When Words and Actions Matter Most

Responding to Harm in Healthcare

The Case for CANDOR

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Origin of CANDOR

A comprehensive, principled, and systematic approach to harm.

NEJM, January 12, 2023

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Safety of Inpatient Health Care

David W. Bates, M.D., David M. Levine, M.D., M.P.H., Hojjat Salmasian, M.D., Ph.D., M.P.H., Ania Syrowatka, Ph.D., David M. Shahian, M.D., Stuart Lipsitz, Sc.D., Jonathan P. Zebrowski, M.D., M.H.Q.S., Laura C. Myers, M.D., M.P.H., Merranda S. Logan, M.D., M.P.H., Christopher G. Roy, M.D., M.P.H., Christine Iannaccone, M.P.H., Michelle L. Frits, B.A., Lynn A. Volk, M.H.S., Sevan Dulgarian, B.S., B.A., Mary G. Amato, Pharm.D., M.P.H., Heba H. Edrees, Pharm.D., Luke Sato, M.D., Patricia Folcarelli, Ph.D., R.N., Jonathan S. Einbinder, M.D., M.P.H., Mark E. Reynolds, B.A., and Elizabeth Mort, M.D., M.P.H.

CONCLUSIONS

Adverse events were identified in nearly one in four admissions, and approximately one fourth of the events were preventable. These findings underscore the importance of patient safety and the need for continuing improvement. (Funded by the Controlled Risk Insurance Company and the Risk Management Foundation of the Harvard Medical Institutions.)

NEJM, January 12, 2023

EDITORIALS

Constancy of Purpose for Improving Patient Safety — Missing in Action

Donald M. Berwick, M.D., M.P.P.

The findings suggest that the safety movement has, at best, stalled. The 2022 National Steering Committee for Patient Safety,[4] as well as the authors of a national action plan for patient safety sponsored by the Agency for Healthcare Research and Quality,[5] reached the same conclusion. The President's Council of Advisors on Science and Technology has been preparing recommendations for the President to reignite an effective safety movement. This effort could hardly be timelier.

Patient Safety in US - 2018

23.6%
Admissions that result in at least one adverse event

9.0%
Of adverse events rated as serious, life-threatening or fatal.

22.7%
Of adverse events preventable

121%
Mean length of stay for admissions with adverse event vs those without (9.3 days vs 4.2 days)

Source: The Safety of Inpatient Health Care: NEJM: Jan 2023, David Bates et all

Editorial

Who killed patient safety?

Carole Hemmelgarn [1], Martin Hatlie[2], Susan Sheridan[3], and Beth Daley Ullem[4]

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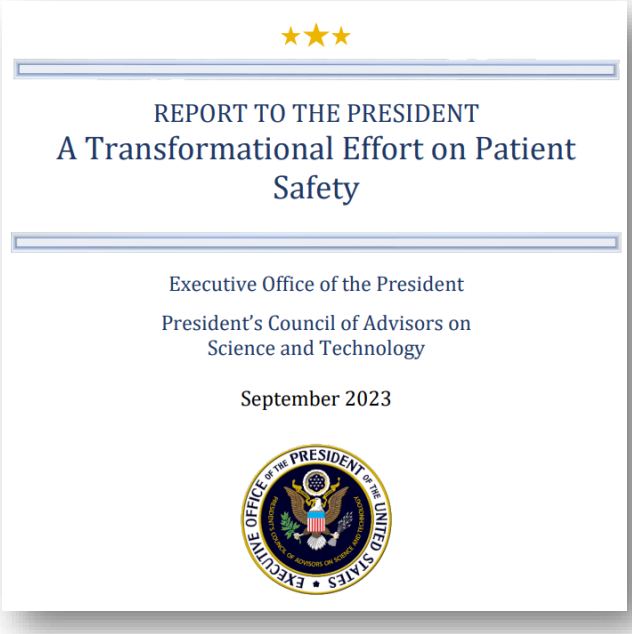
[3] Independent Scholar, Boise, USA
[4] Independent Scholar, San Juan Capistrano, USA

The medical community's commitment to patient safety has withered to over the past 10–15 years afte the original call to action in 2000 with the release of the IOM report, To Err is Human.[1] The tragedy o this decline in action around safety lies in the lives of the families like ours, who have lost loved ones been harmed, and often permanently injured by medical error. What was once a motivating call t action, safety in hospitals and oversight by our government has been deprioritized, defunded, an devalued leaving patients like us to wonder: What happened to Patient Safety?

Transforming Patient Safety

Report Findings

- Preventable harm rates too high
- Progress too slow
- Evidence-based solutions emerging
- Must become a national priority



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REPORT TO THE PRESIDENT

A Transformational Effort on Patient Safety

Executive Office of the President

President's Council of Advisors on Science and Technology

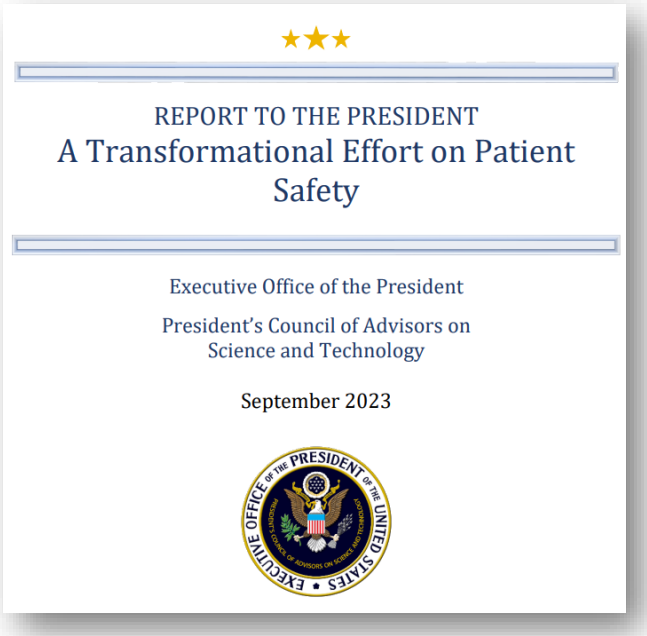
September 2023

Recommendations

- Incentivize Evidence-Based Solutions: CANDOR
- Learning Ecosystem; Just Culture
- Partner with Patients
- Eliminate Disparities
- Leverage data and software

https://www.whitehouse.gov/wp-content/uploads/2023/09/PCAST_Patient-Safety-Report_Sept2023.pdf

Transforming Patient Safety



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REPORT TO THE PRESIDENT

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September 2023

Preventable medical errors and their downstream effects directly contribute to and exacerbate health disparities. System-wide approaches are needed to address these disparities. People experiencing marginalization are more likely to suffer harms as a result of medical errors, inadequate testing and treatment, and inaccurate diagnosis,[49, 50, 51, 52] and they may lack the resources to adequately address harms once they have occurred. Unconscious race and class biases, in particular, can shape how clinicians perceive patients and communicate.

https://www.whitehouse.gov/wp-content/uploads/2023/09/PCAST_Patient-Safety-Report_Sept2023.pdf

Operationalizing Patient Safety Structural Measures

- **Domain 1: Strategic Policy and Organizational Policy**
  - Metrics assessing R.E, LP, SDOH
  - Just Culture within RCA, Peer Review,
  - Patient Safety Curriculum, Credentialing, Competencies
  - **Workforce Safety, Wellness, Support**
- **Domain 2: Leadership Commitment to Eliminate Preventable Harm**
  - Accountability for Metrics and Dashboards
  - Patient Safety within Strategy, Finance, and Operations
  - Staffing
- **Domain 3: Data Management, Surveillance, Investigation, Learning**
  - Stratification of Adverse Event Data
  - Dashboards, Benchmarking, Tracking Precursor Events, Safety Huddles
- **Domain 4: Accountability and Transparency**
  - **CANDOR: Event ID, Rapid Open Communication, Event Review with Prevention and Learning, Peer Support, Financial and Non-Financial Resolution, Patient and Family Ongoing Support**
- **Domain 5: Patient and Family Engagement**
  - Harm events, Unsafe Conditions, and Status of Investigations reported to the Patient and Family Advisory Council

The Unkind Acts Cascade

Collateral Damage of The Wall of Silence
The Empathy Crisis

My biggest failure and regret

A Case To Illustrate The Wall of Silence & the Collateral Damage

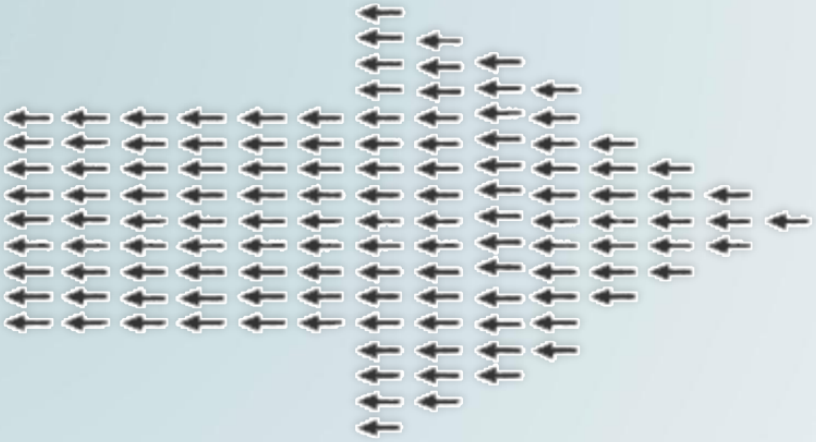
- 39-year-old COO of sister hospitals presents for pre-operative testing
- CBC shows WBC of 1,000
- Not acted upon
- Undergoes surgery
- Post op CBC shows WBC <500
- Not acted upon
- Patient dies 6 weeks later with leukemia
- We “delay deny and defend” for 4 years
- 43 depositions – 12 resident physicians
- Settle for millions
- Learned little and suffer immensely

More importantly,

Karen was a beloved:

- Mother
- Grandmother
- Fiancée
- Sister
- Daughter
- Godmother

What are the barriers to open communication?

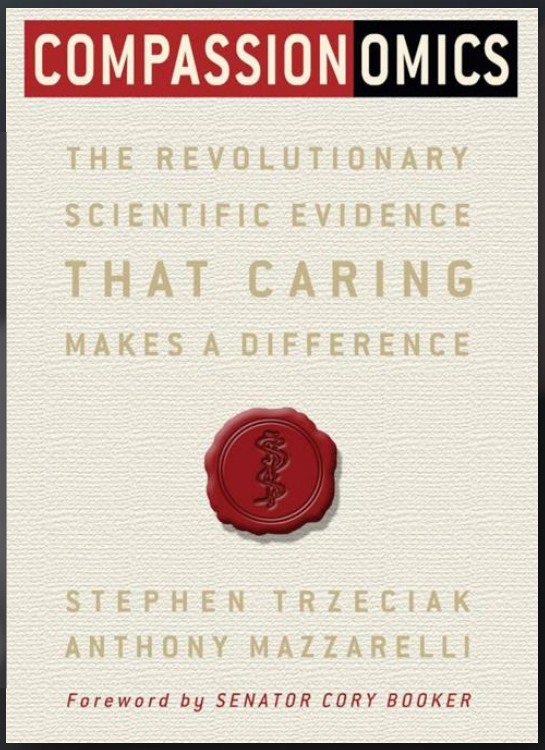


Culture eats strategy for breakfast

Empathy and Compassion Crisis

Facts

- Less than half believe the health system is NOT compassionate
- Just 0.5% show any empathy during office visit
- Empathy mitigates implicit bias
- Compassion promotes health
- Compassion lowers malpractice risk
- Lack of compassion poses a safety risk



Communication Opportunities

MEDICAL MALPRACTICE

By Dwight Golann

Dropped Medical Malpractice Claims: Their Surprising Frequency, Apparent Causes, And Potential Remedies

DOI: 10.1377/hlthaff.2010.1132
HEALTH AFFAIRS 30,
NO. 7 (2011): 1343–1350

Why Do Patients Sue?

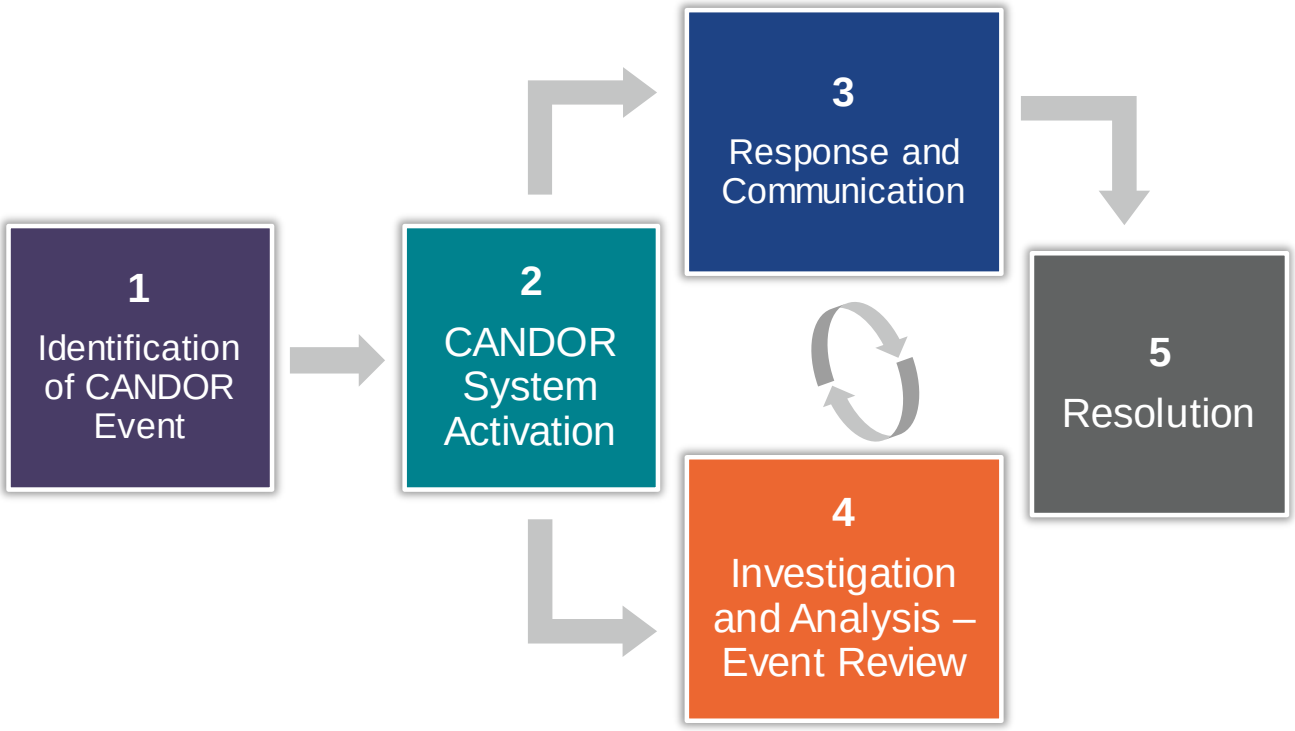
- Patient, family want answers
- A ”sense” that something is being hidden
- Insensitivity or poor communication following unexpected outcome
- Significant physical or financial injury
- Missed or delayed diagnosis
- Unrealistic expectations

Breaking Down the Wall of Silence

The development of a comprehensive approach to the prevention and response to **patient harm**

- ✓ We will provide effective communication rapidly following all serious harm events
- ✓ We will apologize and fairly and rapidly resolve all cases of inappropriate care
- ✓ We will learn from our mistakes
- ✓ We will support patients, families and care givers throughout

Communication AND Optimal Resolution: CANDOR



The Paradigm Shift

Reporting	• from delayed • to immediate
Communication	• from delay, deny and defend • to immediate and ongoing
Event Review	• from shame, blame, and train • to human factors process redesign
Care for the Caregiver	• from suffering in isolation • to immediate and ongoing support
Resolution	• from having to “fight for it” • to early offer

A Chance for Redemption

Behind every case is a face:

Michelle Malizzo Ballog
A second chance

Seven Years Later - Tragedy Strikes: What Next?

- 39-year-old, mother of two children
- Presents for GI procedure
- During procedure multiple distractions
- GI Suite woefully understaffed
- Significant doses of sedation
- Failure to rescue
- Cardiac arrest
- Ultimately develops brain death

More importantly,

Michelle was a beloved:

- Mother
- Wife
- Sister
- Daughter
- Godmother
- Grand daughter

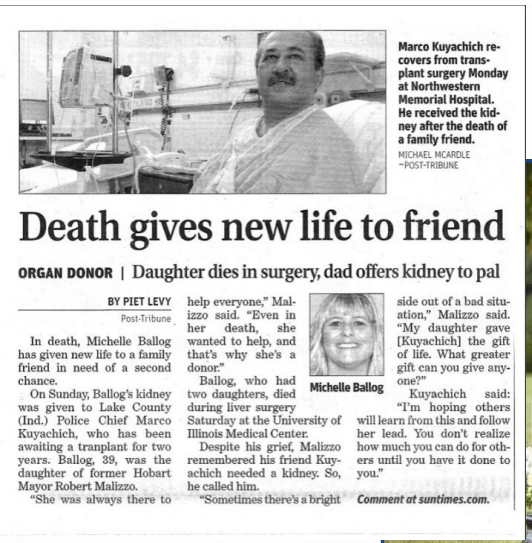
Tragedy Strikes: What Next?

- 39-year-old, mother of two children
- Presents for GI procedure
- During the procedure multiple distractions
- Significant doses of sedation
- Failure to rescue
- Cardiac arrest
- Ultimate brain death
- Go Team launched:
  - Immediate and Ongoing Communication with Family
  - Event Review
  - Immediate and Ongoing Peer Support

Behind every transformation is a story: Bob and Barb Malizzo

What we learned

- Empathy can transform an organization
- We need more Empathic Communication and Peer Support training
- Many warning signs in the data
- A need for earlier intervention on staffing and sedation near misses
- Mandate capnography for moderate sedation



Marco Kuyachich recovers from transplant surgery Monday at Northwestern Memorial Hospital. He received the kidney after the death of a family friend.
MICHAEL MCARDLE ~POST-TRIBUNE

Death gives new life to friend

ORGAN DONOR | Daughter dies in surgery, dad offers kidney to pal

BY PIET LEVY
Post-Tribune

In death, Michelle Ballog has given new life to a family friend in need of a second chance.

On Sunday, Ballog's kidney was given to Lake County (Ind.) Police Chief Marco Kuyachich, who has been awaiting a tranplant for two years. Ballog, 39, was the daughter of former Hobart Mayor Robert Malizzo.

"She was always there to help everyone," Malizzo said. "Even in her death, she wanted to help, and that's why she's a donor."

Michelle Ballog

Ballog, who had two daughters, died during liver surgery Saturday at the University of Illinois Medical Center.

Despite his grief, Malizzo remembered his friend Kuyachich needed a kidney. So, he called him.

"Sometimes there's a bright side out of a bad situation," Malizzo said. "My daughter gave [Kuyachich] the gift of life. What greater gift can you give anyone?"

Kuyachich said: "I'm hoping others will learn from this and follow her lead. You don't realize how much you can do for others until you have it done to you."

Comment at suntimes.com.

Example: Chicago Tribune

- The case that changed the culture at the University of Illinois.

Another Example: Chicago Tribune

- The case that changed the culture at the University of Illinois.

> The doctor walked into the hospital room with a discomforting mission. He was there to admit a medical mistake and apologize to his patient, a woman with breast cancer.
>
> The staff had given her the same injection twice by accident, causing her white cell count to soar, said Dr. Divyesh Mehta, chief of oncology at the University of Illinois at Chicago Medical Center. He recommended she stay in the hospital an extra day or two.
>
> "This is our responsibility, and we are very sorry for it," Mehta said, recalling the conversation.

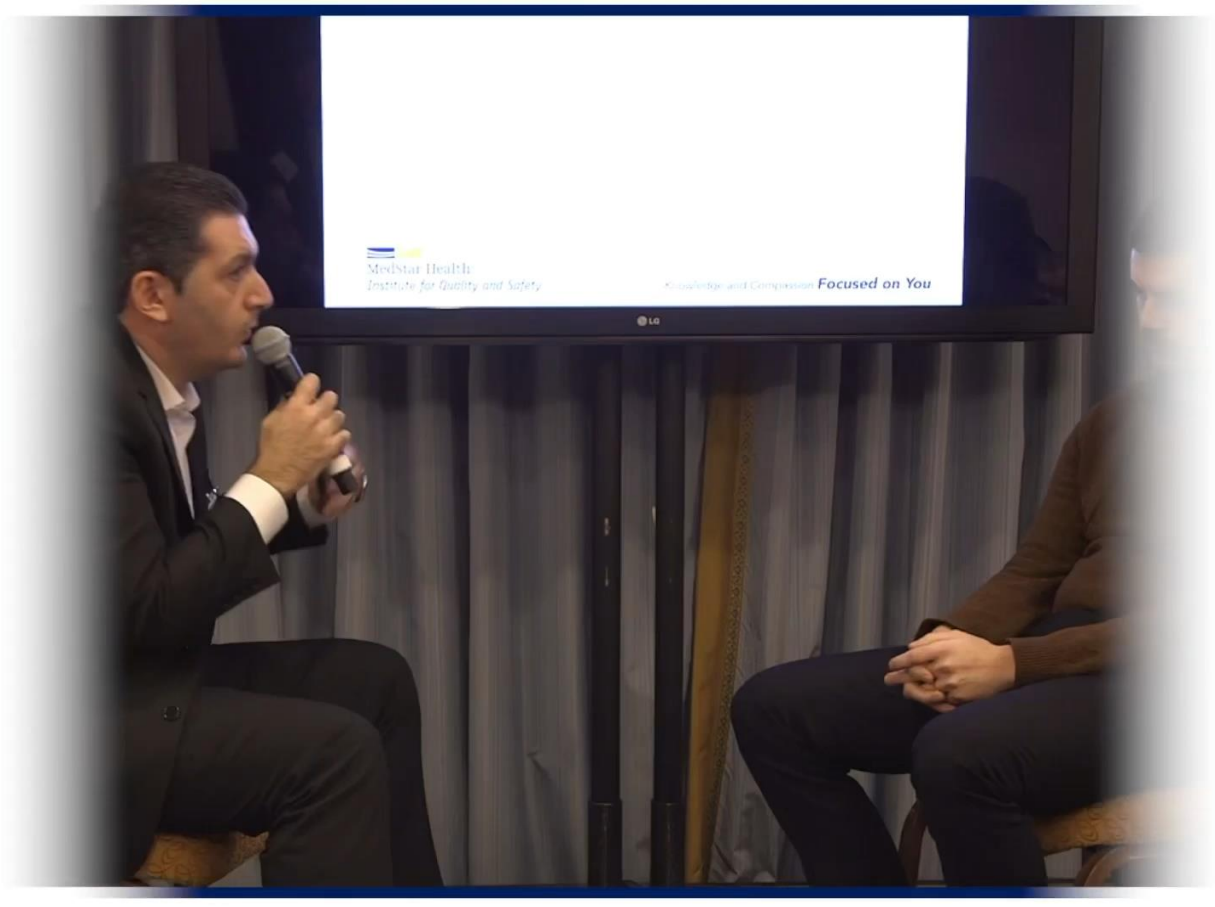
Another Example: Chicago Tribune

- The case that changed the culture at the University of Illinois.

> So is Mehta, who credits UIC for providing leadership and support to doctors who want to do the right thing. "When something like this happens, you feel guilty, you feel angry, you feel terrible. So it's a tremendous relief to be able to share the truth," he said. "I don't want a deception to come between me and my patient."

A young physician's story

- 58 patient with myasthenia gravis
- Severe weakness in need of plasmapheresis x 10 days
- Recovers and needs line removed prior to discharge
- Upon line removal patient develops air embolism
- Cardiac arrest, ultimately dies
- Rapid response to harm ensues



Systemic Issues / Opportunities highlighted in Air Embolism Case

- Lack of pre-procedure checklist for line removal
- Lack of a packet of all needed equipment and supplies for line removal
- Lack of any policy or procedure related to line removal
- Lack of pre-removal huddle to ensure proper preparation
- Lack of morning safety huddle to discuss the appropriate time to pull line – patient was still anticoagulated
- Medication error – the patient was still heparinized, and this was not communicated to team
- Inexperience of physician – competency
- No feeling of psychological safety in asking for help or asking the nurse to stay
- Clear need for peer support/care for the caregiver following this event
- Opportunity to avoid claim by sharing facts learned with family and early offer [CANDOR]
- Power of rapid response to harm [reporting, RCA] that allowed for early cognitive interview
- Staffing and workforce management – the need for contracts to ensure competency of all staff

Power of Empathic Communication

Original Research Paper

Improving Self-Reported Empathy and Communication Skills Through Harm in Healthcare Response Training

Aimee Samuels, DNP, RN, CPHRM[a], Marion E. Broome, PhD, RN, FAAN[b], Timothy B. McDonald, MD, JD[c], Chii-Hui Peterson, MPA-HA[d] and Julie A. Thompson, PhD[e]

Journal of Patient Safety and Risk Management
1–10

DOI: 10.1177/25160435211047643
journals.sagepub.com/home/cri
SAGE

MPL MEDICAL PROFESSIONAL LIABILITY ASSOCIATION

Inside Medical Liability

Third Quarter 2021

Empathy Training Tied to Improved Patient Satisfaction, Lower MPL Risk

Surgeon General's Report on Burnout

- **Invest in peer support model programs, learning networks, and opportunities during working hours to reflect on challenging circumstances and ethical dilemmas.** For instance, the Battle Buddy program has been shown to mitigate burnout, address feelings of isolation, and offer psychological and emotional well-being support and resources in times of crisis.[74, 153] Other

NEJM, 2020 Shapiro & McDonald

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Supporting Clinicians during Covid-19 and Beyond — Learning from Past Failures and Envisioning New Strategies

Jo Shapiro, M.D., and Timothy B. McDonald, M.D., J.D.

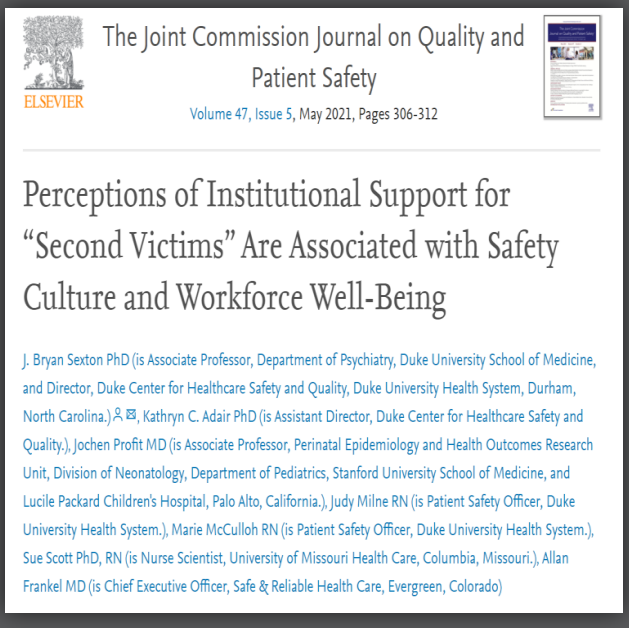
NEJM, 2020 Shapiro & McDonald

> "We have found while providing peer support to hundreds of clinicians that their emotional stress often comes from workplace issues that should be mitigated such as… unprofessional and problematic behavior, including racist and sexist behavior and persistent health disparities."

Summary of strategies

- Frame emotional fallout as an occupational hazard thereby reducing stigma.
- Provide adequate training, resources, and marketing
- Prioritize reaching out rather than self-referral - “if you build it …they won’t come”!
- Easily accessible, psychologically safe “reach-in” services.
- Institutional leadership accountable for well-being.

Helping Our Workforce Heal



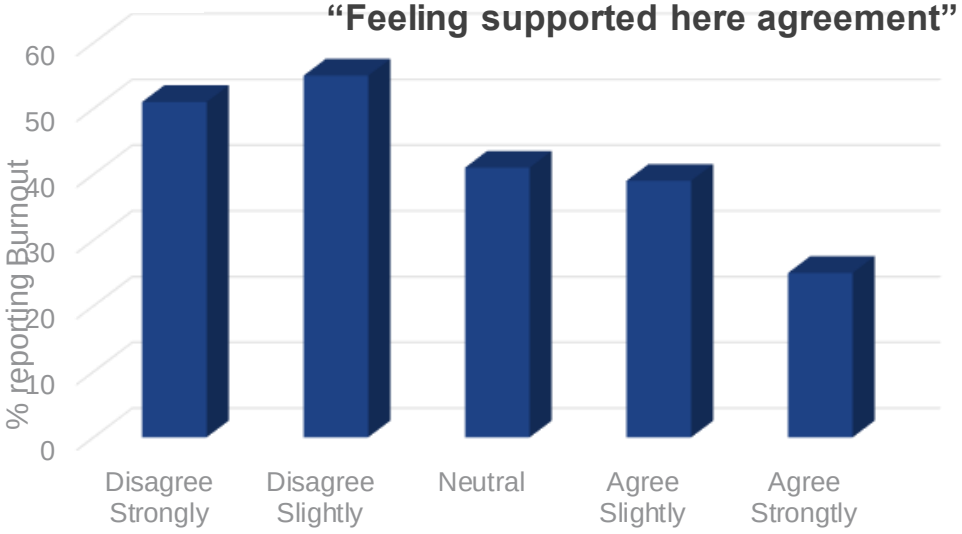
The Joint Commission Journal on Quality and Patient Safety

Volume 47, Issue 5, May 2021, Pages 306-312

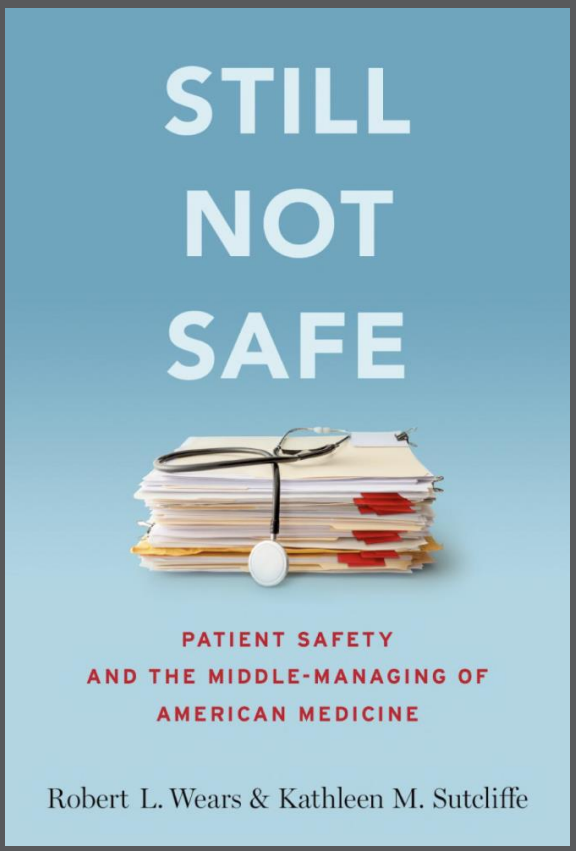
Perceptions of Institutional Support for “Second Victims” Are Associated with Safety Culture and Workforce Well-Being

J. Bryan Sexton PhD (is Associate Professor, Department of Psychiatry, Duke University School of Medicine, and Director, Duke Center for Healthcare Safety and Quality, Duke University Health System, Durham, North Carolina.), Kathryn C. Adair PhD (is Assistant Director, Duke Center for Healthcare Safety and Quality.), Jochen Profit MD (is Associate Professor, Perinatal Epidemiology and Health Outcomes Research Unit, Division of Neonatology, Department of Pediatrics, Stanford University School of Medicine, and Lucile Packard Children's Hospital, Palo Alto, California.), Judy Milne RN (is Patient Safety Officer, Duke University Health System.), Marie McCulloh RN (is Patient Safety Officer, Duke University Health System.), Sue Scott PhD, RN (is Nurse Scientist, University of Missouri Health Care, Columbia, Missouri.), Allan Frankel MD (is Chief Executive Officer, Safe & Reliable Health Care, Evergreen, Colorado)

Does Feeling Supported Reduce Burnout?



- Research done by Brian Sexton at Duke
- Employees who indicated they felt supported by their organization, also reported less burnout
- 60% of nurses under age 25 and 57% of nurses 25-34 generally feel unsupported by their organization.
- Peer Support Programs Make A Difference

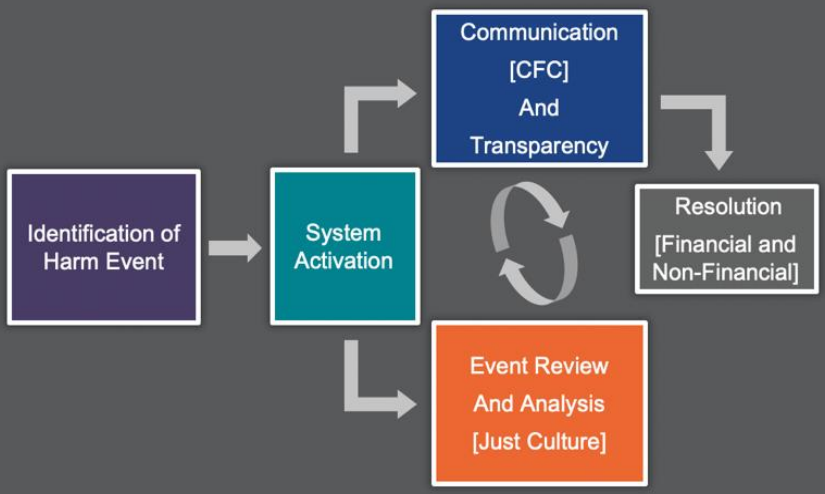


What's the data?

Patient Safety & Risk Mitigation

The Data

- Increase event reporting
- Initiate strong process improvements and redesign
- Reduce serious safety events
- Improve staff engagement, better retention, less turnover
- Decrease claims, lawsuits, legal expenses
- See a reduction in time of event to resolution



Questions