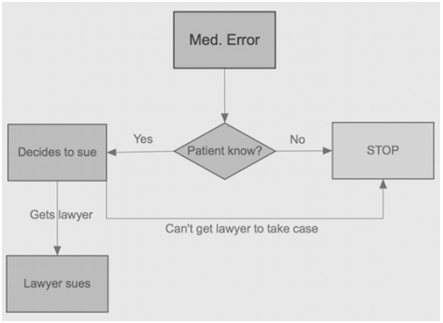
How Communication and Resolution Practices Can Affect Patient Safety

Steve Kraman, MD*

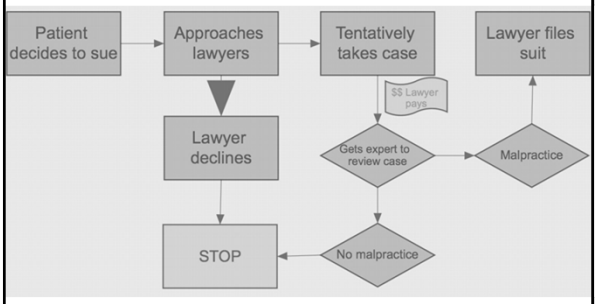
Professor, Pulmonary, Critical Care and Sleep Medicine, University of Kentucky.

*Former chief of staff, Lexington, VA Medical Center.

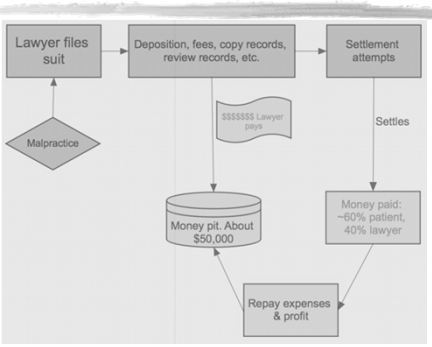
How do hospitals usually respond to patient injury due to medical errors?



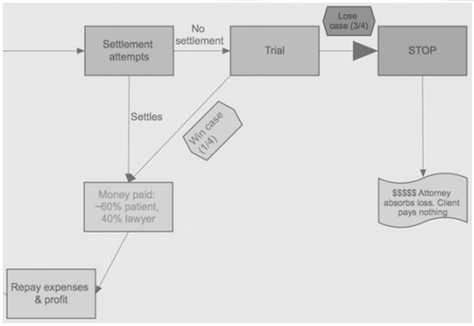
Suing for malpractice-1

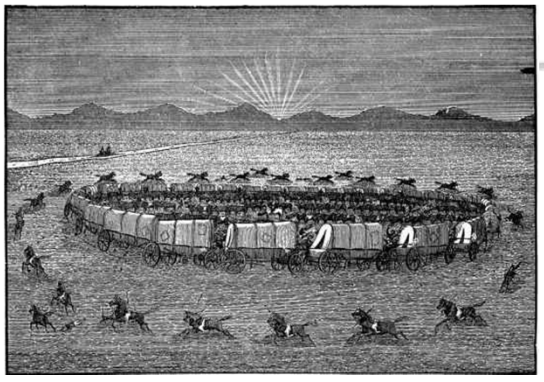


Suing for malpractice-2

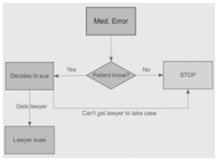


Suing for malpractice-3





Addressing the Systems Failures



To RM & patient safety

Attempt to identify and repair system weaknesses

- Investigate in private.
- Attorney-client work product.
- Peer review protections.
- Maintain security
- ~M&M

How do hospitals usually respond to patient injury due to medical errors?

- Investigate in private.
- Attorney-client work product.
- Peer review protections.
- Maintain security
- ~M&M

Outcome

- Effectiveness hampered by need for secrecy
- Dissemination of findings must be limited or done carefully to disassociate process changes from the original patient injury
- Tracking and trending must be held close to the vest to prevent data from falling into wrong hands
- All of this need for confidentiality extends the time course of investigation and resolution.

Why do they do this?

- ✓ 1. Fear of economic ruin
- ✓ 2. Fear of being the person who caused #1
- ✓ 3. Insurers call the shots
- ✓ 4. That's how everyone does it
- ✓ 5. Risk managers and defense attorneys earn money by the work that they do, not by the work that they avoid.

Consequences

- ✓ The legal consequences are expensive
- ✓ **t**alienates patients, their friends and relatives
- ✓ **t**inhibits the efficiency of patient safety programs
- ✓ **t**disenfranchises the clinical staff making it difficult for them to make peace with the errors they may make and greatly prolonging the time during which a lawsuit regarding a previous error could appear unexpectedly.

Doing it Better

- Has been spoken and written about for several years (including at last year's HealthWatch USA conference)
- The solution, now often called Communication and Resolution (C&R) is gaining ground and offers many advantages. The financial aspects have attracted the most attention but there are more important benefits:
- Patient safety improvement.

Case 1. A 72-year-old man became blind in one eye when a hospital employee gave his wife erroneous advice over the telephone. The risk management committee investigated the circumstances and uncovered several systems problems including a lack of protocols for use by the telephone care program personnel. The investigation included two outside peer reviews to assess the standard of care.

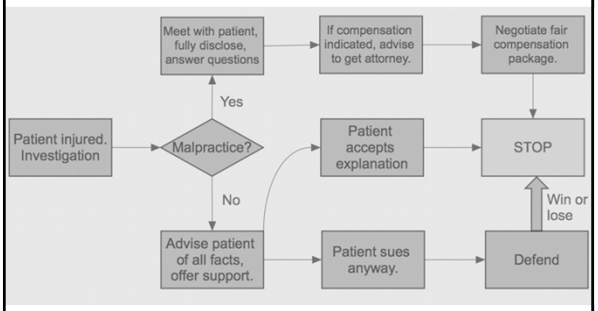
Case 1 (cont.) Once the committee agreed that there was liability, the patient and his wife were notified of the committee's findings. This included an apology and full acknowledgement of responsibility. In response, the patient and his wife stated that they had been aware that his blindness was in part the result of poor advice but said nothing because they feared the husband would lose his VA medical care benefits if they had complained. A settlement was negotiated with the patient's attorney within a few months.

Case 1 (cont.) Within a few weeks, the nurse phone-in service was reorganized and expanded to include procedures for specific complaints.

Outline of a Better Risk Management/ Patient Safety Program

- Knowledge of what's going on
- Effective, timely investigations of incidents
- Maintenance of staff confidence
- Process improvements
- Voluntary, proactive, negotiated fair compensation of injured patients
  - *Facility ethics should mirror medical ethics*

Communication & Resolution



Addressing the Systems Failures

patient safety

Identify and repair system weaknesses

- Investigate and disseminate findings. Track & trend
- Attorney-client work product & peer review protections only as they pertain to individual employees and patients.
- Strict security not needed as there is no residual fear of litigation
- M&M encouraged.

Necessary Components

- Learn about potentially negligent or accidental incidents involving patients in the facility
- Rapidly investigate these incidents
- Involve and support practitioners who have erred
- Fully disclose to affected patients/NOK. Negotiate fair compensation if indicated.
- Never settle nuisance claims
- Be open about the RM/PS program. It shows how you are doing things right.

Getting Buy-in

Getting Buy-in

EXCERPT FROM VAMC MEMORANDUM 00-1

PATIENT SAFETY
(INTEGRATED RISK MANAGEMENT PROGRAM)
Lexington VA Medical Center

PHILOSOPHY: Human error is inevitable, even among the most conscientious professionals practicing the highest standard of care. Identification and reporting of adverse events, including those that result from practitioner error, are critical to our efforts to continuously improve patient safety. Likewise, medical managers have a duty to: (a) recognize the inevitability of human error and attempt to design systems that make such error less likely; and (b) avoid punitive reactions to honest errors.

POLICY: Key components of the patient safety/risk management policy and approach are:

a. All employees and practitioners are responsible for fully cooperating in efforts to improve patient safety and eradicate potential risks. This includes the reporting of events which result in actual or potential injury to a patient.

➢Thanks for your attention