Identifying the Impact of Failure in the Information and Knowledge Transfer Process

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Why?
Harm can happen due to ineffective evidence and knowledge transfer (EKT). Found as a factor in:
- 2001 death of a healthy volunteer
- Death of an infant

Gaps in the knowledge transfer process are important to identify:
- What are they?
- What is their impact?
- How can we improve and increase awareness to be more sensitive to gaps and how they can undermine safe work.

What do we mean by EKT?
The continuum of determining what peer-reviewed science and tacit knowledge are needed, and reliably facilitating information into action and decision making.

What sorts of EKT failures can impact care?:
- Confirmation bias
- Researcher overconfidence of research skills
- Inaccessibility of librarians
- Bad research methodology
- Researcher didn’t know what he didn’t know
- Researcher was pressured, tired, interrupted
- Missed cues in the literature reviews
- No double-check of results
- Wasn’t aware of the library’s search services
- Librarian unhelpful in the past
- Lack of full text availability
- Old drug books accessible
- Relying on uninformed “expert”
- Patient didn’t ask about the research prior to signing on

How?
Identify the holes in the EKT Swiss cheese through failure analysis:

What does the team look like?
- Librarians
- Physicians
- Residents
- Information technicians
- Nurses
- Patients
- Administrators
- Patient Safety Managers

Getting started:
1. Start conversations with clinicians and librarians.
2. Observe and document existing EKT process (the way it really happens - not some ideal process).
3. Use your observations and documentation to identify potential failure modes (places where things can go wrong and the results that could ensue).
4. Work with your patient safety (or quality) manager.

Progress Report:
Conducted training session for librarians; collected anecdotal responses from clinicians and librarians; consulted with experts on failure modes and process.

Seeking Collaborative Solutions
What holes in the “knowledge transfer” process have you seen?

Plans for our project:
1. Pilot within the VA healthcare system
2. Conduct HFMEAs at multiple locations - on multiple subprocesses.
3. Share results VA-wide to provide lessons learned across the entire EKT process
4. Publish identified failure modes to encourage other systems to contribute to resolving patient safety issues related to EKT.

What are they?
- Inaccessibility of librarians
- Bad research methodology
- Researcher overconfidence of research skills
- Inaccessibility of librarians
- Bad research methodology
- Researcher overconfidence of research skills

What is their impact?
- Gaps in the knowledge transfer process are important to identify
- What are they?
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1 McLellan F. 1966 and all that-when is a literature search done? Lancet. 2001;358:646.