COOPERATIVE OF AMERICAN PHYSICIANS

The Patient Safety Advocate

Culture and Communication

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Cultivating a Culture of Patient Safety: What Leaders Can Do

Cultivating a "culture of patient safety" might seem like a dauntingly ambitious goal, but the rewards are huge. No transformation is more essential to engaging the hearts and minds of health care professionals, to effecting (and sustaining) improvement, to revitalizing the workplace, and to turning the tide of the ongoing patient safety epidemic. There's a lot leaders can do to support this transformation.

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Preventing Readmissions Through MD Communication

Good communication between hospitalists and primary care physicians at the time of discharge is critical to patient safety and to the reduction of risk. Historically, this communication has been "one way" in the form of a discharge summary. Studies have shown that "Following hospital discharges, nearly half (49 percent) of hospitalized patients

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Empathy and Support in the Immediate Aftermath of an Unanticipated Outcome

- A surgeon discovers that, despite a correct sponge count during surgery, a CT confirms a retained sponge. He must now tell the patient and reschedule her for surgery.
- A patient with insulin dependent diabetes and mother of three, lapses into a coma resulting from untreated hypoglycemia. She is transferred to the ICU and dies three weeks later.

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October Is Health Literacy Month

Health Literacy is defined as one's "ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions and follow instructions for treatment." For patients with low health literacy,

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Cultivating a Culture of Patient Safety

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Culture of Patient Safety - What It Looks Like

Although many definitions exist, a culture of patient safety is often defined as an organization's collective commitment to patient safety as the number one priority. Further, a robust safety culture is marked by a preoccupation with safety, proactive reporting of unsafe conditions, an emphasis on systems improvement to support performance, a "just culture" response to error—that includes frequent debriefing and sharing of "lessons learned," and an atmosphere of teamwork where mutual respect enables candid discussion among employees and the swift escalation of patient safety concerns.

Leadership Call to Action– An Essential Role

The active and *visible* participation of leadership is essential to making patient safety the number one organizational priority. As rigorous as any political campaign, leaders can inspire cultural change by connecting with managers and staff. Whether it's voicing the need for change, recognizing staff performance, discussing with front-liners what is or isn't working, or making regular appearances at staff meetings—staff look to leaders for inspiration, support, and for cues regarding what matters most. And, because leaders are in the unique position to allocate resources and remove barriers to performance, they need to know what's really going on.

Take the Temperature of Safety Culture

A series of studies on the perception of safety culture within organizations showed that as you ascend the hierarchy from front-line staff, to lower-level and then higher-ranking managers, perception of safety culture become "rosier."[1] Therefore, managers may not always be aware of the cultural deficiencies that impact patient safety. Administering an anonymous cultural survey is an excellent way to get to the truth and ferret out the unexpressed concerns of staff. Required by the Joint Commission and upheld by the National Quality Forum as a "Safe Practice," cultural safety surveys have been administered to tens of thousands of health care workers. Additionally, surveys are predictive—higher scores correlate with improved clinical outcomes and lower infection and readmission rates. [2]

Conduct Leadership Rounds

One of the most effective ways for leaders to demonstrate commitment to patient safety and just culture principles is through Leadership Rounds—where candid discussion with staff about safety issues serve as the catalyst for change. Although the idea of rounding is appealing, making it happen is a matter of resisting the gravitational

pull of the desk, e-mail, and other competing interests. As important to compliance as an "exercise partner," forming and orienting a multi-disciplinary rounding team, maintaining a mandatory rounding schedule, and tracking action items to completion can provide the early success needed to energize this worthy endeavor. http://capassuranceprotects.com/culture-of-safety

Education for All

There is no better method for impressing staff with the importance of patient safety than through a good, comprehensive patient safety orientation. The overarching goal of this education is to impress employees with the very real fact that they work in a high-risk industry and that, but for mindfulness and fidelity to safe practices, they too could find themselves on the sharp-end of medical error. A fascinating blend of cognitive psychology, engineering, and best practices adapted from other high risk (turned highly-reliable) industries, this education can activate the advocacy gene and remind staff of their essential purpose in keeping patients safe. It should be required of all

1 Wachter, R. Understanding Patient Safety. New York: McGraw-Hill, 2012. 260. Print.
2 Ibid, 260.

new employees–nurses, physicians, clinical, and non-clinical staff–and ideally should occur at the earliest opportunity, with refresher courses offered annually. Providing this education to all employees, ensures that everyone is "on the same page" and lays the foundation for other patient safety programs.

Appoint Champions

Many an ambitious improvement initiative has stalled or expired due to a lack of leadership—and there's nothing quite as demoralizing as a spectacular improvement idea that fails for lack of leadership support. To effect change on a large scale, department managers risk managers, and patient safety officers, need project champions with the authority and charisma to motivate the masses, bend the ear of executive leaders, and keep the project moving forward. They key is finding someone who is passionate and well-respected across all strata, who can obtain buy-in from essential groups that might be resistant to change. Physician and nursing leaders are ideal for this role.

Tap Into Local Talent - an Overlooked Resource

To identify the simplest, most effective and sustainable solutions to any patient safety problem, tap into the expertise of staff. Staff members are familiar with workflow, know the obstacles and cultural barriers to performance, and can often generate the simplest and most enduring solutions to any given problem. Guiding their efforts, engaging them in the creative process, and letting them generate solutions can boost morale and transform a unit. ■

Preventing Readmissions

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experience at least one medical error in medication continuity, diagnostic workup, or test follow-up."[1]

The following risk reduction strategies will focus on the transition process from the inpatient to the outpatient setting. These strategies include: timely delivery and improved content and formatting of the discharge summary, as well as discussion on how to improve communication between hospitalists and PCPs.

> The communication gold standard is direct physician-to-physician communication when a patient is discharged from the inpatient setting.

Discharge Summaries

- Just 12 to 33 percent of discharge summaries were available to the PCP at time of first visit.[2]

With the addition of hospitalists, discharge summaries have become a primary mechanism to convey information and to transfer responsibility from the inpatient physician to the outpatient physician. The discharge summary should inform the PCP about the patient's hospitalization and should include, at a minimum, the diagnosis, reconciled discharge medications, results of procedures, follow-up needs, and pending test results. Discharge summaries should be well-formatted and easy to read, with subheadings, and highlighting of crucial information. Also, for the discharge summary to be useful, the information conveyed must be timely (ideally within 24 to 48 hours) and should be received before the patient's first visit with his or her PCP.

Pending Results and Abnormal Test Follow-Up

- Only 25 percent of discharge summaries mentioned pending tests and only 13 percent mentioned all pending test. [3]
- About 25 percent of all medical liability lawsuits arise from failure to follow-up.

Many patients are discharged with pending or abnormal test results that

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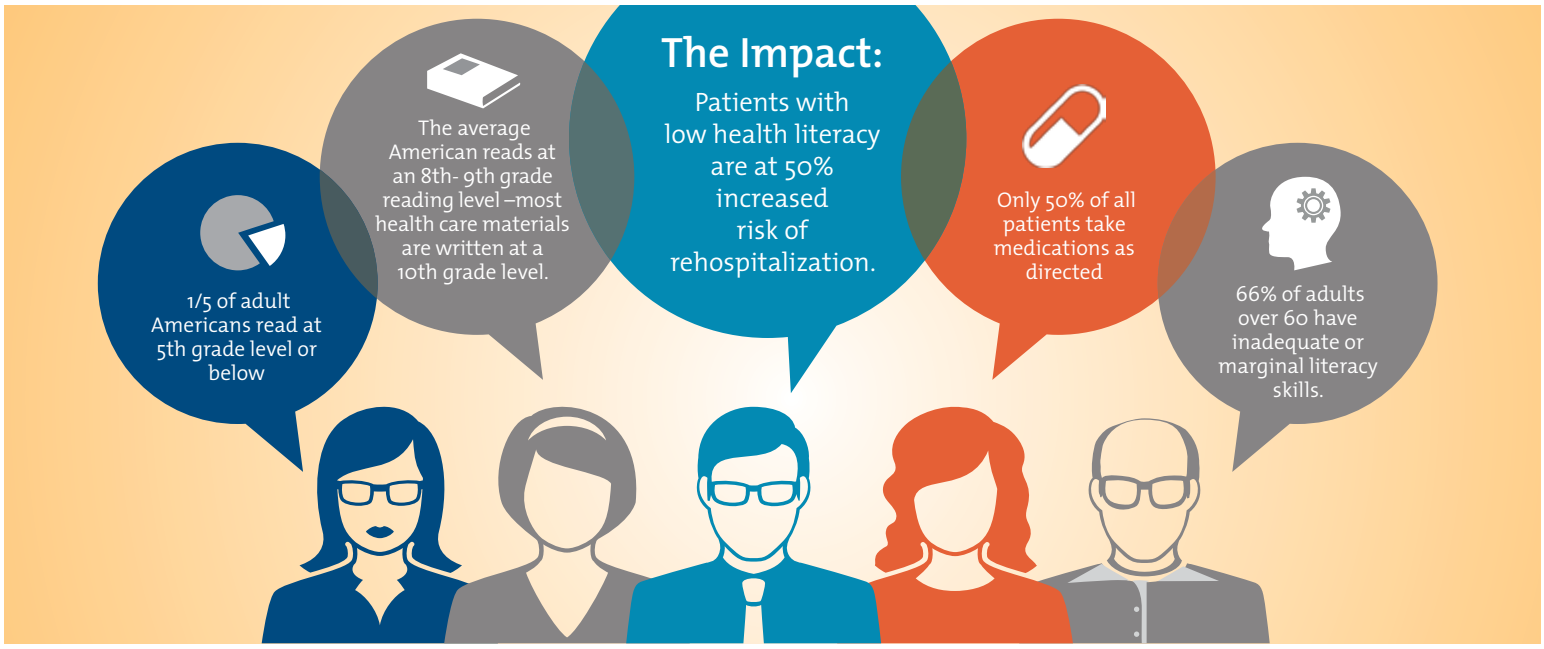

Source: National Patient Safety Foundation, Health Literacy: Statistics-at-a-Glance

Health Literacy Month

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obtaining needed care and complying with treatment instructions can seem impossible. Whether it's reading a prescription bottle, deciphering pages of discharge instructions, completing a health history, or navigating the health care system, low health literacy predisposes patients to poor health outcomes and higher rates of preventable hospital admissions, according to the Department of Health and Human Services.

"Physicians and nurses are patient advocates, and part of that advocacy means helping patients overcome barriers to understanding," says Dr. Weimer, Neurologist, Chair of the Cooperative of American Physicians Education Committee. Dr. Weimer adds that low health literacy is not merely associated with race, ethnicity or low income, "It can affect people of all races, ages, people with mental illness, certainly people with diagnoses like dementia—that directly interfere with cognition. Even the stress of hospitalization or a health crisis can affect one's ability to understand and retain information."

As health care professionals, what can you do to improve health literacy?

Never Assume...Assess!

A patient's health literacy skills may not be evident during the encounter and cannot be detected on the basis of appearance or through casual conversation. Patients with low health literacy are often ashamed of their limitations and try to conceal it from health care providers. Statements such as "I forgot my glasses," or "I'll read this later at home" are ways patients may hide literacy issues. Also, incomplete forms, noncompliance with keeping appointments, or with following the treatment plan should all be investigated, with the utmost sensitivity, for underlying literacy issues.

Use Teach-Back Method, Often

Teach-back is a simple and effective way for staff to confirm a patient's understanding by asking the patient to repeat back in his or her own words what was explained to them. To ease the patient's fear of getting it wrong and to prevent teach-back from feeling like a test, consider prefacing with, "I want to make sure I was absolutely clear," or, "That was a lot of information to take in, can you repeat back in your own words..." Teach-back is appropriate any time we provide essential instruction and can reveal barriers to understanding.

Say It Simply - "Please pass the sodium...I mean salt!"

Avoiding medical jargon, technical language, and using plain language in oral and written instruction is essential to helping patients overcome barriers to understanding. Plain language is language that's understandable the first time it's heard or read. For example, instead of saying to a patient, "Your cardiac condition," saying, "your heart trouble," would be immediately understood by the majority of patients. Also, organizing information to express the main points, first, breaking down information into manageable chunks, repeating the main points, and encouraging questions are all techniques that improve comprehension.

For more information on Tools and Techniques to Improve Health Literacy, see: Quick Guide to Health Literacy http://www.health.gov/communication/literacy/quickguide/quickguide.pdf ■

1 U.S. Department of Health and Human Services. Healthy People 2010: understanding and improving health, 2nd ed. Washington, DC: U.S. Government Printing Office; November 2000.

Preventing Readmissions *continued from Page 3*

require follow-up of which PCPs are not aware. The risk to patient safety occurs when no one takes responsibility for pending results or the follow-up of an abnormal test. The old adage "if you ordered it, you own it" still might be a good place to begin in determining who should take responsibility for pending tests. Hospitalists, who order tests, are ultimately responsible for follow-up of those test results. A system should be developed that notifies the hospitalist of test results after the patient has been discharged. The system should also provide a method for communicating the results to the PCP. Lastly, abnormal test results that need follow-up should be documented in the discharge summary.

Communication

- At discharge from the hospital, only three to 20 percent of the time is there direct communication from hospitalist to PCP.[1]
- More than half of all preventable adverse events that occur soon after discharge can be traced to poor communication.

The communication gold standard is direct physician-to-physician communication when a patient is discharged from the inpatient setting. However, limited time on both ends makes this system impractical. Some other suggestions include: telephone follow-up by the discharging hospitalist, phone message with name and contact information for questions, or electronic delivery through a Health Information Exchange (HIE) of the complete and accurate discharge summary.

No matter which system is used for communicating patient information between physicians, it should be routinely assessed for deficiencies, timeliness, and completeness by all parties to limit the risk of liability and improve patient safety. ■

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1 Kripalani S, Jackson A, Schnipper J, Coleman E. Promoting effective transitions of care at hospital discharge: A review of key issues for hospitalist. J Hosp Med. 2007;2(5):31-323.
2 Roy CL., Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. Ann Intern Med. 2005;143:121-128.
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Mind the Gap!

49% Following hospital discharges nearly half (49 percent) of hospitalized patients experience at least one medical error in medication continuity, diagnostic workup, or test follow-up.[1]

25% Only 25 percent of discharge summaries mentioned pending tests and only 13 percent mentioned all pending tests.[2]

50% Among Medicare beneficiaries requiring readmission within 30 days of discharge, only 50 percent had seen a clinician for a follow-up visit.[3]

1 Kripalani S, Jackson A, Schnipper J, Coleman E. Promoting effective transitions of care at hospital discharge: A review of key issues for hospitalist. J Hosp Med. 2007;2(5):31-323.
2 Were M, Li X, Kesterson J, et al. Adequacy of hospital discharge summaries in documenting tests with pending results and outpatient follow-up providers. J Gen Intern Med. 2009;24(9):1002-1006.
3 Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med. 2009;360(14):1418

Empathy and Support

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- Despite a detailed informed consent discussion addressing risk factors unique to the patient, a surgical patient suffers a stroke inter-operatively. Family and staff are devastated. Everyone has questions about what could have happened.

Both unanticipated clinical outcomes and adverse events are devastating for patients, families, and involved clinicians. Whether the event is a known complication of a procedure, the result of an underlying disease process, or a clear case of preventable patient harm, communication in the immediate aftermath of an unexpected outcome is absolutely essential to supporting patients, preserving relationships, and ensuring that "lessons learned" become opportunities for improved care and patient safety.

Initial Disclosure

The initial conversation with the patient and or family is an opportunity to express empathy, provide support, and focus on the patient's immediate health care needs. In the immediate aftermath, it's important to clearly communicate to patients and their families, the health care team's efforts to stabilize the patient, procure needed care, and protect the patient from further harm.

> "Patients are people and they need to know, first and foremost, that their providers care about them, that they want to help, and that their pain and suffering matters,"

Although patients and families are entitled to understand what happened and why, at this early stage, any information shared about the event should be kept to a minimum and include only the facts known at the time. The ensuing investigation will likely bring to light new information and possibly a totally different understanding of the incident. Therefore, conjecture and speculation about what might have gone wrong should be avoided. "Inaccurate information is worse than incomplete information," says Ann Whitehead, VP of Risk Management & Patient Safety at CAPAssurance. Whitehead adds, "With shifting explanations, one will lose credibility and trust. Additionally, blaming, finger-pointing, and defensiveness are perceived by patient and family as "self-serving" or worse – a cover up—which only adds to the stress and confusion."

Although sharing specifics should be avoided, it is totally appropriate to assure patients and families that every effort will be made to fully understand what happened, why it happened, and what can be done to prevent it from happening in the future. "This is the time for the involved clinician to reach out to the patient and family, to inform them about the plan for supporting the patient, and to promise that every effort will be made to fully understand the incident with the goal of preventing it from happening again," says Whitehead.

The Power of Empathy: Healing for Patient and Provider

After an unanticipated outcome, empathic communication that acknowledges the impact of a traumatic event on the patient's emotional and physical well-being is always appropriate. "Patients are people and they need to know, first and foremost, that their providers care about them, that they want to help, and that their pain and suffering matters," says Whitehead, "This is why what is said, and how it's said in this initial conversation is so important."

Under California law, gestures of benevolence and empathic statements cannot be introduced in court as admissions of fault. However, statements that reflect fault, or apologies, are admissible and therefore, should be postponed until a thorough investigation has been completed. Even in "clear cases" of iatrogenic error, apologies and admissions of fault should follow a thorough investigation coordinated by risk management, so that only the most accurate information is shared with the patient and family. In the immediate aftermath, however, empathy is always the answer and can help both patients and providers heal.

The following statements are empathic while avoiding admission of fault:

- "I'm sorry you're going through this. This must be very difficult for you and your family."
- "This must be so difficult. As we discussed, we knew this was a risk, and this is what we're doing about it."

Acknowledging Emotions - Meeting the Patient Where They Are

Patients experiencing a complication or medical error are impacted physically, emotionally, and likely, financially. Health care professionals must prepare themselves for emotionally charged interactions with patients and family members who are often experiencing a complex range of emotions including fear, anxiety, depression, anger, frustration, and even betrayal. " It can get really messy—and it can be very difficult and painful for the involved provider, but being aware of the patient's emotional state and allowing him or her to express his or her feelings without reacting or becoming defensive is very important," says Whitehead. "Also, sometimes we rush to say something or to find the right words, buts sometimes simply making eye contact, nodding in understanding, and quietly listening as patients share their feelings is of tremendous therapeutic benefit."

Disclosure as a Continuum

Following the initial discussion, caregivers should provide patients and families their contact information and remain in touch. Returning phone calls promptly to answer questions about the treatment plan or to provide much needed emotional support decreases suspicion and helps restore trust and goodwill between provider and family. Without revealing the details of formal investigations, providers can reassure patients and families that the investigation is underway and that patient and family will be fully briefed once completed.

Supporting the Caregiver

Dr. Albert Wu of Johns Hopkins Medical Center coined the term "second victim" to describe the impact of iatrogenic error on caregivers – many of whom are devastated to the point of becoming depressed and wanting to leave their profession. "These unfortunate providers are equally deserving of our care and empathy and must be supported throughout and beyond the course of the investigation." Whitehead recommends peer support, professional counseling, or referring providers to an employee assistance program. "Reminding them, 'We'll get through this- together,' checking in with them in the initial aftermath and throughout the investigation, can help them heal." ■

Universally, patients need the same basic questions addressed after the unexpected occurs:

1. What happened?
2. Why did it happen?
3. How can we prevent it from happening again?

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Inside this issue:

Cultivating a Culture of Patient Safety

When it comes to cultivating a culture of patient safety, we know we must do it, but often get lost in the how-to part.

Empathy and Support in the Immediate Aftermath of an Unanticipated Outcome

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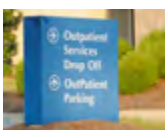

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