Nexus FAMILY HEALING

Restoring Hope. Reshaping Futures.

Creating a Systems-Focused Event Review Process

Or,

"How to get closer to identifying the likely causes of problems without retraumatizing your well-intentioned and exhausted colleagues."

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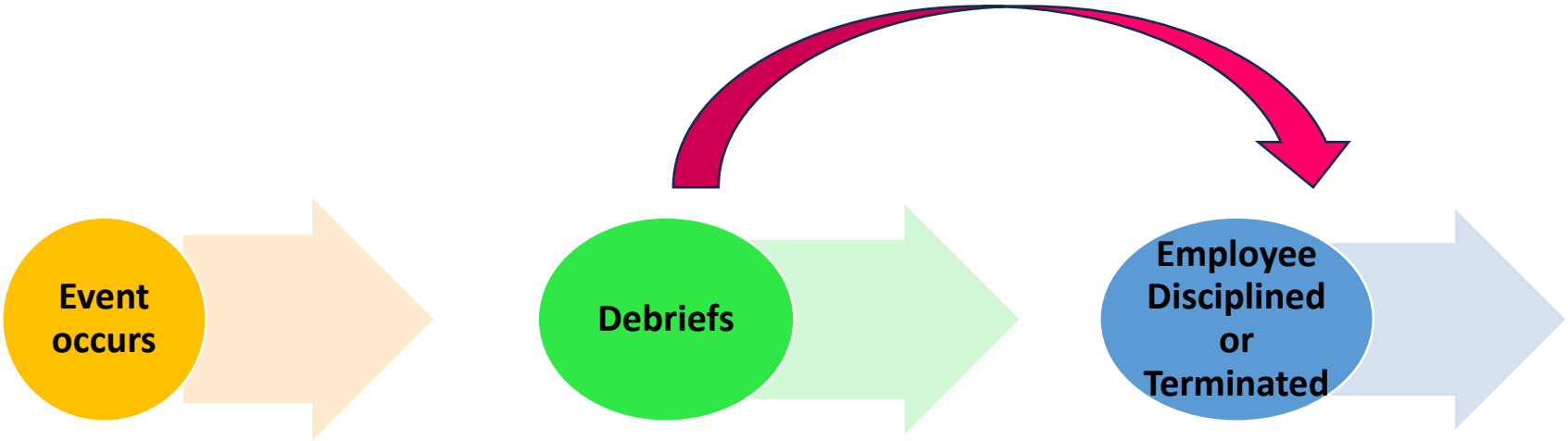
Poll

Think about the last time something very serious happened in your organization. What were the actions taken in the wake of that event?

When something goes wrong…

Does this outcome yield an effective or lasting (preventative) solution?



Is isolating human action as the cause of an incident sufficient, given that causality is often multi-factorial, non-linear, and complex? -(paraphrased from Woods & Cook, 1999 in Holden, 2009).

An example

Safety Science

- 94% of the time, it is a systems failure. -Andrew, D. (2018). *Medium*.
- 27% of medical malpractice is estimated to be due to communication problems. –*Tiwary et al. (2019). Wellcome Open Research*.
- 60-80% of health care errors are due to systems problems. – *Institute of Medicine (1999).*
- In 1999 the Institute of Medicine published *To Err is Human*, recognized as the launch of the patient-safety movement (Wachter et al., 2009).

Blame & Attribution Error

1. **Blame is a reflexive human reaction that reflects culture.**
   - In a UK study of patient safety incidents, individual blame was asserted in 45% of cases.
     - Primary reason cited was a pervasive culture of fear of retribution. (Cooper et al., 2017)
   - Blame implies that behavior was inappropriate, unjustified, or intentional and is a special case of causal explanation (Holden, 2009).
2. **Person-centered attribution can be made in error (or, "causal attribution error").**
   - Distinct from blame in which causality is inappropriately attributed to characteristics of the individual: carelessness, clumsiness, sloppiness, poor attitude, lack of motivation, staff being 'dumb' or risky (Holden, 2009).

Blame & Attribution Error

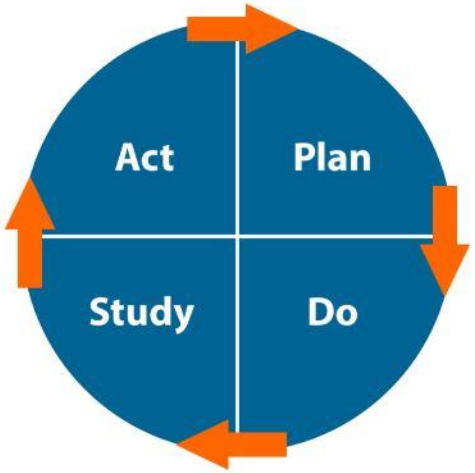
3. **Person-centered solutions (such as discipline or termination) are expedient; provides sense of action.**
   - Feels good – "*we took action*".
   - Got rid of problem leader or staff ("*we cleaned house*").

Our Organization's Need for New Response

- Nexus agency experienced a serious and traumatic event (February, 2021).
- At same time, Nexus launched and was training a new trauma-informed care model.
- Knew that response to staff incident needed to be
  - Thorough
  - Effective
  - But also trauma-informed
    - Must not re-traumatize staff and clients further

Our Organization's Need for New Response

- Clinical debriefings were regular practice
  - Potentially inadequate, given scope and seriousness of incident
- Charge to CQI (Quality Department) was to identify a *better* serious event review process.
  - In-depth;
  - Not blame-based;
  - That produces actionable solutions; and
  - Means of maintaining solutions.



AHRQ (Agency for Healthcare Research and Quality): CANDOR

- Communication and Optimal Resolution (CANDOR)
  - Process for "*health care institutions to respond in a timely, thorough, and just way when unexpected events cause patient harm.*" (ahrq.gov)

    Emphases on:
    - 1) systems-centered analysis of contributing and causal factors and a proactive and
    - 2) transparent communication process with families and patients rather than the traditional "deny-and-defend" approach.

AHRQ Approach: Adoption and Modifications

The CANDOR model: eight modules

1. Overview
2. Organizational Buy-in and Support*
3. Preparing for Implementation
4. Event Reporting, Event Investigation and Analysis
5. Response and Disclosure
6. Care for the Caregiver*
7. Resolution
8. Organizational Learning and Sustainability*

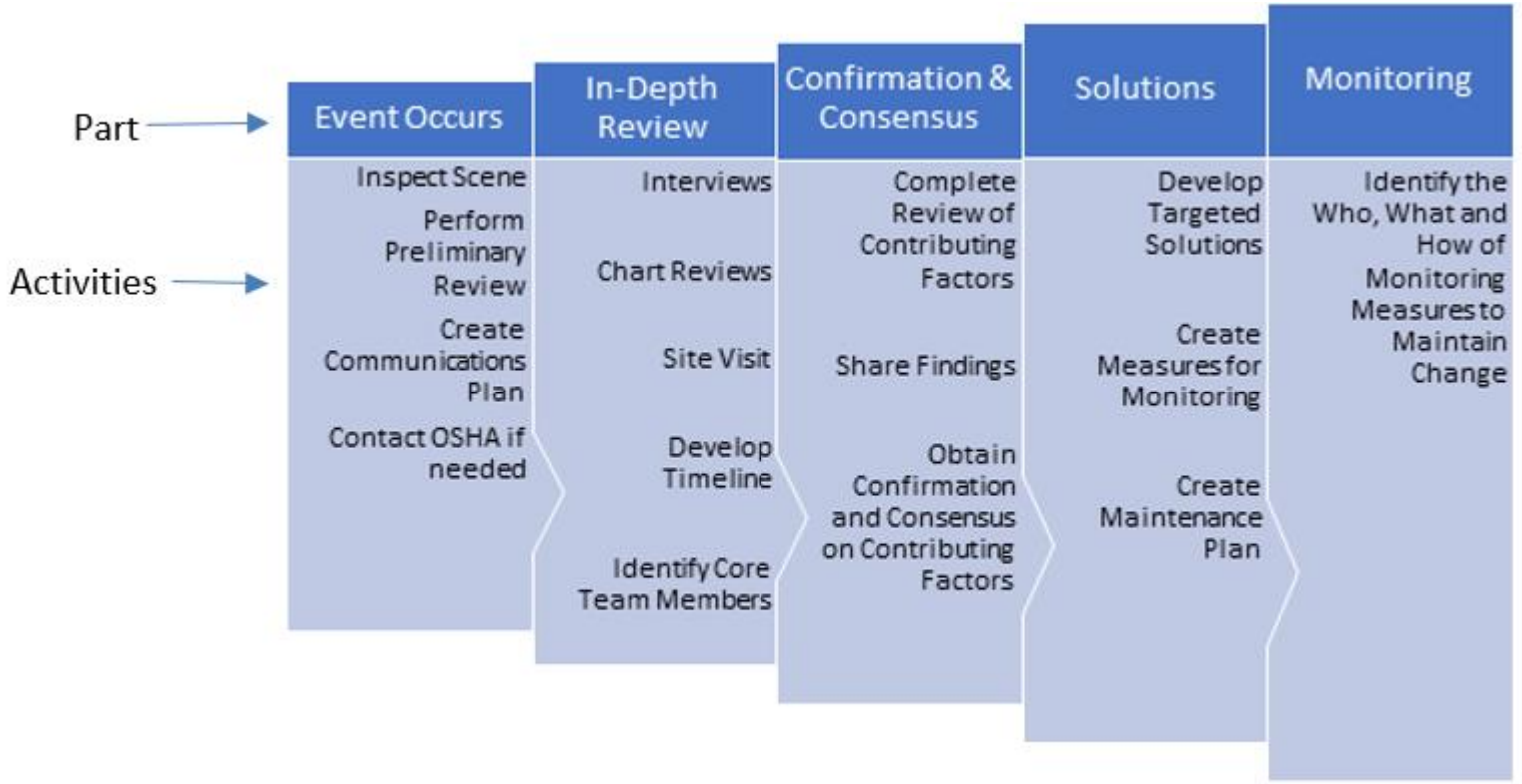
AHRQ Approach: Adoption and Modifications

Already in place:

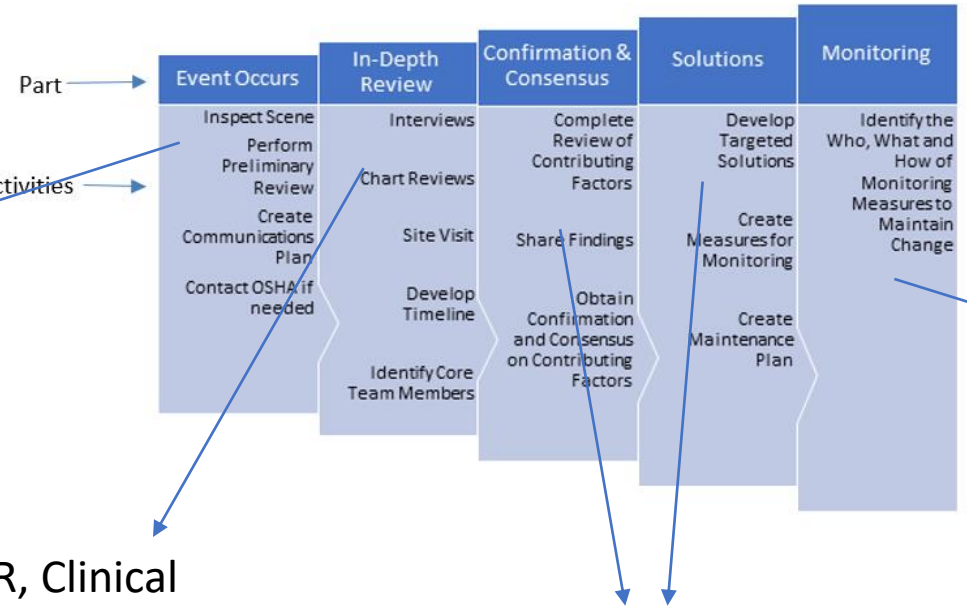
- Data tracking for "high risk" event types.
  - Definitions of event types requiring in-depth review.
- Regular agency and org-level risk management meetings.

Cycle Stage	
Plan	Identification of events of focus and data collection.
Do	Intent to examine events in-depth and venues to do so (clinical debriefs and risk management).
Study	*Stages in need of strengthening.*
Act	

Adoption & Modification: High-Risk Event Review



High-Risk Event Review: Involvement



Stabilization: agency leaders, emergency personnel, etc.

HR, Clinical leadership, Quality

Core Team constructs initial timeline (typically same group.)

Confirmation & Consensus = Core Team plus additional program staff and leaders with knowledge of event (participants, witnesses).

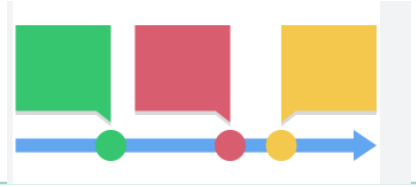
Quality (data tools and monitoring solutions) in partnership with program/clinical leadership.

1.Core Team and In-Depth Review

Purposes:

- Gather perspectives (interviews) and relevant documentation. Be reasonably exhaustive.
- Address conflicting statements of events.
- Construct a timeline of relevant information leading up to the event:
  - Personnel records (timeline may span weeks or months)
  - Client records (45 days prior to event unless longer view is relevant)
  - Other sources as relevant: video footage; police reports; photos of scene; medical assessments, etc.

End Product: Timeline with recommended time points for focus.



Timeline

Timeline Leading to Incident	
6/4/2024	SER: (#) causing property damage >$50; displaying physically aggressive behavior; threatening or attempting elopement.
6/6/2024	SER: (#) threatening or attempting elopement.
6/12/2024	Telehealth therapy with parents (39 min.) - Had recently been offered job at .
6/12/2024	Community support therapy session (37 min.) - Discussion of managing bipolar symptoms in the workplace with upcoming job start.
6/12/2024	Psychiatric visit (20 min.) – Acknowledgement of importance of keeping client busy and engaged given he had graduated high school and becomes bored and acts out without structured time. Emphasis on the importance of the client starting employment.
6/13/2024	SER: (#) displays physically aggressive behavior
6/16/2024	Community support therapy session (38 min.) – Discussion of managing bipolar symptoms and aggression in the workplace as well as boredom when at work. expressed hatred of being on campus.
6/18/2024	Community support therapy session (60 min.) – Role playing activities to build self-regulation skills. did well.
6/18/2024	Community support therapy session (60 min.) – Discussion of room cleanliness.
6/19/2024	Community support therapy session (45 min.) – Work with on restorative work with and harm caused.
6/20/2024	SER: (#) caused property damage >$50; displays physically aggressive behavior; threatening or attempting elopement
6/25/2024	Community support therapy session (30 min.) – expressed desire to spend more time with his family.
6/25/2024	Face-to-face family therapy with (120 min.) – Did work on restoration of relationship and how to move forward.
6/30/2024	Phone therapy with (66 min.) – Planning for attending and how to manage interactions with family at the event.
7/3/2024	IM+ CANS: Progress on some goals noted. continues to have challenges with aggression toward peers and staff. In terms of life skills, has difficulty with money management and cooking. Assessment states that ntentionally sabotages his discharge from program. Goals include improving decision-making and managing symptoms.
7/4/2024	Community support therapy session (55 min.) – Discussed how to be safe and manage emotions and behavior during the next day. Will be the first time he has seen some family members in five years.
7/6/2024	SER: (#) Threatening or attempting elopement.

Timeframe of historical events to include. (This event occurred in mid-July.)

Key time point identified (blue highlight). Key time point is a point in time where subsequent events may have been set in motion, actions were significant and should or could have been different, or Core Team has a strong feeling of foreshadowing. (Can be more than one key time point and often are.)

Timeline typically continues up to the event, or past it, to resolution, as relevant.

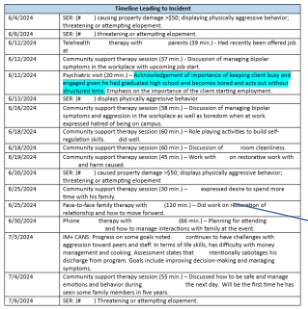
2. Confirmation & Consensus

Purposes:

- Expand view of event (by expanding membership to additional knowledgeable people) – "soft intelligence" (Cooper, 2017).
- Confirm and reach consensus on timeline.
- Confirm and reach consensus on key time points.
  - Identify contributing factors and potential solutions.

End Products: Finalized timeline and contributing factors diagram (fishbone/Ishikawa).

Contributing Factors



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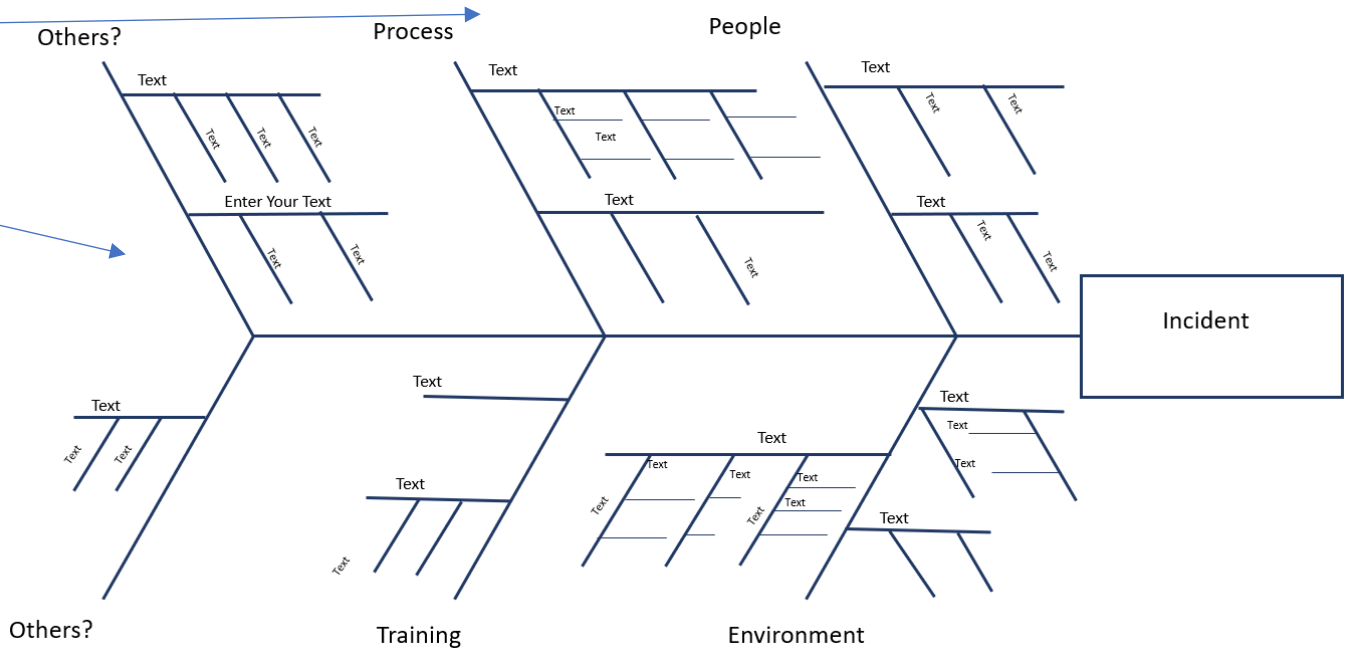


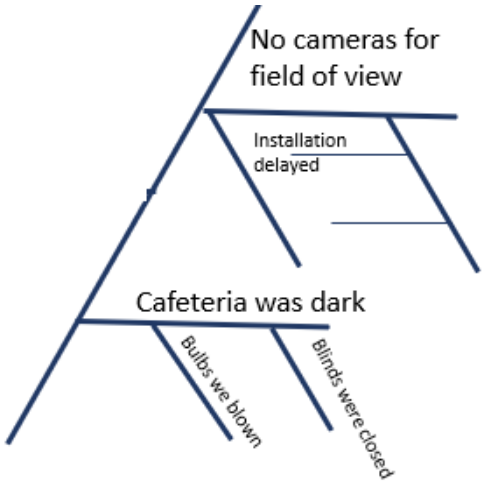
IMPORTANT: Key categories on the main “bones” of the diagram should be deliberately broad and *not driven by the specific incident.*

Contributing Factors: Broad Categories

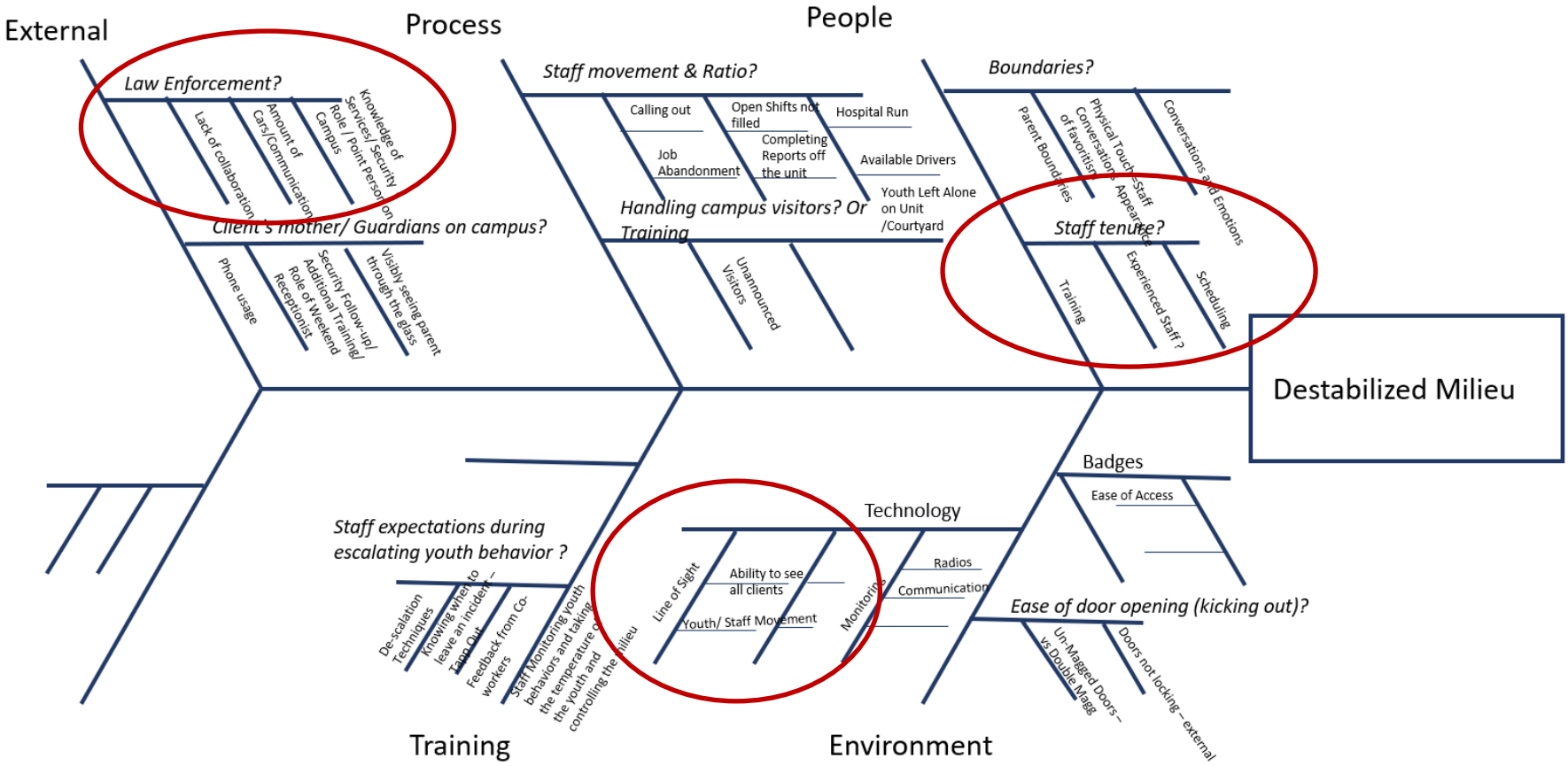
- Broad categories
  - Prevents the limited perspective created by narrow categories (e.g., instead of "lighting in cafeteria", "Environment").
  - Prevents premature "solution-izing".
- Broad categories that are nearly ALWAYS relevant:
  - People
  - Process
  - Environment
  - Training

Diagramming

- Use key time points in the timeline as guides.
- Asking the "5 why's" -
  - If this process is intrusive or feels interrogatory, other phrases can be equally effective
    - *"How did this occur?"*
    - *"What else may be behind this?"*
    - *"What this condition different before? Why, or Why not?"*
- **Example:**



3. Targeted Solutions



Targeted Solutions: Systems, not People

Category	Contributing Factor(s)	Potential Solution(s)
External	**Law Enforcement** Lack of Knowledge of Services Lack of Collaboration Response "overkill"	*Meet quarterly with local police to educate. *Invite local EMS to fall open house.
Environment	**Technology** Insufficient line of sight – Camera location insufficient	*Speak with Finance regarding camera purchase. Order and install.
People	**Staff tenure** Insufficient tenure among staff on duty Training needs of new staff	*Change scheduling criteria to include staff tenure. *Re-train all newer staff in de-escalation.

4. Monitoring

- With solution identification, two additional key pieces are needed
  1. Lead, or responsible party/staff
  2. Due date(s)
- Unless the solution is "one-and-done," identify how the solution's maintenance will be ensured.
  - Data collection / data sources
  - New reports for monitoring/tracking
  - Accountability processes for compliance, as applicable
- Monitoring to occur in agency risk management meetings.

What We've Learned

1. Process modified from a hospital-based approach: further modifications for other service lines.
   - Less intensity/dosage (outpatient, transition) means less direct influence over client's experience or events.
   - Control over a client's experience varies by regulatory nuances (e.g., crisis services and no restraints).
2. Staff trust in the systems-focus is slow.
3. Process may take longer than 30-45 days.
4. Internal interviews to build timeline must be done well and with neutral competence.

What We've Learned

5. New procedures & tools have come from these reviews that may benefit all of our agencies.
   - Improvements to program transition communication.
   - Changes to badge-wearing.
   - Strengthening of relationships with local law enforcement.
   - Changes to training: content and frequency.
   - Earlier identification and action on aggression red flags with staff.
   - Video surveillance improvements identified on campus.

Further Improvement, Next Steps

- Great discussions: speculate about true cross-pollination and inspirational action.
- Hoping that we aren't just creating a more refined way to admire our problems.
- Action and true, lasting change is still a challenge.

Ongoing Challenges for Safety & Quality

- If person-centered attribution persists, there is little to no consideration of wider context and insights are missed (Cooper, 2017).
- Behavioral roles of staff have an important role in error, incidents and learning:
  - *Adaptive Conformer:* Adjusts, corrects errors of others, and improvises without bothering managers.
  - *Disruptive Questioner:* Questions why we do things the way we do and wants to know whether there is a better way.

    In health care, we tend to prefer Adaptive Conformers, but only Disruptive Questioners help us grow and learn (Edmonson, 2004).

Ongoing Challenges for Safety & Quality

- In hospital-based healthcare, finding the right balance between "no blame" and accountability is a challenge.
  - Medical providers won't abide by safety standards unless they understand the rationale for the standard, or the manner in which it will be audited.
  - Individual punishment, when warranted, must be proportional to the offense.
  - "No blame" approaches run the risk of being seen as "guild behavior" if accountability is not part of the process.
  - Classification or penalties system should be aligned to safety practice violations (Wachter, 2009).

AHRQ Behavior Classification

Table 1: Behavior Classification

Normal Error (Human Error)	At-risk Behavior	Reckless Behavior
Inadvertent action such as a slip, lapse, or mistake Manage by changing: ■ Processes ■ Procedures ■ Design ■ Environment	Individual is not educated about potential risk and sees no value in established policies to prevent it Manage by: ■ Removing incentives for at-risk behaviors ■ Creating incentives for positive behaviors ■ Educate about potential risks ■ Redesign of system factors	Conscious and deliberate violations of procedures and policies Manage through: ■ Remedial action ■ Punitive action
Support	**Coach**	**Sanction**

Intended to be a summarizing and reflection step as the high risk event is finalized. Brings clarity and closure to the review.

Resources

- Report template
- Fishbone diagram
- Procedure (simplified from our organization procedure document)

Recommendation: Align your own procedure against the core components of this process to identify your gaps or areas of improvement.

References

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- Edmondson, A.C. (2004). Learning from failure in health care: frequent opportunities, pervasive barriers. *Quality & Safety in Health Care, 13*(supplement II), ii3-339.
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Thank you!

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