TEACHING IMPROVEMENT SCIENCE (TIS): WEEK 9

Today's Agenda

- Recap Week 8
- Error Disclosure
- Wisdom After Adversity
- Health Systems Project

Scenario 1: In-flight Emergency

Scenario 2: Outpatient Infusion Center

Scenario 3: Primary Care Clinic

Leadership	Communication	Situation Monitoring	Mutual Support
Brief	SBAR	Status of the:	Task Assistance
Huddle	Call-Out	Patient	Feedback
Debrief	Check-Back	Team members	Advocacy and assertion
	Handoff	Environment	CUS
		Progress toward goal	

Week	1	2	3	4	5
Dates	8/10- 8/31	9/7- 9/28	10/5- 10/26	11/2-11/23	11/30-12/21
Topic	Systems 1: Intro & Clinical Efficiency	Systems 2: Microsystems & Tools for Improvement	Systems 3: Macrosystems & SDoH	Value-Based Care (+30 min)	Data Science (+30 min)

Week	6	7	8	9	10	11
Dates	1/11-2/1	2/8-3/1	3/8-3/29	4/5-4/26	5/3-5/24	5/31-6/21
Topic	Diagnostic Errors (+60 min)	Systems Errors (RCA) (+60 min)	Teamwork Simulation (+60 min)	Error Disclosure & Second Victim (+60 min)	Narrative Medicine (+60 min)	Present HSPs!

Health System Projects Will Be Completed Across Weeks 4-11

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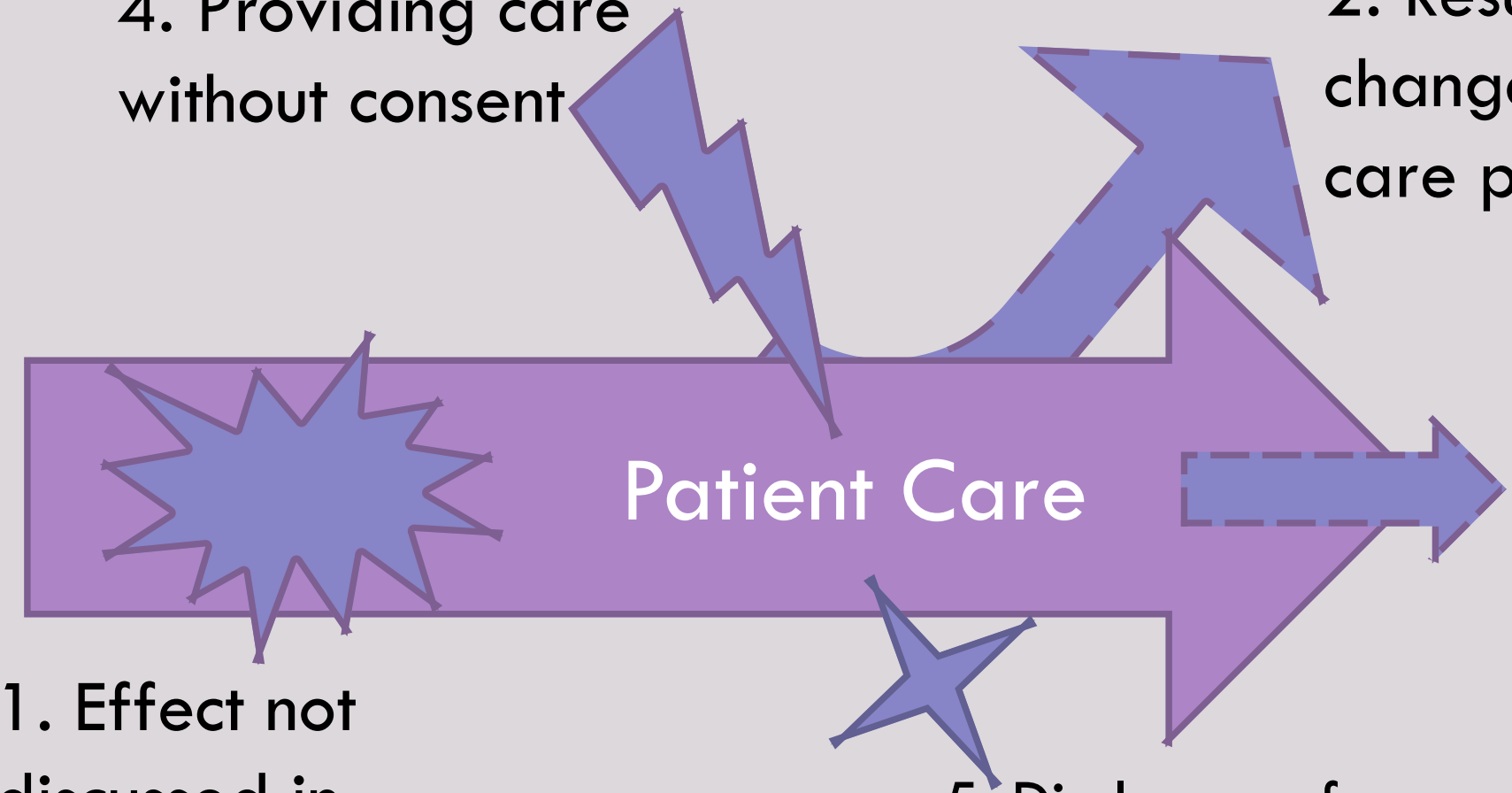
“If one should, and, under law, must, tell a patient about the risks of what *might* happen to them, don’t you think we should tell patients about what actually *did* happen to them?”

Overview of the CANDOR process; AHRQ.com

Disclosure: Common Questions

- When should it occur?
- What are the legalities/ethics?
- How should it happen?

When to Disclose:



4. Providing care without consent

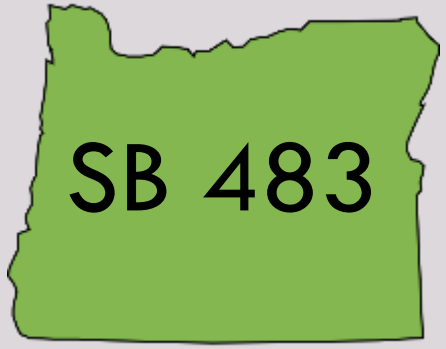
2. Results in change in care plan

3. New future risk to health status

1. Effect not discussed in advance as a risk

5. Disclosure of "close calls" is discretionary

Legalities and Ethics of Disclosure



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Mandated disclosure of "unanticipated medical outcomes"

Legal

- Joint Commission issued nationwide disclosure standard 2001
- Oregon has mandated disclosures of serious unanticipated outcomes to patients
- Apology laws

Ethics/Opinion

- AMA Opinion 8.12: It's our ethical obligation.
- Patients want to know, apologies increase patient satisfaction
- Disclosures with apologies and proactive offers of compensation reduce litigation rate and award amounts.

http://www.theoma.org/node/4781

Should we apologize?

- Per OHSU & VA policy…
  - ***YES:*** *"Do not take responsibility for an error if there has been none, but do give a compassionate explanation and empathy"*
    - If the error ***did not*** involve you… Apologize on behalf of the organization.
    - If the error ***did*** involve you… Apologize on behalf of yourself **AND** the organization.

- What about our legal risk?
  - *ORS 677.082*
    - "Any expression of regret or apology made by or on behalf of the person, the institution, the facility or other entity, including an expression of regret or apology that is made in writing, orally or by conduct, does not constitute an admission of liability."
    - It also says that you may not be examined by deposition for such apologies/expressions of regret.

The Ethical Argument for Disclosure

How to Disclose: Follow the 3-step plan

1. The team should **discuss** the error:
    - Acknowledge what happened in a blame-free environment.
    - Attempt to understand how & why the error occurred.
    - Debrief the emotional impact on the team.

2. The team **plans** the disclosure:
    - Discuss what/when/and by whom the disclosure will be conducted.
    - Anticipate patient questions that will need to be addressed.
    - Risk management might need to involved.

3. **Disclose** to the patient:
    - Inform the patient an adverse event occurred; outline:
        - What happened
        - Implications for the patient
    - Apologize and acknowledge responsibility
    - Update on plan actions and follow up
    - Plan to close the loop

What to say?

- Inform the patient an adverse event occurred
- What happened?
  - *Stick to the facts, do not speculate*
  - *Use easy to understand language*
- Implications for the patient?
  - *Now*
  - *Future*
- Apologize and acknowledge responsibility
- Update on planned actions
- Plan to close the loop

- "Something unexpected seems to have happened"
- "Here's what I know so far…"
- "This is what you can expect going forward"
- "I'm sorry"
- "To prevent this from happening again, we will…"
- "As we get more complete information we will make sure to keep you informed."

https://oregonpatientsafety.org/docs/resources/Disclosing_Unintended_Outcomes.pdf

Disclosure Practice

Scenario 1: In-flight Emergency

Scenario 2: Outpatient Infusion Center

Scenario 3: Primary Care Clinic


BREAK
(5')

Today's Agenda

- Recap Week 8
- Error Disclosure
- **Wisdom After Adversity**
- Health Systems Project

Wisdom After Adversity Coping with Medical Errors

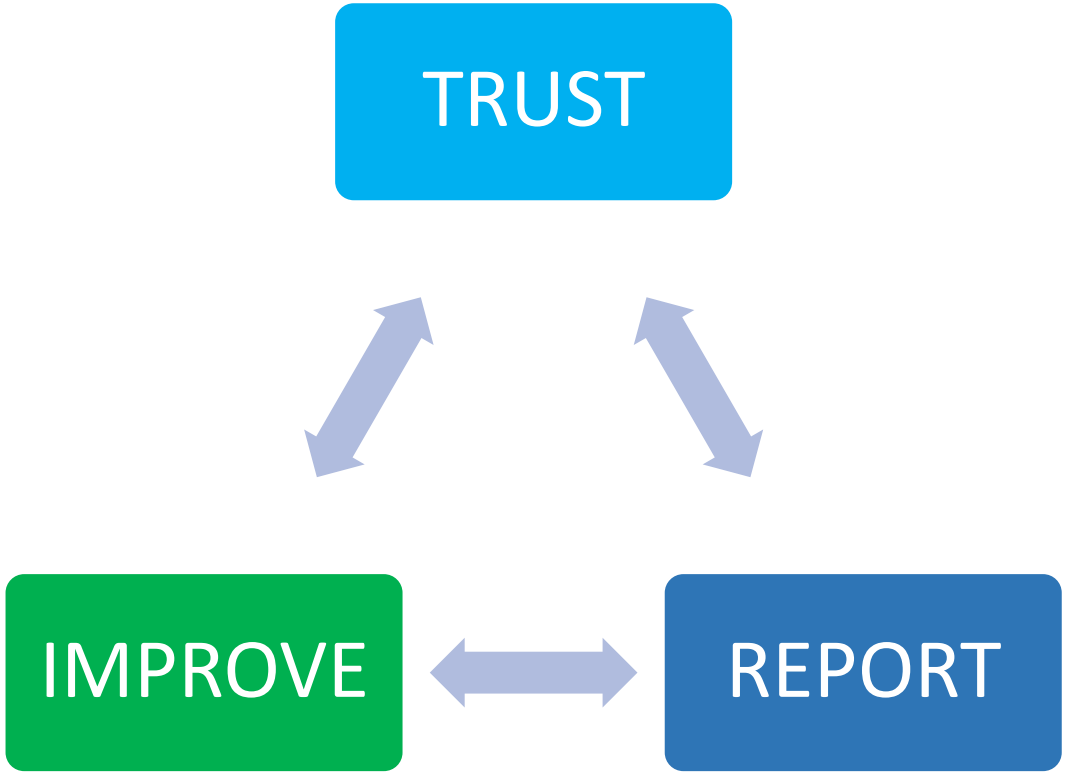
2023

Ground Rules

- We will be talking about highly personal information today please keep the following in mind:
  - Sharing is completely voluntary
  - Do not repeat any information you hear today
  - This is hard, please show empathy

Culture of Safety

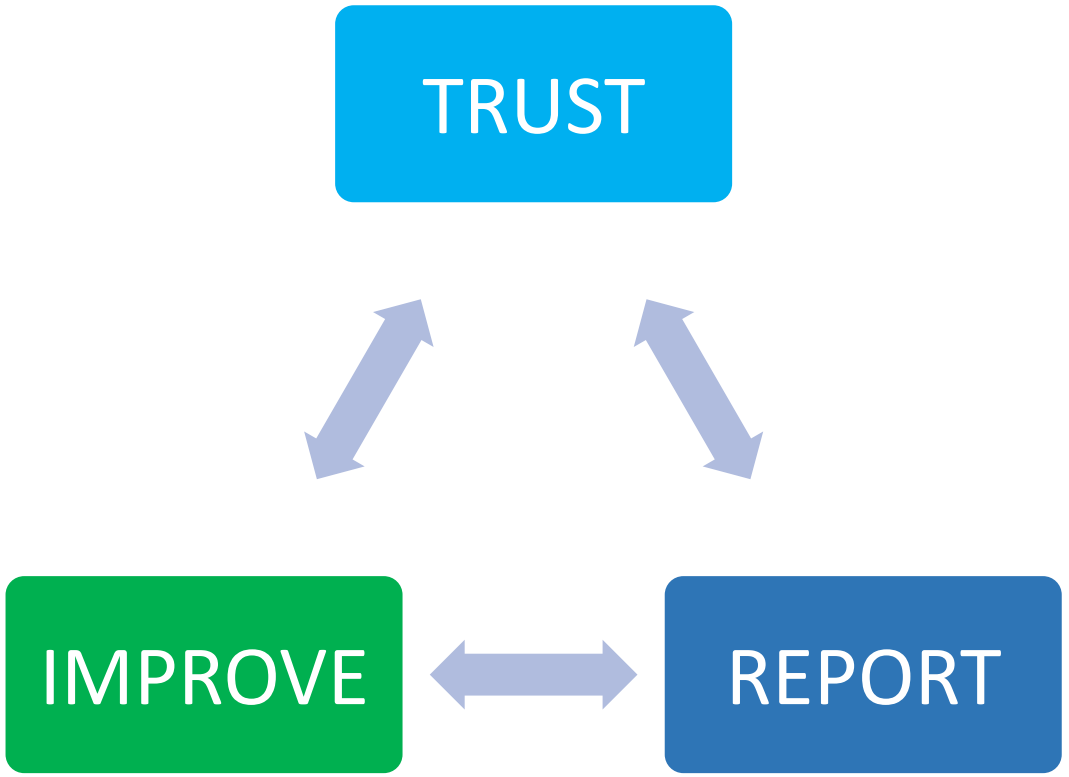
An environment in which **providers are encouraged to speak up** about safety concerns, which makes it safe to **discuss errors and harm openly** *without fear of blame or punishment* AND providers have **confidence that reporting safety events will lead to improvement**



Culture of Safety

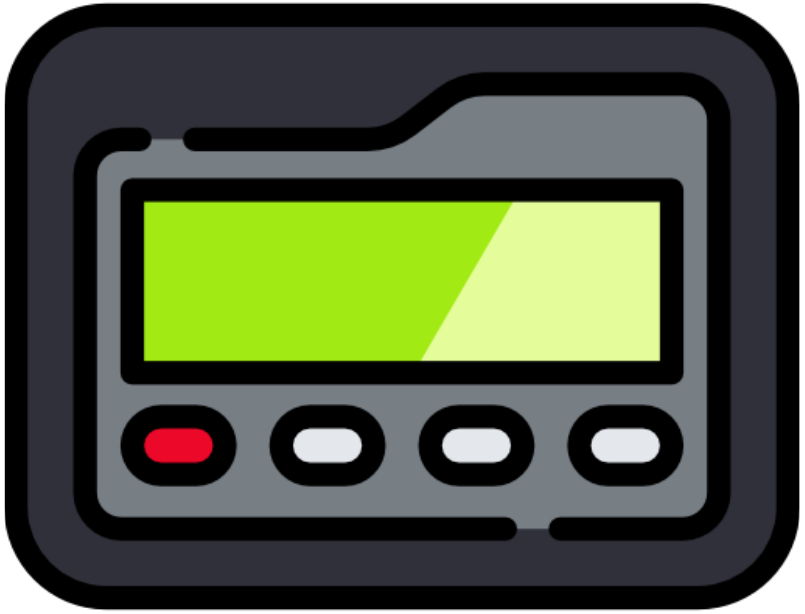
Our Goal:

Talk more openly about medical errors and our mistakes, report them and most importantly, learn from them



A personal experience:
Reflection on a medical error

The situation



- Page for new admit at 4:40 PM:
  - “New admit for 76 YOM from ED, for meningitis”

On chart review…

- 76 YOM w/ hx of CAD, complete heart block now s/p pacemaker, COPD, and dementia.
- Pt was brought in from ALF to ED at 10 AM this morning for fevers and altered mental status
- Per the chart:
  - T 39.2, HR 110, BP 113/85
  - Labs notable for WBC 12 and HS-trop 1400
  - Infectious work up including cultures were sent
  - Head CT is grossly normal. An MRI has not been obtained because the patient has a pacemaker.

We prepare to admit the patient

ED provider is called for sign out who says the patient is altered, but stable. He is septic and is in the process of getting an LP.

On “eyeballing the patient”…

General: An elderly man is lying in bed. He is diaphoretic

CV: RRR

Pulm: CTAB

Abdomen: Soft, nondistended

Neuro: Only intermittently tracks us. Does not answer questions except intermittent groaning and saying “no.” Does not move any extremities on command. Withdraws to pain on the right but not the left.

Extremities: WWP

- Our interview is cut short by the ED team coming in to set up for the LP.

What we're thinking…

- **Could this be a stroke?**
- How could so many providers have seen this patient and not thought this was a stroke? We must be missing something.
- The patient has dementia… maybe this is his baseline?
- Could this be recrudescence?

What happened next?

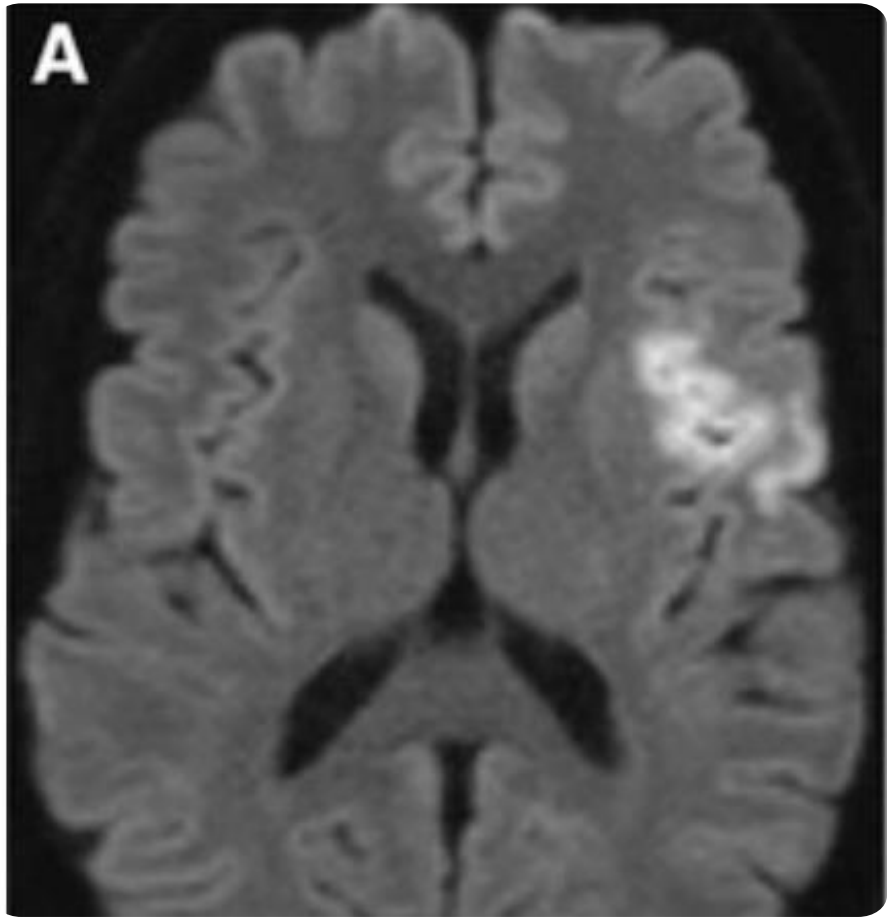
- The ED RN reports she is not sure what the patient's baseline is, or whether he has had any previous strokes.
- We confirm with the ED team that he has not had an MRI because of his pacemaker.
- Upon calling his ALF, we learn the patient's baseline is not what we are seeing
- Upon further chart review, we learn that his pacer is **MRI compatible.**
- We ask the ED team to pause the LP, and to take the patient to get an MRI.

Talking to the experts

- We page neurology to evaluate the patient.
- Neurology resident pages back 30 minutes later (approx. 6 PM) and asks: “Is this a code stroke?”
- We respond that it is **not a code stroke** but we are worried about the pt’s presentation despite the normal head CT

The aftermath

- At 7:30 PM, the MRI read returns: There is a “cutoff point” in the MCA consistent with an ischemic stroke
- The neurology resident evaluates the patient and assess his NIH stroke scale to be 22
- We learn that the patient is not a TPA candidate as he is outside the window of intervention, and that the clot is not amenable to thrombectomy



The aftermath- part 2

- Sadly the patient did not recover from his deficits. He did not recover from his advanced dysphagia
- His fiancé decided it would not be in his wishes to get a PEG tube
- He discharged back to his facility on hospice and passed away 2 weeks later

Small Group Reflection #1

1. Have you ever been involved with or witnessed a medical error?

2. How did you feel immediately after the error was discovered?

3. Did it take you time to process the error?

4. Sometimes we attempt to justify our experience through blaming others. We know this isn't fair, but it is a natural human reaction. It might happen in our own heads, or we might even state it out loud. Did this experience occur for you, or did you witness this happen to anyone involved with the error?

My immediate thoughts following the error

- I could have done so many things differently
- Was the patient passing away my fault?
- How can I take responsibility for this without feeling profoundly sad and guilty?
- How do I show up for work tomorrow?

Disclosure of the error

Notifying the patient's fiancé

- What made it easy?
  - Interdisciplinary nature of the disclosure- both our team and Neurology
  - The patient's fiancé thought he may not have wanted intervention anyway
  - Multiple providers had been involved and not caught the error
- What made it hard?
  - The magnitude of the error that ultimately led to the patient's death


Guilt
Sadness
Anger
Blaming others
Blaming myself

Processing the error

- Discussed with my intern
- Discussed with the night float team
- Discussed with the attending on record (their first day was the following morning)

Small Group Reflection #2

1. What steps did you take immediately after the error?

2. How did you process this event with your teammates?
   - What discussions were held?
   - Who led the discussions and how?

3. Did you or someone on your team have a disclosure conversation with the patient?
   - What was said during the disclosure?
   - Was an apology made with the words “I’m sorry”?
   - What made it easier or harder to disclose the error?
   - How was the disclosure received by the patient/family?

Moving beyond the immediate event

- As time went on, my thoughts changed from focusing on the event to focusing on myself
- I tried to find ways to feel better as a human and as a doctor
- I needed to build my confidence back

Finding healing

- Talking about this with friends/family
  - Trying to ask for what I needed
    - Distraction?
    - Comfort?
- **Talking to other residents**
- Therapy!!!
  - The wellness center is a **great resource –** free and confidential
- Journaling and writing

Small Group Reflection #3

1. What support have you found helpful after this event?
2. Did anything hinder your progress towards healing?
3. How do you deal with imperfections in ourselves and the healthcare system?
4. Did your experience with error change your perspective of the healthcare system?

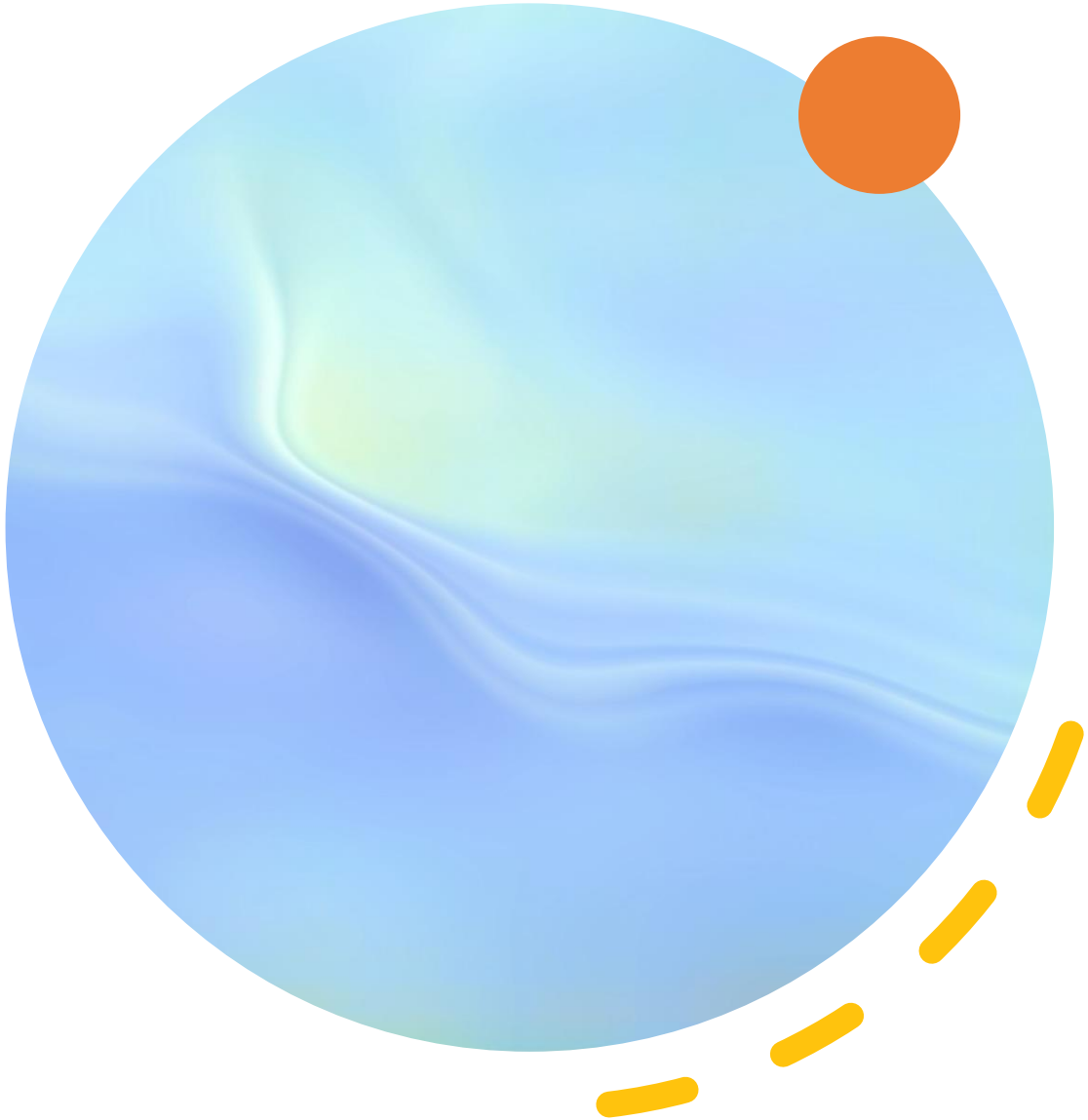
Changing my mindset

How many patients have I discharged without significant errors, who have recovered?

Reminding myself that statistically, medical errors happen to everyone

How can I change the system and prevent this from happening again?

- Discussed with Dr. Ritze, who oversees hospital safety
- Debriefed with neurology
- Call code strokes!



Gaining wisdom, moving forward

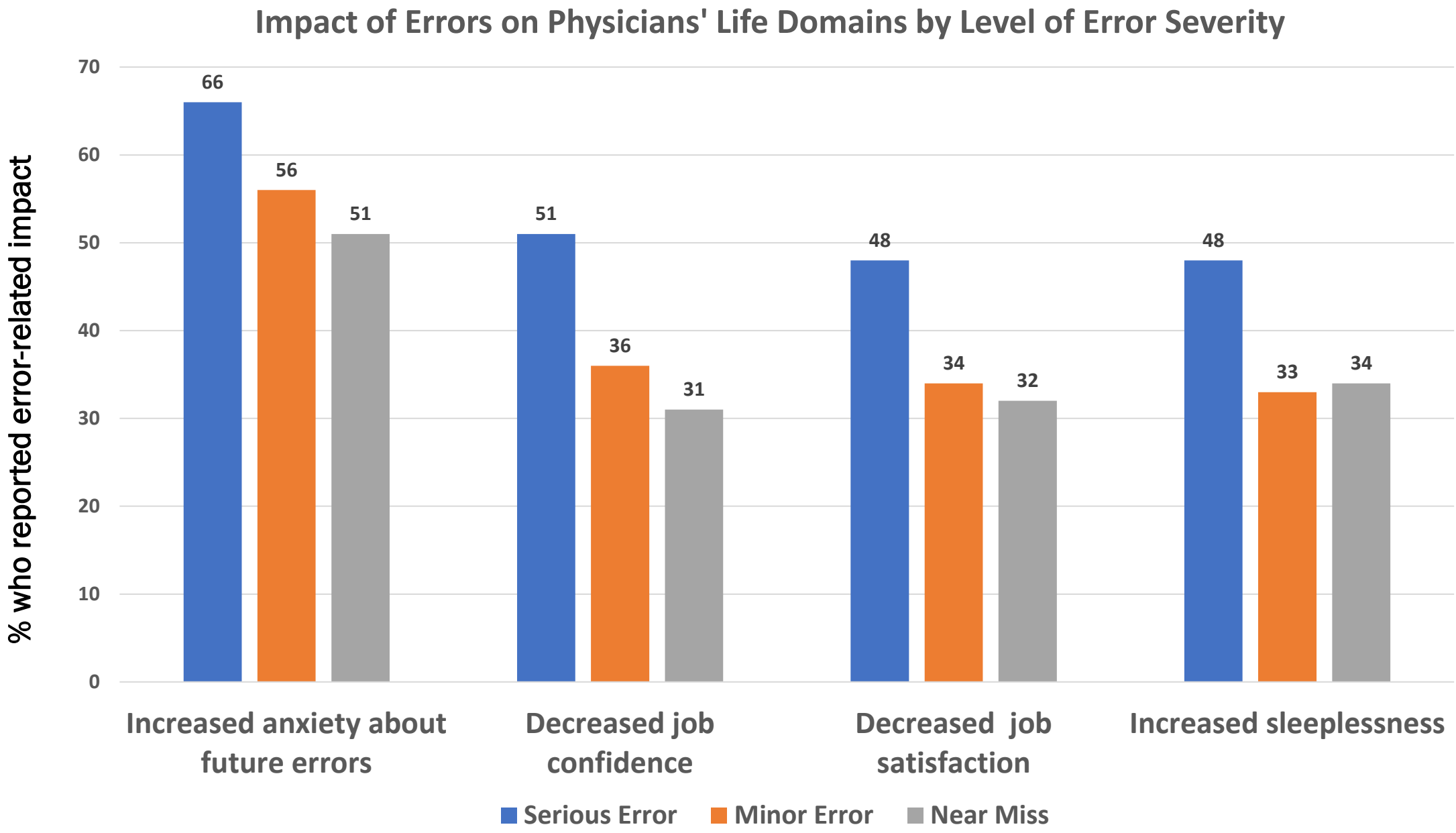
- What is my new narrative?
  - Due to a series of mistakes, there was a grave error in this case. My hope is that I will not commit another error of this nature in my career
  - Just because this error happened, does not make me or my team bad doctors
  - We as a system all have to collaborate to achieve patient safety
- Processing together is important to make sure we have a chance to process our second victim syndrome symptoms, and to help each other heal

Takeaways

- Human error is inevitable
- Systems contribute to error
- Importance of reporting *and* fixing systems
- Impact that errors have on health care practitioners is underrecognized

Second Victim
(The Wrong Term?)

The healthcare provider involved in an unanticipated adverse patient event who is traumatized by the event.


Impact of Errors on Physicians' Life Domains by Level of Error Severity
% who reported error-related impact
70
60
50
40
30
20
10
0
66
56
51
51
36
31
48
34
32
48
33
34
Increased anxiety about future errors
Decreased job confidence
Decreased job satisfaction
Increased sleeplessness
Serious Error
Minor Error
Near Miss

How do providers deal with errors?

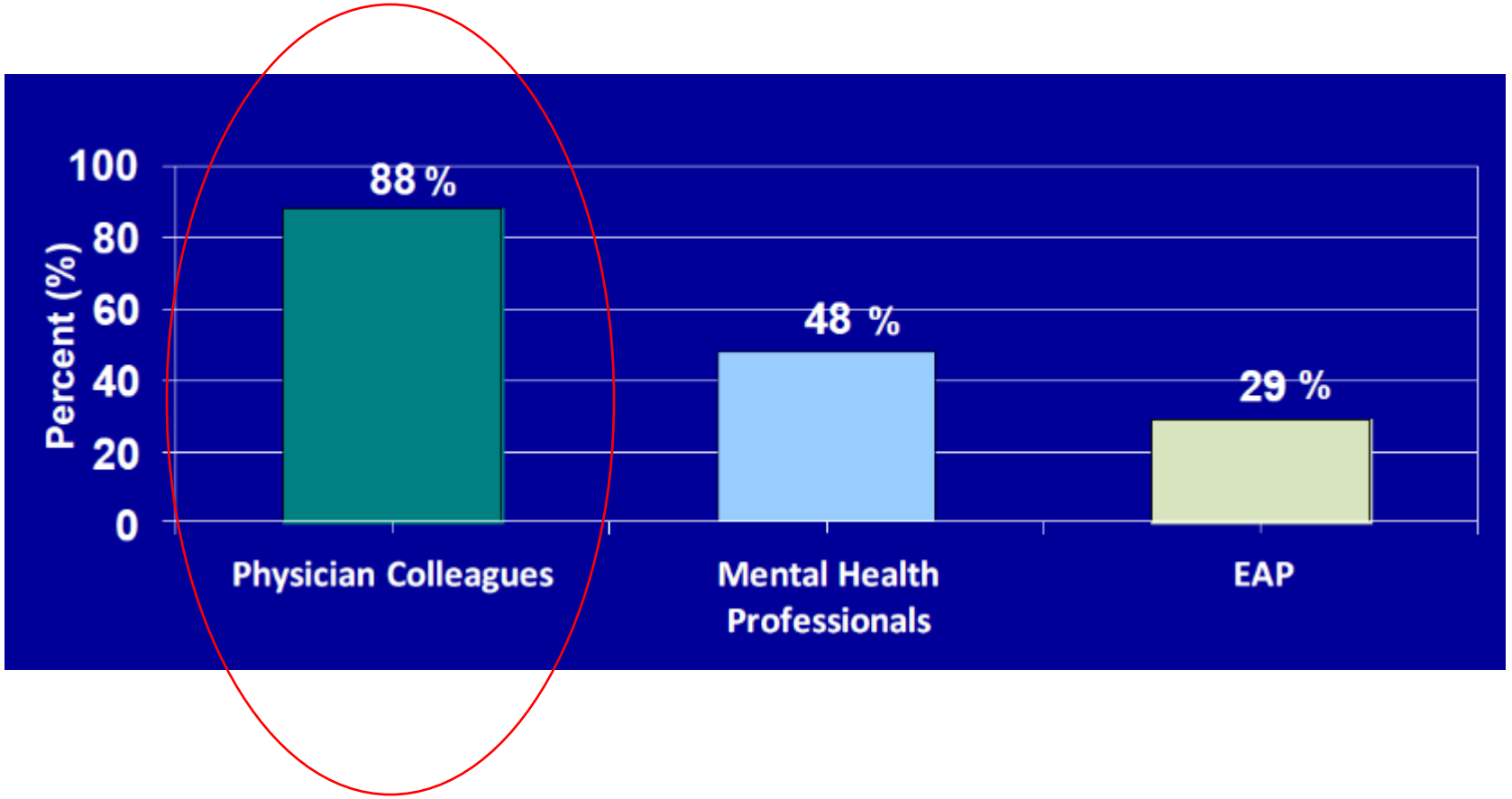
- Negative ways
  - Denial/Isolation
  - Change in profession or location
  - Alcohol, drugs
- Positive ways
  - Improve practice (both personal and system wide)
  - Gain respect for patients and for medicine
  - Insight into who you are as a person and professional

Wisdom in Medicine: What Helps Physicians After a Medical Error?

Margaret Plews-Ogan, MD, MS, Natalie May, PhD, Justine Owens, PhD, Monika Ardelt, PhD, Jo Shapiro, MD, and Sigall K. Bell, MD

- **Talking about it**
- **Disclosure and apology**
- Forgiveness
- A moral context- “doing the right thing”
- Dealing with imperfection
- **Learning/Becoming an expert**
- **Prevent recurrence**
- Helping/Teaching about it

Who Do I Talk To?



Hu, J et al. Attitudes and needs of physicians for emotional support: The case for peer support. Arch Surg 2012.

Support at OHSU

- Peers
- Attendings, mentors, US!
- Program Director/APDs
- Sydney Ey & The Resident Faculty Wellness Center
- Risk Management (OHSU, VA)

In summary

Providers can be traumatized after being involved in an adverse outcome.

Errors will occur (several times) over your career. There is a normal process of healing, much like grief.

Positive ways to help you move on include:

- Talking to your colleagues
- Disclose the error to the patient
- Become an expert/Learn
- Report the event & change the system

FEEDBACK

bit.ly/wistad

(case sensitive)

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- Recap Week 8
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- Health Systems Project

Health System Project (HSP) Timeline:

11/2-11/23	11/30-12/21	1/11-2/1	2/8-3/1	3/8-3/29	4/5-4/26	5/3-5/24	5/31-6/21
Introduction to HSPs	Team & project selection, planning	Background & current state	Targets & metrics	Fishbone & root cause statements	Develop counter-measures	Finalizing PPT	Presentations! 

LAST MONTH

Fishbone Diagram & Root Cause Statement

1. Fishbone Diagram:

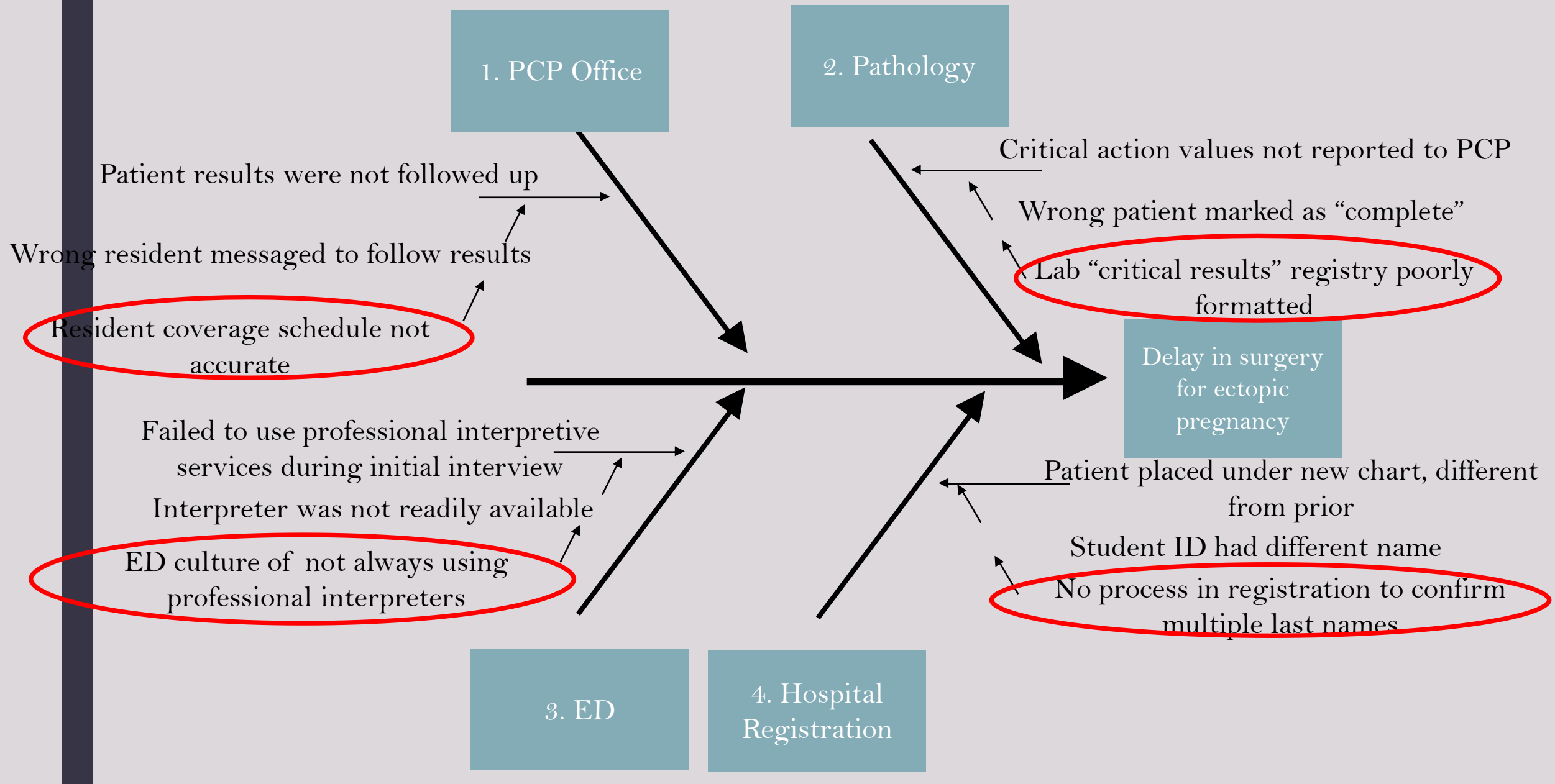
- *Identifies possible root causes for a problem*
- *Allows organized, concise graphical display of the many contributing/causal factors*
- *The ideas here will go on to inform our suggested corrective actions at the end*

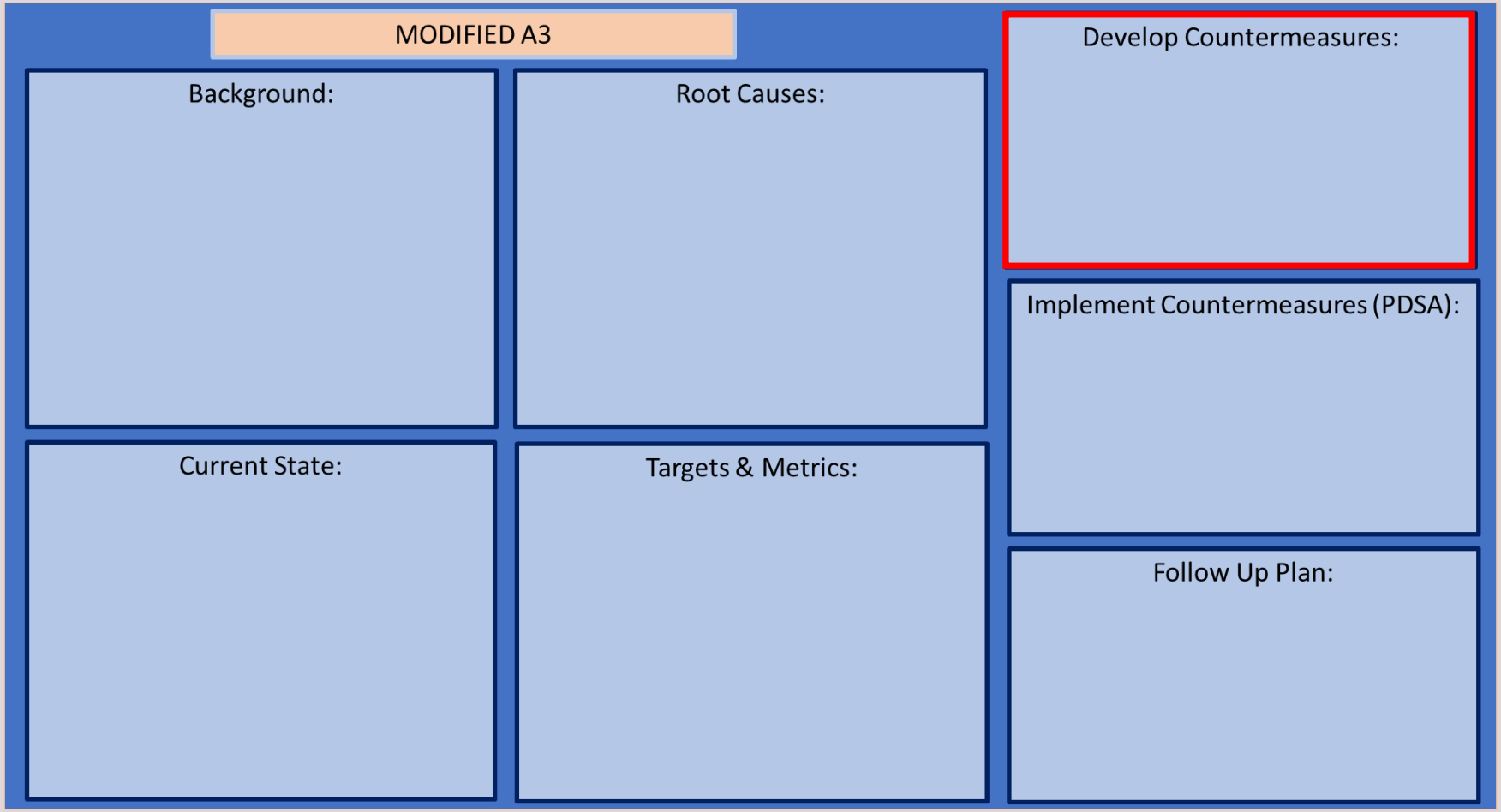
Much of the input for possible root causes should come from individuals you interviewing or literature you reviewed during your background and current state research!

2. Root Cause Statement:

- *Format: "Because x, y (error) occurs"*
  - *X = root cause (often identified from diagram)*
  - *Y = error/harm/problem*

Fishbone Diagram: Identifying Root Causes




MODIFIED A3
Background:
Root Causes:
Develop Countermeasures:
Implement Countermeasures (PDSA):
Current State:
Targets & Metrics:
Follow Up Plan:

Corrective Actions

Systems

Root Causes

1. **PCP Office:** Resident coverage schedule not accurate
2. **Lab**: "Critical results" registry poorly formatted

Most Reliable
- Forced stop function
- Computerized/automated

Somewhat Reliable
- Checklists
- Forced Pause
- Standardization
- Double check

Less Reliable
- Education
- Rules/policy

Social/Structural Determinants

3. **ED:** Culture of not always using professional interpreters
4. **Registration**: No process in registration to confirm multiple last names

Intrapersonal
- Addressing your personal implicit bias

Interpersonal
- Changing your patient interaction

Hospital
- Hiring a more diverse workforce

Community
- Access to healthcare

Research
- Understanding disease process in minority populations

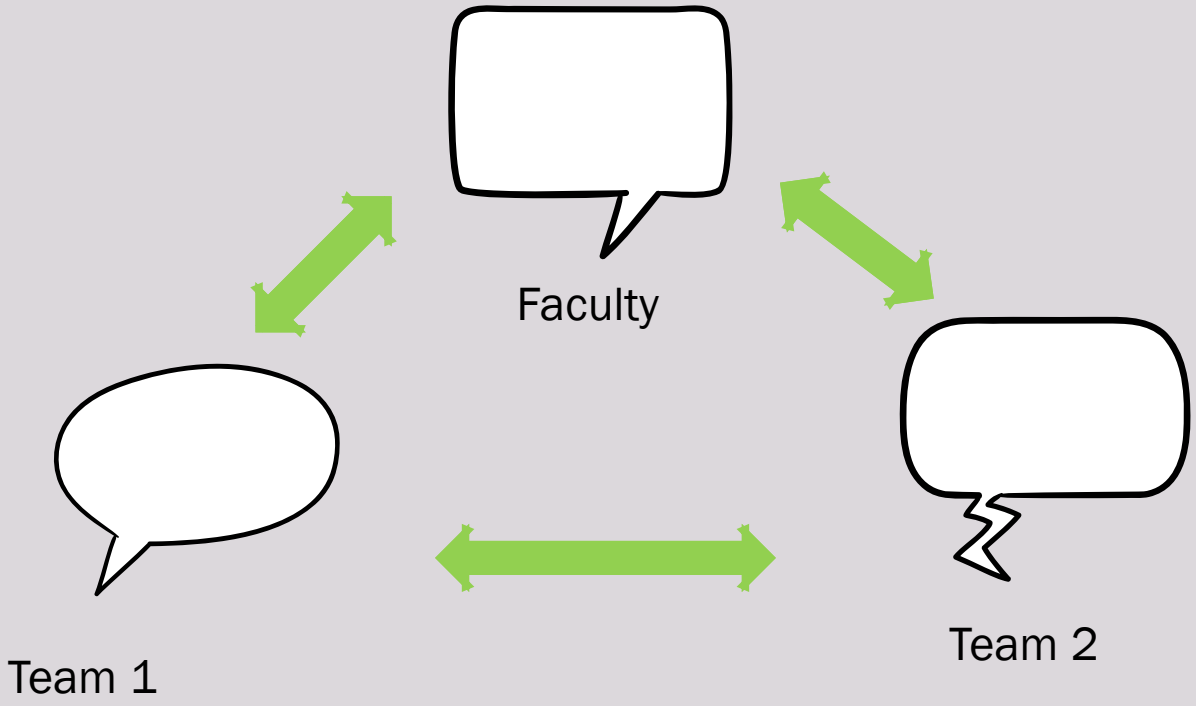
Policy
- Health insurance policy/access

Corrective Action: Examples

	Root Causes	Corrective Actions
Systems	1. **PCP Office:** Resident coverage schedule not accurate	**PCP Office:** Create standard process to ensure resident schedule is accurate and accessible to clinic and non-clinic staff.
Systems	2. **Lab:** "Critical results" registry poorly formatted	**Lab:** Replace current paper registry with notation in patient's chart documenting call to provider and read-back of name/results.
Social/Structural Determinants	3. **ED:** Culture of not always using professional interpreters	**ED:** Diversity training for all ED staff to increase awareness of interpretive services importance.
Social/Structural Determinants	4. **Registration**: No process in registration to confirm multiple last names	**Registration:** Develop standardized process to ensure MRNs are linked to unique identifier(s) to prevent duplicate charts.

Peer Learning:

- Same group as last month
- Update: 3-5 minutes per team to describe the state of your project
- Next Steps: 5-7 minutes for group brainstorming of next steps



Peer Learning:

- **Update: Describe progress with AIM statement and measures**
  - Did you refine your AIM statement since last session?
  - How will you collect data on outcome, process and balancing measures?
    - Is the data easily accessible?

- **Next Steps: Root Cause Statements and Fishbone Diagrams**
  - Develop a root cause statement.
  - Develop a Fishbone diagram.
    - What categories would be most helpful in organizing root causes?
    - Within each category, ask “Why? Why? Why?”