Community Memorial HEALTHCARE

The Impact of Apology and Disclosure:

Staff and Patient Healing

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"Our challenges with openness have significant consequences. Progress in improving health care safety and quality is slowed when a lack of openness impedes learning. It also compounds the suffering of patients who have been harmed by health care, heightens the distress of involved clinicians, and undermines the public trust."

Dr. Thomas Gallagher

The Power of Disclosure

Transparency and Disclosure Overview

What Our Patients Expect

- Tell What Happened
- Hold Accountability
- Offer a Sincere Apology
- How Will You Be Sure This Does Not Happen Again
- Let Us Be A Part of the Solution

Community Memorial Healthcare Journey

- Transparency is one of our core values
- It is the right thing to do
- It is considered best practice in patient safety
- It is a regulatory requirement
- It has always been a part of my practice
- There is support from Leadership and the Board
- There is support from the Insurance Carriers
- There are clear financial benefits

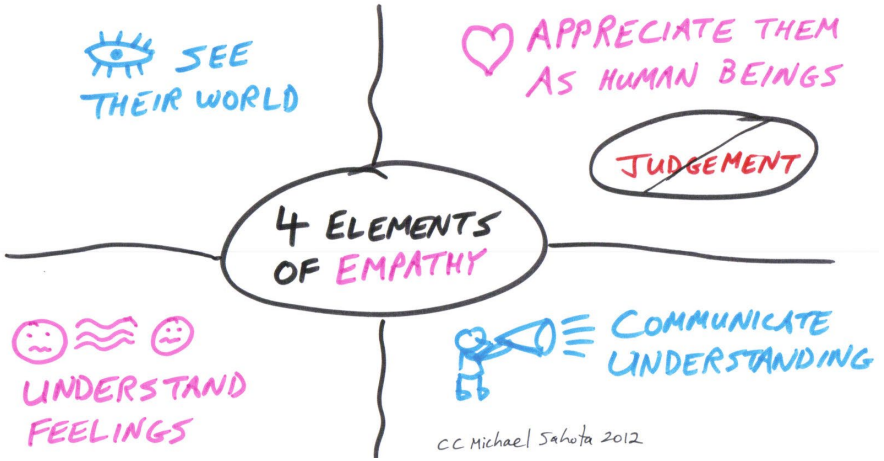
Case One - Portia

- 48 year old, failure to diagnose Guillen-Barre, wrongful death
  - 2020 – beginning of the Covid pandemic
  - Contacted husband to offer condolences and answer questions he may have:
  - *As we discussed, I do want to offer the opportunity to meet together to review Portia's care and answer questions you may have about her treatment. I will arrange the discussion to accommodate you and any family members that you want to participate in the meeting.*
  - *While I completely understand your desire to pursue legal options, it is our sincere desire to work openly and directly with you to manage this differently and respectfully. I can assure you that we will be fair and equitable while we work together to identity opportunities to improve.*
- Meeting with family: Risk Management, CEO, VP Quality, Physician Representative (Palliative Care)
- Settled with family with assistance of mediator

- *But how do we accomplish this process more consistently……*

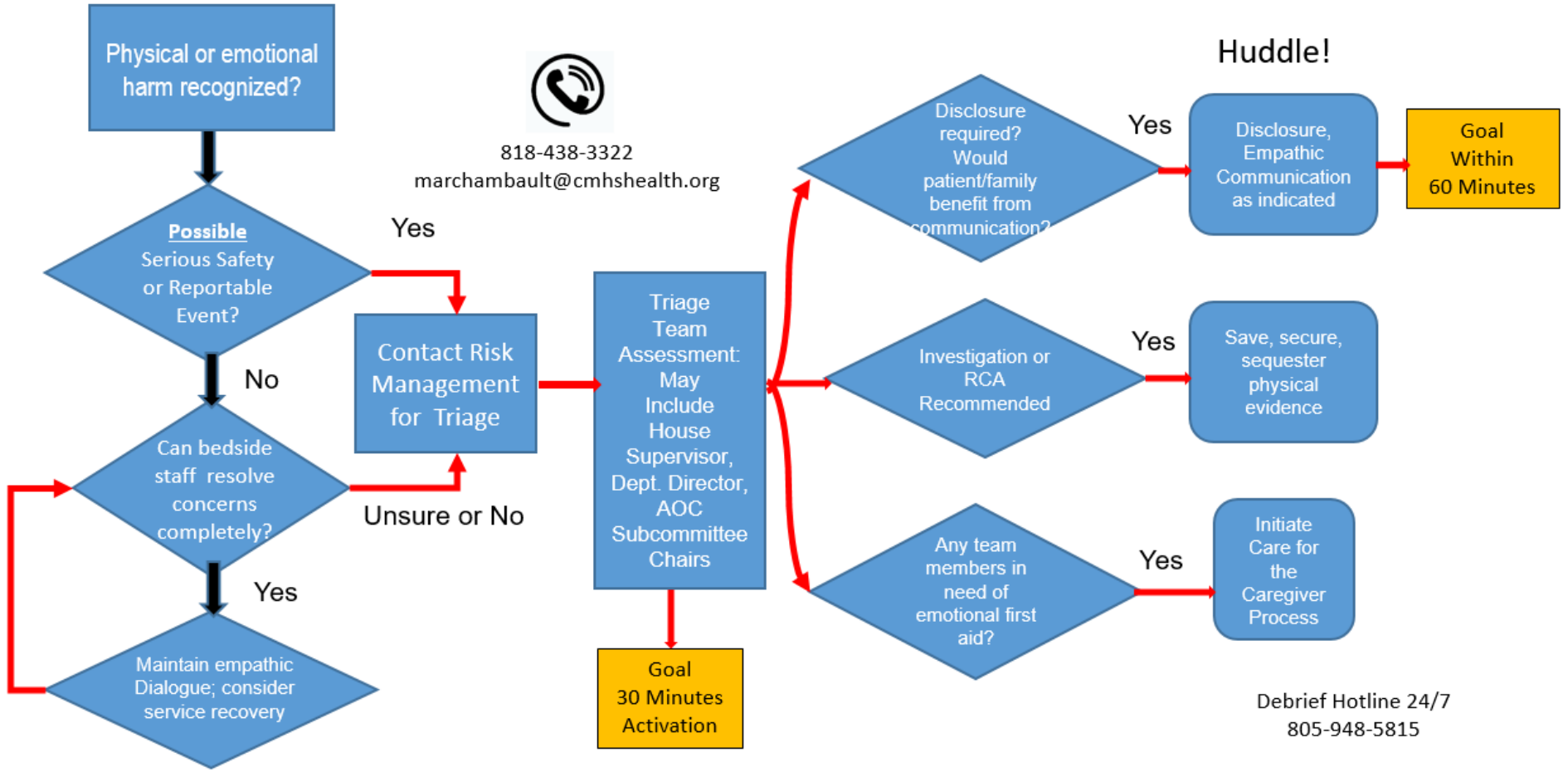
Community Memorial Healthcare Journey

- Create a Communication and Early Resolution Program
  - How do we reach out to the physicians, house supervisors, leadership 24/7
  - Include our process in our event reporting policy and procedure
  - Endorsed by our Board of Trustees
- Tap Into and Escalate the Debrief/Care for the Caregiver Team
  - Core group of trained clinicians
  - Coordinator of Patient Experience – Patient Advocate
- Training of Hospitalists and Nurse Leaders
  - Hospitalists' Quality Performance Incentive
  - Resident Orientation
  - Scheduled in person and online sessions
  - Dr. Tim McDonald and actors for simulation
  - Over a 12 month period



Community Memorial CANDOR

Trigger is HARM Event NOT Fault or Mistake

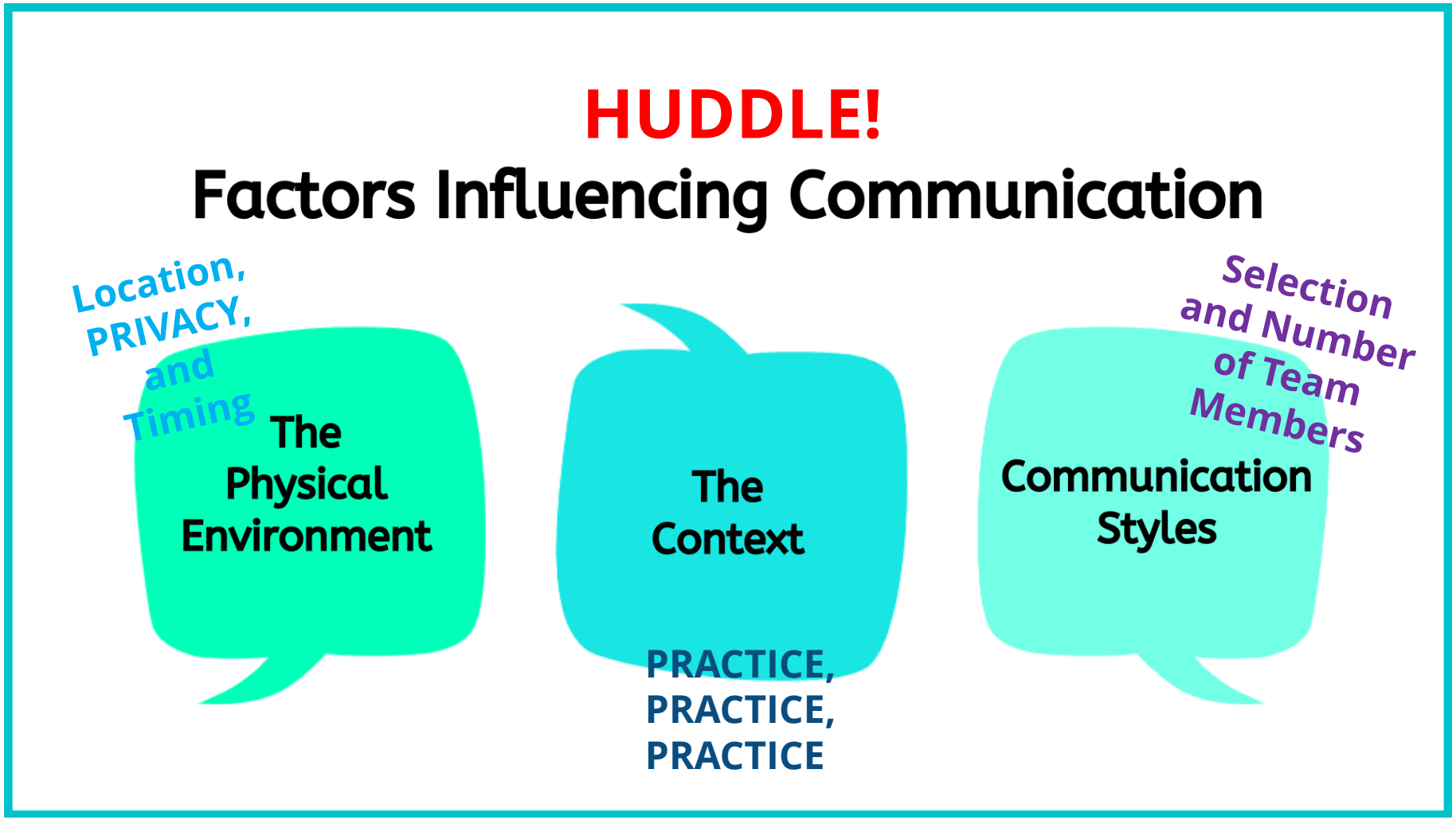


CANDOR Process

Initial Response Following recognition of an adverse event, the following key should be carried out:

- Immediately report the adverse event to the institution or organization (*within 30 minutes of the event's discovery*).
- Ensure the patient's immediate clinical needs related to the risk or adverse event are addressed.
- Ensure the immediate needs of the involved clinicians are addressed, as it is common for clinicians involved in an event that harmed a patient to experience acute distress.
- Engage the patient and family as soon as possible after the event's discovery in establishing priorities and expectations.
  - This includes listening to and communicating with the patient and family about what happened, how the patient's immediate needs are being addressed, what the patient should expect going forward, and unqualified expressions of empathy.
- Monitor and respond to the patient's and family's needs, questions and concerns and share factual (as differentiated from speculative) information about the event as it becomes available.
- Hold the patient's bills, pending outcome of the event analysis.

Communication Lessons Learned



MICRA Changes – Broaden Apology 2023

AB 35 SEC. 5.

Chapter 3 (commencing with Section 104340) is added to Part 2 of Division 103 of the Health and Safety Code, to read:

CHAPTER 3. Expressions of Sympathy, Benevolence, or Fault in Health Care 104340.

- (a) **Statements, writings, or benevolent gestures expressing sympathy, regret, a general sense of benevolence, or suggesting, reflecting, or accepting fault relating to the pain, suffering, or death of a person, or to an adverse patient safety event or unexpected health care outcome**, in relation to an act or omission to act in the provision of or failure to provide health care, and made to that person or the family or representative of that person ***prior to the filing of a lawsuit or demand for arbitration, shall be confidential, privileged, protected, not subject to subpoena, discovery, or disclosure, and shall not be used or admitted into evidence in any civil, administrative, regulatory, licensing, or disciplinary board, agency, or body action or proceeding, and shall not be used or admitted in relation to any sanction, penalty, or other liability, as evidence of an admission of liability or for any other purpose, and all such communications, whether verbal, electronic, in writing, or in any other form, shall also be entitled to the privileges and protections set forth in Sections 1119, 1152, 1157, and 1160 of the Evidence Code.***
- (b) For purposes of this section:
- (1) "Adverse patient safety event or unexpected health care outcome" means any event or condition identified in Section 2216.3 of the Business and Professions Code, Section 1279.1, and any act or omission to act by a health care provider in the rendering of professional services resulting in, alleged to have resulted in, or with the potential to result in injury or death to one or more persons and that is not the result of knowingly or purposefully harmful action.
- (2) "Benevolent gestures" means any action that conveys a sense of compassion or commiseration emanating from humane impulses.
- (3) "Family" means the spouse, domestic partner, parent, grandparent, stepparent, child, guardian, stepchild, grandchild, sibling, half-sibling, adopted children of a parent, a spouse's parent, and in-laws of an injured party.

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Patient Safety and Quality Improvement Activities

- Undertake a rigorous, human-factors-based event analysis that incorporates information and perspectives from the patient and family.
  - Assign counsel
  - Notify insurance carriers
  - Obtain external expert reviews
  - Complete internal peer review
  - Obtain professional association and evidenced-based literature and guidelines
  - Assess current policies and procedures
  - Interview staff, witnesses, patients
  - Complete Root Cause Analysis or Intensive Investigation with action plans
  - Establish value of the case – what is the liability
- Develop and implement plans for preventing recurrences of the event, based on human factors and Just Culture principles.

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Continued Patient Engagement and Movement Toward Resolution

- Hold a resolution discussion with the patient and family and share the final results of the event analysis and prevention plans.
  - Who should be there
  - Location
  - Recording?
  - Always start with introductions and invitation to learn more about the patient and their life
- Proactively offer fair financial and non-financial resolution to the patient and family for adverse events determined to be caused by unreasonable care, rather than waiting for the patient and family to request compensation.
  - Value of the case
  - Explain the action plan to avoid further mistakes, errors, or harm
- Educate patients or their families about their right to seek legal representation at any time.
  - Recommendations for mediators, plaintiff counsel
  - Settlement and release documents (attorney involvement)

Case 2 - Thomas

- Open heart surgery, upon arrival to the ICU it was discovered he had significant IV infiltration, resulting in compartment syndrome
- Immediate return to surgery
- Filet of arm for drainage
- Loss of muscle function and tone, scars
- Immediately notified by surgeon and nursing staff
- Visited several times prior to discharge
- Offered physical and occupational therapy and monetary compensation
  - “Changed his life”
  - Invited to be a member of our Patient and Family Advisory Council
- Lessons learned: visualization of IVs in surgery
  - Peripheral vs. Central Lines
  - Accountability

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Post-Event Dissemination of Patient Safety and Quality Improvement Lessons Learned

- Summarize the lessons learned with identifying information removed and disseminate throughout the organization.
  - Management Forums
  - Huddles
  - Board meetings
  - PowerPoint posters – bullet points
- Take steps to ensure wide distribution of lessons learned so other clinicians and institutions can prevent the same kinds of mistakes. Share with other healthcare institutions, professional associations, and stakeholder groups.

Case 3 – Alyssa and Patrick

- IVF pregnancy, admitted for induction
  - Very specific care plan, natural birth, working with Certified Nurse Midwife
- 24 hours of labor, 3 hours of pushing
  - Fetal monitor not concerning
- Ultimate C Section delivery
- Baby born deceased
- Immediate notification
- Debriefs scheduled for staff and physicians/CNMs
- Frequent visits/discussion with Alyssa and Patrick, requests for medical records
- External reviews, peer review, counsel advice
- Disclosure meeting: Patient Advocate, CNM, Medical Director, Nurse Manager, VP Quality
- Case settled within 3 months of event, minimal attorney involvement
  - Money will be used for additional IVF or attorney for adoption
  - We are on this journey with you
- Lessons Learned

CANDOR and the Future

But important gaps persist. What should the next generation of transparency in health care look like?

I have five recommendations:

- Implement a "transparency bundle"
  - Transparency practices after care breakdowns should also be taught and implemented as a bundle: communication between patients and providers, between providers and peers, between providers and institutions, and across organizations.
- Recognize that openness alone is insufficient
  - While openness has intrinsic value, its focus should be on advancing the higher goals of improved quality, safety, and health care value and developing trusting patient-provider relationships. Seen through this lens, openness is the first, but far from only, step in responding to care problems.
- Prioritize empathy and compassion when sharing information
  - Sharing information about a care problem with patients, families, peers, and the institution comes more naturally than responding to the emotions such situations evoke. The key first step clinicians can take towards implementing the transparency bundle is to improve their emotion-handling skills.
- Invest time, resources, and attention
  - Achieving the next generation of transparency practices requires significant investments both by organizations (policies and culture that are just and psychologically safe, training, systems and processes) and by individuals (awareness of resources supporting transparency, skills to approach these situations, and willingness to take action rather than look away), with leadership from the top.
- Apply improvement principles to transparency practices
  - Transparency is critical to health care quality and safety, but basic improvement strategies are infrequently applied to tracking and enhancing the practices of the transparency bundle. Measures related to CANDOR, as well as tools measuring clinicians' willingness to speak up, are in development, including a transparency dashboard.

– Dr. Thomas Gallagher

“Love is the most powerful force there is, because it has no limits.”

Albert Einstein