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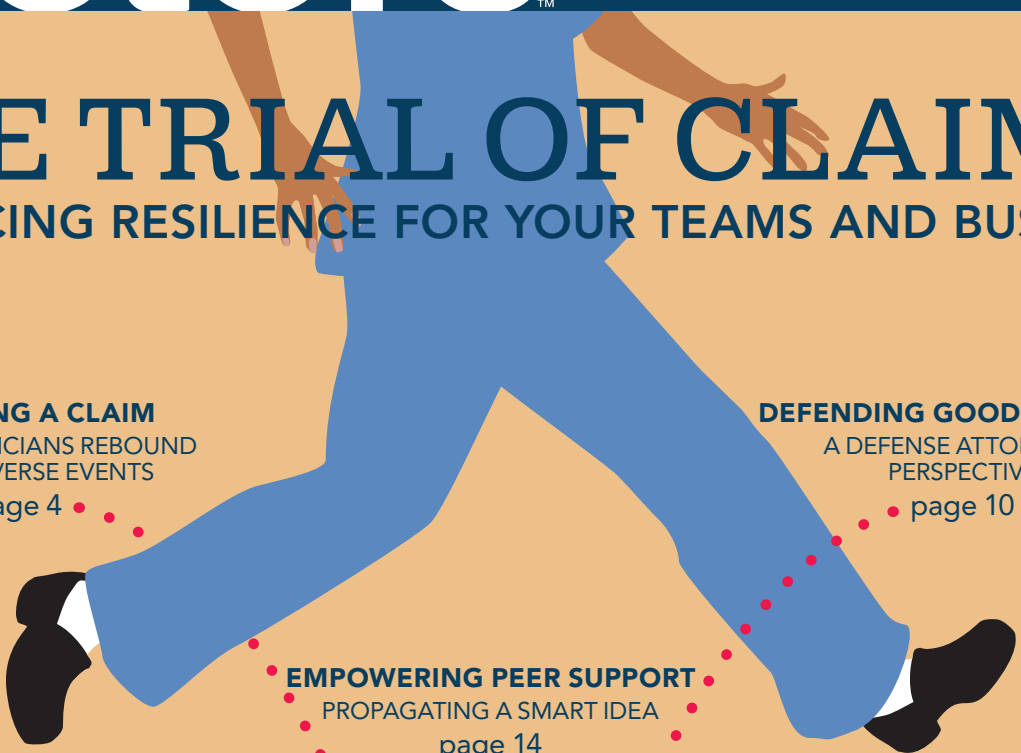
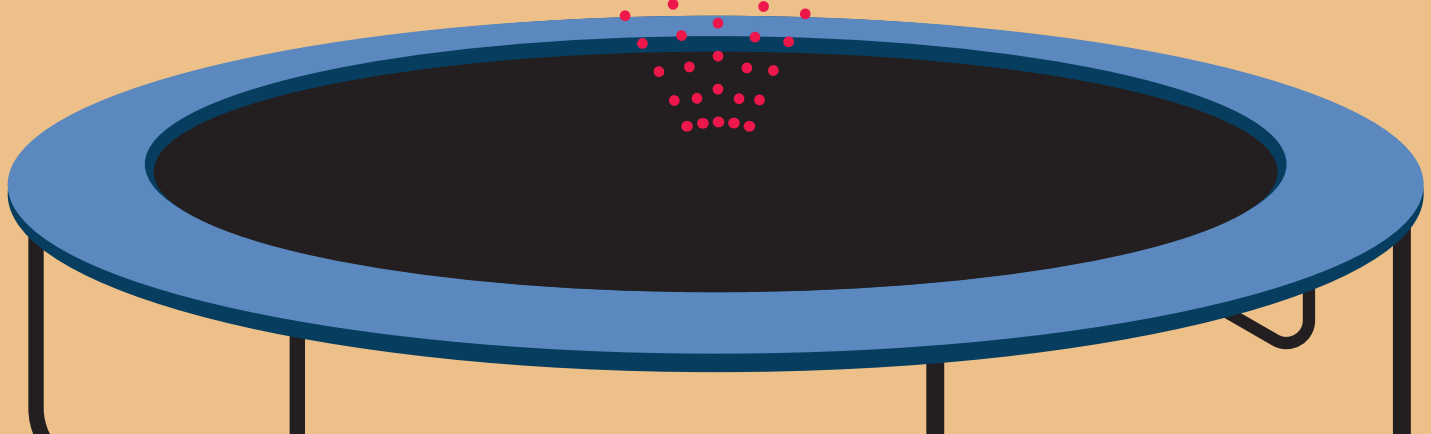
Good for care teams. Good for business.
Fall 2019

Common Factors™

THE TRIAL OF CLAIMS

ENHANCING RESILIENCE FOR YOUR TEAMS AND BUSINESS





You likely noticed that our award-winning publi-cation *Brink*® became *Common Factors*™ with our spring issue. What you may not have noticed is the new tagline in the upper right corner of the cover: "Good for care teams. Good for business." I'd like to focus on that idea for a moment.

In our ongoing quest to keep our magazine relevant for you, we are working harder to highlight the connections between our services—which are all about supporting your care teams—and your business's bottom line, which is healthier when care teams are well supported. It's a case where win-win truly applies.

In each issue of *Common Factors*, we'll blend data, insights and ideas in ways that bring these connections to life. In the current issue, for example, we look at the challenges facing clinicians who are involved in adverse outcomes and explore how negative impacts can be minimized—and resilience enhanced—when care teams themselves are cared for.

- "Surviving a Claim," on page 4, provides a snapshot of how claims impact clinicians, team productivity and the bottom line, laying the foundation for a business case for supporting clinicians and care teams.
- "Emotional Healing" (see page 20) explores the ripple effects of harm events—from the patients, families and clinicians who are immediately involved to organizations, communities and other patients who come to your organization seeking care. With the right support, clinicians are better able to recover, move on and continue serving their patients and communities.
- "Embracing 'Just Culture'" (see page 24) focuses on transforming practice environments in ways that reduce the blaming and shaming of individual practitioners for unintentional errors, and emphasize broad learning from mistakes. Frequently, such transformations lead to a decrease in errors, greater self-reporting of errors and increased patient safety.
- "Empowering Peer Support" (see page 14) describes how grassroots peer support programs are beginning to spring up around the country, answering a deep need for help from colleagues, not just from mental health professionals. You'll find insights about why these types of programs are so effective in enhancing the health and wellbeing of clinicians and care teams.

We're excited about *Common Factors* and our commitment to share with you tangible evidence that what's good for care teams is good for business. Please let us know your thoughts.

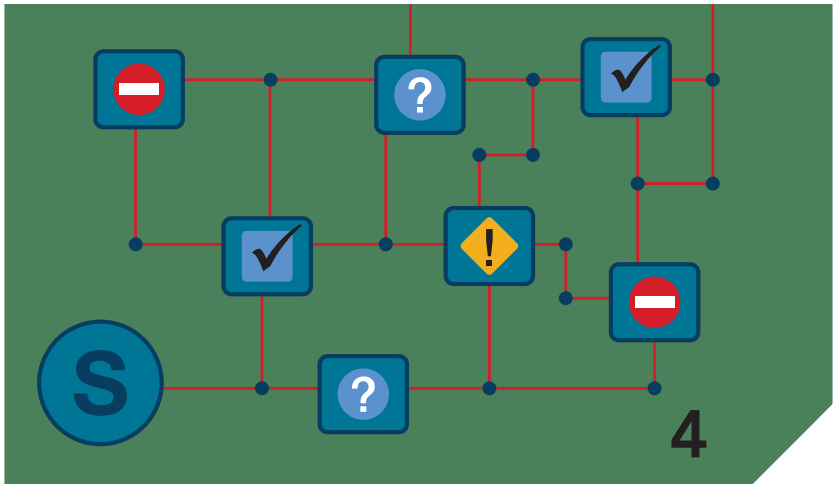
Working with you, together for the common good, is a continuous honor.

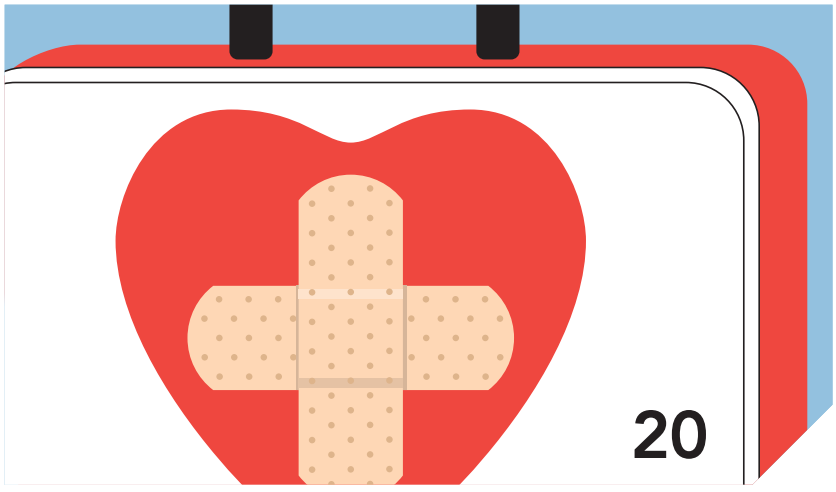
Bill McDonough
President and CEO, Constellation

Constellation®
Together for the common good.

Common Factors™ is published two times annually by Constellation, a growing portfolio of medical professional liability insurance and "beyond insurance" companies formed in response to the ever-changing realities of health care and dedicated to reducing risk and supporting physicians and care teams, thereby improving business results. 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 *Common Factors*, visit ConstellationMutual.com
To contact the editor, please send an email to Liz.Lacey-Gotz@ConstellationMutual.com





Common Factors™

FEATURE SECTION:

THE TRIAL OF CLAIMS

Building resilience for your teams and business

DEPARTMENTS

Notable

RISK REPORT ON HIGH-COST VERDICTS IS NOW AVAILABLE

Are $1,000,000 medical professional liability (MPL) claims on the rise? Trends are showing that claim frequency is down over the past 15 years, but expenses and indemnity payments (the amount paid to the claimant) are up and outpacing inflation. Our deep-dive analysis of Constellation malpractice claims provides a new "Million Dollar Claims" risk report on the frequency and costs of claims, the occurrence of large verdicts, the underlying factors that lead to claims, plus solutions and resources to help you proactively manage in the event your organization is faced with a high-cost claim.

The report along with four others is now available to members and policyholders by signing in to MMICgroup.com or UMIA.com > Risk Resources > Bundled Solutions

- **Million Dollar Claims Risk Report**
- **Preventing Diagnostic Error Risk Report**
- **Long-Term Care Risk Report**
- **Hospital Risk Report**
- **Advanced Practice Provider (APP) Risk Report**

Our risk and patient safety experts can work individually with policyholders to help apply the risk reports' data-driven insights by outlining a unique action plan for organizations.

LEARN ABOUT RISK IDENTIFICATION AND PATIENT SAFETY SOLUTIONS BY CONTACTING PATIENT.SAFETY@MMICGROUP.COM OR PATIENTSAFETY@UMIA.COM OR REBECCA.TUTTON@ CONSTELLATIONMUTUAL.COM

CONSTELLATION POLICYHOLDER FORUM GETS RAVE REVIEWS

Our policyholders are raving about our new Constellation Policyholder Forum, a web-based communication tool for like-minded client groups. Policyholders can connect and share resources, find sample policies and gain expertise on emerging trends. The group is self-run and monitored by one of our risk and patient safety consultants. Conversations are searchable, archived and HIPAA-secure.

TO JOIN, VISIT CONSTELLATIONMUTUAL.COM/FORUMACCESS/

CONSTELLATION COLLABORATIONS BUILD EXPERTISE ON A NATIONAL SCALE

To support our vision of working together for the common good, Constellation has aligned with national groups including the National Rural Health Association (NRHA), LeadingAge, the American Medical Group Association (AMGA), the American Health Care Association (AHCA) and the American Hospital Association (AHA). Working together with these groups, we expand our collective expertise and share collaboratively through speaking opportunities, webinars and other potential events. We also work locally with these groups, attending and presenting to state-level organizations. Our hope is to be an active part of creating the best possible future for health care, for the benefit of all.

SAVE THE DATE! IOWA HEALTHCARE COLLABORATIVE AND CONSTELLATION TO HOST DIAGNOSTIC ERROR CONFERENCE IN 2020

Planning is underway for a national conference to be held June 3–4, 2020, in Minneapolis, MN. The focus will be on strategies and solutions to reduce diagnostic error—including nationwide claim data and case examples to highlight the need to address and limit diagnostic errors.

VISIT CONSTELLATIONMUTUAL.COM/NEWS-EVENTS/ FOR THE LATEST UPDATES AND TO SIGN UP TO RECEIVE THE LATEST NEWS AND EVENT INFORMATION BY EMAIL.

NEW ONLINE AND MOBILE-FRIENDLY RISK ASSESSMENTS

Providing cutting-edge tools to make risk assessments easy, accessible and actionable was top of mind for our risk and patient safety team when they developed new online and mobile-friendly risk assessments.

Three risk assessments—one focused on assessing and minimizing diagnostic errors, a second focused on risks in clinics and a third for senior living organizations, are available at no additional cost to members and policyholders and can be completed by multiple people at one organization to gain different perspectives. Including staff and team members from front-line RNs to CEOs can add valuable information and improve the usefulness of the results.

FOLLOW CONSTELLATION ON SOCIAL MEDIA!

We share educational webinars, quick links to relevant and timely resources, plus articles from *Common Factors*™, health care tips and tools, and much more. We also post educational webinars on our YouTube channel.

Like, Subscribe, and Follow to stay up-to-date and in-the-know on trending health care topics that impact you, your practice and your organization.

Twitter @Together_4_Good
LinkedIn at Constellation, Together for the Common Good.
Constellation YouTube channel, Constellation, Together for the Common Good.

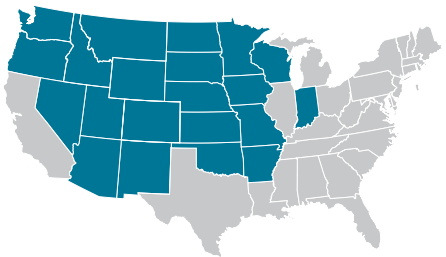
Upon completion, the customer gets a downloadable instant score report with recommendations, best practices and sample policies. Our consultants can then analyze and slice the data in various ways to show how your organization benchmarks against others.

Three more will be available soon, including risk assessments specifically designed for hospitals, OB/Gyn and emergency departments.

CONTACT YOUR RISK AND PATIENT SAFETY CONSULTANT FOR MORE INFORMATION.

MPL INSURANCE COVERAGE NOW INCLUDES OKLAHOMA AND ARIZONA!

Constellation and our insurance partners MMIC, UMIA and Arkansas Mutual are excited to offer a great new choice for medical professional liability (MPL) insurance and more in Oklahoma and Arizona.



2018 CONSTELLATION FINANCIAL HIGHLIGHTS AVAILABLE NOW ONLINE

Year-end review and financial highlights are now online for Constellation, the largest medical professional liability organization in the Midwest and Mountain states. We continue to grow, ending 2018 (our eighth year as a mutual holding company) in a solid financial position. We continue to find ways to help physicians and all those who devote their lives to health care attain their dream—to help and to heal.

VIEW 2018 HIGHLIGHTS AT: CONSTELLATIONMUTUAL.COM/ABOUT-US/

ARE YOU UP-TO-SPEED ON CYBER THREATS AND HOW TO THWART THEM?

You can never be too prepared for a cyber attack. Did you know that, as a policyholder of any Constellation insurance company, you get unlimited access to resources including an online Cyber Security Fitness Check to help you identify your cyber gaps? It's all available to you on our NAS CyberNET website.

Learn how to proactively manage cyber security, be informed on the latest threats, plus get updates on new laws and regulations around data privacy and security. Consider it your online data security risk management service where you can find:

- Online compliance materials
- Expert support online
- Step-by-step procedures to lower risk
- Training modules
- Guidance for handling data breaches

NAS CYBERNET PREVENTION RESOURCES WEBSITE >>

HOW TO REPORT A CYBER CLAIM

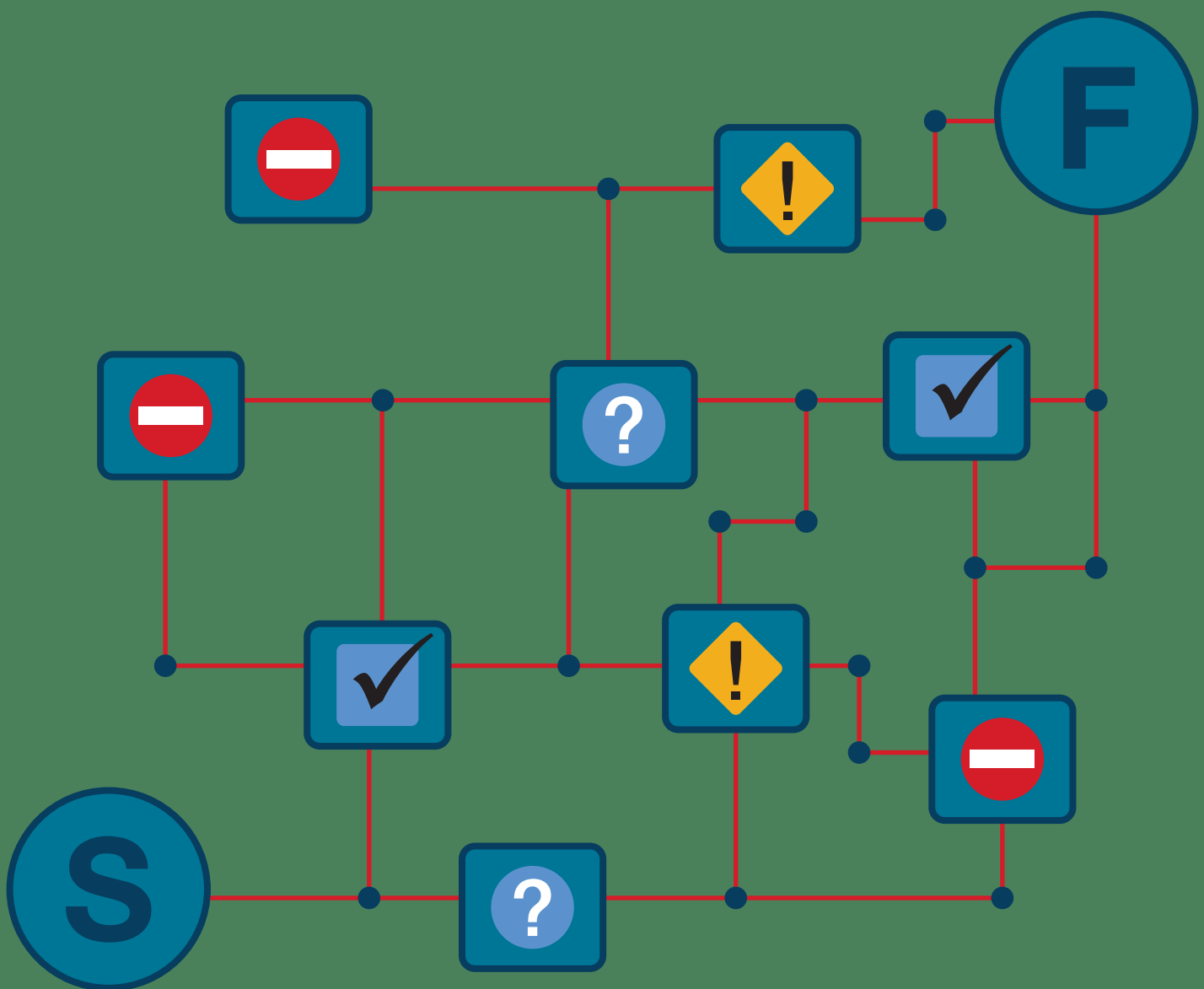
Sign in to your insurance website and click "File New Claim/Report" to report the cyber claim. Your cyber coverage documentation and loss notice will then be sent to NAS for handling.

For after-hours reporting: If a cyber attack occurs outside of regular hours, first report the activity by signing into your insurance website and clicking on "File New Claim/Report." As an additional resource, you can contact the NAS after-hours number, 888-627-8995.

Surviving a Claim

An organization can and must help clinicians rebound from adverse events to promote clinician wellness, safe patients and healthy care teams.

By Lori Atkinson, RN, BSN, CPHRM, CPPS
and D. Michelle Kinneer, PhD, JD, MSN, RN, CPHRM, CHPC, CHC



Burnout is associated with a two-fold increase in unsafe care, unprofessional behaviors and low patient experience.[3]

When clinicians decide to practice medicine, they may be aware that the profession carries risk—that adverse outcomes can, and do, happen to patients. What they are never quite prepared for is that they themselves may be a witness to, a participant in or the cause of harm. Medical procedures have inherent risks, and some patients have risk factors that increase the likelihood of adverse outcomes.

Intellectually, clinicians know this. But when something goes wrong, the experience is devastating and stressful for the very reason they chose medicine as their calling: Clinicians want to serve patients, and they care deeply about them.

Resulting malpractice claims and lawsuits only add to this stress and can drain the passion, compassion and confidence from the most confident clinicians and teams. Clinicians involved in litigation may see fewer patients, disrupt care team cohesion or even leave the practice—actions that lower productivity, raise costs and detract from team and patient satisfaction.

The impact doesn't end there. When clinicians and their teams struggle, the health care organization also feels the pain in the form of losses in care team productivity and engagement, as well as negative business results.

99%

of general surgeons will experience a malpractice claim by age 55.[1]

Clinician, team and business impacts

A frightening result of experiencing a malpractice claim is that the probability of another claim increases. A general surgeon has a 99% chance of a malpractice claim by age 55. A clinician with six or more claims is 12 times more likely to have a subsequent claim.[1] In one study, physicians under age 35 were one-third as likely as older physicians to have repeat claims, and males were 38% more likely than females to have repeat paid claims.[2]

Malpractice claims have several additional impacts:

- **Emotional toll:** Clinicians and care team members involved in the patient's care may feel guilt, shame and remorse, lose confidence in their abilities and worry about their job.
- **Decreased productivity:** Teams under stress may lose focus due to distraction and team unity issues resulting from a blame and shame culture.
- **Patient safety and patient experience:** Stress due to adverse events or claims may contribute to burnout. Burnout is associated with a two-fold increase in unsafe care, unprofessional behaviors and low patient experience.[3]
- **Turnover:** Clinicians or team members suffering after an adverse event or claim may choose to leave the organization. The cost of turnover has a tremendous effect on employee morale and the health care organization's bottom line.
  - **Nurses:** The turnover cost for a bedside RN averages $52,100 (ranging from $40,300 to $64,000), resulting in the average hospital losing $5.7 million (the cost can run from $4.4 million to $6.9 million). Additionally, each percentage point change in RN turnover will cost or save the average hospital an additional $328,400 due to the aforementioned impacts.[4]
  - **Physicians:** Turnover cost for a physician can range from $500,000 to over $1 million per doctor, or two to three times the annual salary. This includes recruitment, sign-on bonuses, lost billings and onboarding costs.[5]

The business case for supporting clinicians and care teams

The benefits of supporting clinicians and care teams during malpractice claims is undeniable and makes sense, including from a business perspective. Such support can have the following results:

- Focused, healthy clinicians and team members
- Improved productivity and teamwork
- Increased team satisfaction and engagement
- Greater retention of top talent
- Enhanced patient experiences
- Fewer preventable adverse events, patient injuries and malpractice claims
- Better business performance

Adverse events and claims

The immediate focus after an adverse event should always be on the patient, their family and the involved clinicians and care team. Communicating after an adverse event is never easy. Discussions with patients and families are challenging (see Resources). If an error has occurred, an apology of regret may be appropriate. Each situation provides unique nuances, and collaboration with your trusted Constellation medical professional liability (MPL) insurance partner will help.

When it comes to cases of liability, our philosophy is to proactively seek early resolution. We conduct a thorough and timely investigation and can:

- Provide emotional support for involved clinicians and team members
- Help you communicate with the patient and family members
- Provide compensation on your behalf if medical negligence was determined

A clinician with six or more claims is

12x

more likely to have another claim.[1]

Medical malpractice is defined as professional negligence or the failure to meet the standard of care. Whether an adverse event is unexpected or due to a known complication, the patient or family may allege negligence and file a malpractice claim or lawsuit against the organization, clinicians or both. A malpractice claim is a demand for money or services resulting from an adverse event.

Sometimes, lawsuits are filed without prior notice of a claim. When this happens, a claim consultant and potentially a defense attorney will assist insured Constellation customers through the claim and/or litigation process.

Claim investigation begins with the claim consultant interviewing involved clinicians and team members. The consultant requests and reviews medical records and may contact experts in pertinent fields of medicine and nursing for peer review on the standard of care. When a determination is made about negligence and liability, the claim or lawsuit may be denied, or settlement discussions may begin.

$52K

Average cost to replace a bedside RN[4]

Each claim or lawsuit is always unknown, scary territory. Arming your organization and care teams with advance knowledge and procedures can ease clinician and team stress.

The legal process step by step

A lawsuit begins when the Summons and Complaint is properly served. These legal documents outline the allegations against the clinician, care team and/or the organization. Emotions at this stage are often raw and varied. We hear many times the first thought after reading the Complaint is, "No, it didn't happen that way," so clinicians or team members should not unduly focus on how the Complaint was worded. There are time-sensitive responses due upon receipt of these documents, so notify your MPL carrier immediately. Legal counsel appointed to represent the clinician or organization will respond.

The next stage is discovery, which is an exchange of documents and depositions. Your defense counsel will assist with the exchange and prepare the involved clinician or team member for a deposition.

$500K–1M
Cost to replace a physician[5]

Mediation and settlement come next. Approximately 69% of Constellation MPL claims and lawsuits are dropped, denied or dismissed. However, based upon the standard of care reviews and in conjunction with the claim consultant and defense counsel, the claim or lawsuit may move toward mediation and early resolution. During attempts to resolve a claim or lawsuit, participation with counsel is invaluable. If attempts at resolution fail, the lawsuit proceeds to trial.

On average, only 4.5% of Constellation's lawsuits go to trial. Of those, we obtain defense verdicts 90% of the time. Going through a trial is stressful. We provide peer support throughout trial and encourage colleagues' attendance at trial to support the clinician and care team.

Documentation and notification

After an adverse event the focus is on providing patient and family support, clinician and care team support, event investigation and proper notification.

- **Organization**
  - **Administration:** Your organization may have notification requirements, including notifying senior team members, higher levels of administration or the board.
  - **Team:** Ensure team members are aware of the need to document and retain or preserve equipment or materials that could have contributed to an event.
- **Insurance carrier:** Notify your MPL carrier with a notice of a claim or potential claim. We encourage early reporting so we can help guide you through this process, provide resources and move toward resolution.
- **FDA:** If a product or medication was involved in the event, a report may need to be filed.

What leaders can do

Actively engaged leaders are visible in the organization. They learn about and witness poor processes, negativity and communication challenges that can lead to patient injuries and malpractice claims and lawsuits. Processes can and should be improved to minimize potential harm to patients. Optimal electronic health record practices are especially important to improve safety and reduce risk.

Effective leaders also know that awareness, knowledge and support are necessary at the care team level. Even in the most proactive environments, negative outcomes—whether caused by error or not—still occur. Leaders can sponsor initiatives that support clinicians and team members through the claim or litigation process. They can provide resources for and support a culture that allows teams and individuals to manage their journey through adverse outcomes by learning from mistakes, maintaining their wellness and enabling them to focus on patient care.

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1. Thiels CA, Choudhry AJ, Ray-Zack MD, et al. **Medical malpractice lawsuits involving surgical residents.** *JAMA Surg*. 2018;153(1):8-13.

2. Studdert DM, Bismark MM, Mello MM, Singh H, Spittal MJ. **Prevalence and characteristics of physicians prone to malpractice claims.** *N Engl J Med*. 2016; 374:354-62.

3. Panagioti, M, Geraghty K, Johnson J, et al. **Association between physician burnout and patient safety, professionalism, and patient satisfaction: a systematic review and meta-analysis.** *JAMA Intern Med*. 2018;178(10):1317-31.

4. Nursing Solutions, Inc. **2019 National healthcare retention & RN staffing report.** bit.ly/2Jm1vFx Published 2019. Accessed July 1, 2019.

5. American Medical Association. **How much physician burnout is costing your organization.** bit.ly/2CNBRXJ Published October 11, 2018. Accessed July 1, 2019.

Resources

Visit MMICgroup.com or UMIA.com, Login > Risk Resources > Bundled Solutions to find resources for:
- Apology and Communication
- Preventing Diagnostic Error
- Hospital Risk

Visit the Wellbeing Center at MMICgroup.com or UMIA.com, Login > Risk Resources > Tools & Resources > Wellbeing Center

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Ten steps senior leaders can take to help prevent adverse events and claims

The best way to reduce the negative emotional and productivity effects of adverse events is to prevent them with a proactive patient safety and risk management program. Senior leaders can take these 10 steps to help prevent adverse events and malpractice claims:

1. Conduct baseline assessments of your risks and patient safety culture.
2. Perform Failure Modes and Effects Analysis (FMEA) on high-risk processes, and reengineer those processes.
3. Create an action plan with ranked priorities.
4. Educate and involve clinicians and care team members in patient safety efforts.
5. Help team members develop critical thinking skills.
6. Boost teamwork skills and communication among the team.
7. Optimize communication with patients and families.
8. Implement clinician and team emotional support services.
9. Make clinicians and team members aware of Constellation's clinician peer support program.
10. Track your organization's patient safety, clinician and team experience, and patient experience performance over time.

The State of Claims

Clarifying Terms: Claims & Lawsuits

Both **claims** and **lawsuits** include allegations of negligence and a demand for compensation. Both **claims** and **lawsuits** may be made/brought by a patient and/or family members depending upon the type of **claim** or **lawsuit**. A **claim** may or may not involve a lawyer. A **lawsuit** will always involve a lawyer and will eventually involve a Court of Law. A **lawsuit** is initiated with the service of a Summons & Complaint. Within the Summons & Complaint there are allegations of medical negligence and a demand for compensation.

27%
Drop in frequency of malpractice claims and suits asserted over 10-year period[2]

More than half, or
61%
of claims were dropped, withdrawn or dismissed[2]

$407K
Average indemnity cost for a claim[1]

Top Three
average indemnity paid for a claim by specialty[1]
$525K OB/Gyn **$512** Neurology **$486** Pediatrics

However: For OB/Gyn, the risk of a claim or suit being filed against them is
down 44%
over 10 years[2]

Top Three
categories of care account for
73%
of MPL cases[2]

1 2 3

1. Surgical treatment
28%
of all cases
Most likely involved?
Orthopedic procedures
AVG indemnity: $347k

2. Medical treatment
24%
of all cases
Most likely involved?
Poor care management or improper performance of a procedure
AVG indemnity: $265K

3. Diagnostic process
21%
of all cases
Most Likely Cause?
Missed or delayed cancer diagnosis
AVG indemnity: $472K

1. MPL Association Data Sharing Project, "Claims Involving Diagnostic Error 2008-2017"
2. CRICO Strategies, a division of The Risk Management Foundation of the Harvard Medical Institutions Incorporated, "Medical Malpractice in American: A 10-year assessment with insights," published 2018

Defending Good Medicine

An attorney's insights on helping clinicians overcome fear, stay focused and see a bigger picture—all while being sued.

By Liz Lacey-Gotz

One time, a physician refused to read mail related to a lawsuit, so Attorney Shawn McGarry scheduled an actual patient appointment just to get time with him. Surprised, the doctor exclaimed, "What are you doing here?" and confessed that the situation was just too emotionally charged for him. The physician then opened a drawer, revealing a pile of unopened letters.

"I'll make you a deal," McGarry said. "I'm going to call you if I need anything pressing, but you have to call me back. Go sit on your patio or some place you can relax, and open and read my letters." The physician continued to open up, sharing his concerns, including his wife's worries about the case. McGarry went to dinner with the couple to hear more. "After that," he says, "the doctor started seeing me as part of the family versus part of the problem."

As an attorney defending health care professionals, Shawn McGarry knows there's more to his job than the legal aspects. Emotional tension and self-doubt run high when a clinician is served with a claim, making it hard for them to engage in the process of planning their defense. Clients may even try to deny the reality of a claim or lawsuit, which can seriously hinder a case.

It takes a team

It's critical for defendants to know the case details and to be practiced in their responses to key questions. They need to be able to be themselves in a courtroom and use clear body language and a calm demeanor to prevent negative interpretations by jurors.

That's where McGarry comes in. An attorney and president of Kipp & Christian in Salt Lake City, UT, he has spent 31 years in the legal profession, 25 of them devoted to defending clinicians. He's seen a lot over that time, and has helped many clients make it through lawsuits.

McGarry sees himself as a part of the larger UMIA team when he takes a case, which is why he loves working with UMIA exclusively. With a team approach, he knows clients will get the support they need, whether it's through a claim consultant, the lawyer or legal team, or wellbeing resources like Constellation's Clinician Peer Support program. Says McGarry, "Whatever level they need, the people who get support and are fully prepared do a much better job presenting themselves in an honest and candid way—which is always the best at trial."

Good Reads for Clinicians Facing a Claim

As an attorney focused on malpractice law who works primarily with UMIA policyholders, Shawn McGarry's approach extends beyond the facts of the case. One way he offers support is sharing books that can help clinicians navigate the troubling waters of a claim or lawsuit. Here are his picks:

- "When Good Doctors Get Sued: A Practical Guide for Physicians Involved in Malpractice Lawsuits" by Angela M. Dodge, PhD, with Steven F. Fitzer, JD
- "Adverse Events, Stress and Litigation: A Physician's Guide" by Sara C. Charles, MD, and Paul R. Frisch, JD
- "How to Survive a Medical Malpractice Lawsuit: The Physician's Road Map for Success" by Ilene R. Brenner, MD

"Actually, the whole litigation process can be somewhat cathartic. They can say, 'Wait a minute, I actually lived through this.'"

The emotional and professional support a clinician needs can vary widely. McGarry observes that some clients may seem fine, but find they benefit from talking with a peer about the case as it progresses. Others appear to need help but resist the resources available to them. "I had a case with a certified nurse midwife who couldn't make it through any aspect of the case without crying," he recounts. "She cried at every preparation meeting, and when we referred her to the peer support program, she said, 'I'm just going to cry.' But she made the call, and the support was invaluable for her."

A lawsuit can change you

Toward the end of a case—when a clinician least expects it—sometimes they begin to see a bigger picture, McGarry says. They've been challenged, their work has been questioned, and yet they got through it. They learned something.

"What happens to a lot of people is that they're frightened, they're concerned, they're threatened by a lawsuit. They think the worst—they question why they even became a doctor," says McGarry. But through the process, he says, clinicians can learn something that allows them to see the events of the case more objectively, and their practice can benefit over the long term. "Actually, the whole litigation process can be somewhat cathartic. They can say, 'Wait a minute, I actually lived through this.'"

In McGarry's experience, this can happen whether a case is won or lost. "I've seen it dozens and dozens of times, that clinicians say, 'This is painful, this is irritating, but wait a minute—I provided good care and at the end of the day what matters is the quality of care I provided.'"

Shawn McGarry is an attorney-and-counselor-at-law specializing in malpractice cases, and president of Kipp & Christian in Salt Lake City. His primary focus is defending UMIA clinicians.

LIZ LACEY-GOTZ
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Top Five Behaviors to Improve Trial Outcomes

These behaviors and practices promote success in defending good medicine. When a case goes well, clinicians have considered the following factors, according to malpractice attorney Shawn McGarry.

1. **Relationship. Relationship. Relationship.** "The number one thing that makes a difference in who gets sued and the defensibility of the case is the relationship the clinician and the patient have. If you are compassionate, if you are involved, if you communicate with the patient, it is more difficult for those patients to pursue and maintain a lawsuit against you."

2. **Be sincere and compassionate, and be prepared to apologize for any adverse/unexpected outcome.** "Respond how your heart tells you to respond." You need to be professional, cordial, thoughtful and empathetic with your apology. If you are unable to respond accordingly, get your team—which may include help and advice from your Constellation claim and/or patient safety consultant—involved to assist you with the apology.

3. **Maintain good charting.** Go beyond using EHR autofill/dropdown options. "Add freehand, add things that aren't just boilerplate for a certain condition. You may have provided attentive, excellent care during your interaction, but by the time you get around to charting it, you are exhausted or you have another patient, and you just click those buttons. It's not fair to judge the care given by rote entries in a stale, cold chart, but it's the reality if that's all you included."

4. **Say "Yes" if you have some memory.** "Every plaintiff wants to push a doctor to say they have no memory of what happened, and that allows them to refer to the chart, which may not show the compassion, interest and care you actually provided. It's a dangerous response because then the plaintiff's lawyer can repeatedly remind you that you didn't remember anything."

5. **Be yourself in the courtroom.** A lot of immaterial things turn out to be very influential in a case. "Jurors make a lot of decisions on appearances. Not like how your hair looks, but appearance in terms of body language, eye contact, how you behave. I had one juror criticize a doctor because the doctor was very combative with the plaintiff's lawyer. They thought, 'If he was that angry, we wondered what he had to hide.' You have to realize you are on stage every minute that jury is in the courtroom. Once you recognize that, it can be empowering."

What's Your EQ?

When care team members cultivate self-awareness, it can boost the strength of the entire team.

By Anne Geske

There it was in her inbox: an email asking Amanda (not her real name) to participate in a deposition for a child abuse suit. Amanda, a risk manager, had anticipated this moment, and for a second, she thought it might send her into a tailspin. A year earlier, a similar event caused her to spend weeks working through her emotions. When she learned about emotional intelligence (EI), Amanda became aware that this type of suit was likely to be an ongoing trigger because she grew up in the foster care system, having experienced abuse. Determined to arm herself for the next time this situation might arise, Amanda had practiced her EI skills, and she was able to manage her emotions better this time around.

Dan Goleman popularized the term "emotional intelligence" in his 1996 book of the same name. EI refers to the ability to recognize and manage one's emotions and extrapolate these skills to relationships and social settings. In his book, Goleman cited research in which Harvard Business School found that EI—or "EQ," as it's sometimes called—was more important than IQ and technical skills in determining a person's ability to navigate complex situations successfully.

Michelle Kinneer, PhD, JD, MSN, RN, CPHRM, CHPC, CHC, risk and patient safety education manager at Constellation, spent much of her professional career in patient safety and risk management and recently studied EI as it relates to professional quality of life for her PhD dissertation. Through her work, Kinneer has seen firsthand how EI can be a key component of coping with traumatic events and eventually moving past them.

Health care workers give to others, Kinneer explains, but they don't always take care of themselves, leaving them vulnerable to difficulties when adverse outcomes happen in the course of their daily work. "Where EI comes into play," says Kinneer, "is knowing yourself. By understanding your emotional self, you will not only understand the potential impact of situations, but you will be able to better manage your response to the event. Ultimately, this has a positive impact, allowing health care providers to continue to give to others."

Knowing yourself also means knowing when you need help—and being able to ask for it. When clinicians like Amanda develop their EI skills for wellbeing on (and off) the job, they're better able to interact professionally and appropriately with team members and patients.

Supporting emotional health and emotional intelligence

Kinneer recommends several ways health care leaders might support the development of EI skills and overall workplace wellbeing after adverse events:

- Understand that care team members go through a phase of self-questioning after adverse events.
- Reach out to discover what teams need; be attuned to their needs after an event.
- Allow care team members to process their emotions through third-party (non-management) means, such as a peer-to-peer program.
- Recognize that emotional processing and debriefings/analysis are separate things.
- Tell care teams that root cause analysis (RCA) is a blame-free, safe zone, and reiterate this message throughout the analysis. RCA is there to learn from and to possibly prevent similar events from occurring.
- Facilitate different channels to process emotions, such as wellbeing programs and physical spaces for team members to congregate.
- Encourage team members to utilize resources, including the attorney, if a claim has been filed.

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Kinneer will speak on "The Resilient Risk Manager: Steps to Strengthen Emotional Intelligence" at the ASHRM 2019 Annual Conference in October. She'll provide an in-depth review of her quantitative dissertation study, which examines risk managers' resilience by comparing use of workplace emotional intelligence skills with the experience of professional quality of life.

Resources

"Emotional Intelligence 2.0" by Travis Bradberry and Jean Greaves

"Working With Emotional Intelligence" by Daniel Goleman

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Empowering Peer Support

Grassroots peer support programs are sprouting up around the country.

By Anne Geske

Along with the joy of practicing medicine comes the inherent responsibility of caring for patients from birth to death and everything in between, including the possibility of adverse and even tragic events. Sarah Freitas, MD, an OB/Gyn physician at Ridgeview Medical Center in Minnesota, knows this firsthand. Experiencing an unexpected outcome like the death of a baby during labor and delivery is one example. "The physician is in the middle of it," she says, "and you're having to emotionally support the family, and it's very exhausting."

Clinicians and care team members have always functioned in an environment with a baseline level of stress, notes Laurie Drill-Mellum, MD, chief medical officer at Constellation, but burnout and depression have increased dramatically in recent years. "It takes remarkable dedication and hard work to practice medicine," she says. "Practicing medicine is hard—and the practice of medicine is even harder than it used to be for a number of reasons. When a traumatic or adverse outcome happens, we know clinicians need an advocate, and we need to take care of them."

An idea gaining traction

In decades past, clinicians could connect and decompress in the "doctor's lounge," but now, these kinds of spaces rarely exist, and downtime has been replaced by long hours at the computer documenting patient notes in the EHR. In recent years, grassroots and organization-sponsored peer support programs have begun to address the gap in health care systems large and small. These programs offer clinicians an opportunity to process adverse events with colleagues. A study published in the *Journal of Patient Safety* concluded that an unmet need exists to provide support to clinicians after adverse events and medical errors[1] and found that Johns Hopkins Medicine saved $1.8 million annually after implementing a peer counseling program compared to costs without the program[2].

Peer support programs are so effective in part because they're accessible to all, unlike employee assistance programs (EAPs), which are available only to employees. And, says Dr. Drill-Mellum, people are much more likely to access informal support programs and talk to someone they know. But physicians and care team members may not be aware of how they might benefit from a peer support program, she explains, "Which is why organizations need to help facilitate the development of these programs at a local level. Peer support should be an essential component in any health care organization's mission to care for the caregiver."

Peer support at Ridgeview

The administrative procedure following adverse events at Ridgeview includes a team debriefing, a root cause analysis meeting and a peer review process—all formal processes where protocol demands that clinicians not talk about the clinical details of the event outside of these meetings, says Dr. Freitas. The experience can be very isolating, she says: "There was no process supporting the physician, or just checking in with, 'Hey, how are you doing? This is hard.'"

"When people are routinely offered help and support—and they feel safe to accept the service—you normalize it."

A few years ago, Dr. Freitas wondered if she might be struggling with professional burnout. An online survey confirmed her suspicions but offered her little direction. "I didn't know what to do about it, or who to ask for help," she says, "so I was doing online searches and reading books, just trying to help myself through it."

Seeing the need to provide physicians with emotional support, Dr. Freitas worked with Sara Urtel, vice president at Ridgeview, to create Connect the Docs. Implemented in 2018, the peer support program is set in motion like other formal processes after an adverse event. "It just automatically happens," Dr. Freitas says, "so it doesn't stigmatize us." Dr. Drill-Mellum, who formerly worked at Ridgeview as an emergency medicine

Ridgeview Medical Center's Connect the Docs program

Program name and description	Connect the Docs is a physician-led peer support program that has become a standard part of the process after an adverse event.
Program goals	To provide a confidential source of support and other resources in times of professional and personal challenge
Roles supported	Physicians; may eventually expand to other roles
Support team members	Physician volunteers
Outreach	The support network reaches out following adverse outcomes or patient harm events; physicians may also self-refer or refer a colleague they think might benefit.
Training for peer volunteers	Listening skills training in conjunction with a community pastor and with help from Laurie Drill-Mellum, MD

"People are looking out not only for your physical wellbeing but for your mental wellbeing—you have a second family support system that didn't exist in a very robust way in the past."

physician, agrees: "When people are routinely offered help and support—and they feel safe to accept the service—you normalize it."

Because the program is informal and physician-led, it lends credibility with physicians and increases accessibility. Urtel explains, "As opposed to an administrative team saying, 'This is what should be done,' our providers have voice and influence and leadership into what they believe should be done to support each other and to ultimately impact patient care."

Peer support at Intermountain Medical Center

As with many hospitals, depression and professional burnout had already been an issue at Utah-based Intermountain Medical Center emergency department (ED) that leaders were looking to address. But the tragedy of a beloved ED tech who took his own life in March 2018 prompted urgent action. Adam Balls, MD, emergency department chairman, and Gary Brunson, RN, BSN, CEN, assistant emergency department manager, co-led the launch of a grassroots peer support program called OASIS to confront the mental health issues and trauma ED caregivers experience. Designed for all ED staff, the program includes support both for traumatic events at work and for life events outside of work.

While programs like EAP are good for some, Dr. Balls says, "Some people in the ED may not feel comfortable discussing traumatic cases—things they've seen that are difficult for them to process and work through—with a counselor who may not understand the level of trauma and death we deal with on a regular basis," he explains. "The peer support piece augments other support programs by allowing a colleague or coworker rather than an official support professional to be trained to recognize concerning behaviors and to support one another."

A main feature of OASIS is that charge nurses are trained to recognize when peer support might be beneficial to their coworkers after an incident, and are empowered to page or email trained peer supporters to reach out to them. Getting the word out is crucial for the program, which is still in its early stages. Leaders promote OASIS by speaking with different groups about mental health and burnout—about how to recognize symptoms and how to address them.

Intermountain's program gets family members involved, too. Evening workshops help care team members' spouses and significant others learn how to better support their loved ones after a workplace tragedy. Now, Brunson says, workmates have come to feel like family. A little more than a year after the program began, the change is palpable. "There's the feeling of a general safety net at work," he shares. "People are looking out not only for your physical wellbeing but for your mental wellbeing—you have a second family support system that didn't exist in a very robust way in the past."

Intermountain Medical Center ED OASIS program

Program name and description	OASIS takes its name from the services it offers: Outreach education, Administrative support, Staff support, Internal/Incident support and Social support
Program goals	To confront PTSD-type symptoms, burnout and mental trauma caregivers can experience at work and to support peers during stressful personal and family situations
Roles supported	All ED staff
Support team members	A diverse group across all ED jobs, including physicians, RNs, techs, social workers and security
Outreach and education	Periodic workshops for family members and occasional small-group social outreach to assist coworkers for personal and family life events
Training for peer volunteers	QPR (question, persuade and refer) training regarding the signs of suicidal ideation and how to address it, as well as education for all staff and their significant others on how to provide support

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2. Becker's Hospital Review. **How a clinician peer-support program saved Johns Hopkins $1.8M annually.** bit.ly/2Yq1AOP Published May 11, 2017. Accessed July 1, 2019.

Resource

Medically Induced Trauma Support Services (MITSS). **Clinician support toolkit.** bit.ly/2MG4P31 Published 2017. Accessed July 1, 2019.

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Five steps

Get started creating a peer support program

Laurie Drill-Mellum, MD, offers this advice for starting a grassroots peer support program:

1. **Decide whom your program will support.** Will your program support one group of practitioners or a broader group?
2. **Brainstorm how to support staff.** List possible elements of your program. Will support be provided only after adverse events, or might it also include support for coworkers with personal/family life stressors?
3. **Select volunteers mindfully.** Peer support colleagues need to step out of the mindset of fixing and prescribing and be able to listen and just be with their peer through their journey.
4. **Train volunteers thoughtfully.** Training may include how to listen in times of grief, loss, shame and guilt—and how to be helpful, not harmful, in a support role.
5. **Get the word out.** In-person presentations, posters and workplace intranet sites are all places to start.

Seven success factors

for a peer support program

1. Make accessibility easy to ensure people know who to ask or where to go.
2. Normalize peer support by routinely reaching out after adverse events.
3. Provide one-on-one informal, confidential support.
4. Utilize peers who are familiar coworkers.
5. Organize informal social events outside of work.
6. Engage leaders to provide backing and needed resources.
7. Create a way for clinicians to refer others for peer support.

BETA Healthcare Group's HEART® program

BETA Healthcare Group based in Alamo, CA, is a health care entity comprehensive liability insurance provider that has developed a holistic program for helping patients, their families and their clinicians through adverse events. The program, BETA HEART®, is a comprehensive, multi-year effort that encompasses organizational culture change with a five-domain approach including a peer support domain called Care for the Caregiver. Deanna Tarnow, BA, RN, CPHRM, senior director of risk management and patient safety at BETA, has this to say of the program:

The initial effort of HEART is to address those situations where there's a patient harm event. When a patient is harmed, we look for our organizations to have a rapid response where someone responds to the patient's family with open and empathic dialog early on, to acknowledge something occurred. Because we know health care providers are also traumatized when a patient is harmed, we're also looking for organizations to develop a peer support program to reach out to the involved clinician with emotional support.

With organizations that begin the HEART program by working on individual domains, Care for the Caregiver is the one that elicits the highest response from organizations because they recognize the impact of these events on their staff—they need a way to provide support to their front line. In California, for the most part, physicians are independent contractors, not employees. A few hospitals were on the fence about opting in to participate in HEART because it's such a significant effort, and it was their medical staff who said they need to participate because of the Care for the Caregiver program.

For more information about BETA HEART, visit bit.ly/2KaNwoC

Between Life and Death

Honoring the lives of patients can be a healing practice for care teams.

For emergency medicine doctors Adam Balls, MD, and Christopher Anderson, MD, medical school didn't provide a lot of training on communicating to families after a loved one dies. But taking time to acknowledge and honor the life of the deceased—even briefly—has helped them process the experience better and have more empathy for those left behind.

Here is Dr. Anderson in his own words:

It was early in my third year of medical school when I had a sick dialysis patient come in. My staff doc that I was working with let me run a resuscitation. It ended up not going well, but he also let me be the primary communicator with the family. And, just about when I was about ready to call the code finally, my staff doc who had been standing in the back of the room kind of overseeing things stepped forward. All he said was, "We're just going to take a minute and we're going to honor who she was. Because, her family is going to come in here in just a minute, and you're going to see that she was a mom, and she was a wife, and she was a sister, and we all have those people in our lives."

One of the things that struck me was that he was very aware of that uncertainty of how other people were processing this death. Young techs in the room, nurses. And it sort of blew me away. I kind of stepped back, and we gave a moment, brought the family back. It just stuck with me. It was so powerful because, afterwards, some of the staff had come up to the doc that I was working with and just said, "Thank you."

I don't know what that was, but it was important, and it needed to happen. I think it's an amazing way for us, as providers, to be reassured that we're good at what we do. We're sort of the last line for the community between life and death, but we can't save everyone. And when we can't, we have to know that we still can come together as a team to identify folks in the room who might need an hour or two to reset. And maybe they even need to take the rest of the shift off, or maybe they need a hug. And letting them know, "You did a good job. Sometimes, we just don't have enough things to save people."

Since then, I've tried to incorporate that into our resuscitations that don't go well and deaths in the emergency department. I haven't really come across anyone who hasn't been thankful for that extra time there. There've been times where I've needed it more than anyone.

Excerpted with permission from StoryCorps and Intermountain Healthcare.

Full story at bit.ly/2WJzpxg

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Emotional Healing

After a harm event, clinicians need support to move forward.

By Sue Campbell

He replayed the day in his mind, trying to figure out if he could have done anything differently.

For patient Linda Kenney, about to undergo an ankle replacement nearly two decades ago, surgery was nothing new. She was born with bilateral clubfeet and up to that point had faced 20 operations. One more felt almost routine. But the events of that day did not unfold as expected.

When the care team's anesthesiologist, Rick van Pelt, injected bupivacaine to numb her leg below the knee, a rare complication resulted. Kenney suddenly, shockingly, had a seizure and went into cardiac arrest. Chaos and noise erupted as the medical team sprang to action, reacting to the crisis. For ten minutes, they tried to restart Kenney's heart, using CPR and a defibrillator. But Kenney didn't respond, and they wheeled her to the hospital's cardiac suite, where surgeons cracked open her chest and clinicians massaged her heart with their hands until she was hooked to a bypass heart-lung machine, saving her life.

Kenney was, people would later tell her, a miracle. But over the next several months of physical recovery, she didn't feel like one. Instead, she experienced deep sadness. She found herself suppressing her emotions to put on a good face for her family. She eventually began to realize the impact her event had had on her care team.

Nor was van Pelt celebrating having helped bring her back from near death. Instead, he experienced guilt for causing a patient harm. He replayed the day in his mind, trying to figure out if he could have done anything differently. Post-incident, his colleagues shied away from him, and he felt isolated. He sank to "the lowest point I've ever been," he says.

Then one day, he had a flash of insight that brought him peace. He would write Kenney a letter to apologize and express his concern for her. He knew the hospital's risk management team wanted to control communication with the patient, but he knew he was doing the right thing, no matter the consequences.

His letter eventually led to a powerful conversation that changed both Kenney's and van Pelt's lives and gave their work a new focus and purpose. When they spoke, Kenney was the first person who had asked van Pelt how he was doing; that compassion was a salve. When she forgave him, van Pelt says, "It was like an 800-pound gorilla leaped off my back."

At the time, it was unusual for a patient and caregiver to come together and talk about the emotional fallout. Van Pelt felt that he and Kenney recognized what others in the field did not. "It is not just some emotional touchy-feely nice thing to do," he says. "How clinicians are supported is tied to patient safety and quality of care."

That's why van Pelt and Kenney saw the lack of support as a health care crisis, one they set out to confront. Back then, they were pioneers, using their shared story to make change and facing skepticism that they would succeed. While change has come, and research provides a roadmap, there's still more to do.

Haunting events, lasting impact

Research from the University of Missouri Health System (MU) shows that clinicians and care team members have remarkably common reactions to experiencing a harm event. Through interviewing physicians, nurses and other care providers and documenting common themes in their recollections, Sue Scott, PhD, RN, director of nursing for professional practice at MU, along with her colleagues charted the stages they experience after a traumatic event. The data showed a critical juncture where, if people received emotional support, they could move forward, even thrive, after a traumatic clinical event.

"If they had a positive supportive presence from their personal social network at home or from a colleague at work," she says, "they made something positive out of the event. They could make statements like, 'Because of what happened, I'm a better nurse,' or 'I learned from this event how to improve patient safety.'"

Without such help, clinicians and nurses tended to recall the event in a negative, haunting manner. Additional research showed that while most people benefit from talking to colleagues, trained peers or risk managers, 14% "have needs that exceed the capabilities of trained peers," Scott says, and they should be referred to professional support.

Scott also learned that almost every clinician will experience at least one harm event over the course of a career. She herself has been part of several in a 42-year career. But perhaps the

> "Leadership needs to recognize that harm events have many ripple effects."

biggest takeaway from MU's research is that traumatized clinicians can't be expected to simply bounce back and return to work as if nothing happened. As she and her team probed the memories of their subjects, all vividly recalled the events. It was as if, Scott says, they had tucked away the memory, and when they pulled it out, emotions surrounding it remained raw. Many suffered in silence, sometimes for decades.

"They don't really get over it. It takes a lot of time. These events stick with clinicians for the duration of their careers," she says. "Because of our findings, I think it's morally and ethically important for health care facilities to have some form of clinician support in the aftermath of an unexpected clinical event."

Looking to leaders

Health care organizations today focus on patient-centered care in their mission statements, says Laurie Drill-Mellum, MD, chief medical officer at Constellation. She urges broadening that goal to include care for care team members, too—especially after adverse events. But it takes commitment from leadership to transform organizations.

Leaders trying to make change need to follow a series of steps, Dr. Drill-Mellum asserts. They must recognize the need to do things differently, find the motivation to act, and put tools and resources into place to allow cultural change to take root.

"As a first step, leadership needs to recognize that harm events have many ripple effects," Drill-Mellum says. "They obviously impact the patient initially and primarily, and their family, friends and community. At the same time, they have a ripple effect on the people caring for patients. Care teams may have problems with depression, anxiety, substance abuse, lack of engagement, turnover. And that ultimately hits patients, the brand, revenue and cost. It's all very circular."

Leaders can be motivated to change out of a sense of doing the right thing for their teams, and doing the right thing for business. "Caring for one another as peers means better care for patients, fewer adverse events and fewer people leaving the system if something happens," Dr. Drill-Mellum says. When it comes to tools and resources, she argues for enough "upstream" buy-in to allow time for change to happen. Too often, institutions bring in a champion for an idea or cause, but once that person leaves, the push to change fades. "The goal is to weave caring into the culture both for patients and workers," she says.

That's what van Pelt and Kenney embraced 20 years ago, and it's work they continue today—Kenney as director of peer support programs at the Betsy Lehman Center for Patient Safety in Massachusetts, and van Pelt as vice president for clinical practice transformation at the University of Alabama at Birmingham.

"I started advocating for change and clinician support long before it was the thing to do," says Kenney, who founded Medically Induced Trauma Support Services (MITSS) in 2002 as a result of her event. "Doctors used to pat me on the head and say, 'Good work, but we don't really need it…' That was frustrating. I could see what they couldn't see."

Resources

Agency for Healthcare Research and Quality (AHRQ). **Second victims: Support for clinicians involved in errors and adverse events.** bit.ly/302cZEQ Updated January 2019. Accessed July 1, 2019.

Medically Induced Trauma Support Services (MITSS). **Clinician support toolkit.** bit.ly/2MG4P31 Published 2017. Accessed July 1, 2019.

University of Missouri Health System. **Stages of processing a harm event.** bit.ly/2xnmRwL Published 2009. Accessed July 1, 2019.

SUE CAMPBELL

Freelance writer and editor

New backlash to old terminology

The term "second victim" to describe clinicians suffering after adverse events has increasingly come under fire by patients and advocates, most notably in an editorial by the University of Kentucky's Melissa Clarkson and colleagues arguing to abandon the term.[1]

The problem: It implies passivity, that care teams can't prevent harm events because they are "random, caused by bad luck and simply not preventable," Clark writes. The term also can paint horrific events for patients as being about clinicians, says Laurie Drill-Mellum, MD.

Despite objections, the term is embedded in research, literature and the vernacular, so likely won't disappear. "We haven't come up with a better replacement yet," says Sue Scott.

1. Clarkson MD, Haskell H, Hemmelgam, C, Skolnik P. **Abandon the term "second victim."** *BMJ* 2019;364:l1233

Six stages of processing a harm event

Traumatized clinicians experience similar reactions, and University of Missouri Health System researchers organized them into six stages.[1] The first three stages may occur one at a time or all together.

1. Chaos and accident response
2. Intrusive reflections that lead to isolation, shame, rumination
3. Restoring personal integrity, in which both fear and acceptance are common
4. Enduring the inquisition—answering questions for documentation or litigation
5. Obtaining emotional first aid
6. Moving on, which encompasses three trajectories:
   - Dropping out
   - Surviving: coping but still having intrusive thoughts and sadness
   - Thriving: gaining perspective, advocating for patient safety, and continuous learning

1. University of Missouri Health System. **Second victim trajectory.** bit.ly/2xnmRwL Published 2009. Accessed July 1, 2019.

Embracing "Just Culture"

Responding to human error with humanity and accountability reduces errors and saves lives.

By J. Trout Lowen

Earlier this year, the Institute for Safe Medical Practices (ISMP) issued a press release[1] appealing to health care organizations to end a longstanding practice: the shaming and blaming of individual practitioners for unintentional medication errors. The ISMP, which works to improve medication safety, urged providers to instead focus on identifying and fixing the systemic flaws that allow such errors to occur. The ISMP's appeal came after criminal charges were filed against a Tennessee nurse who, in 2017, inadvertently administered the wrong medication to a patient who tragically died as a result.

The criminalization of human error, the ISMP argues, undermines safety by creating a climate of fear that discourages the reporting of medical errors. It also limits an organization's ability to learn from its mistakes and prevent future errors.

The ISMP is hardly alone in its opinion. Many health care organizations around the country, from acute care hospitals to senior living organizations, have already begun exploring the idea of creating a more forgiving culture based on a model called "just culture." The just culture model acknowledges that errors do, and will, continue to occur in complex health care settings—and when mistakes happen, a just culture first tries to ascertain why, then focuses on how to improve systems to minimize future errors.

But change, as most of us know from our own lives, can be difficult. And changing the long-standing culture of shaming and blaming that pervades the U.S. health care system is going to take time and require buy-in at every level, from the front line to the C-suite.

So far, adoption of the just culture model differs widely among health care organizations, says Kristi Eldredge, RN, JD, CPHRM, a senior risk and patient safety consultant for Constellation and a just culture trainer who received certification through Outcome Engenuity. "Health care organizations are all over the board," says Eldredge. "Most organizations are aware of the just culture concept, but many think they're going to take a one-day course or listen to a one-hour webinar and they're done. But that's not how the program works—it needs to be an ongoing process."

Just culture is a learning culture that is constantly improving and oriented toward patient safety, Eldredge explains. Establishing it requires significant effort, including clinician and care team time and energy, financial resources, and support

at the highest levels. "It's imperative that the C-suite buys in," she says, "because if you don't have C-suite buy-in, you're not going to be successful."

How just culture works

First developed by the airline industry, the principles of the model are fairly straightforward: When an error occurs, its cause is identified and a solution is implemented. Within this framework, errors are classified under three pillars:

- Human error: when a mistake is literally that, a mistake
- At-risk behavior: when a person does something without knowing the behavior carries risk of error, or knows the risk but believes it is justified
- Reckless behavior: an error caused by substantial, non-justifiable and conscious disregard of risk (gross negligence)

In the just culture model, each error type requires a different response, Eldredge explains. A human error type of mistake may indicate the need for additional education or a redesign of systems and safeguards. At-risk behaviors may require coaching and holding people accountable. Employees who engage in reckless behavior, however—such as being intoxicated at work or falsifying records— face disciplinary action.

It's likely that most errors fall into the human error category, Eldredge says. "Any time you have a human involved, you're going to have a chance for error because, guess what, even doctors are people," she adds. "A just culture recognizes that individual practitioners or staff should not necessarily be held accountable for systems that fail them over which they don't have any control."

For example, in the Tennessee case, the ISMP published an analysis of that event[2] in which it argued that system vulnerabilities contributed to the fatal medication error. In that incident, the patient's primary nurse was covering another nurse's patients and asked an "all-help" (i.e., float) nurse to administer intravenous Versed to a radiology patient who was getting a PET scan. The all-help nurse was unable to find Versed in the patient's profile in an automatic dispensing cabinet (ADC), so she used the ADC's override function to search for the drug by typing "VE"—the first two letters of the drug's brand name. She failed to notice when the machine dispensed vecuronium, a neuromuscular blocker used as part of general anesthesia, instead.

In its analysis, the ISMP listed a number of system vulnerabilities contributing to the error, including an ADC that populates a drug name search based on two letters of a medication name, the lack of additional safeguards to verify the removal and intended use of a neuromuscular blocker via the override function, and an ineffective warning on the vecuronium label. In the wake of the incident, the ISMP also issued new guidelines for managing ADC overrides.

Benefits of a just culture

In a punitive culture, when an error or near-error occurs, clinicians and team members are often afraid to speak up, and that makes it difficult if not impossible to determine why errors happen and how to prevent similar errors in the future, Eldredge says. "Nobody learns from their mistakes in a punitive culture. People get reprimanded. People get fired. People suffer reputation damage."

Changing the long-standing culture of shaming and blaming that pervades the U.S. health care system is going to take time and require buy-in at every level, from the front line to the C-suite.

In contrast, health care organizations that adopt a just culture model are likely to see a decrease in errors, an increase in self-reporting when an error or near-error occurs, and an increase in patient safety. Organizations that embrace the model's principles can also expect to see a decrease in medical professional liability claims, Eldredge says. Studies that have looked at why patients choose to file claims have found that money is often not the chief motivation. In many cases, she says, patients want an explanation of what happened, they want an apology and they want to prevent what happened to them from happening to someone else.

"If we as patient safety and risk consultants could convey the need for one thing to our customers, it would be just culture," Eldredge says. "If they work to make their culture just and reliable, many preventable medical errors and the resulting claims would be eliminated, and health care would be safer for patients."

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1. Institute for Safe Medication Practices. 2019. **ISMP calls for a system-based response to errors, not criminal prosecution.** bit.ly/2LpCqw2 Published February 13, 2019. Accessed July 1, 2019.

2. Institute for Safe Medication Practices. 2019. **Safety enhancements every hospital must consider in wake of another tragic neuromuscular blocker event.** bit.ly/2SlvhR2 Published January 17, 2019. Accessed July 1, 2019.

Resource

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"Just culture" in senior living: What leaders need to know

Creating a "just culture" has the potential to improve team member morale and retention, a benefit particularly important to senior living and long-term care organizations, where high levels of turnover are commonplace.

Though the just culture model is still new in these settings, the basic principles are something the industry is already emphasizing, says Julie Apold, vice president of quality and performance excellence for LeadingAge Minnesota, the largest association of organizations serving Minnesota seniors, whose mission is to transform and enhance the experience of aging. Through its Safe Care for Seniors program, LeadingAge is working to reduce safety events, such as falls, medication errors and skin injuries that can occur in the course of caregiving.

"We are working to create a fair and just culture where people feel more comfortable speaking up, as well as using just culture principles to respond to staff behaviors when evaluating and responding to events that do occur," Apold says.

Changing culture isn't an easy task, she acknowledges. Senior living organizations may not have leaders and staff with experience in applying just culture principles, and administrative and operational leaders alike may see this as just one more thing they need to add to staff training. What's critical for leaders to understand, she says, is that just culture principles align with their existing goals of a safe and supportive environment for residents and staff, and that they likely have a strong foundation upon which to build.

Debunking Old Stereotypes

A review of "This Chair Rocks"

In "This Chair Rocks: A Manifesto Against Ageism," Ashton Applewhite exuberantly takes on what she calls "the last socially sanctioned prejudice." Her account is bracing and refreshing, and once you become attuned to the ways ageism gets a pass in current American culture, which she describes as "grotesquely youth-centric," you can't help but think more critically about the conclusions we jump to—or, more disturbingly, start out with—regarding the people she calls "olders."

"What ideas about aging have each of us internalized without even realizing it?" Applewhite asks. "Where have those ideas come from, and what purpose do they serve?"

She explores how stereotyping serves as a way to avoid dealing with people as individuals and enables us to keep them at a distance. As she notes, seeing people as "other than us" makes their welfare seem "less of a human right."

Then there's the medicalization of aging. She speculates, "Perhaps because health professionals deal with people at the more debilitated end of the spectrum, they're more susceptible than the general public to ageist attitudes and more likely to assume that aging and disease go hand in hand."

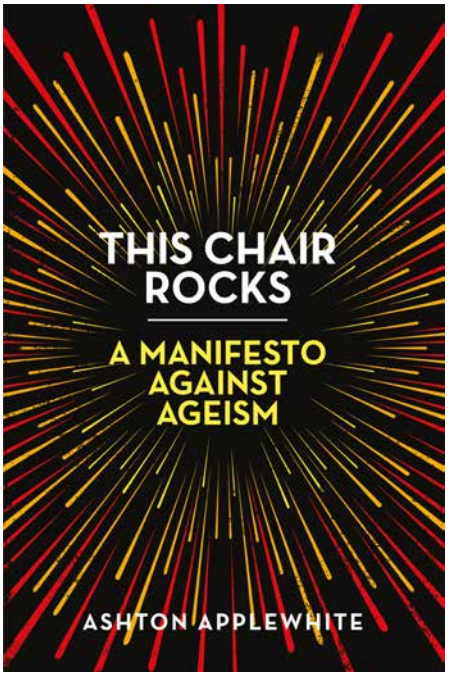
Applewhite muses about her own former complicity in such thinking: "Why had I bought into an unexamined narrative for all these years instead of taking comfort and guidance in the evidence around me?" Finding and sharing that evidence—evidence that contradicts received wisdom—is only one of the services Applewhite provides her readers. As an example, she points out that fewer than 4% of Americans over 65 live in institutional settings such as nursing homes.

The author also does an admirable job of debunking myths about olders in the workplace, such as the contention that they take jobs from younger workers.

Throughout her book, she cites statistics to support larger points. Take the fact that at least five out of six cases of elder abuse go unreported. That appears in a section focused on how ageism legitimizes abuse and shortens lives. And the damage reaches further. "A culture that devalues the old," she says, "places little value on those who work with them," clearly a problem at a time when the number of gerontologists in the United States is dropping at the same time the number needing their care is growing.

True to its charter as a manifesto, Applewhite's book is chock full of actions we can take to right the many wrongs she highlights. In fact, several of her chapters end with "Push back!" sections that call out ways to make a difference, starting today.

The best thing about her suggestions throughout is how inclusive they are, and the pains she takes not to shame those to whom they are targeted. "The point is not to embarrass," she says, "but to make someone reflect for a moment." As an example, she points out the "cloying" subway signs that urge, "Won't you give up your seat to the elderly or disabled?" (complete with a "condescending little heart"). What they should say is, "Please offer your seat to anyone who looks like they might need it."



That could be any of us, and will eventually be all of us. Let's start now to get it right, together.

Resource

ThisChairRocks.com

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Improper Monitoring Leads to Death

Care team members fail to properly monitor and care for an 87-year-old woman living in a senior community leading to a pressure injury, infection and death.

SPECIALTY	ALLEGATION	PATIENT SAFETY & RISK MANAGEMENT FOCUS
⁄ Senior living community	⁄ Failure to follow care plan ⁄ Failure to monitor physiologic condition ⁄ Failure to communicate among the care team and with family	⁄ Improper physiologic monitoring and identification of an acute change of condition ⁄ Breakdowns in communication among the care team and with family

Clinical judgment errors contribute to 96% of claims alleging improper monitoring

Facts of case

An 87-year-old woman had been living in a senior living community for five years. Upon admission, it was documented that she had mild skin redness on her coccyx area. Her care plan included close monitoring of her skin condition, hydration and nutrition status, as well as frequent repositioning to reduce skin pressure injury. During her time at the center, her family frequently brought concerns to the attention of administrators about the care team leaving her in a wheelchair for "hours on end" and in bed without repositioning.

One day, when the woman's adult son was visiting, he walked in and found his mother in bed naked from the waist down and covered in her own feces. The family complained that their mother's general physical condition was not being monitored and the team wasn't ensuring she was receiving adequate hydration and nutrition to prevent skin breakdown. The family also brought these complaints to the director of nursing but never felt they were being listened to or given updates on their mother's condition.

During the woman's last six months of life, she developed a large pressure injury on her coccyx area due to a urinary tract infection and skin breakdown. A care team member confided to another team member that the pressure injury had gotten worse and that her overall condition was declining. Neither team member reported their concerns to the nursing team. The woman's condition continued to deteriorate, and she was eventually transferred to the hospital where she was diagnosed and treated for a coccyx pressure injury and sepsis.

The family filed a malpractice claim against the senior living community alleging failure to properly monitor the woman's physiologic condition and failure to timely transfer to a higher level of care resulting in sepsis and an untimely painful death.

Disposition of case
The malpractice case was settled against the senior living community.

Resident safety and risk management perspective
The investigation into this case revealed that the care team was not following the woman's care plan for monitoring of her skin condition, hydration and nutrition status, as well as failure to reposition her every two hours to prevent skin pressure injuries. When a care team member expressed concern over the woman's pressure injury size and her declining condition, there was no report to the nursing team or her physician. The investigation into the claim revealed the senior community did not provide training in monitoring skills and had no formal process to identify and communicate about an acute change of condition.

Improper physiologic monitoring
In an analysis of Constellation senior living malpractice claims, improper physiologic monitoring was alleged in 20% of claims. The top contributing factor in 96% of improper monitoring claims was errors in clinical judgment, namely critical thinking skills.

Critical thinking has been described as the art of applying theoretical knowledge to actual, real-life situations. Not only does critical thinking require foundational knowledge, but also the ability to analyze and evaluate evidence or a situation and act appropriately. Resident safety requires early recognition of an acute change of condition through appropriate monitoring and timely communication with physicians—necessitating education and processes that support these skills.

Investing time and resources in developing critical thinking, monitoring and communication skills in senior living care team members creates a stronger team and can improve resident outcomes while reducing resident injury and preventing malpractice claims, all improving the organization's bottom line.

Breakdowns in communication with family members
Breakdowns in care team communication with family members is a frequent cause of hard feelings among family members and contributes to the filing of malpractice claims. The communication process with family members begins at admission, with the resident and family interview.

Establish a plan with family members for regular communication, identifying the preferred method of communication. Regular communication with family members about a resident's status enhances the relationship with residents and family members. Communicating only when things go wrong or in the event of an adverse outcome creates a lack of trust and suspicion about the quality of care.

Resources
Find links to improve care team performance and communication about change in condition on the MMIC and UMIA websites by navigating as follows: MMICgroup.com or UMIA.com Login > Risk Resources > Bundled Solutions > Long-term Care

Questions for senior leaders

The following questions may help identify the next steps to take to enhance patient/resident safety and minimize risk:

- ☐ Does your organization assess monitoring skill competency upon hire?
- ☐ Does your organization provide education and training on monitoring, critical thinking and communication skills?
- ☐ Do you communicate regularly with residents' family members to enhance relationships?

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Communication Fail at Transition of Care

A physician misses a positive blood culture result on a post-partum woman at discharge causing a failure to diagnose and treat a Group B strep infection resulting in sepsis with pyomyositis.

SPECIALTY	ALLEGATION	PATIENT SAFETY & RISK MANAGEMENT FOCUS
⁄ Hospital ⁄ Family medicine	⁄ Failure to diagnose and treat infection	⁄ Follow-up system failures ⁄ Breakdowns in transitions of care/failed handoff communication

Constellation data reveals that

35%

of claims involved breakdowns in communication among the health care team

Facts of case

A 25-year-old woman gave birth to a healthy baby at her local community hospital. On day one post-partum, she developed a fever. The on-call physician ordered blood cultures and IV antibiotics. During her hospital stay, she complained of bilateral hip pain, but all her physicians attributed it to a long second-stage labor with her hips flexed.

Early the next morning, the lab reported a preliminary blood culture result indicating gram positive cocci to the on-call physician, a different physician from the day before. He wrote a progress note indicating a need to check for final culture results and sensitivities before discharge. A third physician examined the woman the next morning but did not see the Group B strep (GBS) blood culture results and did not read the progress note from the previous day. He discontinued the antibiotics and discharged her home with instructions to follow up in six weeks. There was no formal handoff communication between the multiple physicians caring for this patient during her hospital stay.

Seven days later, the woman came to the emergency department (ED) with complaints of severe leg pain and backache. The physician in the ED could find no cause for her pain and discharged her with instructions to use over-the-counter medication for pain. Ten days later, she presented to the ED again with extreme leg pain. She was transferred to a tertiary center where she was diagnosed with sepsis with pyomyositis (a bacterial infection of the skeletal muscles which results in pus-filled abscesses) due to an untreated GBS infection. She was later diagnosed with septic arthritis in her hip joints and later underwent bilateral hip replacement.

The woman filed a malpractice claim against the hospital and the physicians alleging failure to diagnose and timely treat GBS infection.

Disposition of case
The malpractice case was settled against the hospital and the physicians.

Patient safety and risk management perspective
The investigation into this case revealed that the standard of care was breached by not reviewing and communicating the positive blood culture result and treating the GBS infection. The expert reviewers stated that not all physicians would have ordered blood cultures based on a post-partum fever, but once the blood cultures were ordered, the standard of care required review of the results and treatment of the infection.

The experts felt her physicians dismissed the complaints of bilateral hip pain due to her long second-stage labor but failed to investigate further when the pain did not resolve in the weeks following delivery. Each subsequent treating physician followed the previous physician's assessment that labor caused the pain and did not expand their differential diagnosis list.

The experts also noted that there was a breakdown in communication among her physicians at transitions of care. They thought the handoff from the physician who was notified of the blood culture result indicating gram positive cocci should have been formally communicated to the discharging physician. During the investigation of the claim, it was determined that neither the hospital nor the physician group had a formal communication process for patient handoffs.

Follow-up system failures
Our review of Constellation medical professional liability claims revealed 17% of all diagnostic error claims originate in the inpatient setting. When diving deeper into the contributing factors of diagnosis-related claims, we found that follow-up system failures contribute to 42% of patient injuries and claims.

Follow-up systems are those processes used to communicate about and coordinate patient care. This analysis revealed that even when appropriate clinical steps are taken to make a correct diagnosis (the ordering of blood cultures in this case), diagnostic errors still occur due to follow-up system failures (the failure to review, communicate and treat the GBS blood culture result in this case).

Breakdowns in communication among the care team
Breakdowns in communication at transitions of care, or handoffs, are a frequent contributing factor in adverse events and patient injury. In the review of our claims, we found that 35% involved breakdowns in communication among the health care team and over half involved miscommunication about the patient's condition. Many health care organizations lack formal processes to assist clinicians and care teams in communicating about the patient condition and treatment plans.

Care for caregivers

Multiple physicians were involved in this woman's care, and all felt guilt and remorse for letting this young woman down by missing her diagnosis because of a failure to review the culture results and communicate with each other at handoffs of care. The physicians recognized, too, that had processes been in place to prevent follow-up system failures and manage communication at transitions of care, this outcome could have been prevented.

Questions for senior leaders

- ☐ Does your organization provide support and tools to prevent diagnostic errors, including clinical decision support tools and reliable follow-up systems?
- ☐ Does your organization have a formal handoff communication process (e.g., I-PASS) for transitions of care?
- ☐ Does your organization have an internal support program to provide support for clinicians in the event of an adverse outcome?

Resources
Find links to prevent diagnostic errors and improve OB care on the MMIC and UMIA websites by navigating as follows: MMICgroup.com or UMIA.com Login > Risk Resources > Bundled Solutions
- ⁄ Preventing Diagnostic Error
- ⁄ OB Risk Solutions

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For the Love of Ourselves and Others

Life offers opportunities
to support each other
in the service of community.

People need to come together when they are grieving. People need support. Sometimes we don't see or identify this need in ourselves and others, but that doesn't nullify the need. Over the years, I have noticed that we in medicine and nursing sometimes need help recognizing that we or our peers might benefit from the support of our colleagues. We may have become so adept at depersonalizing pain and trauma that we may not even recognize its effect on us or our teammates.

This is why our team at Constellation continues to stress the benefits of support to organizations that recognize and attend to these human needs. Because we know well the importance of emotional intelligence, and the positive effect of building support programs for patients, families and clinicians impacted by harm events. It's why we have developed a clinician peer support team for our customers, as well as a whole bundle of wellbeing resources.

As one who has studied cultural anthropology and human behavior, in addition to medicine and public health, I was re-awakened recently, in indelible ways, to the importance of belonging and the support of community. I was reminded of how paying attention to the needs of our fellow team members is, in a way, tending to the public health of a larger community of those who care for others.

In June, I attended a retirement gathering at Ridgeview Medical Center for two long-term ER nurses with whom I shared many experiences of caring for critically ill and traumatized people. The celebration included present and past co-workers and the sharing of many memorable tales. I left this gathering with such a sense of connection, such a sense of belonging and, I'll admit it, such a sense of pride for all of the care we have delivered (and continue to deliver) for our community. I was also reminded of how many really hard things we have witnessed, tried to fix, and literally lived through together, including many of our own challenges. Working in this kind of environment brings one down to the basics of what's really important in life and fosters connection in ways I imagine those in combat together must experience.

One of the attending nurses with whom I reconnected also worked for a large helicopter medical transport service—a dual role that several of our ER nurses fill. Two weeks after our wonderful reunion, this nurse and a pilot she was flying with died in a helicopter crash. To say this tragedy has struck all of us in our emergency department (ED) family as well as in the greater emergency medical services (EMS) family in Minnesota and beyond, would be an understatement.

We may have become so adept at depersonalizing pain and trauma that we may not even recognize its effect on us or our teammates.

A prayer vigil was quickly organized in the town where the helicopter crew was based and where the accident happened. At least 200 people, from first responders to firefighters to paramedics and more, came together to mourn and support each other. This was a gathering to pray not only for the deceased nurse and pilot and their families, but also for the surviving crew member's recovery and the healing of all of our hearts.

In our own small-town ED, 2.5 hours south of this event, the team quickly felt the support of counselors from Ridgeview's employee assistance program, our spiritual care team and our peer support team. We, as a greater tribe of EMS providers in Minnesota, will remember with love these dedicated people, and we will continue to work toward healing, together. For, we really are together for the common good.

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Calendar

PATIENT SAFETY EXPERTS TO SPEAK AT NRHA, ASHRM AND AHCA/NCAL CONFERENCES

On September 19, Constellation Risk and Patient Safety Education Manager D. Michelle Kinneer, PhD, JD, MSN, RN, CPHRM, CHPC, CHC, will speak on "When Things Go Wrong: Apology and Communication" at NRHA's Critical Access Hospital Conference in Kanas City, MO. Go to RuralHealthWeb.org/events for more information.

On October 14, Constellation Risk and Patient Safety Education Manager D. Michelle Kinneer, PhD, JD, MSN, RN, CPHRM, CHPC, CHC, will speak on "The Resilient Risk Manager: Steps to Strengthen Emotional Intelligence" at ASHRM's Annual Conference in Baltimore, MD. Go to ASHRM.org for more information.

On October 15, Constellation Content Manager and Patient Safety Expert Lori Atkinson, RN, BSN, CPHRM, CPPS, will speak on "Preventing and Reducing Falls: Using Malpractice Claim Data to Guide Changes" at AHCA/NCAL's 70th Annual Convention & Expo in Orlando, FL. Go to AHCANCAL.org/events for more information.

MMIC OFFERS EXPERTISE AT FALL CONVENTIONS IN KANSAS AND NEBRASKA

On September 19, Senior Risk and Patient Safety Consultant Traci Poore, JD, CPHRM, will speak on "Vital Signs for Team Communication: Avoiding Life-Support" at the Kansas MGMA Annual Convention in Overland Park, KS. Go to kmgma.org/events for more information.

On October 16, Senior Risk and Patient Safety Consultant Traci Poore, JD, CPHRM, will speak on "Vital Signs for Team Communication: Avoiding Life-Support" at the Greater Kansas MGMA meeting in Overland Park, KS. Go to gkcmgma.wildapricot.org for more information.

On October 17, Senior Risk and Patient Safety Consultant Betty VanWoert, RN, BSN, CPHRM, will speak on "Vital Signs for Team Communication: Avoiding Life-Support" at Nebraska Hospital Association's Annual Convention in La Vista, Nebraska. Go to nebraskahospitals.org for more information.

UMIA RISK MANAGEMENT EDUCATION FOCUS: FACING LITIGATION

Litigation is one of the most difficult experiences you and your practice can face. It's also almost a certainty in a long career. There are things you can do to reduce the likelihood of a claim, manage the stress of the claim process on you and your team, and minimize the negative long-term impact of litigation on everyone involved. Join our claim and risk management experts as they share hard-won lessons about what matters most in these high-stakes situations.

Tuesday, September 24, 6-8:30 p.m.
Kalispell Hilton Garden Inn, Kalispell, MT

Tuesday, October 1, 6-8:30 p.m.
St. George Hilton Garden Inn, St. George, UT

Tuesday, November 26, 6-8:30 p.m.
Salt Lake City Little America, Salt Lake City, UT

For more information, contact UMIA Risk Management Education at: 800.748.4380/801.716.3221 or email Carol Merryman: Carol.Merryman@ConstellationMutual.com

WEBINARS

For the latest on emerging issues and trends in risk and patient safety, we offer webinars throughout the year led by industry experts. Register and watch them live or view them on demand on our **You Tube Channel, Together for the Common Good**. Recently, we partnered with two experts in the field of emergency preparedness and workplace violence to help ensure your organization is ready for the unthinkable.

"Health Care Emergency Management Disaster Preparedness, Response and Recovery," presented by J. Howard Murphy, PhD, FACeM, NPR, CEM, Program Coordinator and Assistant Professor for Anderson University's Emergency Services Management and Homeland Security degree programs.

"Preparing for the Unthinkable: An Armed Intruder or Active Shooter," presented by Steve Wilder, Chief Operating Officer of Sorensen, Wilder & Associates, and nationally recognized subject matter expert on active shooters in health care facilities.

Coming soon on Wednesday, October 2: "Preventing OB Injuries and Claims in Rural Hospitals and Beyond," presented by Betty VanWoert, RN, BSN, CPHRM, Senior Risk and Patient Safety Consultant at MMIC, and Martha Hoffman, RN, C-EFM, Kossuth Regional Health Center OB Clinical Coordinator and Infection Preventionist. For more information and registration, please go to: http://bit.ly/2L8t2uT

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