MMIC

What's Next in Patient Safety and Risk Solutions **Spring/Summer 2018**

Brink

Communication:
To the Heart of the Matter

If improving your team's communication skills isn't near the top of your list of places to focus in 2018, you might be overlooking one of the best ways to move your organization forward on a whole range of fronts. Why? Because better communication can mean more accurate diagnoses, more engaged patients, less care team burnout, fewer errors and a lower risk of malpractice claims.

In our analysis of Constellation claim data, miscommunication among members of care teams is more often a contributing factor than a causative factor in claims, but in those cases where it factors at all, nearly half (49 percent) result in indemnity payments.

In this issue of *Brink,* we look at the value of communication skills and what you can do to up your game. For a quick assessment of your organization's communication fitness, see the checklist on page 6.

Good for patients, good for clinicians

While patients clearly benefit from their interactions with clinicians who communicate well, clinicians benefit, too. One study cited in this issue found a direct relationship between clinician satisfaction and the ability to build rapport and express care and warmth with patients.

An area that trips up even the best communicators is delivering bad news—a necessary part of almost every physician's work—and a learnable skill, according to Constellation's chief medical officer, Laurie Drill-Mellum, MD. "It's a responsibility that takes presence and empathy," she says. "And it's a way of connecting with the patient, and why we chose this profession."

In "When News Isn't Good" on page 7, you'll learn about a training program for pediatrics residents—physicians who face the toughest of tough conversations. This training helps them learn principles, see techniques modeled, and then practice those difficult conversations themselves.

"Citizen Jurors Speak Up," on page 12, explores the readiness of patients to assume a more prominent role in solving communication challenges in the health care setting, particularly related to diagnosis.

We also take a special look at the vulnerable interface between radiologists and clinicians, where most communication occurs as written reports and EHR entries and where the potential for error is significant. On page 10, you'll learn about changes that are already on their way to becoming best practices—changes like standardized protocols for reporting findings and recommendations, and a shared recognition that today's medicine is way too complex not to collaborate more effectively.

With so much to gain from improving our communication skills, I think it's important to remember that good communication is not just about talking. It's also about listening—"generous listening" as Rachel Naomi Remen, MD, calls it. Listening to the experts who have been generous enough to share their learnings and their perspectives in these pages can offer much-needed sustenance on our professional and personal journeys.

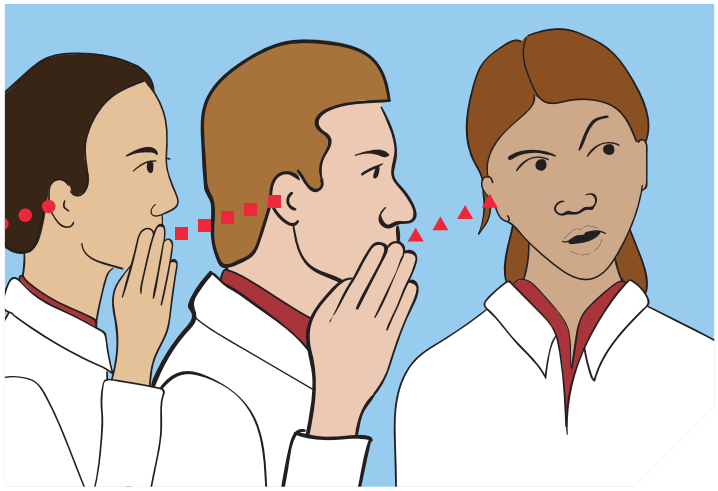
Thank you for the opportunity to serve you.

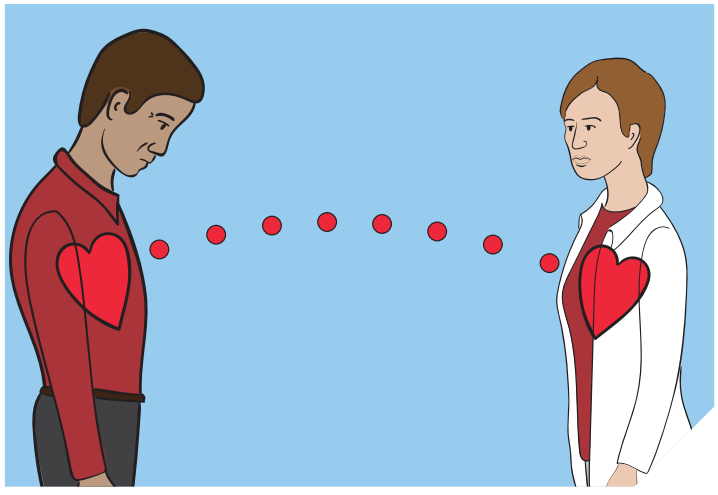
Bill McDonough
President and CEO, Constellation

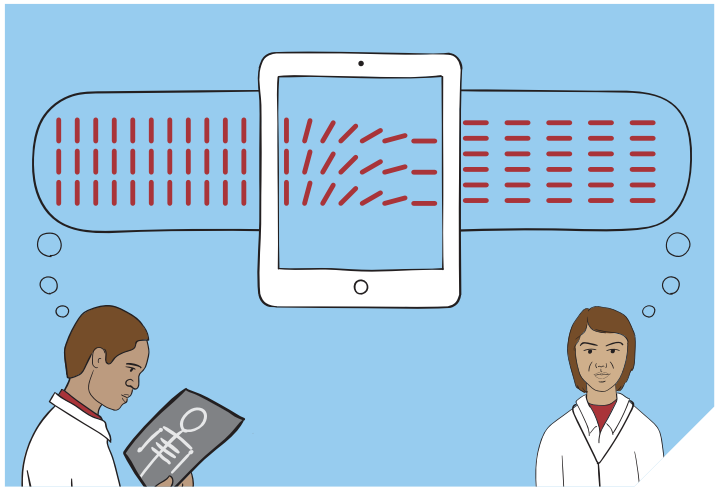
Constellation®
Together for the common good.

Brink® is published two times annually by Constellation. Constellation is a growing partnership of mutual liability insurers and health organizations that unite to provide solutions and support to physicians and other health care providers. Formed in 2012 as a response to an increasingly challenging market, Constellation is guided by its own board of directors comprised of physicians, medical liability professionals and health care leaders. MMIC is a founding member company; UMIA joined Constellation in 2013 and Arkansas Mutual joined in 2015.

To download *Brink*, visit MMICgroup.com. To contact the editor, please send an email to Liz.Lacey-Gotz@ConstellationMutual.com.







Brink

FEATURE SECTION:

COMMUNICATION: TO THE HEART OF THE MATTER

DEPARTMENTS

The Cost of Communication Failure

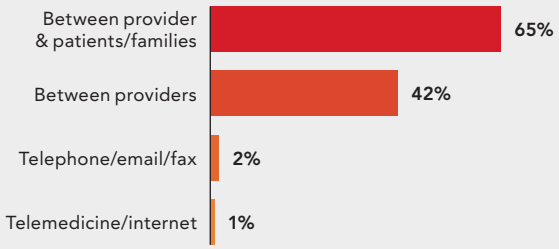
In a Constellation study of 2,413 medical professional liability claims asserted from 2012 to 2016, 35 percent—852 claims—were found to have a communication failure that contributed to an adverse event, medical injury or undesirable outcome. Further, claims with communication failures averaged about $17,600 more each in incurred costs than the overall average. Communication failures were involved in $131.4 million of total costs incurred in this five-year period.

As with any malpractice claim, causation of an event is usually a combination of multiple factors rather than just one. So what else is happening in these claims in the presence of communication breakdowns? We see many claims in which the outcome was a known complication of a procedure, but without a solid informed consent process, the patient lacked understanding of this risk. We also see that communication failures coincide with inadequate patient assessment, such as too narrow of a diagnostic focus or not fully working up a patient. We also see issues in the selection and management of surgical procedures, medical therapies and labor management.

Communication failure is not only costly from a malpractice claim perspective, but can also impact patient outcomes. In this issue of *Brink*, we offer ways to improve communication both within your care teams and with your patients.

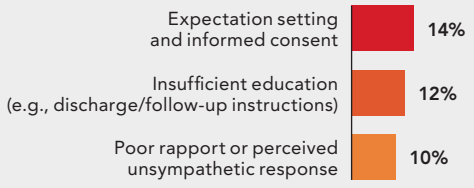
35% of claims involve communication failures and account for **$131.4 million**

Communication Failures—Modes
(A single claim can involve multiple modes.)
N=852



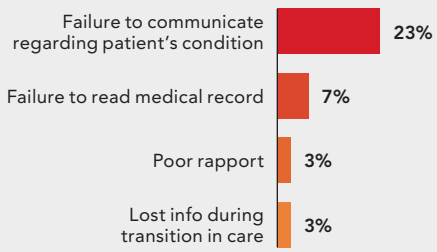
Communication breakdowns were identified when they were considered to have contributed to an allegation, an injury, or an initiation of a claim, and were classified under four major modes. Social media and telemedicine claims under the "telemedicine/internet" mode have begun to appear due to the proliferation of emerging technologies.

Top Communication Failures Between Providers and Patients/Families
N=558

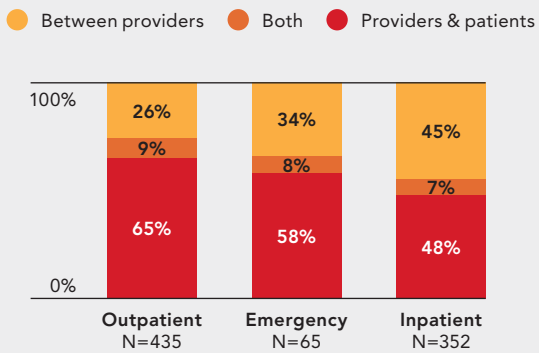


Top Communication Failures Between Providers

N=360

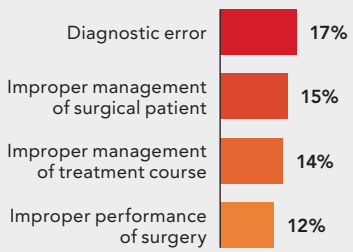


Communication Failures Differ by Setting



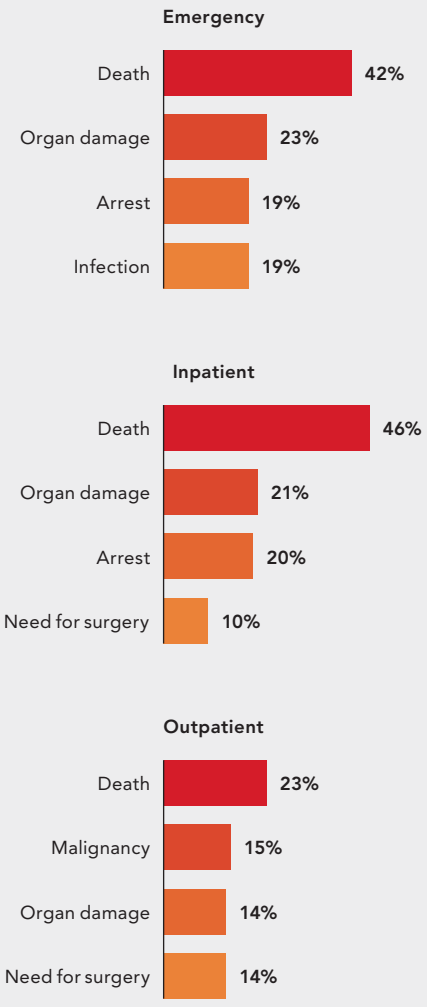
On average across all settings, communication breakdowns occur between provider and patient in 65 percent of claims and between providers in 42 percent of claims. However, the proportion of communication mode failures differ between settings and point to the need for patient engagement and coordination beyond the episode of care.

Top Allegations Impacted by Communication Failure



Across all settings, the top allegations impacted by communication failure account for over half of the claims analyzed.

Top High Severity Major and Minor Injuries by Setting



The resulting injuries in the high severity claims shared death as the top outcome; however, the top injuries—including deaths—differed by setting.

This analysis was made possible through Constellation's partnership with CRICO Strategies and use of their comprehensive risk intelligence platform.

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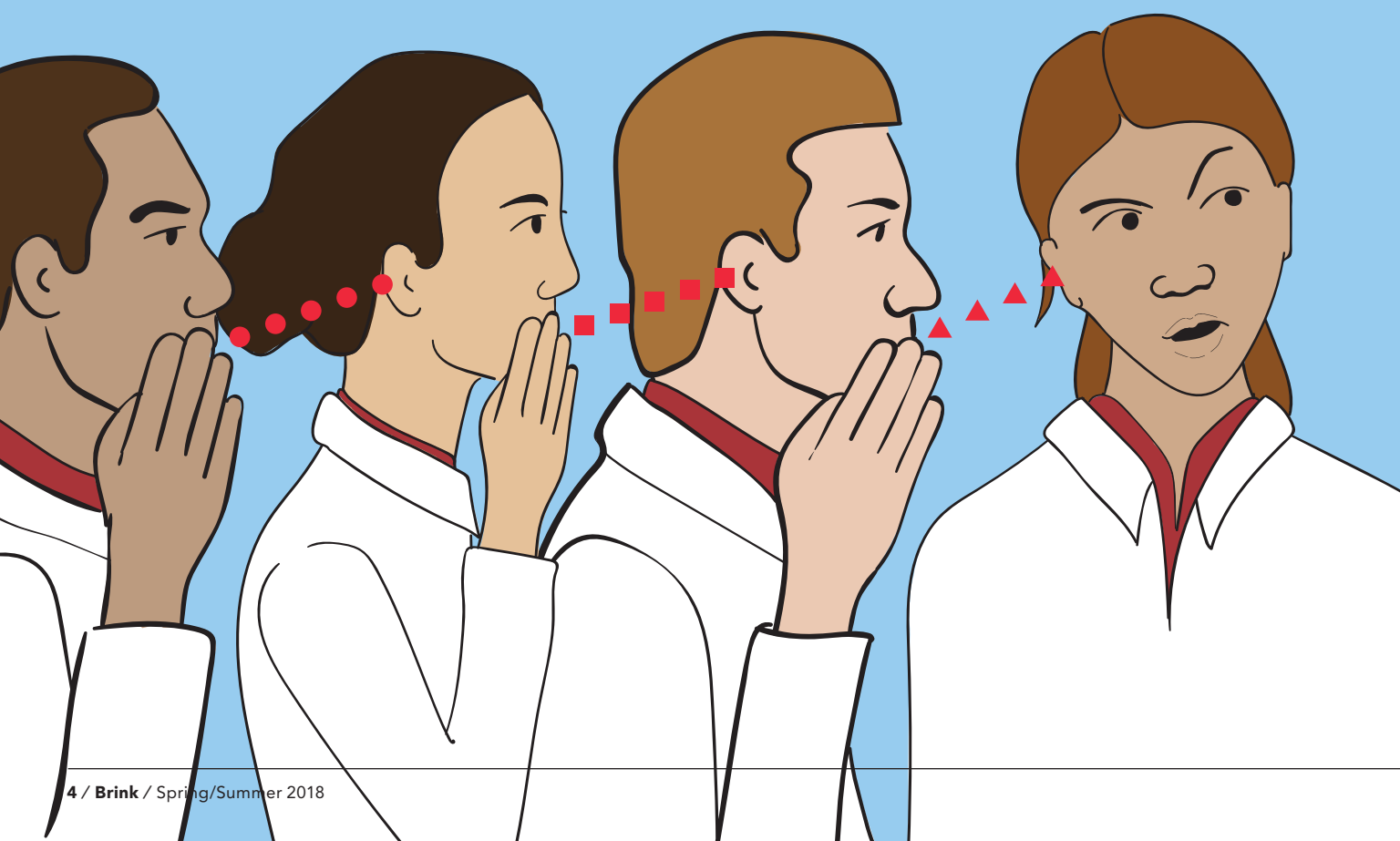
Can We Talk?

Raising your care team communication game can improve patient safety outcomes.

By Betty VanWoert, RN, BSN, CCM, CPHRM



What skills make a good clinician? To answer, many of us begin by listing technical skills like, "They always start IVs on the first try," organizational skills like, "Their appointments always run on time," or indications of satisfaction, "Residents and families always have the best things to say about them." The last time you considered your clinical skills or those of your colleagues, did communication skills come to mind? Rarely do we think of communication skills when asked to describe clinical skills, yet failure to communicate critical information in a timely manner or to speak up about a concerning observation can lead to devastating outcomes.

Care team communication gaps: What's in the data?

Communication failure has long been identified by the Joint Commission as a leading root cause of sentinel events—unexpected occurrences involving death or serious injury. A Constellation analysis of 2,413 medical professional liability claims found that communication failure is a contributing factor in 35 percent of claims asserted from 2012 to 2016. CRICO Strategies' Comparative Benchmarking System (CBS) found similar results in analyzing 23,658 medical malpractice case experiences from across the United States: Communication was a factor in 30 percent of these cases.[1]

According to CRICO Strategies data, failed health care team communication occurred in 57 percent of the above-mentioned cases and accounted for 73 percent of the cases that incurred losses. The most frequent breakdowns occurred with health care team miscommunication in the following areas:

- Miscommunication of the patient's condition—26 percent of cases,
- Poor documentation—12 percent of cases,
- Failure to read the medical record—7 percent of cases.[1]

Because communication within care teams is more often a contributing rather than a causative factor in malpractice claims, it can be overlooked when first seeing an unexpected patient outcome or completing a root cause analysis. Don't be fooled! Claims with care team communication missteps resulted in indemnity payments 49 percent of the time—14 percent more than when communication with the patient breaks down.[1]

Care team communication gaps cause harm that can also result in reputational damage to clinicians and organizations. Patients, residents and families who feel wounded are not only inclined to make a claim, but also to share their experience across social media.

Complexity lends itself to poor communication

It may not look like it to those of us practicing inside the system, but health care is complex. Individuals and teams tend to overlook this complexity when processes become routine, or familiarity with co-workers leads to the assumption, "I know what the other person thinks or wants." Patient care situations that once seemed exceptional are now standard:

- Multiple care team members within the same organization now provide care to the same patient or resident,
- Many patients and residents receive care at satellite locations or increasingly via telemedicine, and
- Referrals are made to multiple practitioners, labs, diagnostic centers or specialty facilities.

Making assumptions is a human reaction to working in a complex environment. But allowing casual, presumptive communication to become the norm across multiple team members can lead to the cracks that patients—and their safety—fall through.

The EHR as a means of communication

A great deal of team communication about patients and residents happens through clinical records within the electronic health record (EHR). While the patient or resident is present at *their* every experience, it would be impossible for any single clinician to be present at each patient encounter. So the EHR provides not only invaluable real-time documentation of events, but the means of communication for care teams throughout and across organizations.

Many communication processes are now integrated into the EHR, adding even more complexity. Remote access to clinical records further makes timeliness of entries even more critical so as to avoid miscommunication. In addition, the complexity of documenting follow-up for consultations, referrals and patient-related messaging between clinicians can be high-risk processes for team members, who may assume that the other party will be responsible to communicate with the patient. Patients, for their part, also assume they'll hear from someone and get confused when they don't hear from anyone.

Assessment tools, such as the SAFER Guides for EHRs found in the resources section below, can help organizations easily review their practices and find ways to improve with this aspect of team communication.

How patients view communication

Much of the time, a clinician's perspective can be centered around their unit, department or organizational teamwork culture. Health care is a team sport, and like any sports team, members play both leadership and supporting roles and watch each other's back.

But patients and residents think in broader terms of their health care community. This can include transitions of care across outpatient services, hospitalization, and their home, which could be a senior living facility. Effective communication becomes more daunting when it occurs between health care facilities. Involvement of more than one physician or health care facility caring for a patient or resident multiplies the opportunities for communication breakdowns.

Teamwork and satisfaction play a role

What part does team satisfaction play in a discussion about communication? It turns out that communication and teamwork influences the quality of working relationships and job satisfaction, and it can profoundly impact patient safety.[2] When a team has good communication around tasks and responsibilities, evidence has shown significant reduction in nurse turnover[3] and improved job satisfaction due to a culture of mutual support.[4]

Job satisfaction can have a positive effect on patient-centered communication. In one study, Larson and Yao found a direct relationship between clinicians' level of satisfaction and their ability to build rapport and express care and warmth with patients.[5]

Organizations can support clinician satisfaction by creating a work environment to include elements contributing to care team satisfaction, such as feeling supported administratively and inter-personally; feeling respected, valued, understood and listened to; and sharing a clear mental model of the team's mission and objectives.

Next steps: Communication systems and policies

Communication awareness, tools and processes can enhance collaboration, strengthen transitions of care, and improve efficient workflows within organizations and across communities. Improving communication is an often-untapped opportunity to increase clinician effectiveness as well as patient safety.

The primary risk management objectives for any organization are:

- Effective communication systems among the entire care team to identify and resolve problems that may compromise patient care and result in injuries,
- Effective policies, procedures and protocols that are consistently followed by administration, clinicians and other staff.

To meet these objectives, periodic review of current communication systems and processes can help ensure identification and promote resolution of potential problems.

References

1. CRICO Strategies. Malpractice risks in communication failures: 2015 CRICO Strategies National CBS Report. bit.ly/2rhkaaP Accessed December 5, 2017.

2. AHRQ. TeamSTEPPS.® ahrq.gov/teamstepps/index.html Accessed December 11, 2017.

3. Lein C, Wills CE. Using patient-centered interviewing skills to manage complex patient encounters in primary care. *J Am Acad Nurse Prac.* 2007;19(5):215-20.

4. DiMeglio K, Padula, C, Piatek C, et al. Group cohesion and nurse satisfaction; examination of a team-building approach. *J Nurs Adm.* 2005;35(3):110-20.

5. Larson, EB, Yao, X. Clinical empathy as emotional labor in the patient-physician relationship. *JAMA. 2005;293*(9):1100-6.

6. Institute of Medicine. *Health Professions Education: A Bridge to Quality.* Washington, DC: National Academies Press; 2003.

Resources

AHA: **AHA Team Training Featuring TeamSTEPPS®** bit.ly/2AX2n1c

AHRQ: **About TeamSTEPPS®** bit.ly/2nAx32X

HealthIT.gov: **Safer EHRs: An Introduction to the SAFER Guides** healthit.gov/safer

Institute for Healthcare Improvement: **How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations** bit.ly/2BLmGw4

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Assess your communication culture, tools and processes

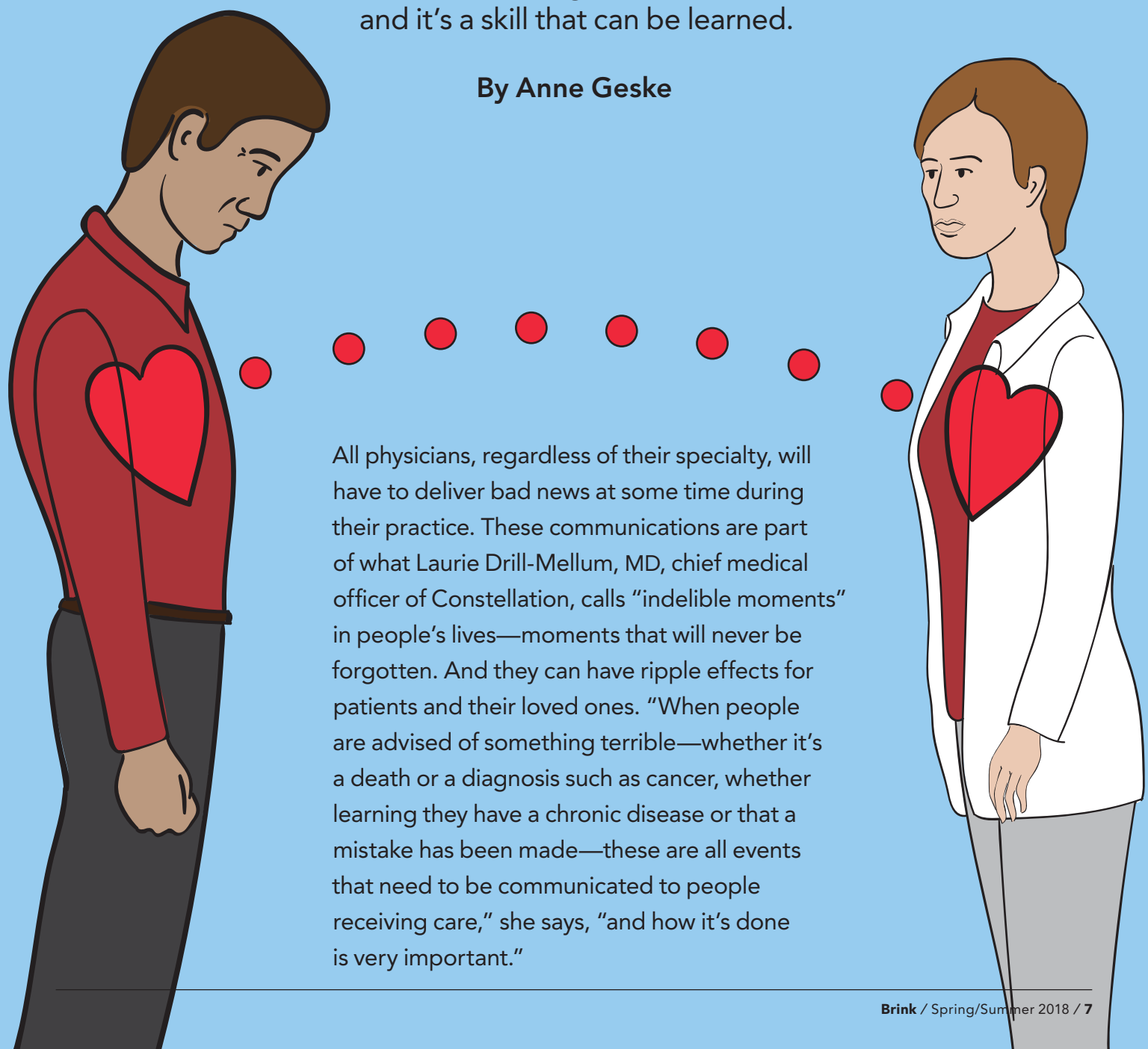
These questions will help you assess your organization's current baseline of communication fitness. See Resources for more ways to get started.

- ☐ **Do you operate under informal practices that have evolved over time?** Risk of patient injury increases when team members operate under differing practices or understandings. Convert informal practices into formal written policies and procedures.
- ☐ **Do you ensure that every care team member is empowered to speak up and bring issues to the forefront for resolution?** Be a learning culture where everyone learns from patient concerns and incidents where communication gaps play a role.
- ☐ **Do you proactively set follow-up and communication expectations with clinicians on both sides of referrals and consults?** Once care has been initiated, clinicians on each side should include in their documentation who has responsibility for follow-up care and communication with the patient.
- ☐ **Do you educate or mentor clinicians and care team members on communication skills?** The Institute of Medicine (IOM) Report on Health Professions and Training[6] underscores the importance of communication training for clinicians and team members.
- ☐ **Do you meet across traditional silos with community health providers to identify and repair communication issues?** TeamSTEPPS® can be valuable, as it offers customizable best practices in teamwork tools and processes. It's easy to use, publicly available, and has been researched and field-tested by high reliability organizations for over 35 years.

When News Isn't Good

The way a clinician delivers bad news can make a huge difference—and it's a skill that can be learned.

By Anne Geske



All physicians, regardless of their specialty, will have to deliver bad news at some time during their practice. These communications are part of what Laurie Drill-Mellum, MD, chief medical officer of Constellation, calls "indelible moments" in people's lives—moments that will never be forgotten. And they can have ripple effects for patients and their loved ones. "When people are advised of something terrible—whether it's a death or a diagnosis such as cancer, whether learning they have a chronic disease or that a mistake has been made—these are all events that need to be communicated to people receiving care," she says, "and how it's done is very important."

Take emergency medicine, Dr. Drill-Mellum's specialty. Often, people in the emergency room don't anticipate being there—as a patient or as a family member. "In emergency medicine especially," she explains, "events in which a patient receives bad news are often unpredicted and fraught with a significant emotional component—and a lasting one at that. Many people can tell you about these indelible moments in their life, and they usually involve shock, fear, grief, surprise, anger, shame, disgust—all these basic human emotions."

How doctors communicate bad news is so important for patients facing a hard truth about their physical health or families trying to comprehend the death of a loved one. It also affects their relationship to patients, and even how they see their work in medicine. "Some practitioners naturally have a gift for communication, but many people don't," says Dr. Drill-Mellum. "But communicating difficult news in a clear, sensitive and humane way is a learnable skill—in fact it should be a requirement for a doctor's skill set. It's a responsibility that takes presence and empathy. And it's a way of connecting with the patient and why we chose this profession."

Ground-breaking training

In 1995, pediatricians Lorene Rutherford, MD, and Janet Serwint, MD, with the support of the Cameron Kravitt Foundation and the Johns Hopkins pediatric training program, developed a seminar focused on delivering news of a death to parents of infants and children. The program exists because Jason and Beverly Kravitt had an unexpected stillbirth they describe as "particularly difficult because the medical community then was extremely poorly equipped to deal with the situation and meet the needs of parents who went from eager anticipation of all life holds into an emotional abyss."[1]

The Kravitts established the foundation in honor of their stillborn son to support families and provide the knowledge and training necessary for health professionals to meet the emotional needs of parents and others in times of great need. A day-long seminar for pediatric residents was born in which participants learn principles, see techniques modeled, and have a chance to practice themselves.

The training has been offered for 24 years at Johns Hopkins, and for 12 years at New York City's Weill Cornell Hospital. In 2017, the University of California, San Francisco, and Cambridge University in the United Kingdom launched new training programs, and the foundation plans to expand their programs to other top teaching hospitals in the United States and overseas.

Staying well to serve patients and families

Emotions around a seriously ill or dying patient can also be difficult and intense for physicians and others on the care team. To help physicians stay healthy and emotionally available, teaching resiliency skills goes hand-in-hand with teaching communication skills.

Dr. Lorene Rutherford has spent her career serving pediatric patients and their families, and is currently a pediatrician at Lakeview Clinic in Chaska, MN. "Burnout is a huge problem for physicians," she says. "Most physicians go into medicine full of optimism and enthusiasm, hoping to make a difference in people's lives. Gradually, stress takes a toll, and unless you develop healthy coping skills, things change and the joy and hope drain away. As you become a seasoned physician, you may learn self-care skills. Sadly, some people learn maladaptive coping skills. In our program, we're now teaching resiliency skills to residents, so they learn to cope with *healthy* habits—and keep filling up their well rather than just continuously depleting it."

> ***"People are looking to their physician for openness, honesty, kindness and a compassionate presence."***

Dr. Drill-Mellum agrees that the importance of attending to the wellbeing of physicians and all those who devote their lives to health care cannot be overstated. "We know that this is a demanding profession," she says, "and that paying attention to self-care promotes physician wellbeing and patient care—it benefits everybody."

Joining with the family at the time of a loss can also be part of self-care. "Physicians have received a message that they can't talk about how they feel or show emotion," says Dr. Drill-Mellum. "There's been misinformation about that. People are looking to their physician for openness, honesty, kindness and a compassionate presence. Expressing emotion lets them know that their loved ones mattered. That's why we went into medicine—because we want to serve people and take care of them."

Reference

1. Cameron Kravitt Foundation. About CKF. cameronkravitt.org/ Accessed December 5, 2017.

Resources

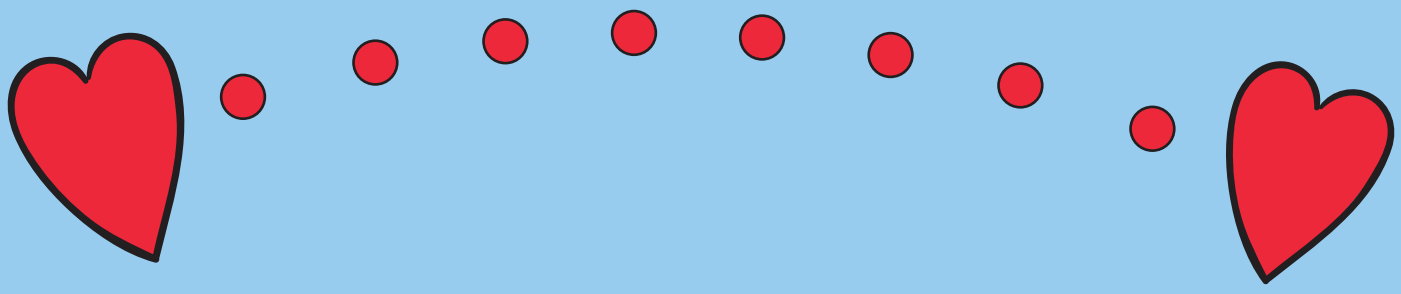
AAP: **Resilience Curriculum: Resilience in the face of Grief and Loss** bit.ly/2A9Vfis

Cameron Kravitt Foundation: **Resources for Health care Professionals** cameronkravitt.org/resources/

Medically Induced Trauma Support Services (MITSS): **Tools for Building a Clinician and Staff Support Program** bit.ly/2iqJs43

Schwartz Center for Compassionate Healthcare: **Schwartz Rounds®** bit.ly/1IjzVkM

ANNE GESKE
Health Care Feature Writer



Sharing bad news in a clear, caring and respectful way

When sharing bad news, Dr. Rutherford says to remember that every situation is different and *requires you to be in the moment.* Use your heart—not just your head—to be available to people in what might be the worst moment of their life. She summarizes here some guiding principles learned from her years of practice:

1. **Find a quiet, private place** without interruptions. Assemble the family and those supporting them. If they have a faith tradition, consider asking if they would like to call a chaplain or pastor for support.
2. **Use the person's name and know their gender.** Getting this right is crucial and shows respect.
3. **Consider asking first what the family already knows.** This will help direct the beginning of the discussion.
4. **Start with a short summary of circumstances** in clear and simple terms. If the news is a death, gently but clearly state that "_____ has died." Pause to let them absorb the news. And resist adding information—they're unlikely to hear it.
5. **Be prepared for a wide variety of responses.** Stay present, sit quietly and avoid becoming defensive if patients or family members lash out. Answer questions simply and directly, acknowledging any uncertainty. If you don't know something, say you don't know it, then offer to seek answers and follow up.
6. **Convey that everything possible was done to help the patient.** Hearing that there was minimal suffering or pain and that the care team did everything possible—if that's the case—can be helpful.
7. **Give the family time alone, and offer to meet with them again** to allow them to ask further questions.
8. **Spend time in self-reflection.** Engage in self-care strategies that help you process your feelings about the situation. Seek additional support from colleagues, friends or family to help manage stress. A provider support group, one-on-one counseling or Schwartz Rounds®, if available, can be very helpful if you're struggling.

Resiliency: Coping with the loss of a patient

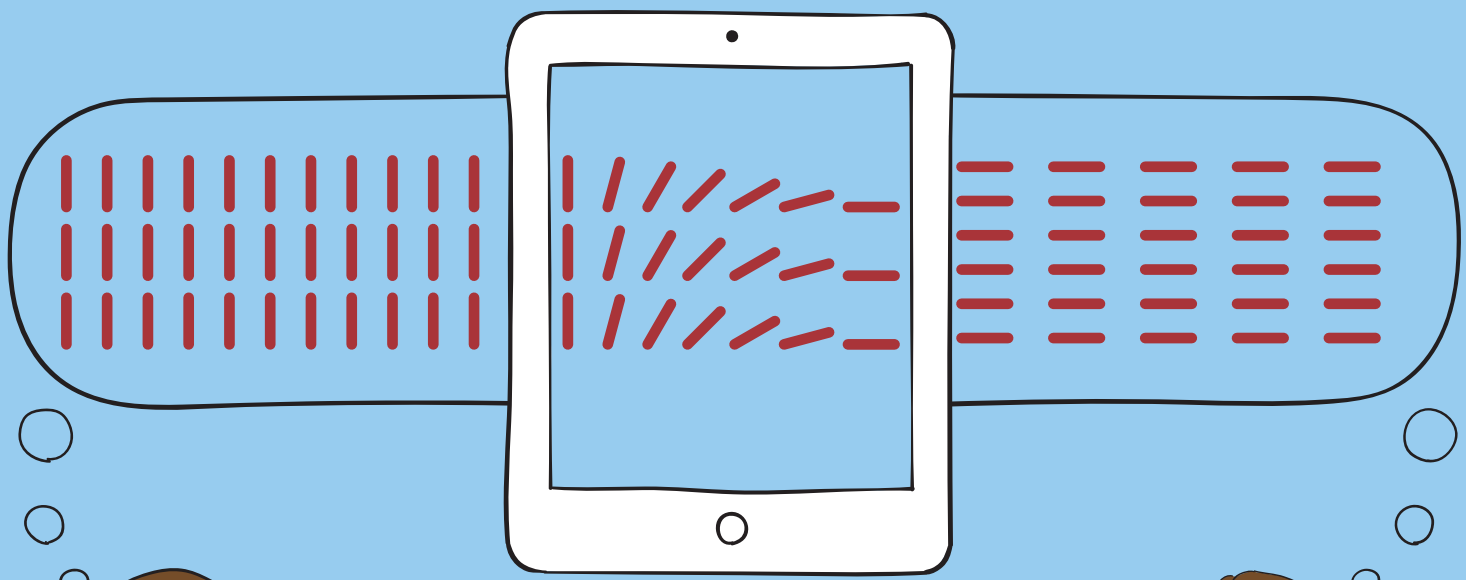
Dr. Janet Serwint is a professor of pediatrics at Johns Hopkins University School of Medicine. She leads the Cameron Kravitt Foundation training in delivering bad news and has been co-teaching the program at Hopkins with Dr. Rutherford for the last 23 years. Dr. Serwint believes resiliency education is critical because physician burnout, depression and suicide are so prevalent.

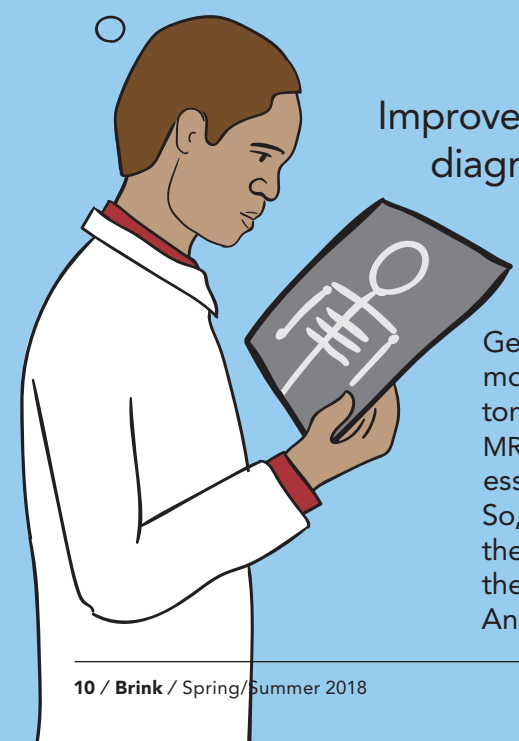
"As pediatricians," she says, "we have wonderful, very joyous jobs. But it's very difficult to work with families and with children who are dying or gravely ill. While we are very much there to support families, it's also important that the physicians and clinicians be supported themselves because this impacts them tremendously."

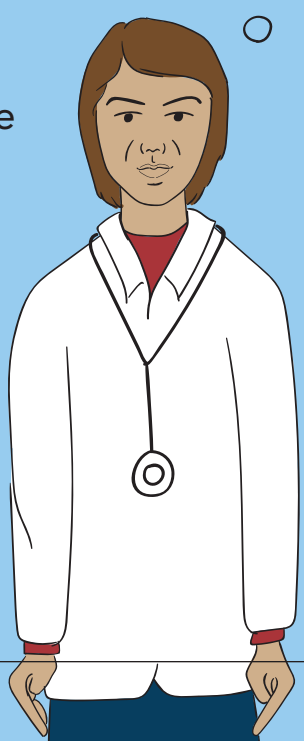
She offers three mechanisms of support for health professionals who are affected by a death or seriously ill patient:

1. **Process the experience.** If it's a death, take time to grieve the loss, joining with the family, reaching out to them, attending the funeral or sending a card. The celebration of the patient's life can be a very uplifting and healing experience.
2. **Debrief.** It's good for physicians and members of the care team to get together to talk about the experience—both the medical decision making and the emotions engendered. There can be much sadness, but also sometimes relief if a patient has suffered a long time. There is also happiness in remembering and celebrating the life of the patient.
3. **Reflect.** Meditate, journal, talk to a colleague. Everyone is different; develop strategies that work for you.

No Longer Lost in Translation







Improved radiology reporting aims to reduce diagnostic and follow-up system errors.

By Anne Geske

Getting the diagnosis right—what could be more important in assessing a patient's symptoms? Imaging tests such as X-rays, CT scans, MRIs, ultrasounds and mammograms are essential tests within the diagnostic toolbox. So, it follows that any communication between the radiologists interpreting these exams and the clinicians who order them is essential. And yet, it's not so simple.

Radiology is a complex specialty, and radiologists use their own intricate language, which must then be translated, so to speak, into a clear and comprehensible interpretation—even for the highly trained medical professionals who order them. Given that communication between radiologists and clinicians usually takes place within written reports and the electronic health record (EHR)—not in person or via phone—the potential for error is significant. In fact, MMIC found that the misinterpretation of tests and results, including radiologist-to-clinician communication, is a contributing factor in 27 percent of malpractice allegations.[1] More effective communication between radiologists and ordering clinicians may have made a difference in these cases.

The reference process

The American College of Radiology (ACR) is actively engaged in defining processes to reduce diagnostic error. In 2015, the ACR supported a process radiologists could use when communicating to referring clinicians through the radiology report: The radiology report should include a standard management recommendation suggesting next steps for evaluation and a reference supporting that recommendation.

Sue A. Crook, MD, FACR, is a radiologist with Suburban Radiologic Consultants (SRC) in Bloomington, MN, whose staff works with large Twin Cities health systems that have been rolling out the "reference process," as it's referred to in short, since 2015. "We help clinicians know what the next step is, if they're unaware of it," says Dr. Crook. "Following the impression of our report, we suggest further follow-up—such as another imaging test or a recommendation for a specialist—and what the evidence-based reference is for that."

In her work with larger systems, the move toward having all clinicians follow similar protocols for work-ups involving radiologists is progressing. The reference process is a way for radiologists to uniformly use consensus guidelines in their recommendations.

Reducing human error

Without such a process, the referring clinician interprets the complex terminology in the radiologist report and makes their own determination for next steps. And because clinicians are human, perceptions and second-guessing may come into play. Radiologists have sometimes had to work to overcome perceptions by striking a balance between what might be seen as over-diagnosing, which is making sure results aren't dismissed that point to further work-up, and under-diagnosing, in which more serious issues might fall through the cracks.

"In the past, there have been lawsuits where a radiologist interpreted results correctly," Dr. Crook explains, "but the referring physician thinks the radiologist overcalled it and decides to dismiss the issue. With this new process, I can say in my report, 'I'm worried this patient may have cancer. We need to do the next test, and here is the evidence-based reference.'" The reference process helps ensure that patients who need further evaluation get it.

It's not surprising, then, that this relatively new patient-safety process may soon become a common best practice. Its implementation is recognized as a cutting-edge way to ensure that communication between radiologists and busy clinicians doesn't fail. "Along with physicians, we have PAs and NPs referring patients to us," Dr. Crook says. "They're busy, and when they see the report—the history, findings, impression and, at the very end, the management recommendation—it kind of pops out to them. It's something they can look at and pay attention to make sure that they *understand* the report, the words used and why those words are important."

At SRC, the management recommendations started with the Fleishner Criteria for pulmonary nodules and has branched out to more and more areas as the ACR collaborates with societies, creating consensus papers. "These consensus papers are great," Dr. Crook explains, "because, as a radiologist, they help give guidelines that may help protect you legally. We're using published guidelines for our decision-making processes."

Culture shift

In Dr. Crook's experience, health care culture is becoming more collaborative. More radiology groups are using management guidelines to prevent diagnostic error, prevent follow-up system failures and improve communication with clinicians. But it wasn't long ago that the atmosphere was less collaborative. "Ten years ago, if a management recommendation was included in a radiology report back to a physician, it may have been perceived that the radiologist was encroaching on their turf and ability to decide the next steps for their patients," says Dr. Crook. "Now, clinicians are asking for more management recommendations encompassing multiple diagnoses. The expectation is to integrate management recommendations as a support tool into the EHR, which is a radiologist-driven way to help the clinician with evidence-based tools that are easily available to them in the EHR."

As medicine—the tests, procedures and knowledge base clinicians are expected to have—gets more complicated, medical professionals are realizing they can't do it all. "That's why you look to the expert in that area," Dr. Crook says. "Just in radiology, there are ten specialties. If I can't know all of radiology, I certainly can't know all of medicine. As we get more collaborative, physicians are happy for the help—they're more accepting of it. Health care is becoming more patient-centered and more of a team effort."

Read a real-life story of communication failure between radiologist and clinician in "Cancer Diagnosis Missed," page 18.

Reference

1. *Brink*, 2017 Spring Issue. bit.ly/2AUyler Accessed December 4, 2017.

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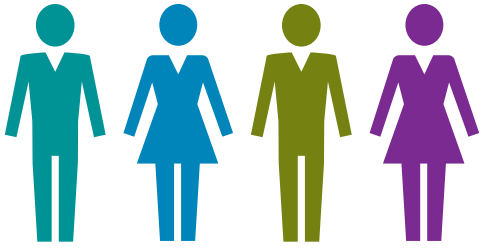

Citizen Jurors Speak Up

Patients weigh in on ways to reduce diagnostic error.

By Liz Lacey-Gotz

Improving communication and culture in health care settings isn't solely an issue for clinicians and providers—there's another group of people highly invested in improving their care: Patients.

Patients are ready to step up, speak up and share responsibility for their care, according to new research from the Jefferson Center, an engagement and public policy organization that used a citizen jury to engage patients to help tackle the staggering problem of diagnostic error.

Diagnosis in health care has become big news since the 2015 Institute of Medicine (IOM) report stated, in no uncertain terms, that diagnostic errors are frequent and costly.[1] According to MMIC data, diagnosis-related allegations in malpractice claims are the third most frequent, and account for the second highest cost—$84.7 million in total.[2] The IOM report, *Improving Diagnosis in Health Care*, is a watershed report that includes eight recommendations focused on health care teams and systems.

The Jefferson Center research took a different angle: a patient-centered approach. And the result is five recommendations that have the capacity to go well beyond improving diagnosis, to positively impacting a patient's entire health care journey.

How can non-experts help reduce diagnostic error?

As health care consumers—five percent of whom will experience a diagnostic error while seeking outpatient care in a given year[1]—patients have a lot to gain. According to Jefferson Center Executive Director Kyle Bozentko, "This was a unique opportunity to use the citizen jury method to explore how to meaningfully bring patient voices into diagnostic error improvement and quality improvement."

The center's proprietary process employs citizen juries that are immersed in a topic through presentations by experts. They're then given time to discuss and develop ideas, and bounce these ideas off subject matter experts. Eventually, the juries develop a set of recommendations they feel can improve the subject at hand. Unlike a focus group, citizen jurors hear testimony from subject matter experts before they discuss, so conversations move from opinions and emotions to ideas and possibilities for actionable improvement and change.

The Jefferson Center recruits citizen juries to be diverse and demographically balanced; the diversity of the diagnostic error group allowed them to gain insights into how their ideas could be actionable for a broad spectrum of people. "The patients came from a wide range of health care and clinic settings," explains Bozentko. "We had people ranging from those who have had employee-based private insurance or general hospital coverage their entire life, to retirees and veterans who had experienced VA care, plus people who were uninsured, underinsured or had not visited a care facility or had access to a doctor in years." The jury on diagnostic error included 20 individuals selected to participate for 50 hours over two weekends.

Bozentko has been impressed by the insights non-experts can provide. "Patients bring some of the same thematic and bigger-picture understandings that experts bring, but they can present and communicate their ideas much more clearly and more accessibly. They're less technical, less legalese-focused, and their recommendations are more likely to be utilized and

How the Citizen Jury Works

The Jefferson Center's process provides citizens and communities with the resources they need to unleash new ideas and create change.

Define purpose and scope

Before a jury is recruited, the center involves partners, community members and other stakeholders to define the purpose and scope of citizen engagement on a specific issue.

1
Recruit participants

Thousands of individuals in the target community are randomly invited, then selected to ensure demographic diversity, so that each jury is a microcosm of the larger community.

2
Provide background

The jury is provided with unbiased background information and expert speakers to inform their conversations.

3
Facilitate deliberation

Creative deliberation takes place over many days to allow the jury to understand the issues and generate quality recommendations.

4
Offer recommendations

The jury creates recommendations to address the issue through dialogue and voting.

Amplify and implement

The center takes the jury's recommendations and works in partnership with participants, sponsors, community members, community organizations, businesses, public officials and others to support, amplify and implement them.

Adapted with permission from The Jefferson Center.
Learn more at Jefferson-Center.org.

understood more clearly by other patients." says Bozentko. "Rather than just hearing the background and having an opportunity to share ideas, they were grounded in the realities of provider constraints, administrative concerns, and legal and operational challenges that might come up."

The Jefferson Center's process allows the jury's initial ideas to be further vetted and revised as ideas are discussed with health professionals. "We want to take it from more than just, 'What do patients come up with?'" says Bozentko. "[The ideas] got beta tested along the way, and that feedback was brought back to the [jurors], who considered it in their final evaluation and recommendations."

A valuable learning curve for jurors

Bozentko noticed that the jurors' understanding was transformed by the insights into the health care system they learned from doctors, clinicians and other relevant professionals. Two key learnings had a significant impact on the participants and their recommendations.

First, they began to see that diagnosis is a process rather than a one-time event or appointment. "The notion of diagnosis as a process that's ongoing and emergent made an observable difference in how patients who participated understood the issue," says Bozentko, "rather than simply thinking and feeling as though 'you walk in, you have this one conversation, you provide your lab sample or imaging, and all of a sudden you should know what it is.' That's a cultural expectation that seems to be pervasive."

Second, they understood better the constraints and systems that can limit clinicians' time spent with patients and shortchange the diagnostic process. "An expert was discussing time limits that he and his colleagues were facing in the clinic," relates Bozentko. "That was a real eye-opener for patients to say, 'Wow, I never realized they were operating under those parameters. I just thought maybe they didn't want to see me, not that they were obligated to get out of the room quickly.' That changed their understanding and appreciation of why a doctor was more to the point, or brusque, with questions or other things."

Five strategies for patients, from patients

Because jurors approach the issue from the patient perspective, their recommendations can offer valuable information on how to improve communication and collaboration in health care settings. Bozentko observed that jurors, as patients, often "feel they are not being actively involved, but rather simply processed."

Once empowered and informed as jurors, however, they could see the value of speaking up more during appointments and taking on more responsibility for their care—but only in ways that help their care teams do the best job possible. "Patients didn't want to run rampant and take over the whole process," says Bozentko. "They simply wanted to be clear on where there were opportunities to serve in the role of being a team member, and provide the information that was helpful and not anything more."

At the end of deliberation, jurors identified five main strategies patients can employ to help improve the diagnostic process and limit errors:

1. **Present symptoms clearly and completely.** Be truthful and accurate when discussing your medical history, and come to your appointment prepared to discuss your symptoms thoroughly. For example, eight characteristics of symptoms are: quantity, quality, aggravating factors, alleviating factors, setting, associated symptoms, location and timing.
2. **Assert yourself in the relationship.** Be clear, concise and persistent. Ask detailed questions, and keep your provider informed if your condition worsens or changes. And, consider a second opinion if you are concerned about the accuracy of your diagnosis.
3. **Coordinate your care.** Seek out ways to better coordinate your health care, and maintain your medical records. Find physicians and clinics that can help you in these efforts.
4. **Ensure accurate records and tests.** Keep your own set of medical records—including tests, appointments, follow-ups, notes and images. Point out errors or inaccuracies and work with providers to get them corrected.
5. **Manage your care.** Manage expectations and ensure your communications are heard. Follow up on your physician's recommendations—including making follow-up appointments, completing testing or imaging, and taking medications as prescribed.

Moving forward

Next steps for the Jefferson Center and other organizations involve exploring the use of these strategies in clinical settings, plus additional research to test how to measure the success of these ideas and their effect on the diagnostic process. The Society to Improve Diagnosis in Medicine is already utilizing these patient-centered recommendations as they further explore ways to improve the diagnostic process.

This citizen jury project, entitled "Clearing the Error," ran from late 2014 to early 2017 and was a collaborative effort between the Jefferson Center, the Maxwell School of Citizenship and Public Affairs at Syracuse University, and the Society to Improve Diagnosis in Medicine, with funding from the Agency for Healthcare Research and Quality.
Learn more at Jefferson-Center.org

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1. National Academies of Sciences, Engineering, and Medicine. Improving diagnosis in health care. bit.ly/2u1l7qj Published September 22, 2015. Accessed December 20, 2018.
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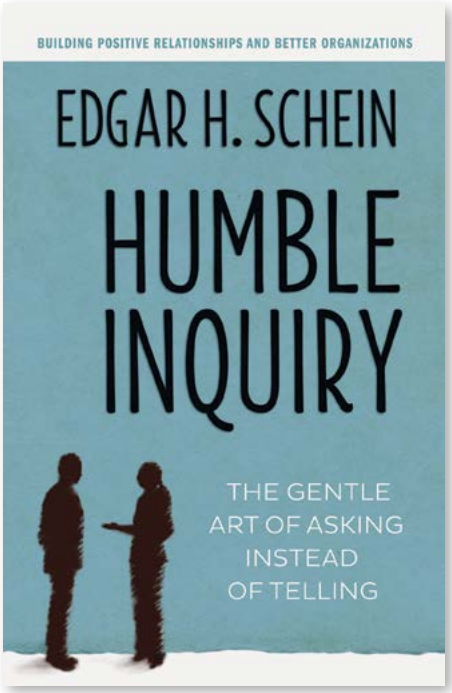
Ask, Don't Tell

Seeking deeper connections can lead to better outcomes.



In "Humble Inquiry: The Gentle Art of Asking Instead of Telling," Edgar Schein makes the case that asking is almost always more effective than telling. This simple shift can dramatically enhance relationships, improve health care outcomes and create better organizations. Humble inquiry, he explains, is "the fine art of drawing someone out, of asking questions to which you do not already know the answer, of building relationships based on curiosity and interest in the other person."

The shift from telling to asking fundamentally changes the dynamics of a relationship, says Schein. Telling implies that the other person does not already know what I'm telling them, and that they ought to know. Asking, in contrast, empowers the other person and makes me vulnerable; in essence, the other person knows something I want to know. This leads to a conversation that builds trust: it's an interactive process in which each party invests something and gets something of value in return.

This shift, in my view, has implications for leadership. Very often, leaders report that they've had conversations with their teams about a change in process and received little or no input. The leaders then implement the change, discover it's not effective and wonder what went wrong. When you ask the teams, they say that they were never asked and did not feel safe approaching their leader to voice their concerns.

What went wrong? In many cases, I suspect, people were informed of the change but did not feel empowered to provide feedback or suggestions. Their input was never really solicited. While leaders may think it's their team's responsibility to "bring things up," the fact is that organizations have hierarchies, and unless you actively change the dynamic, these communication gaps will persist.

I think humble inquiry is especially relevant in the health care environment. The most common medical errors we see involve missed or delayed diagnoses. Often, the issues are systemic—for instance, a test is not entered into the medical record, or a critical piece of information about a patient remains unknown to their physician. In some cases, nurses, technicians or others know the information but don't feel safe sharing it with the physician.

For their part, physicians sometimes conduct one-way conversations with a patient, engaging only long enough to determine a diagnosis, and not asking enough questions before telling a patient what they should do. Patients often feel in an inferior position and don't provide critical information, assuming the physician knows better than they do.

As "Humble Inquiry" illustrates, these are not good/bad scenarios. They're simply the normal outputs of a culture that rewards people for individual success, entrepreneurial approaches and knowledge. If we desire deeper connections and more effective outcomes, we must actively change our relationships—with colleagues, patients and family members.

The author suggests several ways to facilitate this change. First, slow down. Often, we're in such a hurry, we miss important cues, like body language. Ask if people feel good about a direction being considered, rather than whether there are any questions. Reflect more, and ask yourself humble inquiry questions as you engage: *What's going on here? What am I trying to accomplish? What are the constraints? Who is depending on me and on whom am I dependent? What might I be missing?*

Such reflection causes us to be more mindful. Sometimes a question like *What else is happening here?* can make all the difference.

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Are We Trending?

The implications of social media in health care settings.

Chances are your health care organization has already made forays into social media. But how savvy are you on the risks and responsibilities inherent in these platforms?

Twitter, Facebook, Instagram, LinkedIn, location sharing and review sites are just a few of the social media outlets that people use every day. Some social media sites allow users to make posts that allow others to respond; others serve as platforms for photo or file sharing. No matter what the focus or setting of your organization, social media impacts your practice of care.

Advantages

Social media can be a great way for providers to promote themselves, attract employees and get a feel for who is interested in their services. For senior living communities, it can be a great way to stay connected to residents' families by sharing information on upcoming events and posting photos if agreements are signed. Social media can present a friendly face for your organization to the public, improve marketing of services, help recruit employees, and establish a unique brand personality online.

Risks and restrictions

Some uses of social media may violate federal and state laws related to providing health care, and it can get complicated fast. Potential harm to organizations can include reputational damage as well as financial penalties. Harm to residents and patients also includes reputational damage, as well as loss of privacy and dignity.

The Health Information Portability and Accountability Act (HIPAA) may be violated when staff members share pictures of residents without written authorization, and HIPAA protects 18 identifiers of a person, not just a person's name. State agencies see HIPAA violations as abuse allegations. Even a simple gesture such as holding a resident's hand could be considered abuse if the resident or their family feels their dignity was lost when a photo was shared. When photos are published without permission, HIPAA requires organizations to say who will receive them—and on certain platforms, there is no way to tell for sure.

The CMS Conditions of Participation also require senior living communities to protect residents from abuse and harassment. Images, videos and posts may be considered evidence of harassment or abuse. Social media activities may trigger an abuse investigation depending on the content depicted.

Keeping this in mind, we offer here some practical tips for social media use. You may also contact your senior risk and patient safety consultant to discuss any questions you might have.

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1. Pew Research Center. Tech adoption climbs among older adults. pewrsr.ch/2pWRh2J Published May 17, 2017. Accessed December 5, 2017.
2. National Labor Relations Board. The NLRB and social media. bit.ly/1HiHtnV Accessed December 5, 2017.

Resources

ACP: **New Recommendations Offer Physicians Ethical Guidance for Preserving Trust in Patient-Physician Relationships and the Profession When Using Social Media** bit.ly/2ASUycT

AHCA: **Social Media** bit.ly/2iUguxb

AMA: **Code of Medical Ethics, Opinion 2.3.2** bit.ly/2jSfgPs

LeadingAge: **Social Connectedness and Engagement Technology for Long-Term and Post-Acute Care: A Primer and Provider Selection Guide** bit.ly/2ipUsi5

NCSBN: **White Paper: A Nurse's Guide to the Use of Social Media** bit.ly/2BAzF2U

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Practical tips for using social media

- **Remain silent on comments:** If a complaint or negative comment is posted on your site or in the public domain, it's best not to respond because it might violate federal or state privacy laws. If you must respond, consider a standard response, such as "Please direct questions to _____. We do not respond to complaints, questions or comments through social media." As for positive comments—they speak for themselves.
- **Take proactive steps to mitigate misuse:** Rather than waiting for a report of misuse, use tools available on the internet, customizing alerts from general to specific mentions of organization names. Learn reporting and removal processes for various sites before an incident occurs. Consider implementing an anonymous reporting mechanism to encourage reports of misuse.
- **Handle reports of misuse immediately:** When a report of misuse by an employee is received, immediately determine the safety of the resident/patient, and separate them from the accused individual. If the misuse is limited to a potential HIPAA violation versus a potential situation of abuse, reporting timelines differ. Work with the social media site to remove the post, and support or protect the reporting staff member from retaliation by the accused colleague.
- **Educate on best practices:** Educate all staff on best practices and privacy rules for social media, beginning at orientation. Include example scenarios of potential violations, reporting mechanisms, facility policy and applicable laws. In senior living communities, consider including residents and their families—the Pew Research Center reported that 67 percent of seniors use the internet, including social media sites.[1]
- **Develop social media policies:** When developing policies, tailor the language to state and federal law requirements. Overly broad or restrictive policies are typically found unlawful when reviewed by the National Labor Relations Board.[2] It's a good practice to invite staff members, residents and their families to participate in policy development. Policies that are flexible are more useful due to the ever-changing forums available.

Do

- ✓ Be aware of facility requirements for the reporting of lost or stolen devices and report lost or stolen devices that may contain protected health information (PHI) immediately.
- ✓ Conduct organization-wide training using practical scenarios.
- ✓ Ensure residents, patients, families and visitors are aware of social media policies.
- ✓ Audit the use of your organization's name through tools like Google Alerts, Mention or Social Mention.
- ✓ Make sure that any sites you link to are reputable.

Don't

- × Shy away from social media—just know the risks as well as the benefits.
- × Use personal devices for patient care.
- × Provide clinical advice.
- × Post or discuss information relating to residents, patients or clients.
- × "Friend" or "follow" those in your care.
- × Respond to any comments.
- × Acknowledge that a particular person is your patient or resident by commenting on their post.
- × Share any protected health information (PHI).

Cancer Diagnosis Missed

An abnormal finding on a pre-operative chest X-ray is not followed up, causing a one-year delay in diagnosing lung cancer.

SPECIALTY	ALLEGATION	PATIENT SAFETY & RISK MANAGEMENT FOCUS
⁄ Orthopedic surgery ⁄ Radiology ⁄ Anesthesiology ⁄ Hospital surgery center ⁄ Family practice	⁄ Failure to timely diagnose and treat lung cancer	⁄ Follow-up system failures

Facts of case

An orthopedic surgeon scheduled a left total knee replacement for a 70-year-old man with osteoarthritis. The orthopedic surgeon ordered pre-op lab tests and referred the man to his family physician (FP) for a pre-op physical. There were also orders for a routine chest X-ray on the anesthesia pre-op orders in the name of the orthopedic surgeon.

Following completion of the imaging, a radiologist reviewed the chest X-ray, documented that there was an irregular lung parenchymal mass in the left upper lobe that was suspicious for malignancy and recommended follow-up care. The radiologist also documented an attempt to contact the ordering orthopedic surgeon by phone. The report states that the radiologist was unable to speak with the surgeon and left a voicemail message about the abnormal finding. The surgery was completed without incident. There was no follow-up of the abnormal chest X-ray.

One year later, the man saw his FP for complaints of congestion, cough and fatigue. The FP diagnosed an upper respiratory infection. Several weeks later, the man returned to see his FP for increasing shortness of breath. The FP ordered a chest X-ray that showed a left upper lobe mass with interval enlargement. A subsequent CT and lung biopsy indicated poorly differentiated adenocarcinoma. The FP referred the man to an oncologist and several months later the man died from lung cancer.

The man's family filed a malpractice claim against the orthopedic surgeon, the radiologist, the anesthesiologist, the FP and the hospital surgery center, alleging failure to timely diagnose and treat lung cancer.

Disposition of case

The malpractice case was settled against the radiologist and the hospital surgery center.

Patient safety and risk management perspective

The investigation into this case revealed that the chest X-ray was ordered by the hospital surgery center pre-op nurse on the anesthesia pre-op orders under the name of the orthopedic surgeon. Neither the orthopedic surgeon nor the anesthesiologist authorized the chest

Of cases involving diagnostic error in the outpatient setting

45%

involve failures during follow-up and coordination, including breakdowns in communication[1]

X-ray order. In the patient's electronic health record (EHR), the portion of the pre-op evaluation form where the chest X-ray finding was to be entered was left blank, implying no one reviewed the radiology report prior to or following the surgery. The orthopedic surgeon testified that he did not receive a voicemail message from the radiologist and that he would not have looked for a test result on an image he did not order.

The radiology experts who reviewed the case had mixed opinions as to whether the radiologist met the standard of care by leaving a voicemail message for the orthopedic surgeon. They opined that there were other options such as directly talking with a delegate of the orthopedic surgeon to communicate the abnormal findings, as well as communicating directly with the patient.

All the experts who reviewed the case were critical of the hospital surgery center for using a confusing process whereby the pre-op nurse entered pre-op anesthesia orders in the name of the operating surgeon without authorization or a process to review and communicate test result findings.

Follow-up system failures

Follow-up system failures contribute to almost half of all diagnostic error malpractice claims. Even when appropriate clinical steps are taken to lead to a correct diagnosis, diagnostic error due to failures in follow-up systems still occur, as illustrated in this claim review.

An analysis of MMIC diagnostic error malpractice claims reveals that follow-up system failure claims are significantly less about breakdowns in patient assessment and interpretation of diagnostic studies, and more about:

- Communication breakdowns with the patient and family
- Communication breakdowns among clinicians
- Failure/delay in obtaining consult/referral
- Patient factors such as non-compliance with follow-up appointments
- Failure in reporting findings and revised findings
- Failure in follow-up systems for coordinating care

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Patient safety and risk management tips

Assess and analyze risks

- Assess your risk for diagnostic errors by completing the Improving Diagnosis Self-assessment.
- Evaluate your test management and follow-up systems using a failure mode and effects analysis (FMEA).
- Analyze your diagnostic error adverse events using a root cause analysis (RCA) process to identify areas for performance improvement.

Educate team members

- Educate clinicians and health care team members on the causes of diagnostic errors and follow-up system failures.
- Educate clinicians and health care team members on teamwork skills and communication processes.

Implement safer care policies and communication processes

- Optimize the safe use of processes and EHR technology for test management.
- Implement a formal communication policy and process for critical, abnormal, non-routine, pending after discharge, and discrepancies in test and image results.
- Communicate directly and formally with patients about test results and engage them as part of the health care team.

Resources

Links to resources on preventing diagnostic error and follow-up system failures can be found on the MMIC and UMIA websites by navigating as follows: MMICgroup.com or UMIA.com Login > Risk Management > Bundled Solutions > Preventing Diagnostic Error.

Resorting to Surveillance

A family installs a hidden video camera to confirm suspicions that their family member is being abused in a skilled nursing facility.

SPECIALTY	ALLEGATION	PATIENT SAFETY & RISK MANAGEMENT FOCUS
⁄ Senior living/skilled nursing	⁄ Failure to prevent verbal and physical abuse	⁄ Communication with residents and family ⁄ Video camera surveillance

Failure to ensure resident safety, primarily falls, was the

#1

most frequent and most costly allegation in claims involving skilled nursing facilities and senior living

Facts of case

A 62-year-old woman with a history of dementia and combative behavior was living in a skilled nursing facility (SNF). She was assessed as a high fall risk and the SNF care team implemented interventions to reduce the incidence of falls and fall-related injuries. Despite their efforts, she would get out of bed or up from her wheelchair unattended, and was frequently found on the floor in her room having sustained multiple bruises from her falls. Her family grew concerned about what they saw as increased bruising and asked the SNF for an explanation.

The SNF care team discussed her falls with the family, but the family was unsatisfied with the explanation. The family installed a hidden video camera to confirm their suspicions of abuse. When the family reviewed the video camera recordings, they saw a SNF nurse "throw" the resident to the floor from her wheelchair, turn off the lights and leave the room. They also observed a care team member yelling at the resident in response to her repeated cries for help.

Following this, the family moved the woman to a different SNF, filed a complaint with the state nursing and facility licensing boards, and filed a malpractice claim against the SNF alleging verbal and physical abuse resulting in physical injury and emotional distress.

Disposition of case
The malpractice case was settled against the SNF.

Resident safety and risk management perspective
The investigation into this case revealed that the family felt they were "given the runaround" when they asked the SNF administrator and care team about the woman's increased bruising. Family members testified they complained on several occasions about the SNF's efforts to reduce the resident's falls. The SNF administrator testified that the family wanted the SNF to use full bed rails to keep the resident in bed but didn't understand that bed rails should not be used because of the increased risk of injury.

The SNF nurse testified that the incident on the video footage was of her transferring the resident to the floor to protect the resident because she refused to stay in bed. The nurse testified she was worried the woman would sustain a fall injury when she tried to climb out of bed.

The experts who reviewed the case were critical of the SNF's communication with the resident's family and the documentation of resident's falls, and injuries sustained in falls. They were also critical of the SNF nurse and other team members' actions while caring for this resident whose behavior was due to her dementia condition. Experts commented that the SNF may need to do more to educate care team members about caring for residents with dementia.

Breakdowns in communication with residents and families
Breakdowns in communication with residents and families is a frequent contributing factor in senior living professional liability claims. In working with residents and families, it is important to effectively convey the risk of falls and fall-related injuries. The failure to ensure resident safety—primarily falls—was the number one most frequent allegation and the number one most costly in our analysis of claims involving skilled nursing, assisted living and independent living settings. Conversations about fall risk and realistic expectation-setting around falls and fall-related injuries should begin upon admission and continue with residents and families periodically—in care conferences, after a fall or with a change in condition.

Surveillance cameras in care settings
The use of video camera surveillance to deter or detect abuse and neglect in senior living and skilled nursing settings is not without controversy. Family members want the option to communicate with their loved one, observe and monitor their loved one's care, and confirm or deny suspected abuse. However, senior living organizations worry about other residents' rights to privacy and the adversarial relationship that hidden cameras can create. Residents and families fear retaliation when they request to use video cameras or when hidden cameras are found.

Most state laws do not permit or prohibit resident and family use of video surveillance cameras in a resident's room. In some states, residents and families have gone to court to use surveillance devices, and several states have laws that give residents and families the right to use electronic surveillance devices.

Resident safety and risk management tips

- Communicate routinely with residents and families, including in care conferences, to foster understanding, trust and goodwill.
- Provide timely and empathetic communication with the family when residents fall or suffer adverse events, in order to help prevent feelings of distrust or suspicions of abuse.
- Document family notification, resident/family concerns and attempts to alleviate concerns.
- Understand the laws in your state regarding the use of electronic surveillance in health care facilities. If there are no laws or regulatory guidance, know the consent-to-recording laws in your state.
- Consider developing a proactive policy with regard to family use of video surveillance, taking these issues into consideration:
  - Consent to recording/surveillance
  - Privacy protections
  - Notice of recording/surveillance
  - Conditions, limitations and restrictions
  - Resident agreements

Resources
Links to fall prevention resources can be found on the MMIC and UMIA websites by navigating as follows: MMICgroup.com or UMIA.com Login > Risk Management > Bundled Solutions > Long-Term Care > Best Practice and Evidence-based Resources > Falls Prevention.

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PART 2 IN A 2-PART SERIES

Missing: Critical Thinking Skills

Helping care team members improve critical thinking skills is the next step toward enhancing resident safety.

By Lori Atkinson and D. Michelle Kinneer

In Part 1 of this series (Fall/Winter 2018 issue of *Brink*), we described errors in clinical judgment as one of the top contributing factors to resident injury and malpractice claims in senior living and skilled nursing settings. Clinical judgment, which is the result of combining critical thinking skills with clinical reasoning, aids individuals in interpreting care situations.[1]

The good news is that critical thinking skills can be learned. There are different models on critical thinking,[2] and they differ by focus, components and measures. No matter the model your setting endorses, the skills relating to recognizing problems and changes in condition, decision making, implementing care plans and prioritizing care decisions have the most impact on resident safety and quality of care. The quickest way to improve critical thinking of care team members is to focus efforts in these areas.

Critical Thinking Defined

The American Philosophical Association defines critical thinking as purposeful, self-regulatory judgment that uses cognitive tools such as interpretation, analysis, evaluation, inference, and explanation of the evidential, conceptual, methodological, criteriological, or contextual considerations on which judgment is based.[3]

Critical Thinking Skills

- Problem recognition
- Decision making
- Skill implementing
- Care prioritizing

Assess your care team members and culture

Get started by doing a baseline assessment of your organization's culture and the current level of critical thinking skills among care team members.

To find out how your teams are doing, most researchers recommend a multifaceted approach that includes using assessment tools, reviewing variance reports or near misses, and observing actual clinical practice.[2] Another good tool for assessing these skills is to have team members complete self-inventories to rate their own abilities.

Once you understand your baseline culture, teaching and mentoring can begin. Does your organizational culture support critical thinking? Some good questions to ask are:

- Are team members encouraged to be inquisitive?
- Do you share learnings from near misses and errors?
- Do you support the reporting of resident safety issues?

Teach critical thinking skills

Experience and time are what individuals need to develop critical thinking skills naturally. As experience increases, it becomes possible to consider alternative outcomes to actions and decisions. Want to speed up the process? Here are a few good ways:

- **Training programs** can serve as a starting point for education. Provide group exercises with clinical scenarios and facilitate brainstorming to consider the outcomes of various actions.[3]
- **In-services and team meetings** are good ways for organizations to continue scenario-based learning.
- **Mentoring within a formalized program** allows for novice team members to learn to think through clinical scenarios they face.[4]

Education on critical thinking can be explicit—that is, directly stating what the processes of critical thinking are and expanding on them. Or it may be implicit, such as developing a training or course in which these processes are included within course objectives.[3] It can be beneficial to use a combination of methods. Here are some tried and true methods:

- Use Bloom's taxonomy when creating learning objectives to provide the level of knowledge and application you want participants to achieve in your course.[5]
- Create brainstorming scenarios that prioritize care decisions.
- Guide the discussion in learning scenarios by asking questions related to the problem in the scenario.
- When the problem is identified, turn the discussion to the decisions about next steps, and forecast the possible outcomes of those decisions.

Find teachable moments

How do we find teachable moments for care decision discussion? Sources of clinical scenarios can come from issues of *Brink*, our magazine on patient safety and risk solutions, and from our policyholder website. Media reports are another good source for developing scenarios that align with practice areas. Using examples of near misses or adverse outcomes that have arisen in your organization or community can serve as teachable moments as well.

Another source for scenarios is using the root cause analysis (RCA) process to examine errors or near misses that occur in senior living communities. During an RCA, those involved in the situation search for answers to questions involving who, what, when, where, and how; the RCA team then works to find strategies that will reduce the chances for future similar occurrences.[6] The learnings from the RCA can be used to develop and stimulate critical thinking for all team members.

Critical thinkers ask questions—are questions encouraged in your organization?

Create a culture that supports critical thinking

Organizations must prioritize critical thinking as an area of focus, and foster a culture that supports it. Critical thinkers ask questions—are questions encouraged in your organization? Does your organization support care team members who report resident safety issues and recommend solutions? An organizational culture that shares learnings from near misses and errors is one that enhances resident safety and team member wellbeing.

Attend the webinar, **Developing Critical Thinking Skills in Senior Living Teams,** March 14, 2018 at 12:00 CST. Register at MMICgroup.com or UMIA.com.

References

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4. Lasater K, Nielsen AE, Stock M, Ostrogorsky TL. Evaluating the clinical judgment of newly hired nurses. *J Contin Educ Nurs.* 2015;46:563-71.
5. Adams NE. Bloom's taxonomy of cognitive learning objectives. *J Med Libr Assoc.* 2015;103(3):152-3.
6. Hand MW, Seibert SA. Linking root cause analysis to practice using problem-based learning. *Nurs Educ.* 2016;41:225-7.

Resources

AHRQ: **Nursing Home Survey on Patient Safety Culture** bit.ly/2jk1uWy

The Joint Commission: **Framework for Conducting a Root Cause Analysis and Action Plan** bit.ly/2AWbtLx

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Finding the Words

Effective communication can help patients—and physicians—heal.

Indelible moments: Times seared into our memories, usually upon experiencing extreme feelings of joy, shock, grief, shame, fear, disgust or pain.

As a physician in training, I realized I would play an influential role in the formation of others' indelible moments. I was a resident in emergency medicine when I came to appreciate my responsibility, as an ER doc, in delivering bad news. It led me to a deeper study of communication, and to think about what I might want to hear and how I might want to be treated when on the receiving end of bad news.

It wasn't until I meditated more on the topic that I realized that some of my memories of *delivering* bad news are indelible, too:

I will always remember telling a father that his 4-year-old son, found unresponsive in the family's backyard pool the day of a big picnic, had drowned. A pool alarm, recently installed to warn of unnoticed entries, was turned off that day as there would be plenty of adults around to mind the swimmers.

I remember telling a middle-aged woman (mother of a 9-year-old), who had come to the ER alone with abdominal pain, that she had metastatic gastric cancer.

I remember telling a man that his beloved wife had sustained a life-ending intracerebral bleed.

I remember continuing CPR on an infant, long after there was any hope or chance of recovery, until the father could arrive and witness that "everything" possible was being done to save his son.

The list goes on.

I'm reminded of Tim O'Brien's book, "The Things They Carried," a collection of linked short stories about a platoon of American soldiers in Vietnam that elucidates some of the wounds we *all* carry, because none of us gets out of life unscathed.

From one of my heroes, Dr. Rachel Naomi Remen, I learned that we humans, who all suffer grief and loss, also all deserve access to healing and "generous listening" as we navigate our professional and personal journeys.

As physicians, we have the privilege of listening to and helping to heal the wounds of our patients, their families and our colleagues. Standing at the door, about to enter the room to deliver devastating news, is an awesome responsibility. By learning to care for and communicate with others more effectively, the indelible memories we help to create will have a greater potential for healing—both our patients and ourselves.

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New+ Notable

CONSTELLATION EXPANDS VALUE WITH SOLUTIONS "BEYOND INSURANCE"

We at Constellation know our clients' business concerns extend far beyond MPL insurance. By building a collective of like-hearted partners and solutions, we hope to enhance our value to our policyholders. These solutions that extend "beyond insurance" help our clients solve a wider range of business challenges.

Our first solution was the Physician Empowerment Suite (PES), introduced in January 2017. PES, developed by SE Healthcare Quality Consulting, is an online platform designed to help health care providers deliver better patient experience and improve operational performance and effectiveness. It produces credible and actionable feedback that will improve operations, reduce risk and enhance economics. After a year in the market, overall feedback is positive from the 1,500 health care providers who have used the online platform, through which—among other things—patients can be quickly surveyed regarding their care experience.

On January 1, 2018, we announced a second solution: a strategic collaboration with leading health care professional services firm CliftonLarsonAllen (CLA). CLA serves more than 8,300 health care and senior living clients across the country. "Our agreement with CLA marks a significant milestone as we expand our offerings beyond managing the risk of medical professional liability," said Bill McDonough, CEO of Constellation. "CLA's deep industry specialization and ability to integrate with customers' existing programs and products, combined with a desire to truly understand and help customers, make it an excellent fit for Constellation. We are proud to help connect CLA with our physician, hospital and long-term care clients."

Both solutions are available in all markets where MMIC, UMIA and Arkansas Mutual currently conduct business.

TO LEARN MORE, CONTACT BRIAN.WIESE@CONSTELLATIONMUTUAL.COM OR JIM.DUNN@CONSTELLATIONMUTUAL.COM

ENHANCED POLICIES IN 2018

Constellation is proud to offer one of the broadest professional liability insurance policies in the industry. We've recently updated our policies with simplified language to make it easier for policyholders to read and understand. We've also included additional coverage enhancements and clarified certain coverage provisions.

High-level changes include:

- Improved readability and navigation
- Updated terminology
- Expanded additional benefits
- Enhanced extended reporting period (tail) provisions
- Modified policy provisions and exclusions to clarify coverage and improve transparency

LOOK FOR THESE ENHANCEMENTS WHEN YOUR POLICY RENEWS IN 2018.

MMIC, UMIA and Arkansas Mutual: Joining together to offer a nationwide network

As Constellation member companies, MMIC, UMIA and Arkansas Mutual share resources and expertise. Together, we gain a nationwide perspective into the medical professional liability insurance (MPLI) industry—with the scale, efficiencies, capital and support to better serve our policyholders.

Together, we aspire to be a leading force in the health care industry, offering innovation and risk solutions to better support all who devote their lives to health care.

TELL US WHAT YOU THINK!

We're looking for feedback, and we'd love to hear from you! What issues or articles have you enjoyed? What topics would you like to see explored?

Please share your thoughts by emailing Liz.Lacey-Gotz@ConstellationMutual.com

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