ASHRM AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT
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AHRMNY The Association for Healthcare Risk Management of New York, Inc.



Can We Talk?

Analysis of Medical Malpractice Claims where Communication Failures contributed to Medical Error and Patient Harm

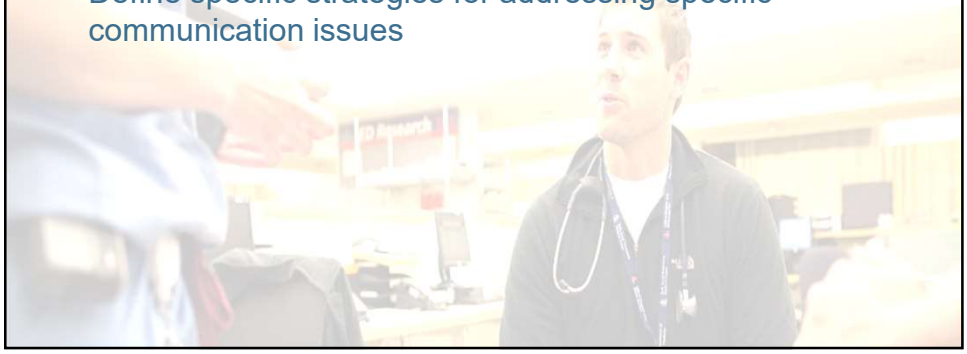
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Objectives

- Explain the breadth / impact of communication issues in malpractice cases
- Discuss specific examples of how communication failures lead to patient harm
- Define specific strategies for addressing specific communication issues



"I know you think you understand what you thought I said but I'm not sure you realize that what you heard is not what I really meant"…

- Alan Greenspan



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Communication in Healthcare



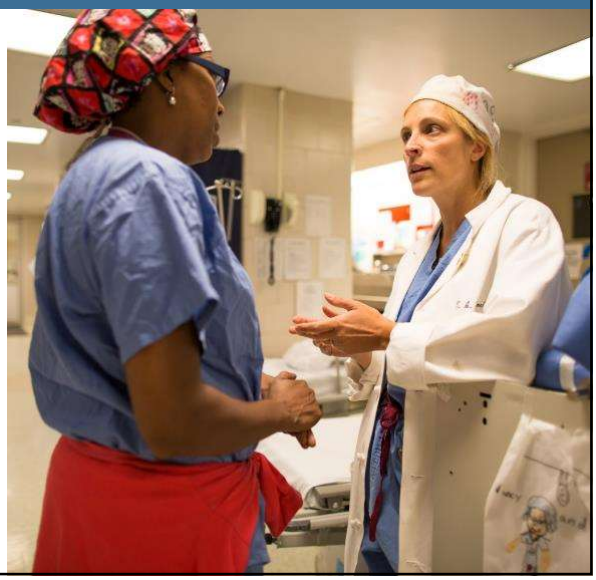
The Cost of Communication Failures

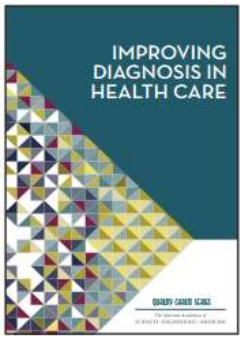
The average 500-bed hospital **loses $4M/yr** as the result of communication inefficiencies

(j healthcare management)

80% of serious medical errors involve miscommunication between caregivers during patient transfers

(joint commission ctr for transforming healthcare)





The (IOM) committee defines diagnostic error as "the failure to:

a. establish an accurate and timely explanation of the patient's health problem(s)

or (failure to)

b. **communicate that explanation to the patient"**

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crico
Protecting Providers.
Promoting Safety.
Annual Benchmarking Report
Malpractice Risks in
Communication Failures


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Data-Driven Risk Management & Patient Safety
CRICO
Captive insurer of the Harvard Medical Institutions
40 years' proven success in data-driven risk management and patient safety
Proprietary coding taxonomy analyzes malpractice claims and shares learnings for process improvements
CRICO Members
Harvard-based affiliates including academic, teaching and community hospitals and physician practice settings
CRICO Strategies
~20 years as a division of CRICO
Extends CRICO's data driven strategy (and proprietary taxonomy) to a national community of
Comparative Data (CBS)
Sharing solutions/best practices
Strategy Partners
Captive and commercial insurers representing > 400 hospital / healthcare entities and 165,000 physicians
Comparative Benchmarking System and National Community of Learning
Nealry 400,000 Medical Malpractice Cases representing ~30% of all paid physician claims in the US

Data Source

CBS is a national database of MPL claims coded for analysis of the patterns and trends that contribute to medical error

CBS; Comparative Benchmarking System – a National Database of Medical Malpractice Cases	Data
All cases	~ 400,000
Hospitals / Healthcare entities AMC's / Teaching and Community Hospitals	~ 500
Physician Providers	165,500
New cases per year	~ 8 - 10,000

Includes:

- Claims & Suits (open & closed)
- Clinical, legal & financial attributes
- Hundreds of causation codes for rich analysis of clinical errors / trends
- Individual & Comparative Reports
- Represents ~ 30 % of the NPDB*

*NPDB (National Practitioner Data Bank)



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What can We Learn from Malpractice Claims?

Using medical malpractice claims data to understand root causes of medical error

Small N – "*invalid*?"

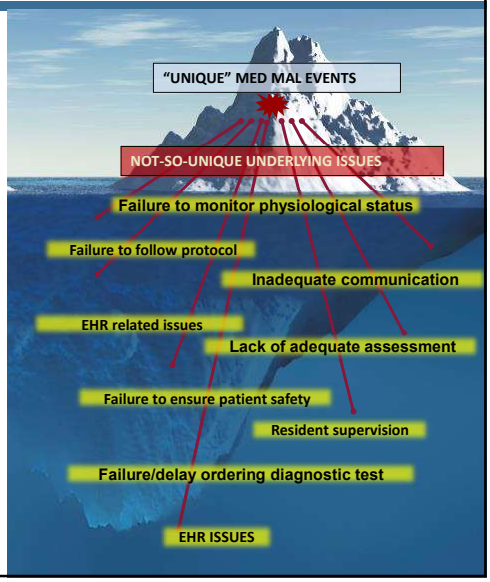
- Emphasis on most severe injuries
- Representative of larger #'s not reported
- CBS multiplies the value

Aged info – "*fixed it*?"

- Richer details available for analysis
- Consistently trends significant events often lost in "fix and move on" process

Unique convergence – "*too rare*?"

- Looks beyond the "headline"
- Provides common causation factors
- Breaks down "silos" of service specific focus



Communication is the Currency of Safe Care



Health care communication is defined as the successful exchange of information needed to diagnose and treat patients.

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3 Key Communication Failure Types

1. No communication takes place—no exchange of information



2. The communication contains incorrect or incomplete information



3. The information is exchanged but misunderstood or misinterpreted



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No Communication

No communication takes place—no exchange of information

Failures occur when:

- Information is not conveyed: human or electronic error of omission

PCP does not send information to consultant

PCP, aware of elevated PSA, sends to pt urologist without any further information.

Pt has UTI, tells urologist this is the reason for his visit. PSA is never discussed (and PSA results not in system).

2 yrs later, pt with prostate cancer.

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No Communication

No communication takes place—no exchange of information

Failures occur when:

- Information is not conveyed: human or electronic error of omission

Caregiver did not convey concern / speak up

In OR, RN aware of pt allergy to latex gloves, but last time tried to raise concern, was dismissed/admonished, so doesn't speak up.

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No Communication

No communication takes place—no exchange of information

Failures occur when:

- Information is not conveyed: human or electronic error of omission

Patient does not receive information/results

Uterine biopsy performed during inpatient stay - results not available at discharge.

Provider plans to follow-up in office when results are available.

Patient cancels follow up appointment …x2….

Loop never closed, results routed into EHR and never reviewed or shared with patient. Had a positive finding….

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No Communication

No communication takes place—no exchange of information

Failures occur when:

- Information is not conveyed: human or electronic error of omission
- Information is not received, not read, or mis-routed: human or electronic error

Results mis-directed to wrong provider

Results posted for Dr. J. Smith, vs Dr. K. Smith and never received by treating physician.

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No Communication

No communication takes place—no exchange of information

Failures occur when:

- Information is not conveyed: human or electronic error of omission
- Information is not received, not read, or mis-routed: human or electronic error

Provider did not receive—or know to look for—results

Radiologist calls PCP to report suspicious findings on CXR, warranting follow-up. Cannot reach PCP, no message left. Delay in reviewing results and scheduling follow-up testing.

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Incorrect or Incomplete Information

The communication contains incorrect or incomplete information

Failures occur when:

- Human or electronic conveyance relays wrong information

Incomplete information, no warm handoff

Pt in ED, dx with sepsis. ABX ordered, waiting on pharmacy. Bed ready, pt transferred to ICU before ABX was hung.

ED RN documented that drug was ordered, ICU RN assumed it was administered.

8 hr delay before first dose of ABX given.

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Incorrect or Incomplete Information

The communication contains incorrect or incomplete information

Failures occur when:

- Human or electronic conveyance relays wrong information

The EHR converts the dose of the drug ordered – Decimal point has moved (from .1 to 1.0) in dose of digitalis.

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Incorrect or Incomplete Information

The communication contains incorrect or incomplete information

Failures occur when:

- Human or electronic conveyance relays wrong information
- Documentation lacks complete data or information

H&P does not include known allergy to Morphine

Pt to ED having kidney stones, needs urgent relief, Morphine ordered and administered.

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Misunderstood or Misinterpreted

The communication is misunderstood or misinterpreted

Failures occur when:

- Communication lacks appropriate direction or sense of urgency
- Receiver applies different "criteria" to content, drawing different conclusion

Provider does not understand/appreciate concern in RN's call

RN: "I think you should come in."

OB: "Do I really need to come now or can I see my next patients?" RN: "Well, I'm a little concerned..."

Vs.

RN: "I'm really concerned. This is a category II tracing and I need you now."

Misunderstood or Misinterpreted

The communication is misunderstood or misinterpreted

Failures occur when:

- Communication lacks appropriate direction or sense of urgency
- Receiver applies different "criteria" to content, drawing different conclusion

Expectation setting

MD: "This procedure will reduce your back pain."

Patient hears: "This will make my pain go away."

An analysis of medical malpractice claims asserted between 2009-2013 found that 30% of the claims had one or more communication factors contributing to the event.



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Of the 7,149 cases that cited one or more communication issues, four clinical services account for more than 50% of all claims.



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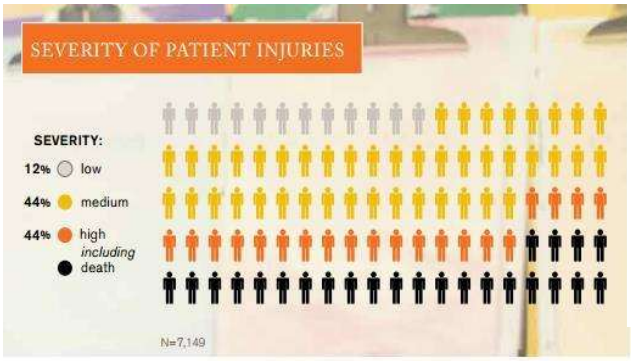
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More than 2/3 of all Cases w/ Communication Issues occur in the Ambulatory Setting

	% of Cases	Location
Ambulatory	68%	
Inpatient	30%	
Emergency	2%	

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44% of claims with a communication issue result in a clinical outcome of serious harm or death.

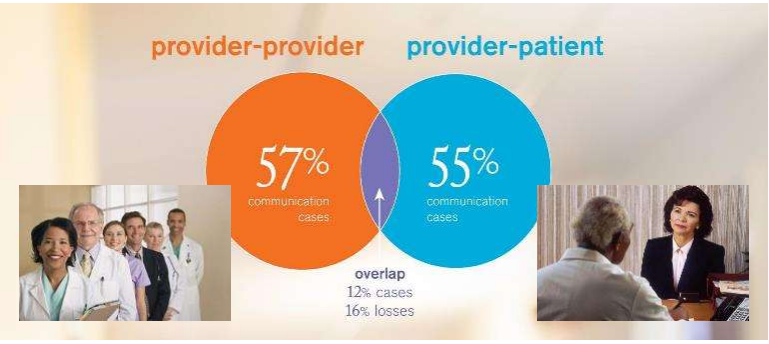


24 % of the total claims resulted in death

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Different Communication Issues Drive Claims in Each Group



Top Provider-Provider Factors

miscommunication re: pt's condition 26%
poor (missing / inc) documentation 12%
failure to read the medical record 7%

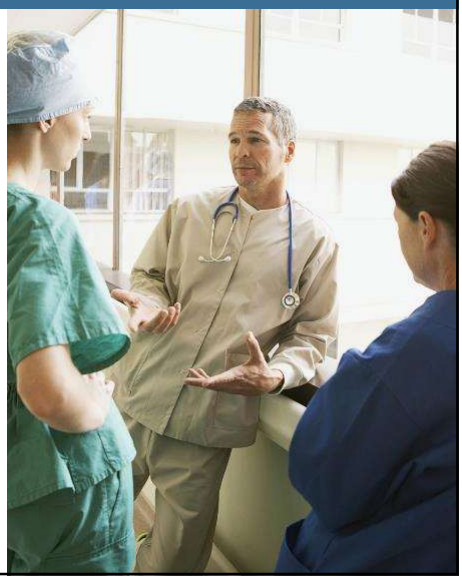
Top Provider-Patient Factors

inadequate informed consent 13%
unsympathetic response to pt complaints 11%
inadequate education re: medication 5%
no or wrong results given to patient 4%

41% of Cases with a Provider-provider Communication Event Resulted in a High-severity Injury

Key provider-provider factors:

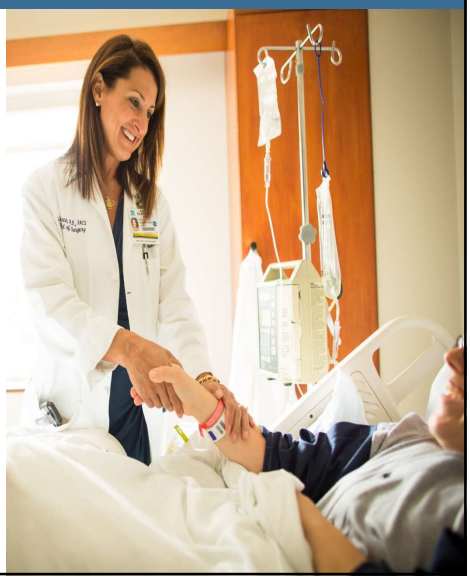
- Lack of communication re: patient clinical status
- Lack of clarity (need for) / follow-up in tests, consults
- Lack of role clarity (among providers – who "owns" it)
- Hierarchical and team barriers
- Failure to document and read record



19% of Cases w/ a Provider-patient/Family Communication Event Resulted in a High-severity Injury

Key provider-patient factors:

- Poor rapport or unsympathetic responses to patient concerns
- Inadequate informed consent
- Inadequate education (e.g., medication management, discharge teaching)



Communication Analysis: Outcomes & Impact

Cases with provider-provider communication failures are significantly more likely to result in payment than provider to patient.

Communication case types	Close with Payment	Average Indemnity
Communication - all	41%	$433k
Provider-provider	49%	$484k
Provider-patient	35%	$381k

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Among Providers, the %s Vary Slightly, but Communication Failures Occur Across All Services



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Communication Claims Analysis: General Medicine



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Almost Half of General Medicine Communication Cases Occur During the Diagnostic Process



45% involve misdiagnosis
- 20% missed cancers
- Acute processes – MI, CVA, Sepsis

60% involve high severity injuries

- Relevant **information not forwarded by PCP to consultant** narrows focus and leads to misdiagnosis.
- Positive pathology **result not flagged for PCP review** results in 1 year delay of cancer diagnosis
- **Failure to respond to calls from a diabetic patient** (documented but not relayed by office staff) is followed by collapse and death from diabetic ketoacidosis.

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What Diagnoses/Processes are Involved?

Cancer	• Lung • Prostate • Breast • Colon
Medication Management	• Anticoagulation • Narcotics
Complication of medical / surgical treatment	Responding to care in progress
Acute Dx Processes	Missed Diagnosis • CVA • MI • Sepsis
Psychiatric Issues	Anxiety / Depression Substance Abuse

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General Medicine Cases Often Involved Failed Communication with Other Medical Specialties

Services	Specialty
Medical Specialties	Cardiology Gastroenterology Neurology Pulmonary Nephrology Hospitalist
Medical Specialties	e.g. Missed DX / Incidental Findings
Medical Specialties	Orthopedics General Surgery

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Consult Communication: "He said… She said…"

According to a study in **Archives of Internal Medicine**

- **69.3% "of PCPs** reported they **"always" or "most of the time"** send notification of a patient's history and reason for consultation to specialists…
- ..but **only 34.8% of specialists** said they **"always" or "most of the time"** receive such notification.
- Likewise, **80.6%** of **specialists** said they **"always" or "most of the time"** send consultation results to the referring PCP…
- …but **only 62.2%** of **PCPs** said they **"always" or "most of the time"** receive such information.

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General Medicine relies on the accurate exchange of information across extended time and distance.



Poor documentation is miscommunication.

39% of provider-provider communication cases reflect insufficient, inaccurate, delayed, or illegible documentation of clinical findings.



Medication without communication can lead to patient harm.

19% of provider-patient communication cases reflect inadequate education/ instructions regarding medications. Analgesics and anticoagulants were the most common drugs involved.

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Improving Communication Among Providers and Between Patients/ Families in General Medicine

Focus on 3 key risk-prone processes (including documentation):

- Systems that support management of test results
  - **Explain significance** of test to patient
  - Ensure **testing has occurred**
  - Ensure **results are communicated** to patient and follow-up plan established with care team
- Systems that support management of referrals
  - **Explain significance** to patient & ensure consult appt is made and kept
  - **Communicate key information to specialist** and plan for obtaining findings/report from visit
- Processes for patient medication education
  - **Educate patient** on risks, side effects, dosage

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Improving Communication in General Medicine

Focus on 3 key aspects of patient communication

- During visits
  - Ensure you are **effectively and respectfully listening**, seeking confirmation of clarity, encouraging **shared decision-making**
- Between visits
  - Consistent **management of portals** and follow-up on care plans
  - Offer **multiple forms of communication** for patients – especially for acute needs (calls, letters…)
- After visits
  - Provide ways to offer **feedback on office practices** and patient safety
  - Provide **transparent, timely, and supportive follow-up** after dissatisfying experience or adverse event/outcome

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Communicating with Dissatisfied Patients/Families, or after an Adverse Event or Outcome

When Things Go Wrong in the Ambulatory Setting Guidelines

The Joint Commission Journal on Quality and Patient Safety

Forum

Doing Right by Our Patients When Things Go Wrong in the Ambulatory Setting

Gordon Schiff, MD; Paula Griswold, MS; Bonnie R. Ellis, RN, BSN; Ann Louise Puopolo, RN, BSN; Namara Brede, BA; Harry Reyes Nieva, BA; Frank Federico, RPh; Nicholas Leydon, MPH; Judy Ling, BA; Deborah Wachenheim, MPP; Lucian L. Leape, MD; Madeleine Biondolillo, MD

In 2006 two events occurred that marked turning points in patient safety and in the care of patients and families who may have been harmed by medical error. Rival Harvard teaching hospitals came together to produce a historic consensus document, *When Things Go Wrong*, which emphasized the need to disclose errors to patients and families, and, when appropriate, take responsibility and apologize for any resulting harm.[1] In the same year, then Senators Hilary Clinton and Barack Obama jointly introduced new legislation calling for health professionals to truthfully disclose errors.[2] The legislation called on physicians concerned about medical malpractice to work together with patients to "make patient safety the centerpiece of medical liability reform." At the center of their National Medical Error Disclosure

ineffective processes to improve patient safety and reduce the risk of a medical malpractice lawsuit.

These three key processes in ambulatory practice have repeatedly (and not surprisingly, given their high volume and complexity in the fragmented health system in the United States) been shown to represent areas vulnerable to errors and in need of improvement.[6,7] Studies have shown, however, that many malpractice suits do not simply occur because of problems in various primary care processes, nor are suits inevitable any time a patient suffers an adverse outcome. Rather, malpractice suits often occur because of breakdowns in communication and trust when things go wrong.[8,9]

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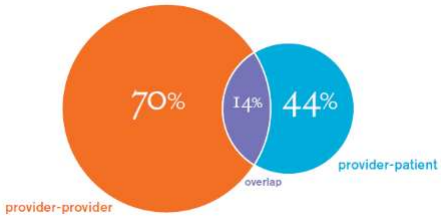
Communication Claims Analysis: Obstetrics



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Preponderance of Communication Challenges Occur Between Providers



72% occur in the inpatient setting

56% involve high severity injuries

- A prenatal **positive Strep B status is not transferred to the hospital record**, thus not conveyed to the L&D team; baby is infected via vaginal delivery
- Mother's **request for tubal ligation following caesarian delivery is not known by** covering OB. Subsequent pregnancy leads to claim
- **RN fails to communicate sense of urgency to OB** regarding possible decelerations noted on EFM strips, leading to delivery of a severely compromised baby.

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Communication Failures vary at Each Stage of Obstetrical Care

Management of Pregnancy
35% involve communication issues

PREGNANCY
e.g., tubal ligation, VBAC, post-date management/ testing, induction

provider-provider 63% | provider-patient 57%

Management of Labor (treatment of fetal distress)
41% involve communication issues

LABOR
e.g., EFM assessment, handoffs, patient's birth plan

79% | 32%

Management of Delivery
35% involve communication issues

DELIVERY
e.g., prolonged 2nd stage, handoffs, resuscitation, episiotomy, skin-to-skin request

73% | 43%

Improving Communication in Obstetrics

- Establish standards for "prenatal to L&D" transfer of information
  - Interdepartmental/inter-institutional connectivity of EHR (or transfer of records if no EHR)
- Obstetrical Team Training (e.g. TeamSTEPPS)
  - Ensuring **situational awareness** and **role clarity**
  - Leveraging **multidisciplinary team meetings** (huddles, briefs, debriefs) to review safety concerns for all patients
  - **Clear escalation processes** and conflict resolution strategies
  - Team-based **simulation for emergencies**
- Standardized communication between providers
  - **Shared EFM training (RN/MD)** to develop shared understanding and lexicon to communicate issues (e.g. "Stat C/S")
  - Process for written and verbal handoffs (SBAR..IPASS)

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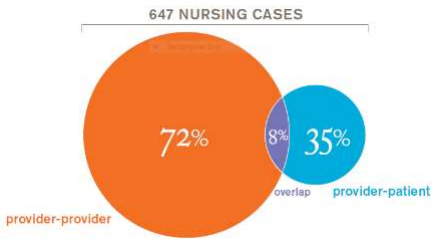
Communication Claims Analysis: Nursing



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Nurses' Pivotal Role in Clinical Communication Increases their Risk of Communication Failures



75% occur in the inpatient setting

33% resulted in death

- **Nurse fails to communicate notable change in d/c VS** (temp & pulse) to ED physician; pt returns several hours later in acute sepsis
- Diabetic pt's **small wound that went unattended due to poor documentation of skin assessments** eventually worsened and led to amputation
- **Patient at risk for falling, arrives in Radiology without any fall risk indicator** (note, bracelet, slippers) and falls during procedure.

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Effective Communication by Nurses is Critical in Preventing High-Severity Injuries



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Improving Communication in Nursing

- **Culture, Culture, Culture**
  - Location, Location, Location
  - Academic vs. Community
- **Individual accountability: Elevate nurses' awareness** of key role played in assessment & communication of patient status
  - Closed loop communication (including electronic communication)
  - Advocacy, Escalation, and Accountability
  - Structured communication tools: SBAR, IPASS for Nursing
  - DOCUMENTATION – accurate, timely
- **Interdisciplinary Team accountability:**
  - Role Clarity - Define roles and expectations for all team members
  - Standard practice for handoffs
  - Multidisciplinary rounds including RN, MD, consultants, wound care, etc.) - (Getting Started Kit: Multidisciplinary Rounds How-to Guide IHI

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Communication Claims Analysis: Surgery



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Communication Failures Span the Entire Surgical Process, from Consent to Recovery & Discharge



50% occur in the outpatient setting

34% resulted in high severity injuries

- Surgeon **fails to communicate abnormal finding in pre-op EKG** to anesthesiologist, and patient experiences in cardiac event in surgery
- **Abdominal pain/hematocrit drop in post-op patient are not communicated by RN to surgeon** before d/c from surgicenter. Patient dies from post-op hemorrhage.
- Patient with **multiple post-op visits for continued pain** following hip surgery **files suit for alleging the neurosurgeon "promised to get him right**."

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Informed Decision-making and Consent

Provider-provider failures are more frequent in cases involving management of the surgical patient (often post- operative, often failure to rescue)



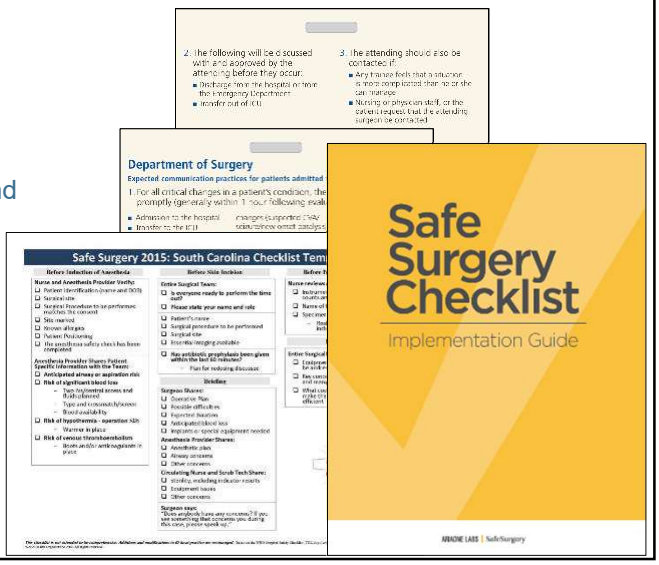
- 64% Cardiac Surgery
- 61% General Surgery
- 53% Vascular Surgery

Provider-patient failures more frequent in cases alleging a performance-related issue often tied to consent process/expectation management/post-op follow-up

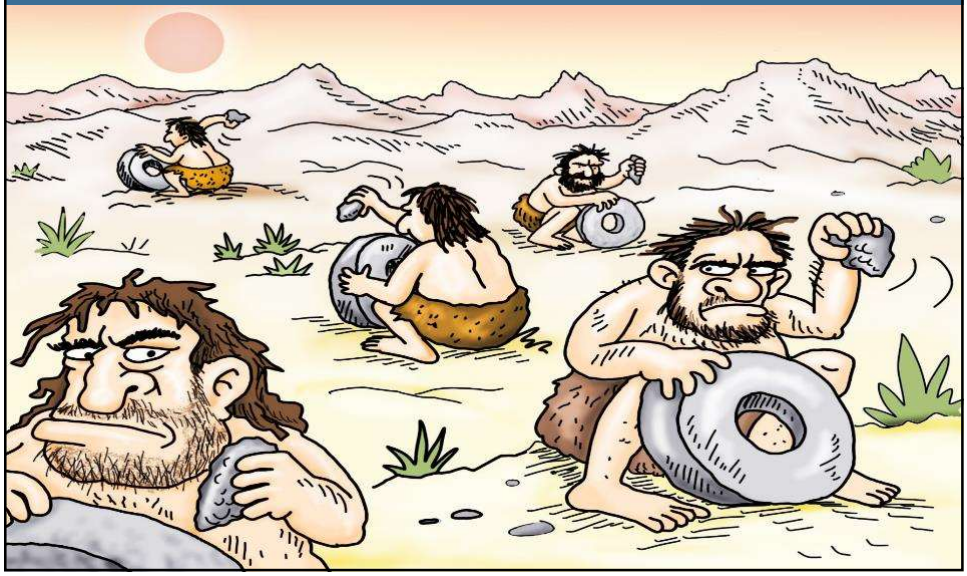
- 74% Plastic Surgery
- 74% Urology
- 65% Orthopedics
- 65% Neurosurgery

Improving Communication in Surgery

- Trigger cards
- SBAR
- Checklists
- Team Training
- Communication and Informed Consent



Questions



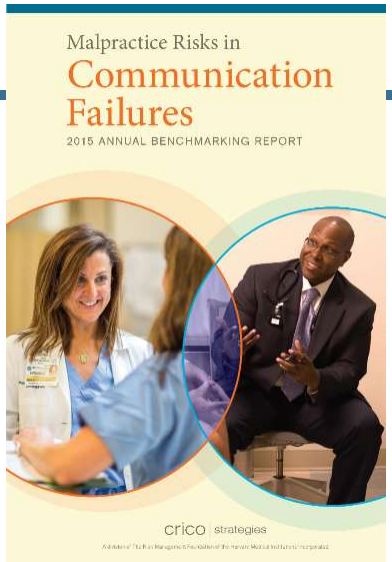
How Does Your Organization Compare?

Comparative Benchmarking System (CBS)
Data reveals areas for improvement in patient safety.
Contribute to the ever-growing national database of malpractice claims.



THE MOST ROBUST MALPRACTICE CLAIMS DATABASE IN THE WORLD.

For copies of this (or any of our other Annual Benchmark Reports) please visit http://www.rmf.harvard.edu/CBS



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