Opportunities to Engage Patients and Families in Addressing and Communicating about Serious Safety Events

Hospital Improvement Innovation Network (HIIN) PFE Learning Event

July 11, 2019
Welcome and Roll Call

Welcome back!

Who is in the room?

Tom Workman, PhD
Senior Advisor, PFEC
Today’s Agenda

Today’s Speakers:
• Barbara Pelletreau, Senior Vice President, Patient Safety, Dignity Health
• Victor Waters, MD, CMO, St. Bernardines Medical Center
• Dan Ford, Independent Patient Advocate

Discussion
• Everyone!

Moving Forward in Action
• Tom Workman, PFEC
Barbara Pelletreau
Senior Vice President, Patient Safety
Dignity Health
Spreading CANDOR

Barbara Pelletreau
Senior Vice President, Patient Safety
CANDOR is…

• Communication and Optimal Resolution
• A dynamic toolkit published in May 2016 by AHRQ
• Replacement for traditional “delay, deny, and defend” to harm events

CANDOR is…

A comprehensive, principled and systematic approach to the prevention and response to patient harm

• Provide effective communication rapidly following all serious harm events
• Apologize and fairly and rapidly resolve all cases of inappropriate care
• Learn from our mistakes
• Support patient, families and care givers throughout
# The Paradigm Shift

<table>
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<th>Category</th>
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| 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 support                                              |
| Resolution             | • from having to “fight for it”                                    |
|                        | • to early offer                                                    |
CANDOR Flow

1. Identification of CANDOR Event
2. CANDOR System Activation
3. Response and Disclosure
4. Investigation and Analysis
5. Resolution
Defining CANDOR at Dignity Health

- *An unexpected event or set of circumstances occur that may have resulted in harm to a patient.*
- The Patient Communication Team or WeCare™ Team is activated at a hospital.
- It is the intention and commitment to communicate with the patient and family within an hour of the event, even when it is not clear what exactly happened.
- There is also the commitment for ongoing communications with the patient and family as additional factual information is learned.
10 Steps for Adoption – System Level

1. Board presentation
2. Leadership presentation
3. Claims discussion
4. Multi-disciplinary trainings
5. Establish PCT Team
6. Track CANDOR events
7. Establish process hold bills
8. Share CANDOR events
9. Establish “life-lines”
10. Share results

1,300 leaders trained
200 recorded events
100 physicians trained
100+ sessions
75% adopted
25% in progress
40 gap/needs analysis
4.5/5 ratings
CANDOR Training

Participants
• Providers
• Risk management
• Senior leadership
• Claims staff
• Legal counsel
• Clinical leads
• Insurers
• Patient safety

Components
• Communication
• Care for the Caregiver
• Event Reporting - Review
• Event Review
• Resolution

Workshop Design
• Interactive
• Simulation – Role Play
• Huddles – Table Top
• Case Reviews
• Inclusion of patients/families
Learn – Huddle – Debrief

Role - Play with Actors

Patient & Family
5 Steps to Declare Adoption - Hospital

1. Training leadership, managers, physician leaders
2. Establish Patient Communications Team
   - Chief Medical Officer
   - Chief Nursing Officer
   - Quality Director
   - Patient Safety Officer
3. Activate Patient Communications Team
4. Establish Care for the Caregiver
5. Present CANDOR to Medical Executive Committee and Board
Dr. Victor Waters

Victor Waters, M.D., J.D.
Chief Medical Officer
Saint Bernardine Medical Center
Hospital Perspective
Victor Waters, MD
Chief Medical Officer
St. Bernardine Medical Center
Define success

- CMO trained and leads CANDOR
- 26 multi-disciplinary staff trained
- Physician champions identified
- Positive response from all
- Adoption of WeCare™
- Immediate response crucial
Key Learnings

- Training in empathy and showing emotional connection is invaluable
- Physician leader is essential to provide answers to medical questions
- All feel supported emotionally, mitigate burnout
- Opportunity for closure
- Opportunity for learnings and improvement
Physicians’ Comments

... In the era of physician burnout and escalating malpractice costs, the CANDOR process provides us with a meaningful and positive way to address adverse events.

... The CANDOR program has brought together our hospital - nurses, physicians, and administration - to collaborate and communicate as a team when an unexpected clinical event occurs. It has helped us to focus on doing the right thing for patients and their families, inspiring us to communicate early and openly with those impacted.

... I believe in compassionate care and work hard at practicing that. But, CANDOR has helped me build the skills necessary to be compassionate effectively, and to believe in the human side of medicine.
Tips for Success

✓ Always do what is right
✓ Identify key stakeholders to gain support
✓ Establish “lifelines” for real time guidance
✓ Bring in those who have “done it” to share
✓ Remove obstacles with diplomacy and facts
✓ Utilize “experts” to forward your agenda
✓ Culture eats strategy
✓ It is a journey
CANDOR is a comprehensive, principled, and systematic approach to the prevention and response to patient harm.
Publication: Summary of Studies and Results


Kachalia et al. **Liability claims and costs before and after implementation of medical error disclosure program.** *Ann Intern Med* 2010.


Kachalia et al. **Effects of a communication-and-resolution program on hospitals’ malpractice claims and costs.** *Health Affairs* 2018.

McDonald et al. **Implementing communication and resolution programs: Lessons learned from the first 200 hospitals.** *Journal of Patient Safety and Risk Management* 2018.
Patient Perspective

Dan Ford
Voluntary Patient Advocate
Diane Ford: Medical Error Story

• Background
  – Wife, mother, student, teacher

• Clinical Treatment (First 24 hours)
  – Two surgeries, overdose, brain damage

• Clinical Treatment (cont.)
  – Two additional surgeries; three more hospitalizations

• Post-operative Life
  – A world turned upside down; lives changed forever
Response to Family Questions
Patient Inclusion

• **18-Year Advocacy Journey**
  
  – Outspoken proponent of providers inviting the patient/family to participate in their root cause analysis (RCA): data gathering, discussion and action plan development.
  
  – Any hospital that purports to be transparent, but does not invite the patient/family to participate in their RCA, is disingenuous.
  
  – Dan’s article, “Case in Point” in Dorland’s Health (December, 2013), online journal, is a “hot potato.”
Barriers and Reticence to Patient Inclusion

- Barriers and reticence by providers and caregivers
  - Politics/power gradient and condescending attitudes
  - Providers decide that patient/family may not understand the language
  - “We don’t do things that way.” “Not done before.”
  - Expectations of finding patient involvement awkward and threatening
  - Fear of openness, candor, and emotions
Benefits of Patient and Family Inclusion

• It’s the right thing to do
• Contributes to healing for all
• Break down barriers and/or prevent barriers from growing, following sentinel events
• Contributes to learning: patient or family member is the common thread through patient experience
• Continuation of partnering started in physician office and through hospitalization
• Contributes to a just culture
• Demonstrates patient’s leadership when their suggestions for action plan are constructive
• Demonstrates caring when the patient/family can comfort a caregiver involved in the RCA
Patient Inclusion: The Beginning of Healing

“If done well, patient inclusion in the system analysis process will not only encourage more accurate investigative findings but can also help involved healthcare providers and patients and their families to begin the healing process in a positive and effective manner.”

Teri Zimmerman and Geri Amori
ASHRM Journal (2008)
Two options for RCA involvement:

- Voluntary patient safety advocate serves as a member of the RCA team
- Constructive input in the RCA process as well as clearing the way for inviting the harmed patient/family member to participate in the RCA process

And/Or

- The harmed patient/family member is invited to participate in their own RCA process, in all three steps.
- Invitation could be extended during/after the first step of investigation/data gathering.

Not all patient/family members should be invited and not all will accept.
Joy and Forgiveness

- Preventable harm can be messy and hurtful, and cause serious life and family changes.
- Possibly financially devastating situations
- Life changing and gut wrenching to clinicians
- Why not minimize this by inviting the patient/family to participate in their RCA process?
  - FORGIVENESS
    - Have direct and honest conversations with the clinicians involved about what happened,
    - And, discuss how it can be prevented in the future.
- That inclusion may bring **JOY** to all parties involved.
- The presence of the third party Voluntary Patient Advocate may help facilitate this.
Contact Information

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Rockford, MI (Grand Rapids Area)
Discussion

Use the chat box or phone to:
• Provide comments
• Ask a question, or
• share your story and lessons learned.
Stay Tuned for More from the PFEC

The monthly PFE Learning Event for August will take place on the **second Thursday of the month** from 1:00-2:00 p.m. ET.

Watch your inbox for information about the next PFE Learning Event on **August 8, 2019**!

Do you have a best practice or success story to share? Please let us know at [PFE@air.org](mailto:PFE@air.org).
Thank You!