tension, rapid breathing, extreme sadness, appetite disturbances, and difficulty concentrating.

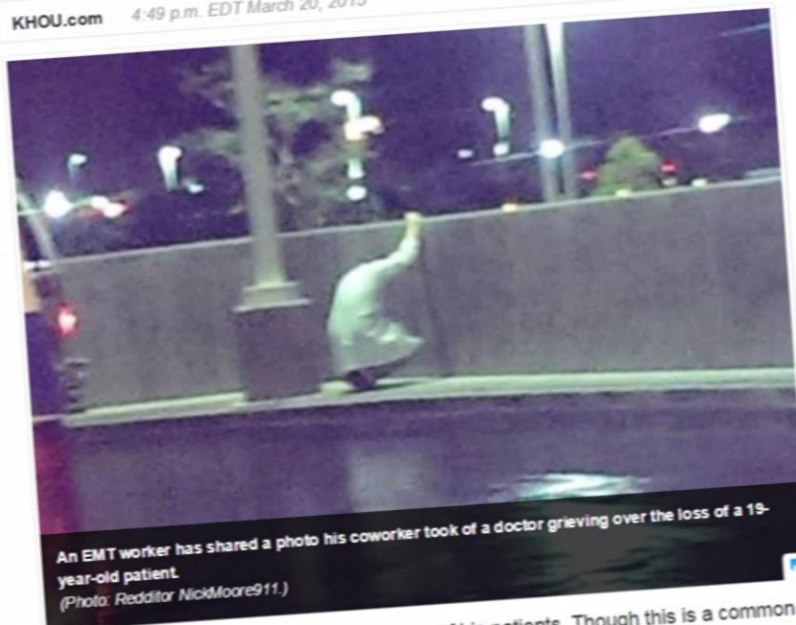
While awaiting investigation of the error, the second victim is often plagued with fears of losing a job and the financial consequences of unemployment and levied fines; being labeled as incompetent or careless by colleagues, their family, and the patient's family; loss of coworkers' respect; involvement in a civil or criminal court proceeding; and loss of a professional license.

(Grissinger, M. (2014). *Too Many Abandon the "Second Victims" Of Medical Errors. Pharmacy and Therapeutics*, 39(9), 591-592.)



Heartbreaking photo captures doctor's grief after loss

KHOU.com 4:49 p.m. EDT March 20, 2015



An EMT worker has shared a photo his coworker took of a doctor grieving over the loss of a 19-year-old patient.
(Photo: Redditor NickMoore911.)

"The man pictured was unable to save one of his patients. Though this is a common occurrence in our field of work, the patients we lose are typically old, sick, or some combination of the two. The patient that died was 19 years old, and for him, it was one of those calls we get sometimes that just hits you," wrote redditor [NickMoore911](#).
"Within a few minutes, the doctor stepped back inside, holding his head high again."



Prepare for Analysis





General Approach

Facilitator (with IA knowledge) paired with a leader (with operational accountability)

Determine scope

Apply legislation if applicable

Identify team members (interprofessional!)

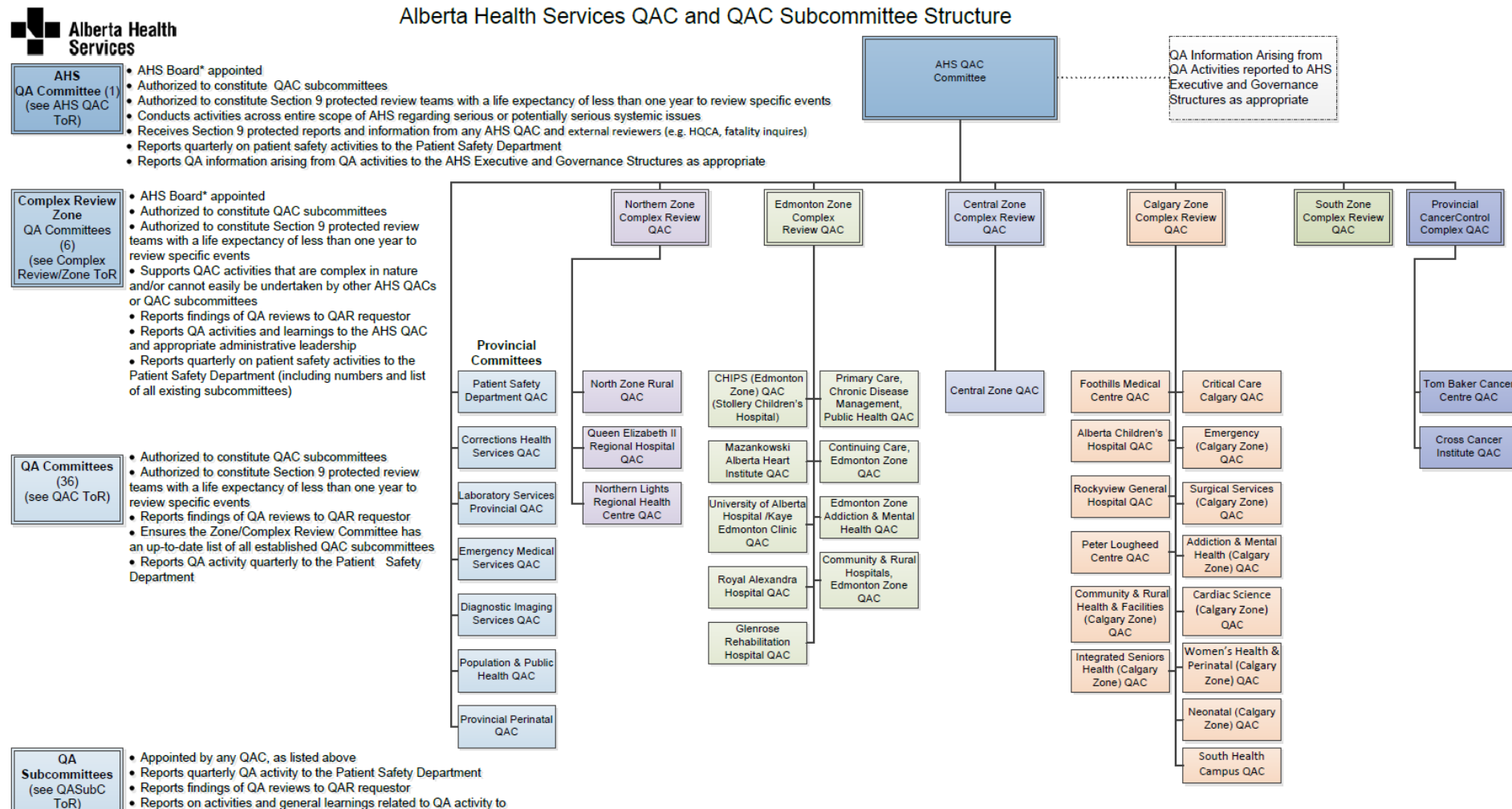
Book interviews (patient/family, staff, physicians, etc), and meetings

Prepare materials



More About Section 9

Alberta Health Services QAC and QAC Subcommittee Structure





Prepare for Analysis

<https://www.youtube.com/watch?v=2t4zJH29n40>



Prepare for Analysis

Preliminary investigation:

Start ASAP

- Memory fades, dominant story tellers emerge

Secure
'usual's

- Pumps, IVs, bottles, packaging, containers, sharps

Secure
'unusual's

- Rhythm strips, fetal monitoring tracings, telemetry logs, shift assignments, OR list, paging log, CCTV



Prepare for Analysis

Preliminary investigation:

Documents

- Secure / review health record and incident report
- Are these a good “black box” ???

Come prepared

- Think about themes that require a deeper dive
- E.g., equipment, environment, teamwork, communication, policies / procedures

Probe to ‘blunt end’

- Challenging but mission critical for improvement to occur



Supportive Interviewing

Preparation

- Consider where, when, with whom, by whom

Opening

- Introductions / purpose / confidentiality

Communication

- “Tell their story” and “re-enact”; try not to interrupt
- Open-ended questions and active listening
- Do not make or agree with derogatory comments made regarding others involved in the care
- Record interview in a comfortable way

Closing

- Thank the patient/family member
- What to expect next

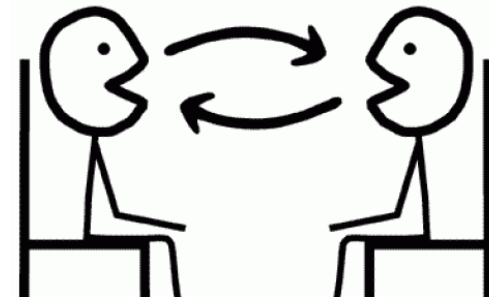


Patient Safety Incident: Mr. I.O.

Table Exercise – Work in Pairs!

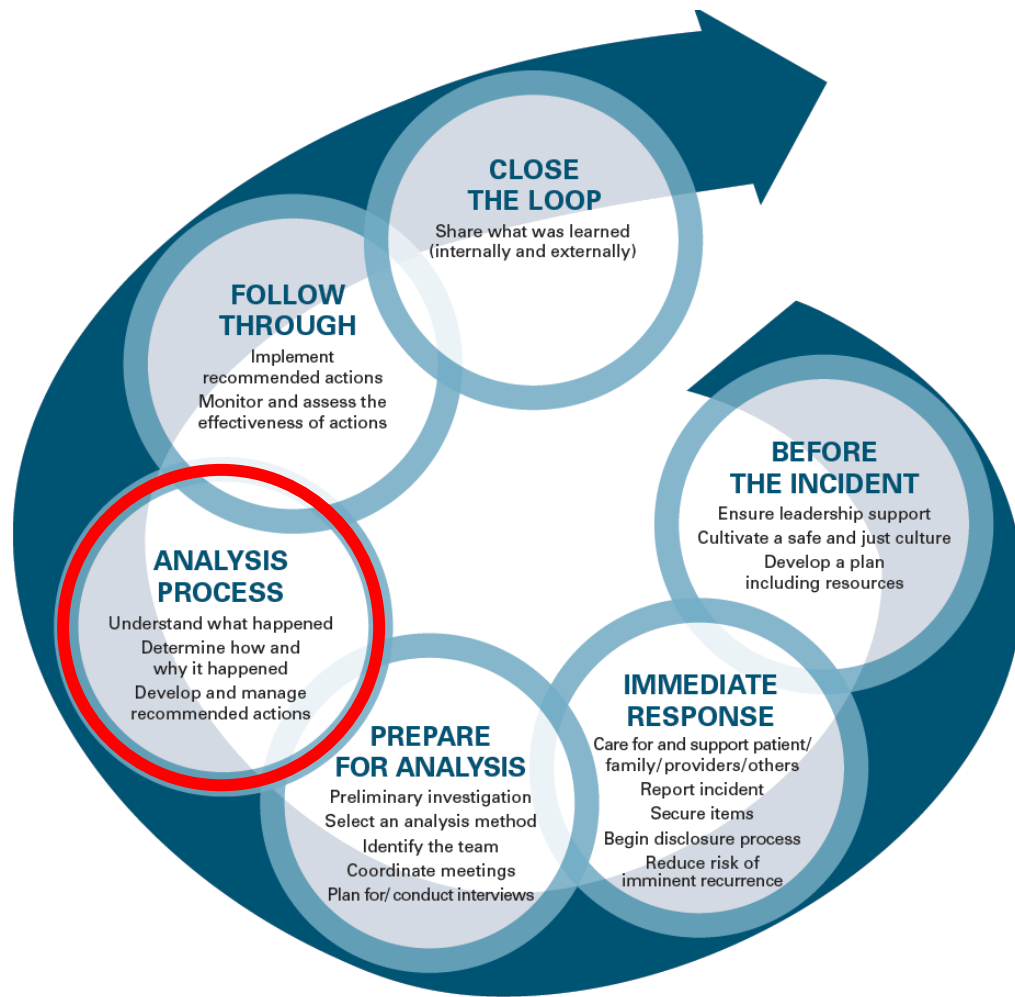
As part of the QAR process, the QAR lead is meeting with Mr. I.O.'s daughter, for an interview.

- ***Pick up one 'A' and one 'B' role description***
- Read your roles and prepare for the sim (5 minutes)
- Conduct the sim (7 minutes)
- Debrief at your tables (8 minutes)





Analysis Process

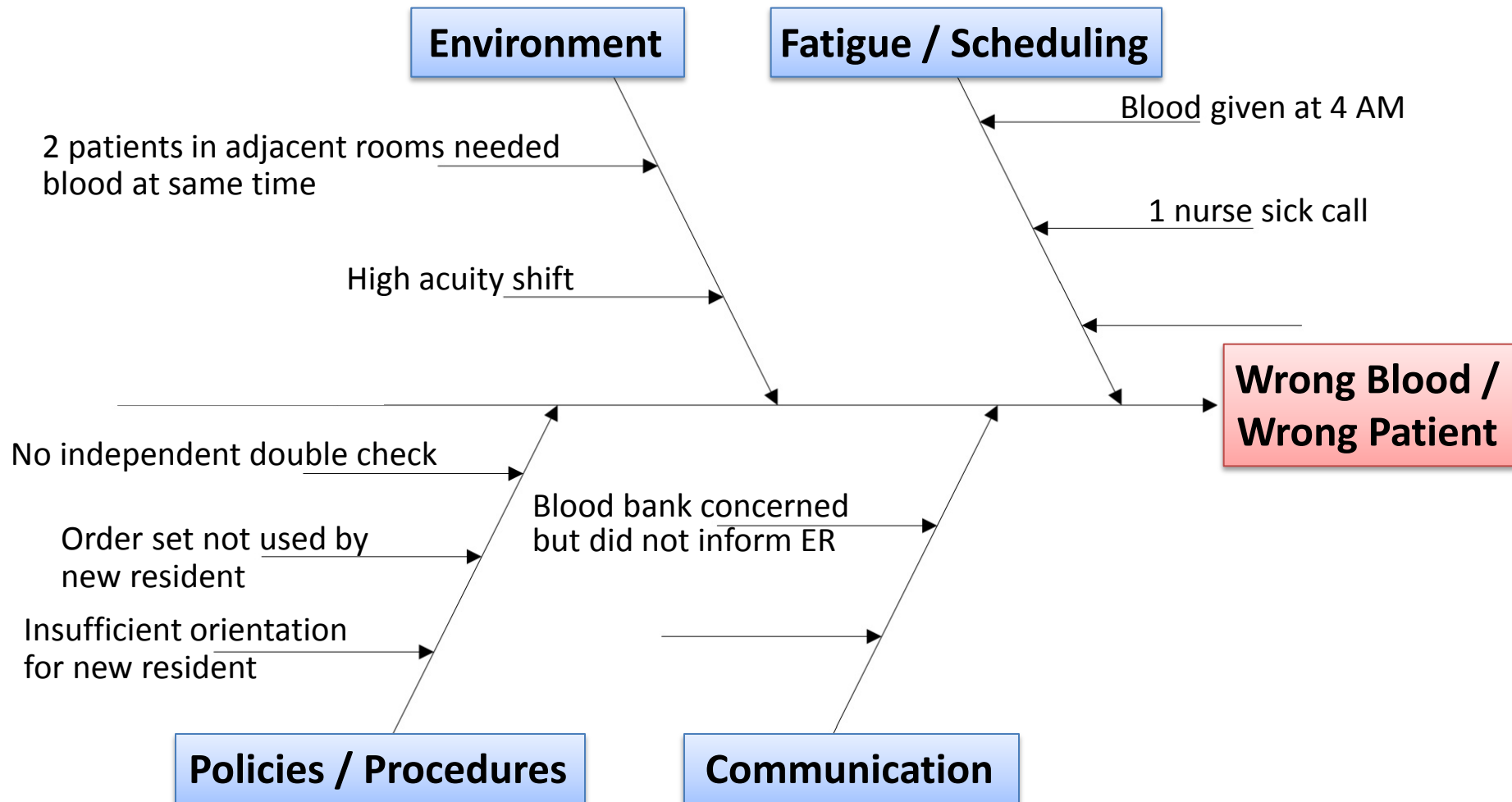


Analysis Process:

- ▶ Understand what happened
- ▶ Determine how and why it happened
- ▶ Develop and manage recommended actions to reduce risk of future similar recurrence

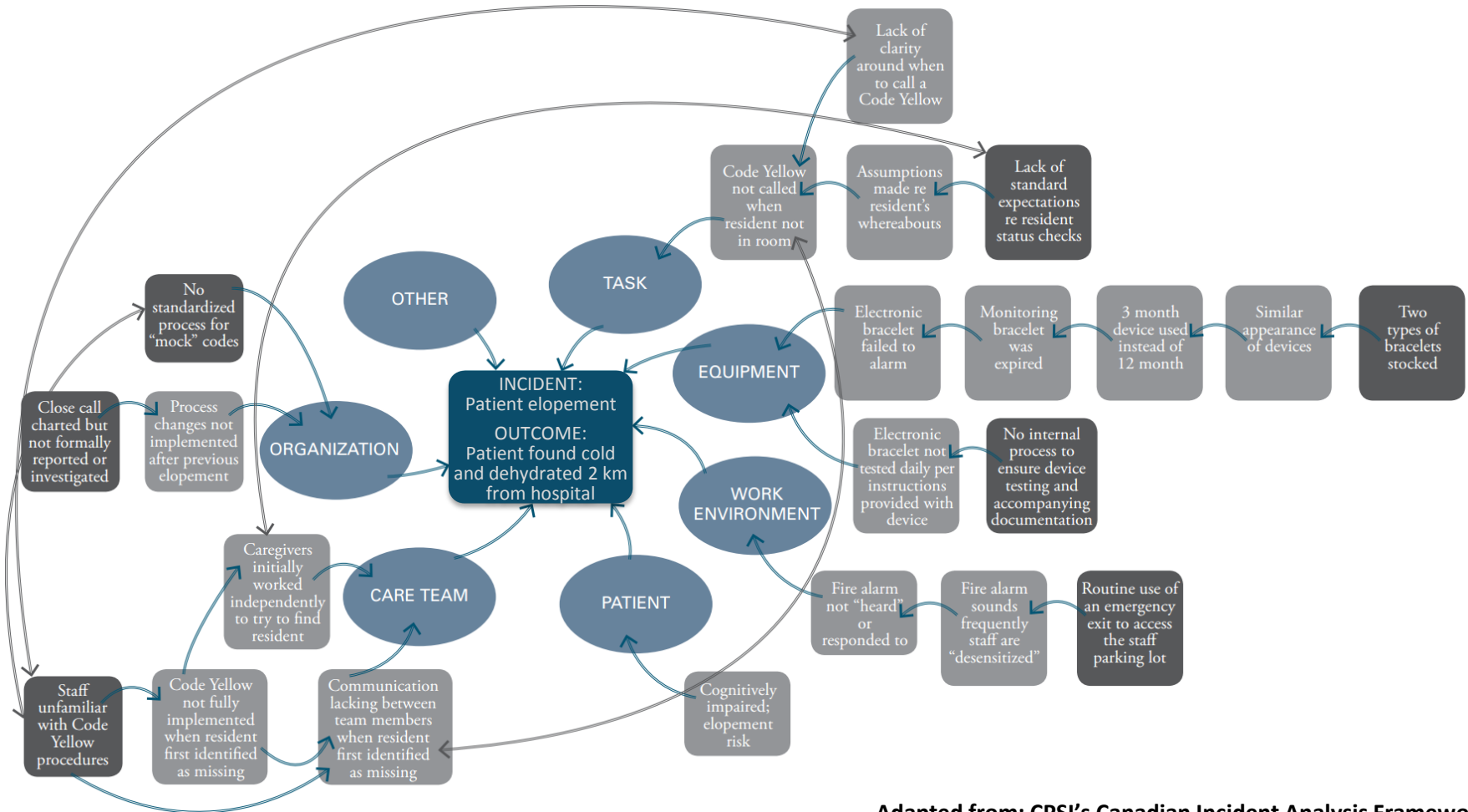


Ishikawa (Cause and Effect) Diagram





Constellation Diagram



Adapted from: CPSI's Canadian Incident Analysis Framework



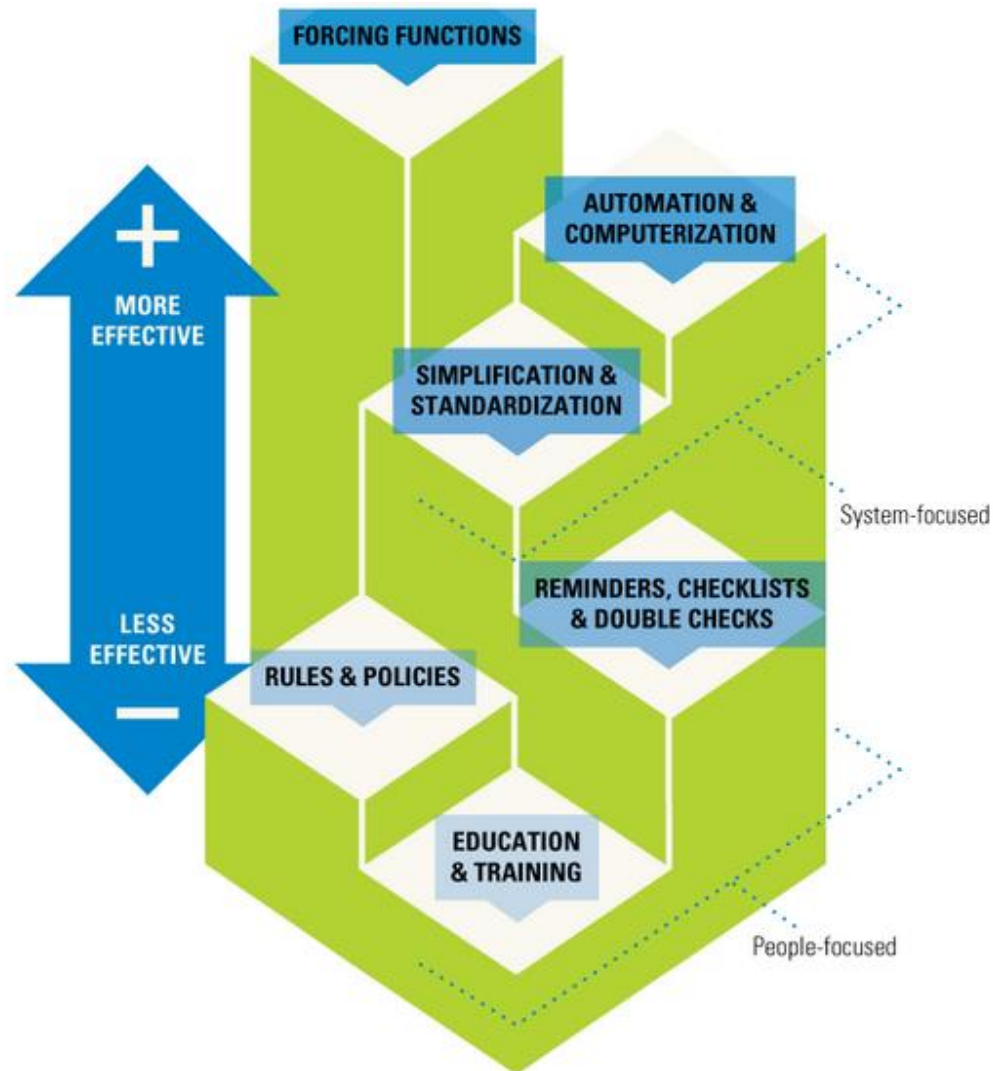
Recommended Actions

- Address risks/factors identified
 - At appropriate system level
 - Evidence based, long term solution
 - SMART
- Assign responsibility at appropriate level

Category	Recommended Action	Accountability	Target Date	Status
Policy / Procedure	IDC for insulin	CNO	June 1, 2015	Complete
Equipment	Barcoding pilot	Dir. Pharmacy	Sep 1, 2015	In Progress



Hierarchy of Effectiveness





Patient Safety Incident: Mr. I.O.

Table Exercise – your table is the analysis team!

The QAR Lead is leading the analysis team through recommendation development. A member of the analysis team, a senior leader, notes that if the glucose had been tested the patient would not have died. She asks, “who was accountable for testing the glucose?”

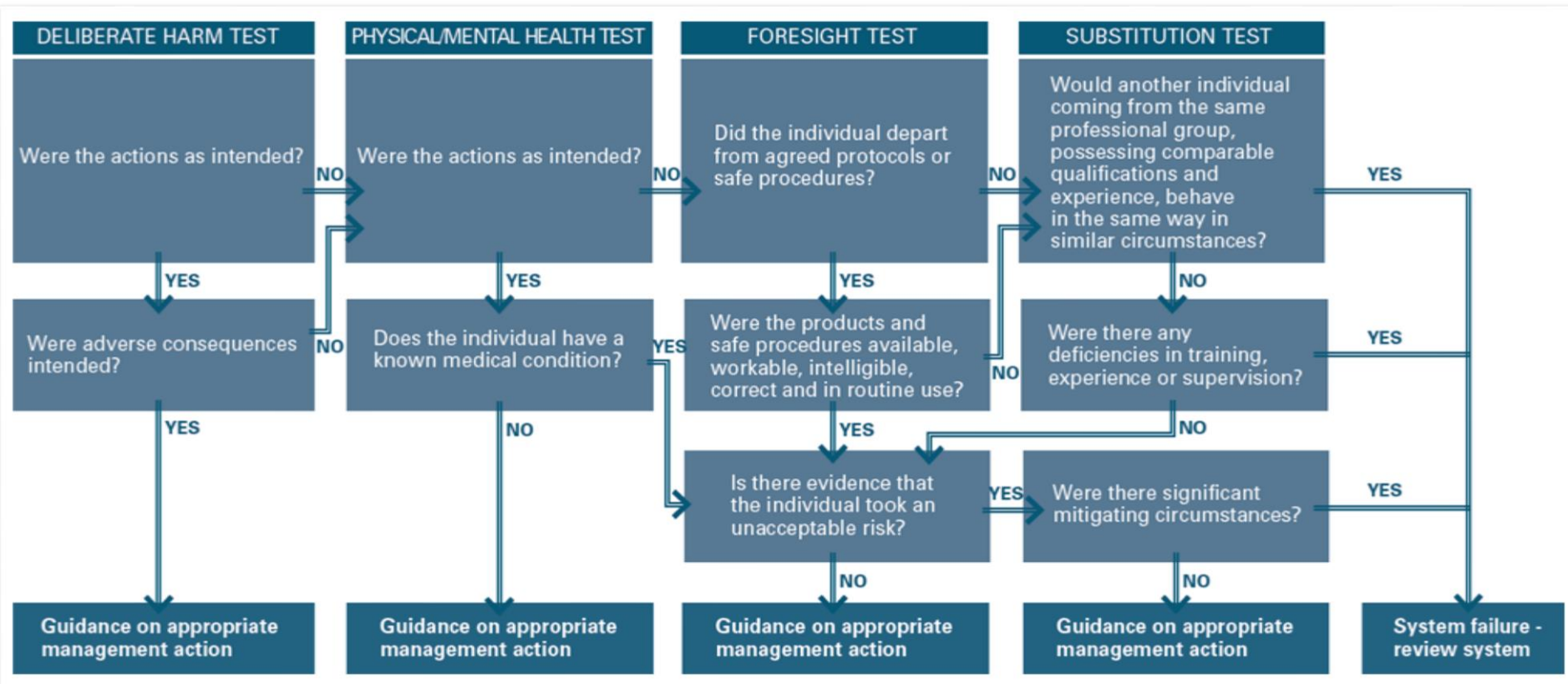
- ***Who should be disciplined?***
- ***What is your approach this question?***





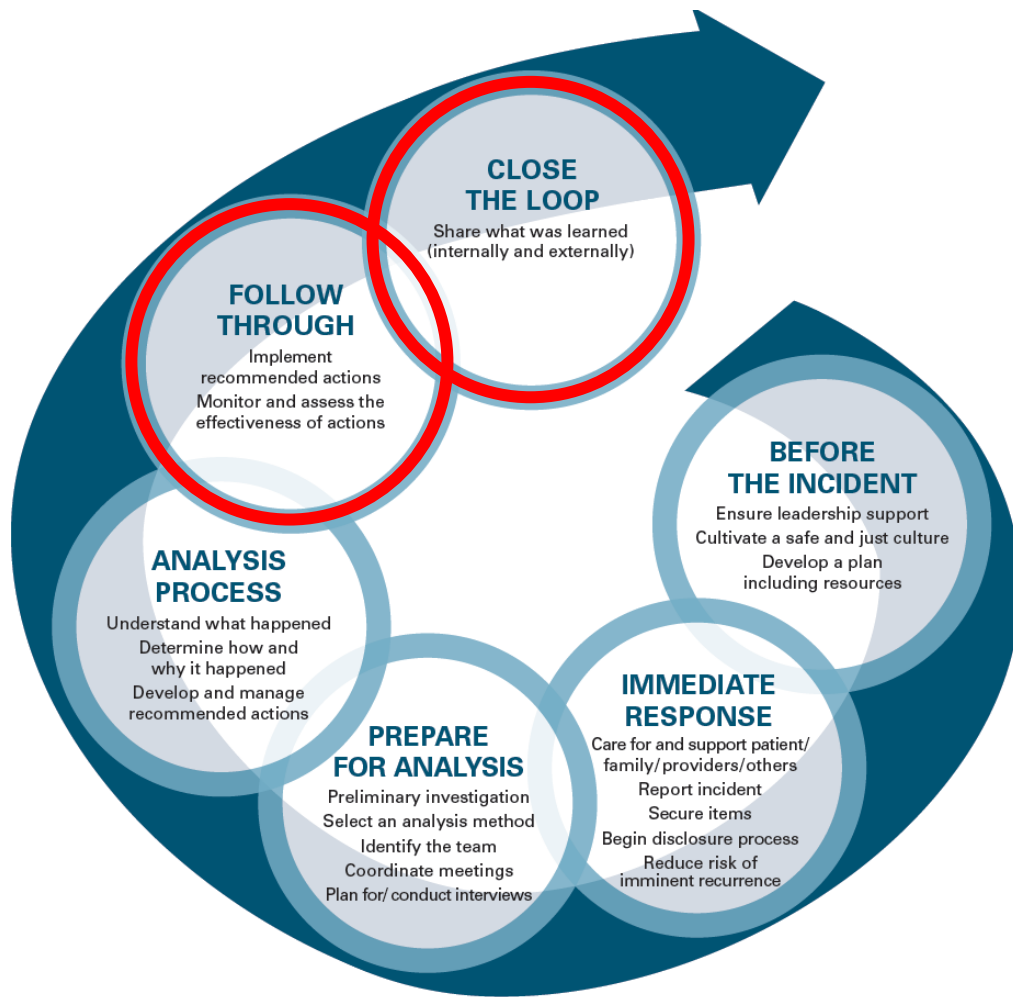
AHS Administrative Review Decision Tree

Individual performance vs systems issue?





Follow Through and Close the Loop



Follow Through:

- ▶ Implement recommended actions
- ▶ Monitor and assess the effectiveness of actions

Close the Loop:

- ▶ Share what was learned (internally and externally)



Summary

- Incident analysis is critical to a safe and just culture
- Burning platform for improvement work
- Opportunity for patient / provider / system healing
- Preparation is key
- Share learning broadly
- Accountability for recommended actions!





Learning Objectives

- Outline the principals of incident analysis and steps in immediate management
- Describe the analysis process and range of methods / tools, including the importance of patient/family interviews
- Explore the intersection between individual and system accountability



More information?

Quality Assurance Committee

- [QAC Chair Handbook](#)
- [QAC Quick Reference Guide](#)
- [AHS QAC Structure](#)
- [QAC Terms of Reference Modifications](#)
- [Engaging Patient Advisors on AHS QAC](#)
- [QAC Meeting Agenda Template](#)
- [QAC Meeting Minutes Template](#)
- [QAC Chair Contact List](#)
- [Appropriate Accountability Decision Support Tool](#)

Quality Assurance & Patient Safety Review Tools

- [Quality Assurance Review \(QAR\) Handbook](#)
- [SAM Handbook](#)
- [The Overview: Learning from Adverse Events in AHS](#)
- [QAR Quick Reference Guide](#)

AHS Patient Safety Learning Summary

- [Patient Safety Learning Summary - Tips & Worksheet](#)
- [Patient Safety Learning Summary - Template](#)
- [Patient Safety Learning Summary - FAQs](#)
- [Patient Safety Learning Summary - Process Flowchart](#)

Resources

- [QAR Request & Acceptance Form](#)
- [QAR Process Flow Map](#)
- [QAR G.O.A.L Tool](#)
- [QAR Project Plan](#)
- [QAR Ownership Confirmation Reference](#)
- [QAR Checklist](#)
- [QAR Interview Tracking Form](#)
- [QAR Interview Guidelines](#)
- [QAR/PSR Reference Card](#)
- [QAR Document Control Checklist](#)
- [Disclosure Support](#) (external site)

Templates

- [QAR Timeline Template](#)
- [QAR Team Membership Template](#)
- [QAR Email Templates & Instructions](#)
- [Confidentiality Agreement for Non-AHS Employees Participating in a SAM](#)
- [QAR Summary Template](#)
- [Patient Safety Review Summary Template](#)
- [QAR Summary Peer Feedback Checklist](#)
- [Recommendation Assessment & Prioritization Tool](#)



Questions?

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"Off hand, I'd say you're suffering from an arrow through your head, but just to play it safe, I'm ordering a bunch of tests."