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New Conference

Harms from Disrespect
The Neglected Preventable Harm

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Outcomes

1. Identify a framework for capturing, assessing, and tracking emotional harms from disrespect that utilizes existing institutional resources and processes.
2. Explore the foundational elements necessary to engage in the Practice of Respect, including patient-family engagement, proactive communication after adverse events, peer support, inter-professional respect, provider safety, and organizational structure.
3. Develop a roadmap for building towards the Practice of Respect, including the foundational elements, at your institution.

Raise Your Hand If…

- You have Patient Family Advisors working with you within your organization.
- You have a committee that focuses on the patient experience.
  - What is its relationship to the quality/safety committee structure?
- You feel that others in your organization recognize or understand the problems with the patient/family experience.

Case 1

An 85 year old man who is an inpatient in the hospital with pneumonia suffers a fall in the early evening. The team caring for him obtains x-rays and discovers he has fractured his hip. No one calls the family to let them know about the fall. The first notification to the surrogate decision maker (son) to let him know about the fall is from the orthopedic surgeon calling to get operative consent for repair of the broken hip. There had been no notification to the family about the fall or the subsequent x-rays. The family is very upset.

Case 2

A patient posts this on the hospital's Facebook page. "Ok… I have surgery scheduled today and the paperwork says check in at 5AM. I wake at 3:30AM to make the one hour drive from Cape Cod only to learn that one can never check in before 6AM?? The staff here states it is a little trick they do. Hope surgery doesn't have any little tricks or surprises!" Upon investigation, it's discovered that the surgeon's office staff has been telling patients to get there early as the traffic in Boston is terrible and a lot of patients scheduled for the first case of the day arrive late.

Case 3

A patient comes to the hospital for an elective surgical procedure on a Monday morning. He is sedated in the holding area and fully anesthetized in the operating room. It is then that the staff realize that the surgeon is not in the hospital that day.

The surgeon did not have a case on his calendar and was just returning from vacation later that day.

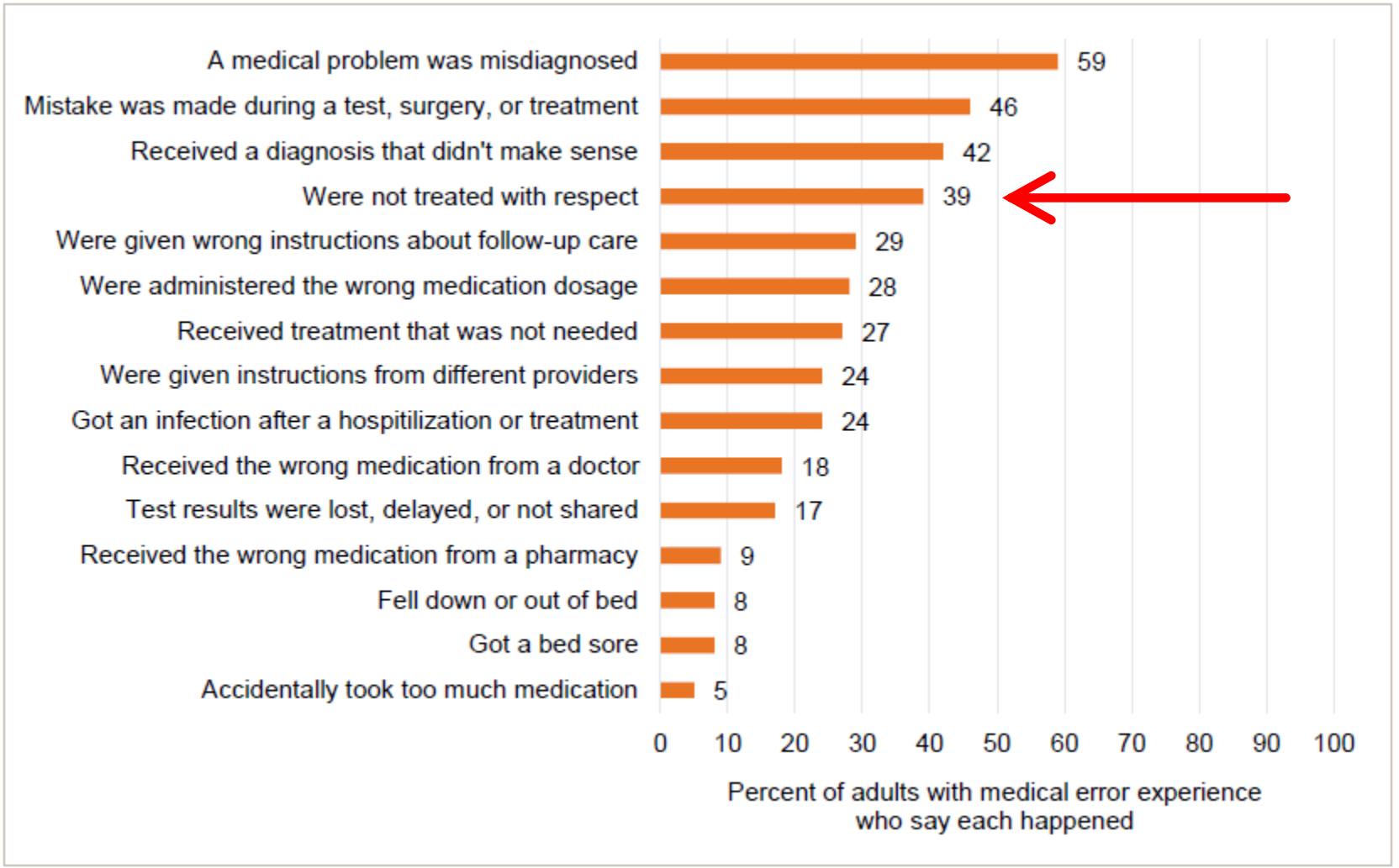
Case 4

A patient and her sister come to an appointment with an oncologist. The patient is greeted in the clinic and placed in the room by a medical assistant. Thirty-five (35) minutes later, the patient's sister comes out to ask about the delay in being seen. It is then discovered that her oncologist is not in the clinic that day. When the sister asks how this could happen, a staff member responds by saying "It's not my job to schedule appointments." The patient takes her care to another hospital.

Case 5

An inpatient being taken in for a procedure is asked to remove his wedding ring, which is a family heirloom that belonged to his now deceased father. A staff member takes the ring and says he will “lock it up.” When the patient awakens from his procedure no one remembers who took the ring, and it cannot be found. The heirloom is lost and never recovered.

Taking a New Perspective



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Taking a new perspective

- When asked about harm, patients emphasize the non-physical
  - Evidence suggests they may be equally as prevalent as physical harms
- Some patients seem to be at higher risk of non-physical harm
- Such harms can persist long after the inciting events
- Impacts extend beyond patients
  - Families
  - Health care professionals
  - Health care organizations
- Such harm can be treated with the same rigor we apply to physical harm
  - Utilize existing institutional resources and processes

Relationship between disrespect & non-physical harm

Many different professional and organizational behaviors can be perceived as disrespect

<u>Non-physical harm</u>
Emotional
Psychological
Socio-behavioral
Financial

<u>Physical harm</u>
Diagnostic error (Giardina et al. 2018)
Treatment-related problems

Taking a New Perspective

Harm can be…

- Physical
- Emotional, psychological, social, behavioral, financial

“Non-physical” harm is prevalent and matters

- We should treat such harm with the same rigor we apply to physical harm
  - Utilizing existing institutional resources and processes

Many ways to learn about where improvements are needed…

- Reportable measures
- Adverse event analysis
- Patient-family advisors

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Preventable Harm at BIDMC

In 2007, we stated a goal:

"eliminate preventable harm by January 1, 2012"

Preventable: standard of care was not met, or there are reasonable improvements that would decrease the likelihood of a similar future event

Spoiler alert…

…we didn't get to zero!

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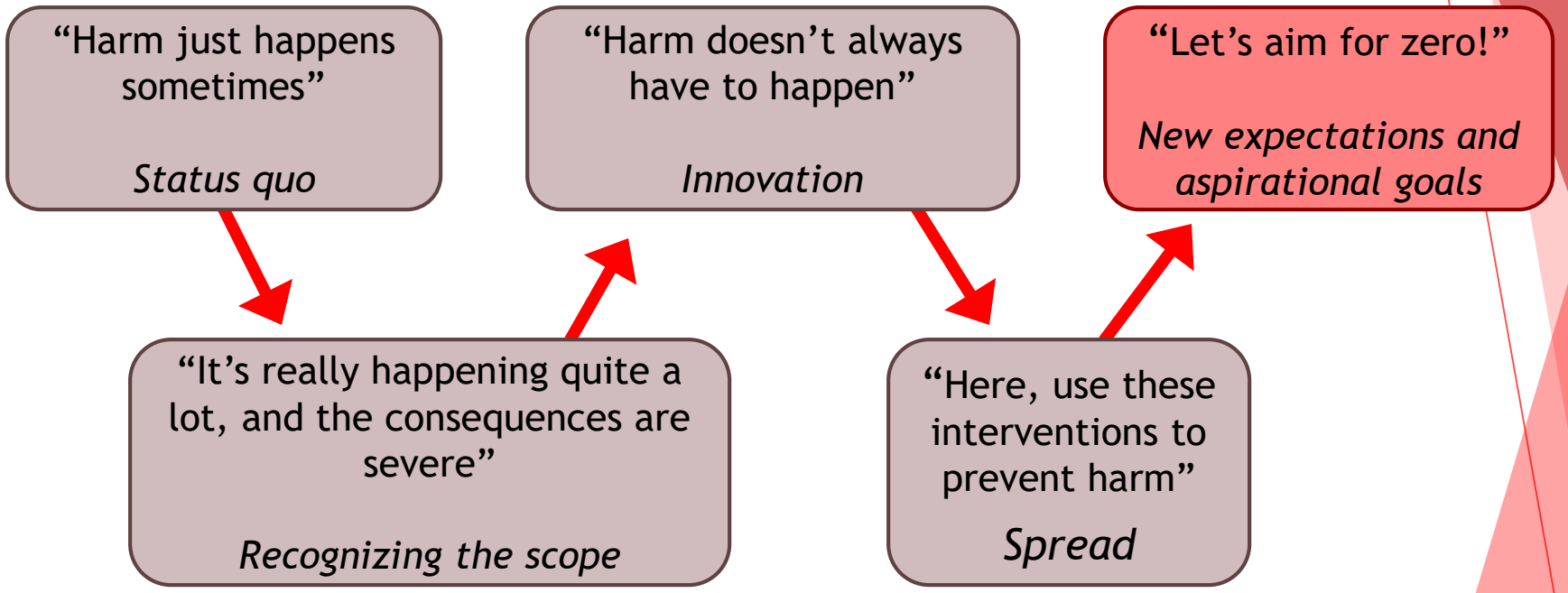
Considering the history of preventable physical harm e.g. CLABSIs



Supported by systems for identifying, capturing, analyzing, and discussing harm events

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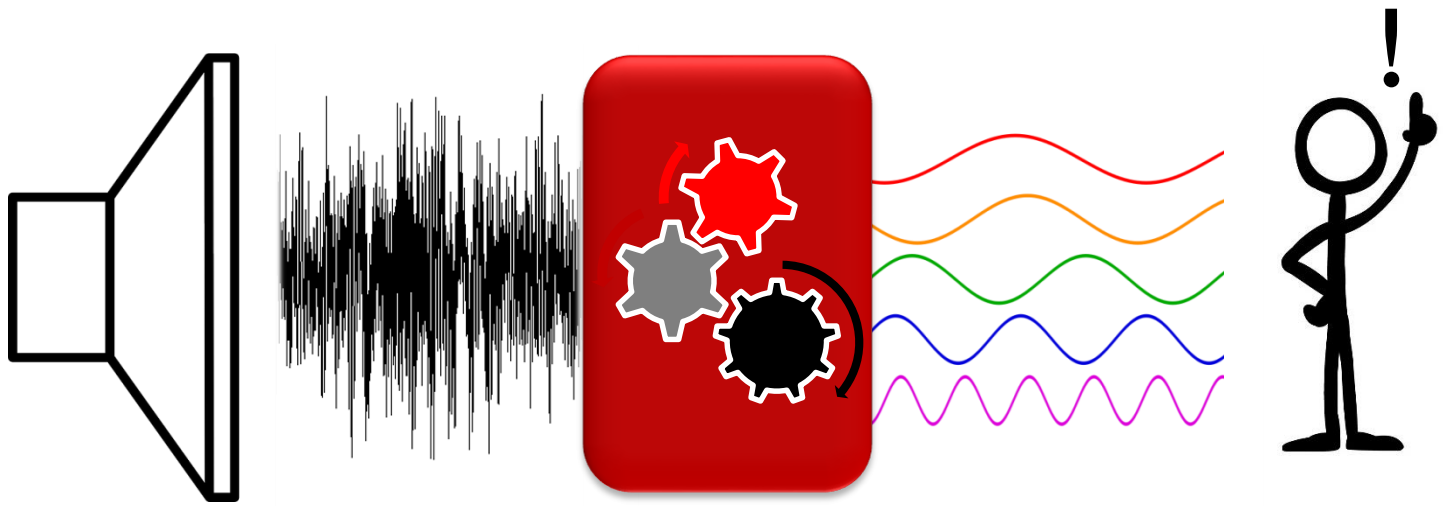
Experience with Physical Harm



	~7000	~150	43
# of incidents per year			Severe and “preventable”

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Why report individual events instead of rates?

Both are useful and important

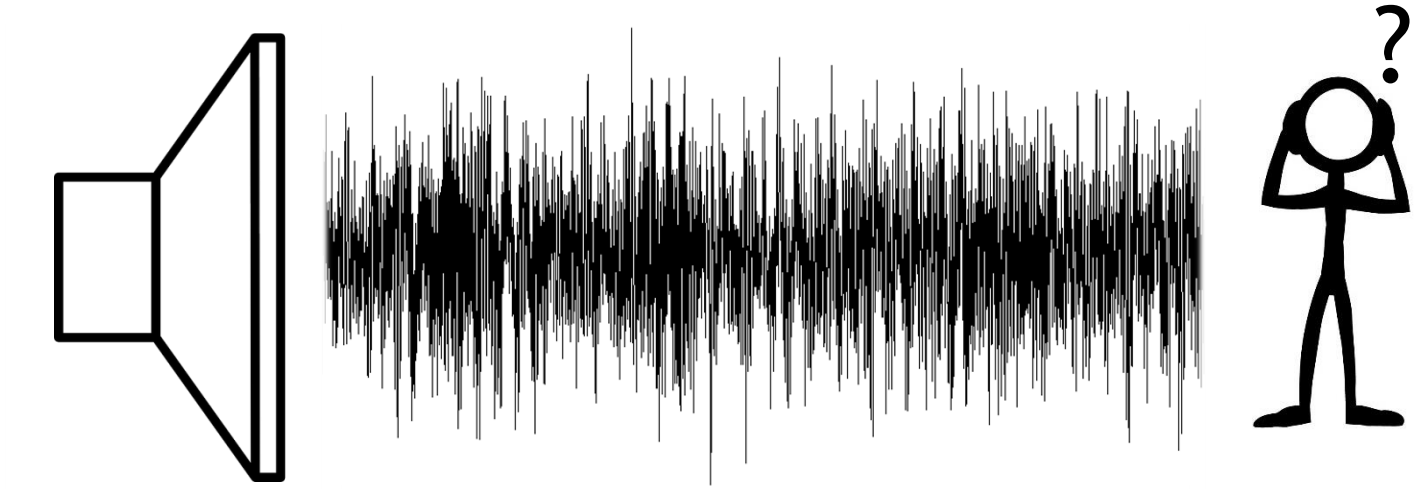
Stories about actual events are more engaging

- Tangible and aspirational

Rates require a numerator and a denominator

- The numerator is the count of individual events
- The denominator is anyone who was at risk – often hard to determine

Experience with Non-physical Harm



Patient Relations

"Noise"
~3,400 incidents reported each year

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Working Group

Patient Safety
Health Care Quality
Nursing
Hospital Medicine
Social Work
Palliative Care
Ethics Support Services
Interpreter Services
Communications
Volunteer Services
Community Benefits
Patient Care Assessment Committee Member
Performance Assessment and Regulatory Compliance
Patient-Family Advisors

Definitions

Dignity
Each person's intrinsic, unconditional value as a human

Respect
The actions that honor and acknowledge dignity

Learning about events

Calls/emails/letters to Patient Relations

Adverse event reports from staff

- Same system for physical harm
- Witnessed or second-hand

Reviewing events

Interdisciplinary group

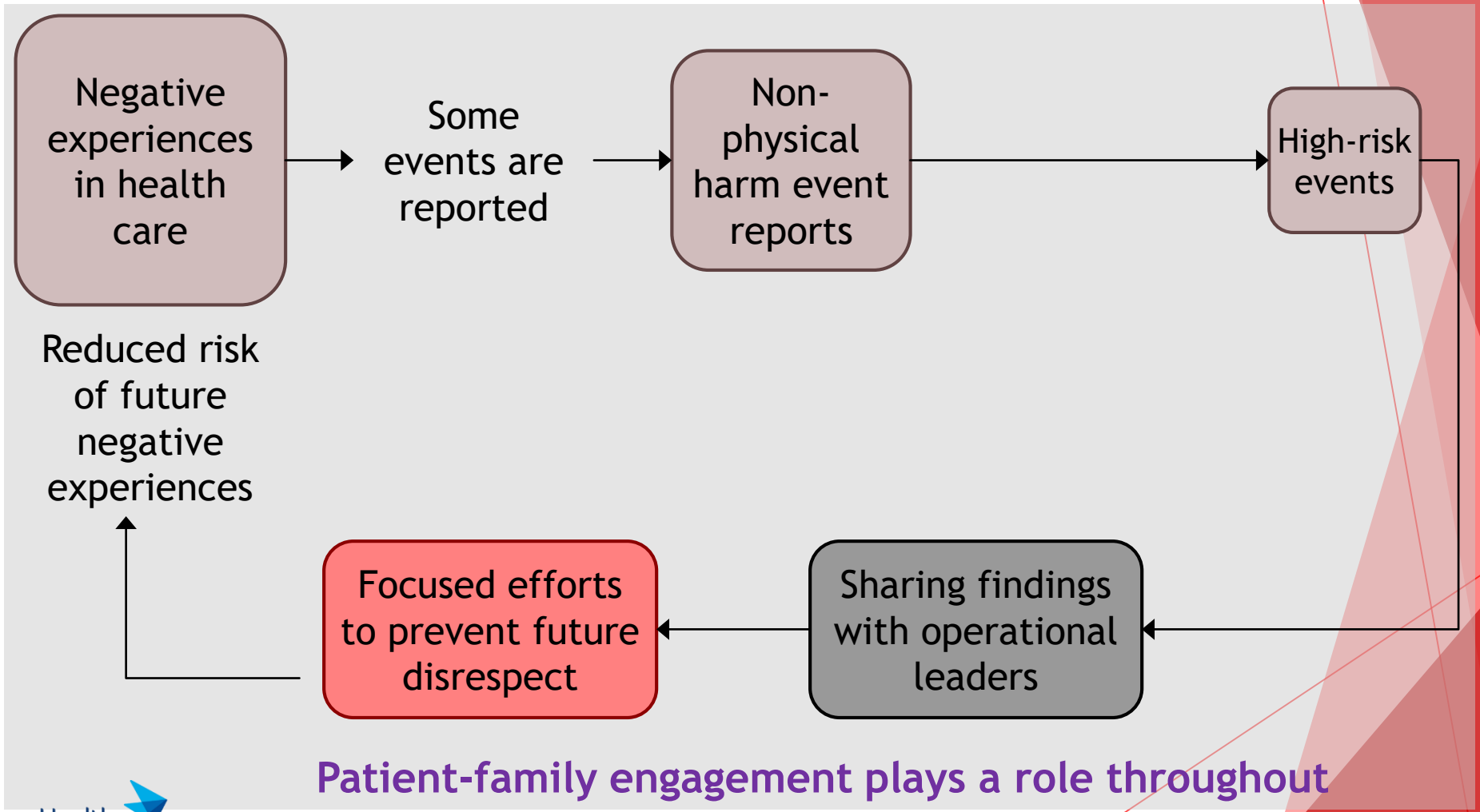
- Director of Patient Safety
- Patient Safety Coordinator
- Patient Relations specialist
- Patient Safety Project Manager

Initially independent, then all together

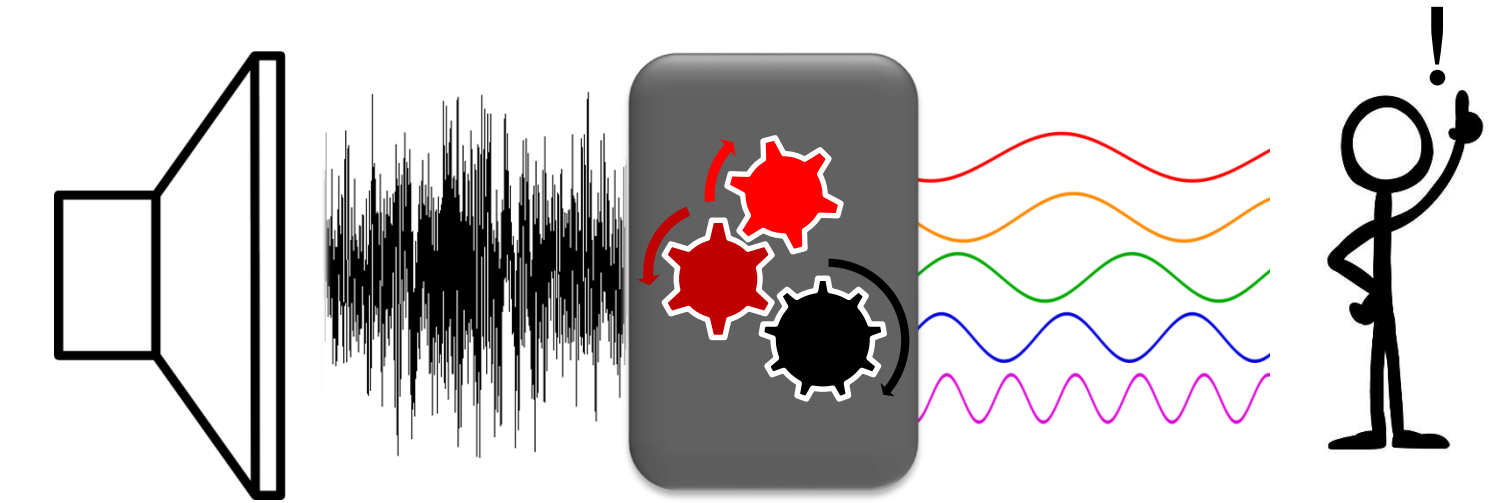
- Describe, categorize, prioritize

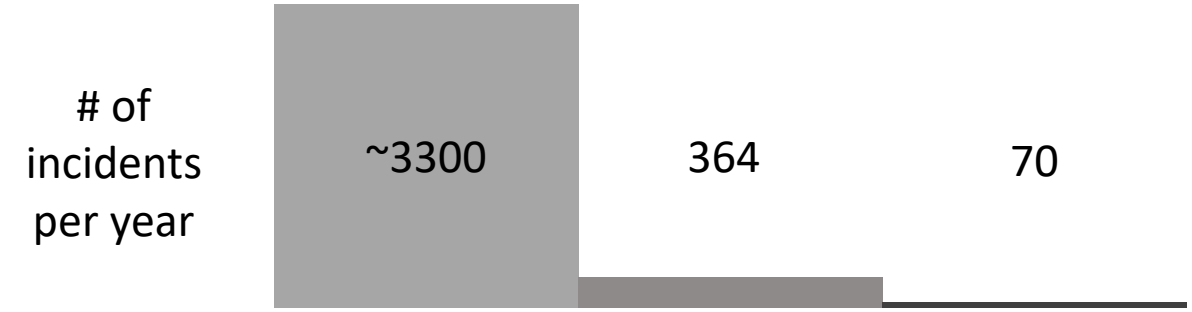
Incident analysis for non-physical harm

Using an RCA^2-like approach



Experience with Non-physical Harm





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Pivoting prospectively to prevent harm

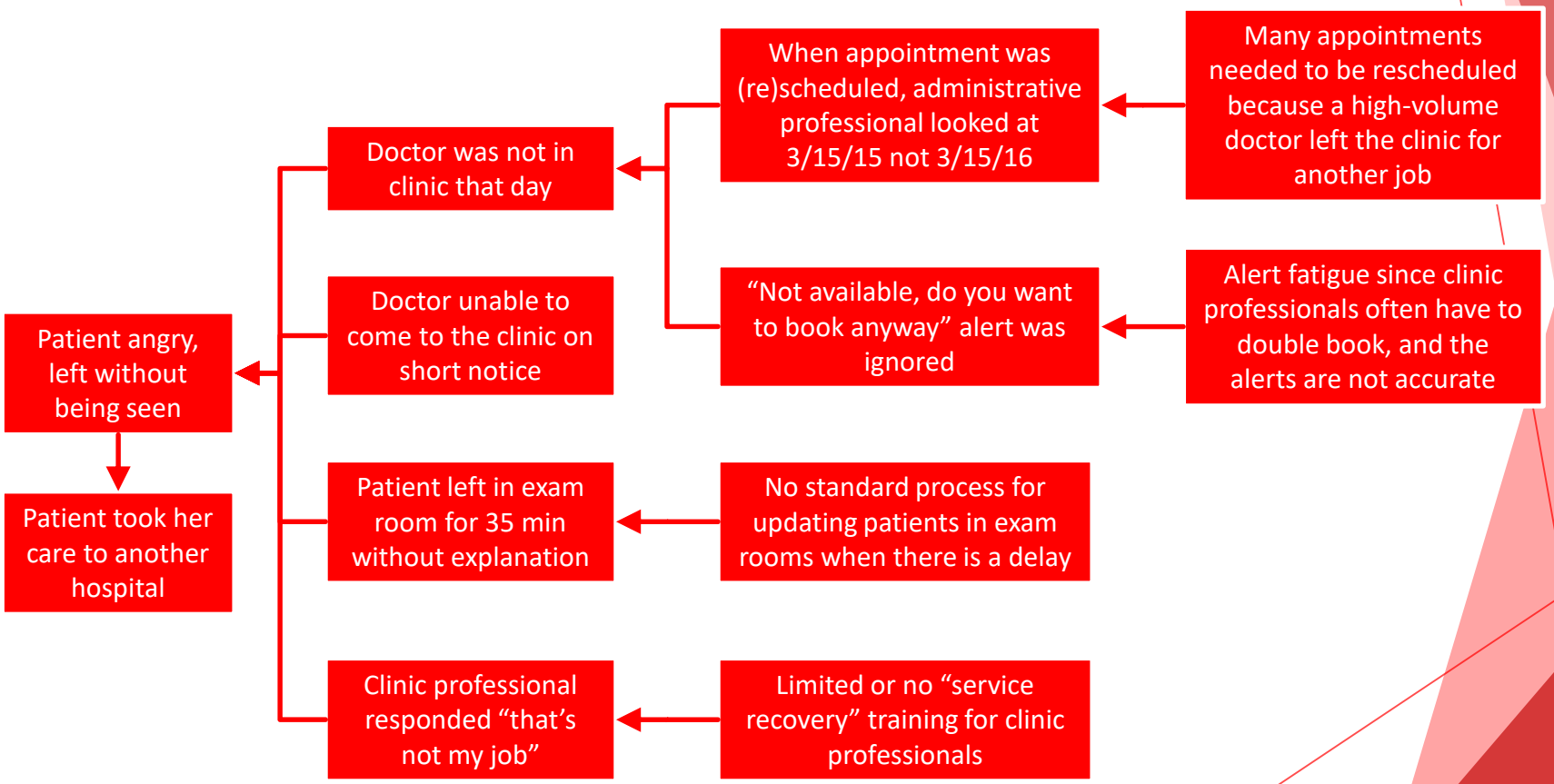
Cases are discussed at a series of meetings…

- **Departmental Quality Improvement (QI) Directors**
- **Board-level Quality and Safety Committee**
- **"Action Meeting"**
  - 1 hour, monthly
  - Quality/Safety and Operational leaders, and soon a Patient/Family Advisor
  - De-identifed, brief but comprehensive analyses of all high-risk cases since the last meeting
  - Ask ourselves:
    - *What themes are we seeing month-to-month?*
    - *Is there an existing related initiative that will help prevent similar future events, or do we need a new one?*

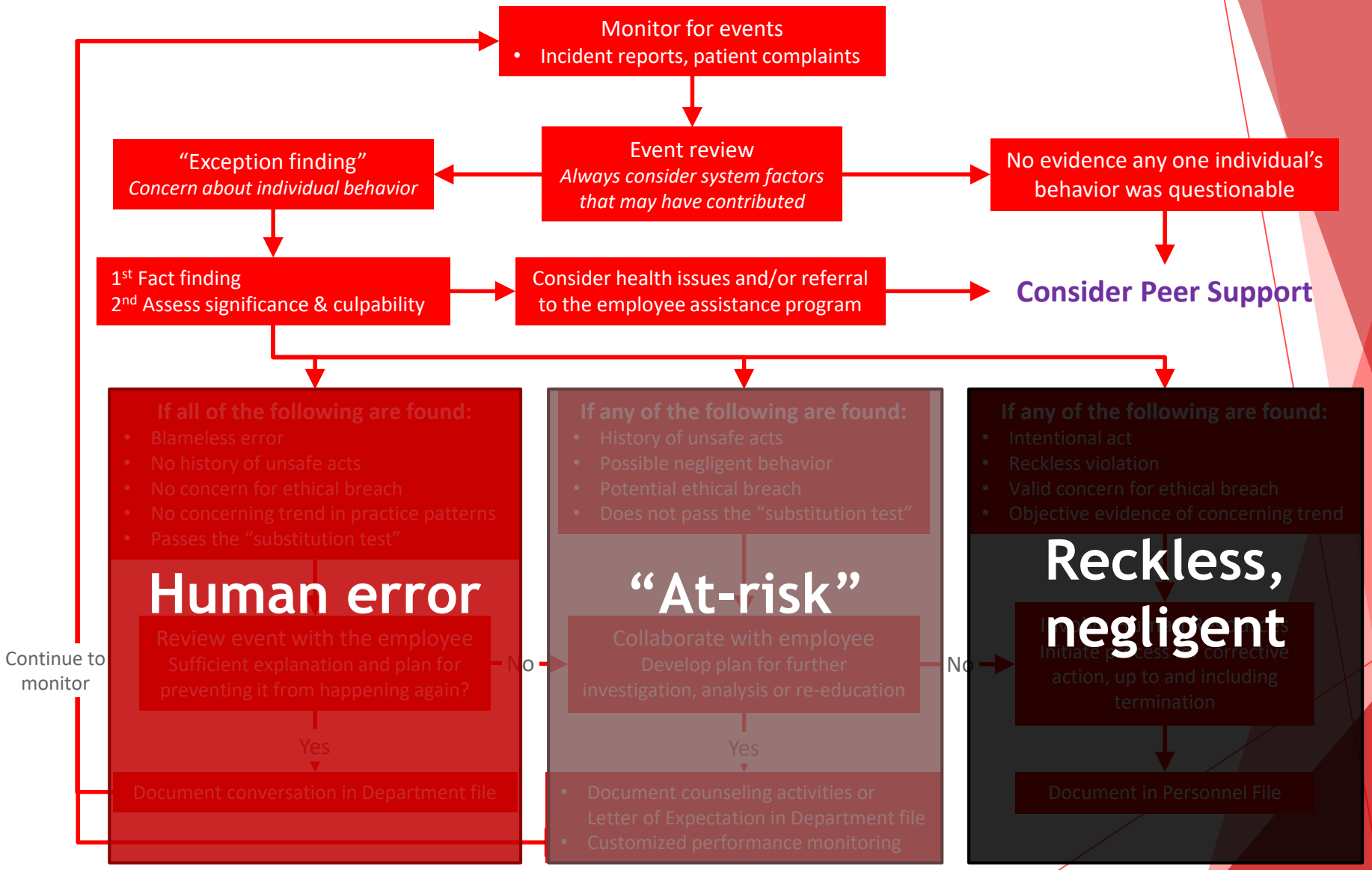
Case

Patient and her sister come to an appointment with an oncologist. The patient is greeted in the clinic and placed in the room by a medical assistant. 35 minutes later the patient's sister comes out to ask about the delay in being seen. It is then discovered that her oncologist is not in the hospital that day. When the sister asks how this could happen – a staff member responds by saying "It's not my job to schedule appointments." The patient takes her care to another hospital.

Analysis: Cause map



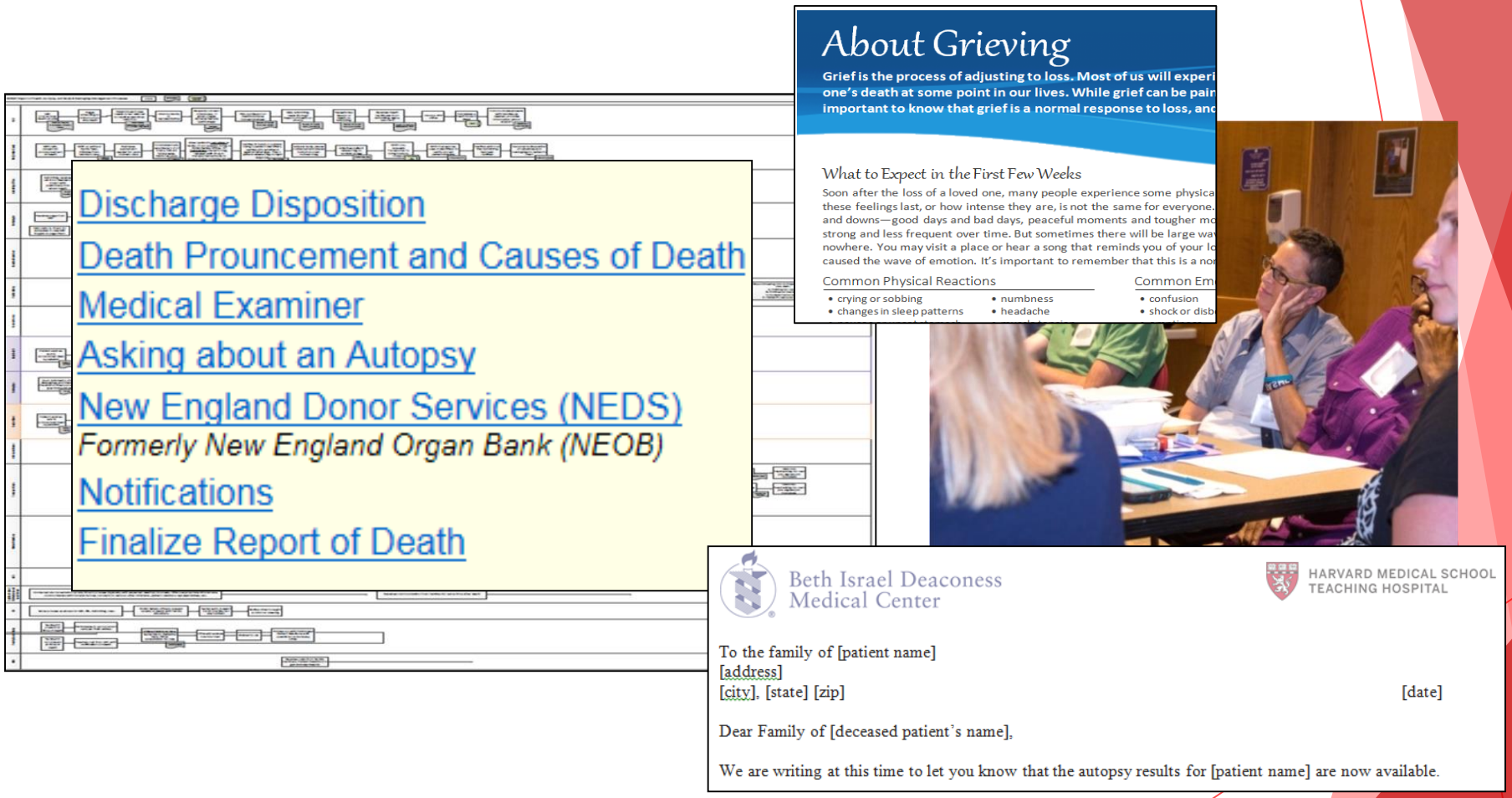
Guidelines for Fair and Just Decision Making After Adverse Events



Aspects of Care

- Clinic scheduling, waiting
- Introductions
  - Verbal and non-verbal
- Interpretation for limited-English proficient patients
- Disability accommodations
- Daily inpatient care
  - Washing, transferring, toileting
- Environment of care
  - Noise, cleanliness, etc.
- Pain management
  - Peri-procedural and otherwise
- Peri-procedure management
  - Informed consent, coordination
- Delirium/restraint related
- Privacy
  - Auditory/Information, physical
- Advance care planning
- Adverse event management
- Personal possessions
- Discharge
  - Coordination, timing
- Post-death
  - Timeliness of report of death, autopsy-related

Example: Care after death



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RESPECT & DIGNITY: PREVENTABLE HARM AT BIDMC

	Q1 FY18	Q2 FY18	Q3 FY18	Q4 FY18
Disrespectful Communication (Severe)				
Language-Related	0	2	0	0
Etiquette/Rudeness	1	2	0	3
Failure to Be Patient-Centered	0	0	0	0
Insensitivity	5	5	4	5
Uncoordinated Care	6	4	7	4
Prejudice or Discrimination That Affects Care	0	0	0	0
Minimization of Patient Concerns (Including Pain Management)	1	2	1	0
Failure to Conduct or Incorporate Advance Care Planning	0	0	0	0
Adverse Event-Related	0	0	0	0
Failure to Maintain an Environment That Preserves Dignity (Severe)				
Privacy Violation – Auditory/Information	1	2	0	0
Privacy Violation – Physical	1	0	0	1
Visitor Mismanagement	0	0	0	0
Prolonged Unclean Conditions – Environment	0	0	0	0
Prolonged Unclean Conditions – Personal	0	0	0	0
Failure to Provide Appropriate Care After Death (Severe)				
Body Mismanagement	0	0	0	1
Bereavement-Related	0	0	0	0
Failure to Care for Personal Possessions (Severe)	0	0	0	0
Other Disrespect Causing Harm to Dignity (Severe)	0	0	0	0
TOTAL SEVERE	15	17	12	14
TOTAL REVIEWED	67	40	45	46
PERCENT SEVERE	22%	43%	27%	30%

MUST HAVES…

- Commitment from the top. This is essential.
- A strong belief that this is important… it's not just a slogan.
- Appropriate resources, both financial and designated personnel

References

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Thank you!!

Questions?????