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California Hospital Patient Safety Organization

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Prioritizing Response to Serious Adverse Events

The Institute for Healthcare Improvement recently released an important document: "Respectful Management of Serious Clinical Adverse Events" (2nd ed). This is the first in a series of articles discussing crisis management.

The four hallmarks of a strong crisis response are immediacy, transparency, apology and accountability. When responding, the first priority is the patient and family, second frontline staff and then the organization.

Priority One: Patient and Family

In the event of an unanticipated patient outcome, there are certain key considerations identified by individual patients and organizational stories that facilities should enact.

- Honest communication to patient and family by a team of at least two staff persons, including a clinician who has a pre-established relationship with them
- Acknowledge their pain, make an empathetic statement ("I'm sorry this happened") and issue an apology after an appropriate assessment
- Perform a full clinical assessment of the patient
- Engage patient and family immediately in the investigation and invite to participate in some way in the root cause analysis, which increases RCA credibility
- Provide ongoing support to the patient and family; consider reimbursement for any out-of-pocket expenses
- Stay engaged to bring case to a respectful resolution
- Position the organization to never lose sight of the patient and family

An adverse event does not necessarily erode trust the patient has in the organization. The way an organization responds after such events can and often does. The following elements are offered for organizations to consider achieving the goal of never losing sight of the patient and family when responding to a clinical adverse event:

- Focus first on patient's immediate clinical needs while assembling the facts
- Communicate about the harm the patient experienced, state what happened, why it happened and what's being done to prevent it from happening again

Register Now for Must-Attend Annual Meeting Online at CHPSO.org

Accelerate patient safety initiatives at your hospital by joining your colleagues at CHPSO's Annual Meeting — Take a Stand for Patient Safety: Eliminate Preventable Harm — March 13, 2012 in Glendale. Nationally renowned experts (see article, page page 3) will share patient stories, case studies and critical elements to achieving a culture of safety. The program is designed for hospital executives; quality, risk and patient safety leaders; and physician and nurse leaders.

Participants will learn strategies to engage senior leadership and physicians, use data to target actions, improve processes at the front line, encourage out-of-the box ideas from staff and increase funding. Speakers will answer questions, as well as facilitate a CEO roundtable discussion.

Patient safety is not only a moral and business imperative, but also an area of focus that is mandating changes. Beginning next year, laws will require hospitals with high admission rates to participate in a patient safety organization. By 2015, all hospitals must participate in a PSO as a condition of certain insurance reimbursement.

CHPSO is committed to helping hospitals eliminate preventable harm. Collaboration is key to making this happen. Partners include the California Hospital Association, the Hospital Association of San Diego and Imperial Counties, the Hospital Association of Southern California and the Hospital Council of Northern California. Sponsors include the California HealthCare Foundation and Kaiser Permanente.

More information is at www.chpso.org/2012meeting.php. To register go to www.cvent.com/d/8cq8p2/4W.

- Appoint an appropriate staff member as a patient and family point of contact that is available 24 hours a days, 7 days a week

- Keep patient and family informed of new information about the event

- Engage patient's extended care team, including patient's primary care physician

- Never let patient and family encounter excuses, a dead end, emotional distance, or inappropriate body language

- Ensure that all communications are culturally and linguistically appropriate

- Address any concerns patient and family have as soon as possible

Caregivers, patients and others agree that disclosure is the right thing to do. Questions persist about the definition and elements of an appropriate apology. At a minimum, the apology process has four components:

- Acknowledgement of the offense

- The explanation

- Various attitudes

- Behaviors including remorse, shame, humility and sincerity

According to G.K. Chesterton, "A stiff apology is a second insult…the injured party does not want to be compensated because he was wronged; he wants to be healed because he has been hurt." Research indicates that disclosure of adverse events is often associated with higher ratings of quality by patients and a drop in malpractice suits. Mediation and ombudsman programs can be helpful in four ways: bringing a case through to resolution, learning through helping to manage the event, offering a compassionate organizational response in a respectful manner and discovering what patients and families truly need.

Priority Two: Frontline Staff

Serious harm to a patient is the last thing that health care staff wants to happen in the delivery of care. There is significant research on the short and long-term toll these events can have on those involved. Key considerations in the aftermath of an event are:

- Provide on-the-spot coaching to staff involved in the event as they prepare for emphatic communication, disclosure of the event, service recovery and reimbursement

- Provide ongoing support to clinicians and team at the front line of harm; determine if they are safely able to return to providing care; and offer for the CEO to meet with the frontline staff

- Invite frontline staff to participate in the RCA; at a minimum, be interviewed as part of the RCA

- Actively involve staff members to bring case to resolution

- Ensure mechanisms are in place for learning and healing across the organization

- Never lose sight of the staff at the front line of harm

Elements to consider when responding to adverse events:

- Appropriate accountability

- Send clear message of support to all staff involved

- Establish and practice principles of a fair and just culture

- Appoint trained staff member who staff involved in the event can contact 24/7

- Offer support through Employee Assistance Programs and peer support groups

Research indicates that disclosure is met with approval and relief on the part of the health professionals. Mitigation requires a fair and just culture with supporting policies and practices and appropriate levels of individual and shared accountability. James Reason's Incident Decision Tree can be helpful in getting to this fair and just culture.

Priority Three: Organization

Serious harm can place an organization in significant crisis and can lead to reputational risk. On the other hand, it can result in enhanced community positioning based on respectful, effective crisis management. Key considerations in the aftermath of an event are:

- Visible CEO

- Issue call to action grounded in values, integrity and doing the right thing

Subscription service: www.chpso.org/lists/
Questions or comments: Rory Jaffe, MD MBA rjaffe@chpso.org

- Activate Crisis management team under strong executive leader with clear chain of command
- Notify Board of Trustees
- Activate RCA immediately
- Prepare careful and rapid internal and external communications immediately
- Provide clear understanding of who can make what promises to patients, family members and staff

The organization and its leadership must never lose sight of the patient, family, staff and community when responding to serious clinical adverse events. Respectful management demands time and attention over long periods. Suggested actions include remembering patients and family on major holidays or birthdays or checking with patient when case is seemingly lost in litigation. Hospital leaders should meet with staff involved in events as the case goes to trial.

— Bobbie Dietz, bdietz@chpso.org

References

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The Incident Decision Tree: Information and Advice on Use. *National Health Service National Patient Safety Agency*; 2003. Available at: www.chpso.org/just/IDTadvice2003.pdf.

New Director Operations and Communications

Frances Sutz Brown has joined the CHPSO staff as operations and communications director. She brings in-depth knowledge of health care issues and an extensive background in marketing communications. She spent ten years with the California Hospital Association as director of publishing, editor of CHA News and assistant director of public affairs. Most recently she worked as a consultant, helping organizations develop and implement marketing communications strategies. Contact her at fsutzbrown@chpso.org or 916.552.7598.

CHPSO Membership Free for CHA Member Hospitals

Is your hospital a CHPSO member? The Patient Safety Act extends legal protection to a PSO to facilitate the collection of a wide range of data from many organizations. CHPSO is your premier resource for proactive patient safety information. The benefits of participation in CHPSO are enhanced by integration and coordination with the Regional Hospital Association collaboratives. Contact Rory Jaffe at rjaffe@chpso.org or 916.552.7568 for more information.

Leading safety experts to speak at CHPSO Annual Meeting

Speakers at CHPSO's March 13, 2012 Annual Meeting in Glendale are among the country's top leaders in patient safety. CHPSO is excited to bring the following experts together for an engaging and productive program.

- James Bagian, MD, director of the Center for Healthcare Engineering and Patient Safety at the University of Michigan. Dr. Bagian, a former NASA astronaut, was the founding director of the VA National Center for Patient Safety.
- Allan Frankel, MD, co-chief medical officer at Pascal Metrics. Dr. Frankel also is senior faculty at the Brigham and Women's Hospital Patient Safety Center of Excellence in Boston and the Institute for Healthcare Improvement.
- Dan Ford, Fellow of the American College of Healthcare Executives (FACHE). Ford speaks frequently on patient safety, leadership and executive search. He volunteers with several patient safety, patient/family-centered care and quality committees regionally, nationally and internationally.

Additional speakers include C. Duane Dauner, president/CEO of the California Hospital Association, and Rory Jaffe, MD MBA, executive director of CHPSO. For more information and to register, visit chpso.org. Also, see the article on page page 1 of this edition of *CHPSO Patient Safety News*.

— Frances Sutz Brown, fsutzbrown@chpso.org

Show Your Support for Patient Safety

Wear CHPSO buttons to proudly show your stance on patient safety. Two designs: "No Harm", and "Take a stand for patient safety" are now available (see images to the right). These may be ordered directly from the manufacturer by sending an e-mail to info@purebuttons.com. Include your shipping address, billing address, quantity ordered. and state if the buttons are needed by a specific date. Specify which button: "CHPSO Red" for the "No Harm" button, and "CHPSO Blue" for the "Take a stand..." button. The company will respond with the price, shipping cost, and payment information. To support our effort, the manufacturer is offering 10 percent off their retail price (include the discount code CHPSO2011 when ordering). Expedited processing is available for an additional charge. Their pricing tiers as of December 1 (before discount) for 2¼" buttons are:

Quantity at least	Price per button	Quantity at least	Price per button
50	$0.420	1,500	$0.249
100	$0.300	2,500	$0.230
250	$0.286	5,000	$0.200
500	$0.275	7,500	$0.190
750	$0.270	10,000	$0.180
1,000	$0.260	25,000	$0.178
1,250	$0.255		

Information needed for order:
Shipping address
Billing address
Quantity
Design (CHPSO Blue or CHPSO Red)
Discount code (CHPSO2011)
Date needed by (if expedited processing is requested)

About This Newsletter

CHPSO Patient Safety News provides lessons learned from reviews of patient-safety events and news of patient-safety activities in this state. We hope you will find it useful in your efforts to improve patient outcomes. This newsletter may be freely distributed in its original form. Copies of each newsletter are archived on the CHPSO website (www.chpso.org).

Prospective authors may submit articles to Rory Jaffe, MD, MBA: rjaffe@chpso.org, 916.552.7568. Typical articles will be brief — between 200 and 600 words. A completed publication agreement form must be submitted prior to publication.

Calendar

The following upcoming events are still open for enrollment. For more information or to enroll, use the contacts listed below.

December

9: *CAPSAC*: California Patient Safety Action Coalition meeting. Los Angeles.

12: *CHPSO*: Members Call. 10–11 AM

13: *SCPSC* (Southern California Patient Safety Collaborative): Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

13: *PSCSD&IC* (Patient Safety Council of San Diego & Imperial Counties): Lean Practitioner Course. San Diego.

13: *PSCSD&IC*: Sepsis/HAI Elimination. San Diego.

15: *PSCSD&IC*: Standardizing Dosing Limits. San Diego.

For further information on these events:

CAPSAC: John Keats John.Keats@CHW.edu or www.capsac.org

CHPSO: Rory Jaffe rjaffe@chpso.org

PSCSD&IC: Lindsey Wade lwade@hasdic.org

SCPSC: Julia Slininger jslininger@hasc.org