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Safety Issues in Living Donor Kidney Transplant Identified by a Proactive Web-based Safety Debriefing Tool

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Feinberg School of Medicine

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PRESENTER DISCLOSURES

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The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

NO RELATIONSHIPS TO DISCLOSE

- *I have no financial relationships to disclose within the past 12 months relevant to my presentation.*
- *My presentation does not include discussion of off-label or investigational use.*
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SAFETY RISKS

Healthcare is a complex field with many safety risks

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RECOGNIZING RISKS

Marbles → Safety Risks

- Just we avoid stepping on the marbles →we navigate around risks

A systems approach allows us to *identify the safety risks*

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TRANSPLANT SAFETY RISKS

The New York Times

November 18, 2007

Infected Patient's Lawyer Says Risk Wasn't Disclosed

By THE ASSOCIATED PRESS

A woman in
told that the
her lawyer s

The lawyer,
woman, ask
involving th

Los Angeles Times

Wrong patient got kidney at USC

USC University Hospital shut down its kidney transplant program last month after realizing the error. The hospital said transplants may res

February 18, 2011 |

USC University Hospit
transplanted into the w
transplants in Los Ange

THE MONITOR

McAllen teacher dies after donating kidney to her mother

Naxiley Lopez
2011-02-12 20:30:27

McALLEN — Myra Lee Martinez died Tuesday after saving her mother's life.

The 28-year-old McAllen Memorial High School teacher underwent a kidney transplant in San Antonio Jan. 28 to help her mother, who was undergoing dialysis after becoming ill about a year ago, said Martinez's father, Juan R. Martinez.

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SAFETY BRIEFINGS

A systems approach:

Safety Briefings

Key Modifications for transplantation:

- Web-based
- Anonymous

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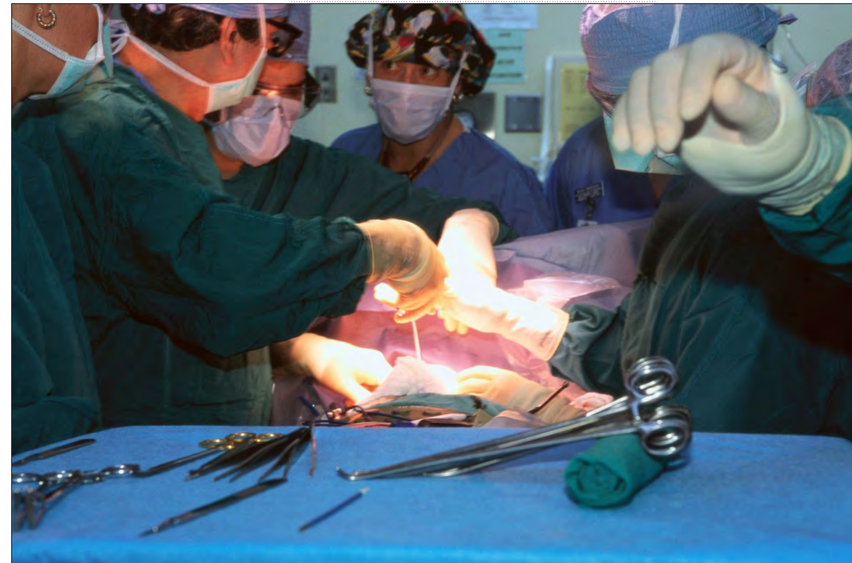
SAFETY DEBRIEFINGS

Strengths

- Proactive
- Multiple perspectives
- Immediate recall
- Improves safety culture
- Identifies opportunities for improvement

Limitations

- May not capture all contributing factors
- May be inconsistent
- Response rate challenges



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SAFETY DEBRIEFINGS

- Near Misses
- Systems Issues
- Minor Incidents
- Medical Errors
- Safety Risks
- Annoyance/Frustrations

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SAFETY DEBRIEFINGS

Each debriefing yields unique information

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WEB-BASED SAFETY DEBRIEFINGS

NUTORC TRANSPLANTATION SAFETY DEBRIEFING HOME

Select you

Project Tit
Principal I
Supported

The purpo

This safety
access to i

SETTING AND ROLE

Please sel

Surgical P

Surgical P

-Click Here

SUBMIT

ORGAN AND PATIENT TYPE

Please select the org

Liver (Living Donor)

Please select which t

Recipient in your descr

-Click Here-

BACK SUBMIT

ISSUE IDENTIFICATION: PAGE 1 OF 2

Progress: 40%

We would like to ask you to comment on several areas and select from the following options: Not Applicable, No Issue(s), or I Occurred (see description). You will be asked for further details on those areas in which you indicate that an issue occurred. Pl describe any and all related issues.

We are interested in any and all issues or problems you experienced or witnessed, even if they are minor and had no impact o outcome of today's procedure (near misses). Please do not use any names (patients, clinicians, staff, etc.) when answering the questions.

Please note, you can click on the (?) symbol next to each area category to view example issues.

Communication with the Patient and Family (?) — Not Applicable / No Issue(s) / Issue(s) Occurred (see description)

Informed Consent (?) — Not Applicable / No Issue(s) / Issue(s) Occurred (see description)
Briefly describe: Consent form for recipient liver biopsy not in patient folder

Inter-Provider Communication (?) — Not Applicable / No Issue(s) / Issue(s) Occurred (see description)

Distractions (?) — Not Applicable / No Issue(s) / Issue(s) Occurred (see description)

OR Scheduling/Coordination (?) — Not Applicable / No Issue(s) / Issue(s) Occurred (see description)
Briefly describe: Last minute room change

Patient Identification (?) — Not Applicable / No Issue(s) / Issue(s) Occurred (see description)

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WEB-BASED SAFETY DEBRIEFINGS

ISSUE IDENTIFICATION: PAGE 1 OF 2

We would like to ask you to comment on several areas and select from the following options: Not Applicable, No Issue(s), or Issue(s) Occurred (see description). You will be asked for further details on those areas in which you indicate that an issue occurred. Please describe any and all related issues.

We are interested in any and all issues or problems you experienced or witnessed, even if they are minor and had no impact on the outcome of today's procedure (near misses). Please do not use any names (patients, clinicians, staff, etc.) when answering the following questions.

Please note, you can click on the (Example) link next to each area category to view example issues.

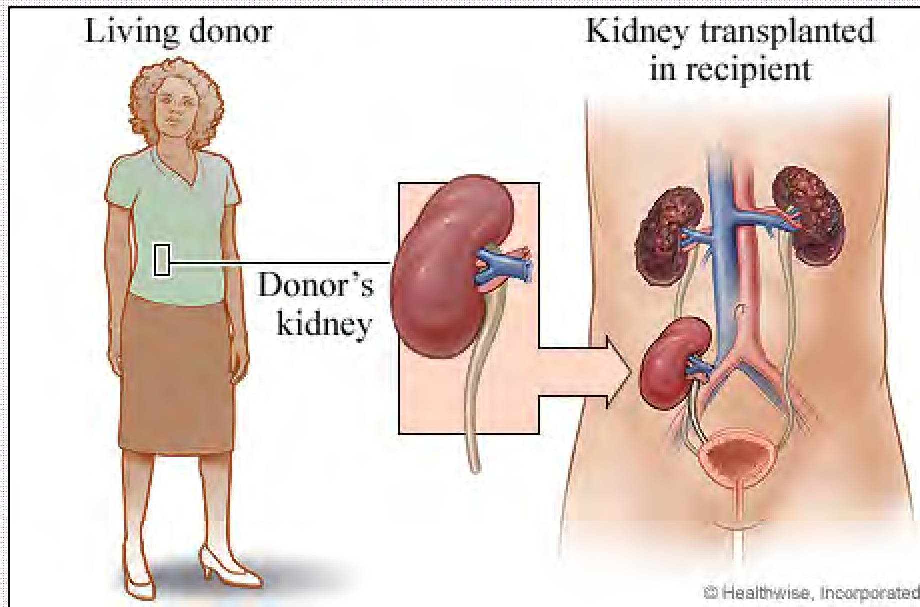
Communication with the Patient and Family (Example)
Not Applicable | No Issue(s) | Issue(s) Occurred (see description)

Informed Consent (Example)
Not Applicable | No Issue(s) | Issue(s) Occurred (see description)

Inter-Provider Communication (Example)
Not Applicable | No Issue(s) | Issue(s) Occurred (see description)
Donor case | Recipient case | Both cases
Briefly describe: Surgeon disrespectful and yelling at anesthesiologist

Distractions (Example)
Not Applicable | No Issue(s) | Issue(s) Occurred (see description)
Donor case | Recipient case | Both cases
Briefly describe: pagers continuously going off and phone ringing

RESULTS



- 152 LDKT
- 3/09-3/11
- 235 debriefings

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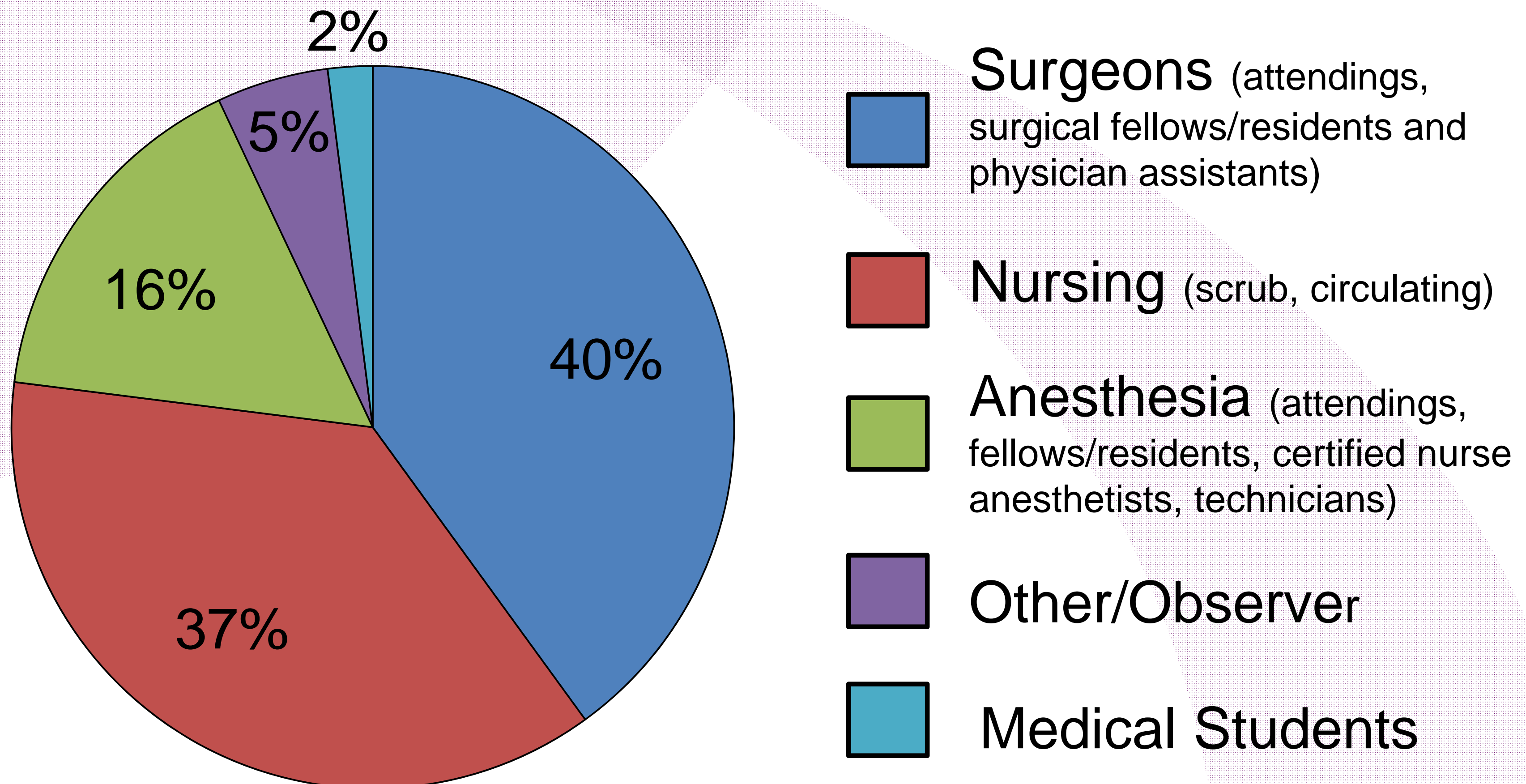
RESULTS

13 types of respondents completed debriefs, representing the entire clinical team:



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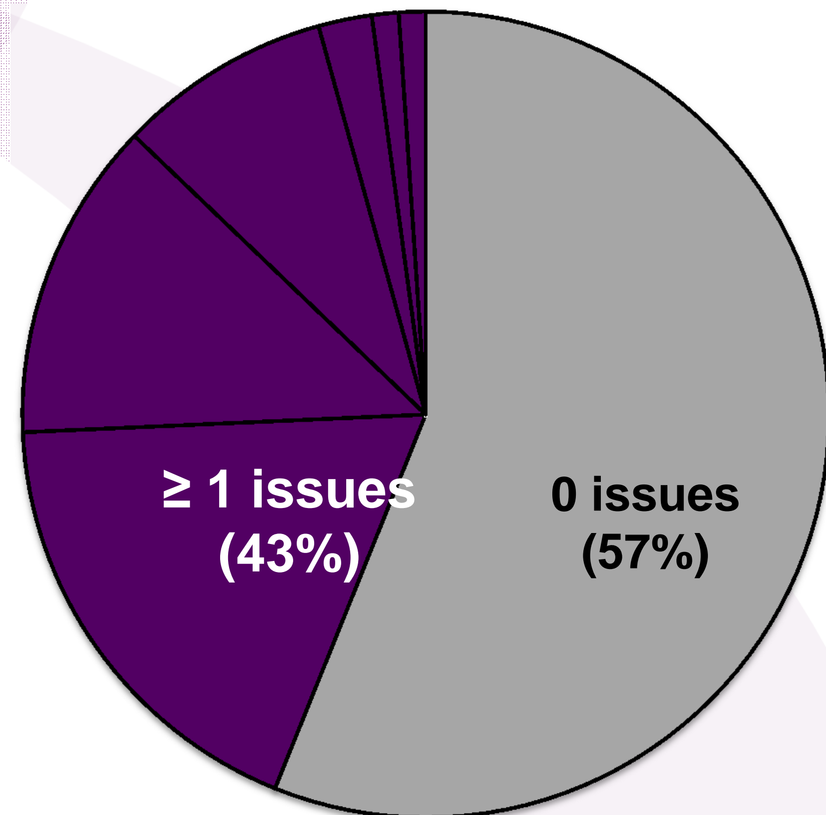
RESULTS

ISSUE COUNT	DEBRIEFS	PERCENT
Issue Count: 0	**120**	**51%**
Issue Count: 1	*41*	*17%*
Issue Count: 2	*35*	*15%*
Issue Count: 3	*27*	*11%*
Issue Count: 4	*5*	*2%*
Issue Count: 5	*3*	*1%*
Issue Count: 6	*1*	*‹1%*
Issue Count: 7	*0*	*0%*
Issue Count: 8	*3*	*1%*
Issue Count ≥ 1	**115**	**49%**



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RESULTS

5 most frequently reported safety issues:

ISSUE	EXAMPLE OF SAFETY VULNERABILITY	#	%
Equipment	Small retractor missing correct blades	34	16%
OR Scheduling/ Coordination	OR room was changed 4 times	21	10%
Distractions	Circulating nurse expected to answer non-urgent pages and cell phone calls	21	10%
Procedure Preparations	Could not be verified in the medical record that the patient actually received the peri-operative antibiotics	15	7%
Inter-provider Communication	Inadequate communication between surgery and anesthesia teams regarding preoperative treatment of hyperkalemia	15	7%

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RESULTS

Hospital Reporting System (NETS)

- **27** safety events reported

Transplant Safety Debriefings

- **250** safety issues reported

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CONCLUSIONS

- Hospital-based reporting system vastly under estimated safety issues
  - NETS: ~10% the number of issues
- Extensive, granular data on safety issues
- Prospectively risk assessment before harm occurs
- Used in combination with observation, Failure Modes Effects Analysis, and medical record review

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SAFETY IMPROVEMENTS

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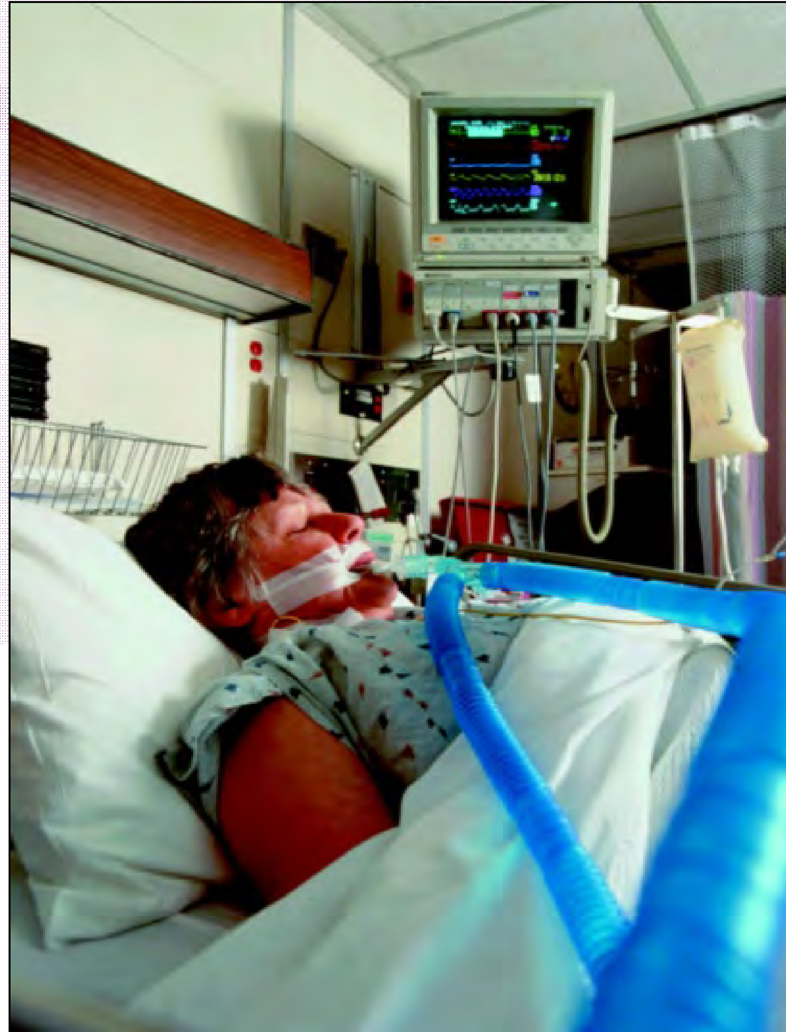

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TRANSPLANT SAFETY IMPROVEMENTS

Identifying and Eliminating Risks:

Distractions:

- New policy banning cell phones from the OR*

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TRANSPLANT SAFETY IMPROVEMENTS

Identifying and Eliminating Risks:

Access to Necessary Clinical Data:

- Consistent comments related to OTTR access for other services

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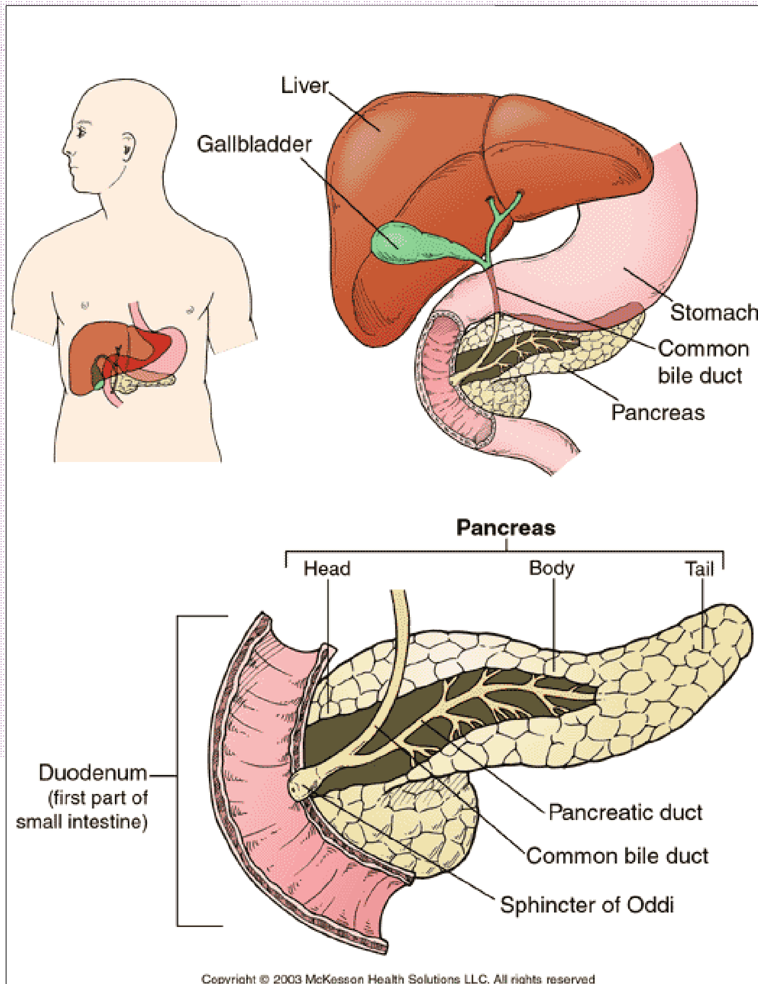
NEXT STEPS: Other Transplants



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NEXT STEPS: Organ Procurement

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NEXT STEPS: Other Centers

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QUESTIONS

Thank you for your time!

Please contact Olivia Ross at
o-ross@northwestern.edu or
visit www.nutorc.org for more information

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