D16/E16: Insults to Dignity
A Neglected Preventable Harm

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IHI NATIONAL FORUM

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The presenters have no relevant disclosures

Undertaking “the practice of respect”

Learning Objectives

- Review the existing preventable physical harm framework
- Frame emotional harm in terms of “respect” and “dignity”
  o Breakouts: discuss types of disrespect experienced by patients & families
- Describe a novel framework for emotional harms from disrespect
  o Breakouts: assign categories and assess severity to a real-world case
- Discuss how this method is promoting patient-centered care
What is your primary role?

- Show of hands....
  - Risk Managers?
  - Quality Leaders?
  - Board Members?
  - Lay Leaders?
  - Hospital Administrators?
  - Educators?
  - Patients?
  - Clinicians?
Experience with physical harm

Incident reporting system

“Noise”

~7000 incidents reported each year
Experience with physical harm

“Noise”

“Signal”

# of incidents per year

~7000

~150

43

Category Q4 14 Q1 15 Q2 15 Q3 15 TOTALS
Cardiac Arrest - - - 1 1
Bloodstream Infections - 1 1 - 2
Falls with Injury - 1 1 2 4
Surgical Site Infections 5 - - 4 9
All Other Harm (10 categories) 9 3 4 11 27
TOTAL 14 5 6 18 43

Detailed preventable harm dashboard
Experience to date

### Preventable Harm Events By Category, 2008-2015, in Half-Year Increments

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<td>12</td>
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<td>4</td>
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<td>Surgical Site Infections</td>
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<td>35</td>
<td>35</td>
<td>37</td>
<td>33</td>
<td>27</td>
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<td>2</td>
<td>6</td>
<td>8</td>
<td>5</td>
<td>6</td>
<td>5</td>
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<td>All other (10 Categories)</td>
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<td>30</td>
<td>19</td>
<td>8</td>
<td>14</td>
<td>14</td>
<td>17</td>
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<td>9</td>
<td>16</td>
<td>12</td>
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Case

A patient has a type of advanced cancer in her abdomen. When she tries to talk with her cancer doctor about how serious it is, he says “you’re not dying from it now.” She feels relieved to hear this.

But soon thereafter, she begins to experience problems with nausea, difficulty moving her bowels and pain. These symptoms worsen and she has to go to the hospital. There they discover the cancer has caused a bowel obstruction.

She is very sick and is told she needs emergency surgery or she may die. The family requests to see the cancer doctor, but he is unavailable. Instead, one of his colleagues reviews the patient’s medical record and speaks with the family. He says “this cancer is not treatable.”

This is the first time the patient and family have heard this. They are shocked and upset. The patient agrees to the emergency surgery but suffers complications afterwards, never regains consciousness and dies in the ICU a few days later. Months afterwards, the family still thinks about this on a daily basis.
The Boston Globe

Metro

Doctors need to treat their patients with respect

By Thomas Farragher | GLOBE COLUMNIST APRIL 24, 2015

We are blessed to live in a medical mecca, where world-acclaimed hospitals employ medical professionals whose skills are unequaled, people who perform life-saving miracles that move patients and their families to tears of gratitude.

So how is it that these medical wizards, so deft in operating suites and emergency rooms, can be so utterly tone-deaf when it comes to basic courtesy, dignity, and respect?

“Nothing’s more important than respect,” said Jim Conway, an adjunct lecturer at the Harvard School of Public Health. “It can’t just be an aspiration. You have to build this into your system.”
Experience with emotional harm

~3,400 incidents reported each year

Respect Working Group

- Patient Safety
- Health Care Quality
- Nursing
- Hospital Medicine
- Social Work
- Palliative Care
- Ethics Support Services
- Interpreter Services
- Patient Care Assessment Committee Member
- Communications
- Volunteer Services
- Community Benefits
- Performance Assessment and Regulatory Compliance
- Patient-Family Advisors
Defining Emotional Harm

Dignity
- The recognition that each person has intrinsic, unconditional value

Respect
- The actions we take towards others that protect, preserve and enhance their dignity


Table breakouts: Types of disrespect

- 10 minutes
  - At your table: each share a succinct example of disrespect patients suffer in health care, and how you become aware of these events in your institution

- 5 minutes
  - We will call on a few tables to share an example from their discussion
How can we learn about these events?

- Calls/emails to Patient Relations from patients
- Reports from staff
  - Witnessed or second-hand
  - A way to advocate for vulnerable patients
  - Logged through the adverse event reporting system
    - Same as for physical harm

Review process

- Experienced interdisciplinary group
  - Director of Patient Safety
  - Manager of Patient Safety
  - Patient Safety Coordinator
  - Patient Relations specialist
- Initially independent, then all together
  - Assess severity
    - Separately consider the patient/family and institutional perspectives
  - Place in categories
A patient has a type of advanced cancer in her abdomen. When she tries to talk with her cancer doctor about how serious it is, he says “you’re not dying from it now.” She feels relieved to hear this.

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### Severity Assessment

**Patient/family: Severe**

- She is very sick and is told she needs emergency surgery or she may die. The family talks with her cancer doctor about how serious it is, he says “you’re not dying from it now.” She feels relieved to hear this.

**Institution: Severe**

- But soon thereafter, she begins to experience problems with nausea, difficulty moving her bowels and pain. These symptoms worsen and she has to go to the hospital. There they discover the cancer has caused a bowel obstruction.

### Categorization

- Individual communication skills
- Systems for advance care planning

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**After the categorization and severity assessments...**

- **Peer review**
  - Root cause analysis
    - Consider preventability: “Are there reasonable improvements that would decrease the likelihood of a similar event in the future?”
  - Just culture
- **Quality Improvement (QI) Directors**
- **Patient Care Assessment Committee – board level**
- **Monthly meeting to identify next steps for each case**
  - Can we share the case with an existing initiative?
  - Do we need a new initiative?
Experience with emotional harm

Patient Relations & provider reports

“Noise” “Signal”

~3500

341

63

# of incidents per year

Experience with emotional harm

Detailed example: Quarter 2, 2015

~875 Incidents

86 With possible disrespect

22 Severe Preventable

Domains of Respect

<table>
<thead>
<tr>
<th></th>
<th># of incidents</th>
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<tbody>
<tr>
<td>Communication</td>
<td>15</td>
</tr>
<tr>
<td>Privacy and Cleanliness</td>
<td>4</td>
</tr>
<tr>
<td>Care after Death</td>
<td>1</td>
</tr>
<tr>
<td>Personal Possessions</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
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<tr>
<td><strong>TOTAL # Determined Severe &amp; Preventable</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>
Benefits of this work

- Brings rigor to emotional harm
- Important discussions
  - Not only staff/provider → patient/family disrespect
  - Patient/family → staff/provider disrespect
  - Staff/provider → staff/provider disrespect
- Proactively prevent harm and more patient-centered care
  - Communication with transgender patients
  - Privacy protection systems
  - Body and autopsy management
  - Belongings management

Table breakouts: Case review

- 10 minutes
  - Individually consider your case and assess its severity
  - Consider whether the patient/family and institution might have different perspectives
  - As a group, discuss the factors you considered

- 10 minutes
  - We will call on tables to share reflections from their discussion
Challenges in this work

- Gaining institutional buy-in
- Developing reliable severity assessment and categorization systems
- Crafting initiatives that will successfully proactively prevent emotional harm and make care more patient-centered

Questions?