Post-Procedure Debriefing:
Opportunities to Improve Cath Lab Communication and Patient Care

Michael A. Kutcher, MD, FSCAI
Henry S. Jennings, III, MD, FSCAI
The SCAI-Quality Improvement Toolkit was developed with founding support from Daiichi Sankyo, Inc., and Lilly USA, LLC., and support from AstraZeneca. The Society gratefully acknowledges this support while taking sole responsibility for all content developed and disseminated through this effort.
The pre-procedure “time out” is a standard of practice.

A “post-procedure time out and debriefing” affords an extra opportunity for the interventional attending to take the lead in a short, focused huddle with the cardiac cath lab staff immediately after procedures with complex challenges or complications.

This format can engender a better team approach to problem solving and communication.
A “post-procedure debriefing” may occur after any procedure. Specific situations that may warrant a debriefing are:

- Cases that required complex strategy
- Primary PCI STEMI cases
- Cases that had complications in the cath lab
- Cases that ended in a cath lab death
The interventional attending can explain strategy decisions to address a particular procedural problem.

- Discuss alternative strategy pros and cons.
- Invite cath lab staff feedback and ideas.
- If strategy is novel, arrange for further formal discussion at an interventional or cath conference.
- Consider writing up a strategy sheet for future similar situations.
Primary PCI STEMI Cases

- Review the door-to-balloon time metrics.
- Discuss any logistical issues such as time frames, hand-offs, or ancillary support.
- Review details such as lead hook-up, defibrillation options, and hemodynamic support measures if they were necessary.
- Remember to thank and acknowledge the cath lab staff. The success of STEMI PCI is a team effort.
- If problems have been identified, outline these and send to Cath Lab or QI Director.
Specifically identify sequence of events that led to the complication.

Review rationale for measures taken to address the problem.

Invite cath lab staff feedback and ideas.

The debriefing may serve as an initial data foundation for subsequent hand-off and follow-up.

If significant, the event should be reported to the Cath Lab or QI Director and formally reviewed at a Mortality and Morbidity conference.
Specifically identify sequence of events that led to the death.

Review the rationale for measures taken to address the critical problems.

Remember that many young staff members may have little experience with direct death. Be nurturing and supportive.

Emphasize the positive with your staff. By critically examining the circumstances, we may derive better alternatives to address future events.
Cases with In Lab Death

- Determine if the case should be discussed with a medical examiner.
- Make your procedure note comprehensive and ask for cath lab staff input for details.
- Use the “post-procedure debriefing” to develop data for a formal report.
- Immediately notify the Cath Lab or QI Director.
- The death should always be formally reviewed and discussed at a Mortality and Morbidity conference.
Follow-up with the cath lab team in the next few days. Keep an open dialogue for any questions.

Remember that this is a rare but unsettling event for your non-physician and younger staff members. Identify adversely affected individuals and spend one-on-one time with them.

Although the circumstances and outcome are negative, the way you handle it as a team will promote positives for the future.
Not every case needs a “post-procedure debriefing.” But selection of complex cases for debriefing will be worth the extra time and effort.

Reflection and input from cath lab staff after a case can lead to more accurate documentation in procedure notes.

The “post-procedure debriefing” allows for immediate reflection. These can serve as a focus for formal follow-up Quality Improvement (QI) initiatives and Mortality/Morbidity Reviews.
Post Procedure Debriefing - References


If you have feedback, questions, or suggestions for current or future SCAI-QIT Tip of the Month topics, please submit them at info@scai.org or at the e-mails listed below.

Michael A. Kutcher, MD, FSCAI
mkutcher@wakehealth.edu

Henry S. Jennings, III, MD, FSCAI
henry.s.jennings@Vanderbilt.edu
Stay in Touch with SCAI....

www.SCAI.org
www.SecondsCount.org

Follow us on Twitter:
@SCAI
@SCAINews
@SecondsCountorg
@SCAI_Prez

Join our network:
LinkedIn/SCAI

Like Our Pages:
Facebook.com/SCAI
Facebook.com/SecondsCountorg