Insults to Dignity
A Neglected Preventable Harm

Thursday, March 31
10:45 AM - 11:30 AM

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The Practice of Respect

Learning Objectives

• Review an existing preventable physical harm framework
• Frame emotional harm in terms of “respect” and “dignity”
• Explain a novel framework for detecting and categorizing emotional harms from disrespect
• Describe the role of the nursing leader in advancing work for the prevention of harms to dignity
• Discuss how this method is promoting patient-centered care
672 beds (77 ICU)

5,000 births

50,000 inpatient discharges

>6,000 employees
   1,200 nurses
   1,250 physicians

$230 million research funding

600,000 outpatient visits

Level 1 trauma, heliport, 55,000 ED visits

3 community hospitals
   Urgent care
   Specialty clinics
   Community health centers
   Extended care facilities

Beth Israel Deaconess Medical Center
How did we get here today?
An audacious goal..........

BIDMC will eliminate all preventable harm by January 1, 2012. We will accomplish this by continually monitoring all preventable and non-preventable occurrences of harm, and continuously improving our systems to allow the greatest opportunity to reduce harm.
Spoiler alert ........................

we didn’t get to zero!
Experience with physical harm

Incident reporting system

“Noise”

~7000 incidents reported each year
Experience with physical harm

"Noise" ~7000 # of incidents per year

"Signal" ~150

43
## Detailed preventable harm dashboard

<table>
<thead>
<tr>
<th>Category</th>
<th>Q4 14</th>
<th>Q1 15</th>
<th>Q2 15</th>
<th>Q3 15</th>
<th>TOTALS</th>
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<tbody>
<tr>
<td>Cardiac Arrest</td>
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<td>Bloodstream Infections</td>
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<td>2</td>
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<tr>
<td>Falls with Injury</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
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<tr>
<td>Surgical Site Infections</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>9</td>
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<tr>
<td>All Other Harm (10 categories)</td>
<td>9</td>
<td>3</td>
<td>4</td>
<td>11</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>14</td>
<td>5</td>
<td>6</td>
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<tr>
<td>Preventable Harm</td>
<td>FY14 Q3</td>
<td>FY14 Q4</td>
<td>FY15 Q1</td>
<td>FY15 Q2</td>
<td>FY15 Q3</td>
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<tr>
<td>Death Related to Medical Management</td>
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<td>Disease Progression or End Organ Injury (reversible or permanent) Related to Medical Management</td>
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<td>Cardiac and/or Respiratory Failure or Arrest Related to Medical Management</td>
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<tr>
<td>Nosocomial Catheter Associated Bloodstream Infections</td>
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<td>Nosocomial Surgical Site Infections (SSIs)</td>
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<td>Nosocomial C. Difficile Infections</td>
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<td>Other Nosocomial Infection</td>
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<td>CARE RELATED</td>
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<td>Falls Resulting in Injury</td>
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<td>Soft Tissue Injuries (Includes Pressure Sores)</td>
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<tr>
<td>Procedure Related Harm/Complication (Non Infectious)- Non-Surgical Services</td>
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<tr>
<td>Obstetrical Harm/Complication (Non Infectious)</td>
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<tr>
<td>Neonatal Harm/Complication (Non Infectious)</td>
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<tr>
<td>Other</td>
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Subtotal: 16 14 5 6 18
Case

- An 85-year-old inpatient who has pneumonia suffers a fall in the early evening. The team caring for him obtains x-rays and discovers he has fractured his hip.

- No one calls the family to let them know about the fall.

- The first notification to the surrogate decision-maker (son) to let him know about the fall is from the orthopedic surgeon, calling to get operative consent for repair of the broken hip. There had been no notification to the family about the fall or the subsequent x-rays. The family is very upset.
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.”
Anesthesiologist trashes sedated patient — and it ends up costing her

By Tom Jackson

Sitting in his hospital bed, the patient pressing remote controls
But as soon as
he had received
off to sleep

Doctors Behaving Badly

By Roni Caryn Rabin  August 21, 2015 1:13 pm

Ohio hospital somehow loses infant’s remains

By the Associated Press  September 29, 2015
Experience with emotional harm

Patient Relations

“Noise”

~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

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
Assessing Severity

- **Mild** - Unfortunate for the patient but would be expected to cause little harm

- **Moderate** - Disrespectful toward the patient but would not be expected to cause long-term harm

- **Severe** - Disrespect that could be expected to cause severe, lasting harm (avoidant behavior, re-experiencing, depression etc.)
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?”
- Use Just Culture approach
- 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?
An 85-year-old inpatient with pneumonia suffers a fall in the early evening. The team caring for him obtains x-rays and discovers he has fractured his hip. No one calls the family to let them know about the fall.

The first notification to the surrogate decision-maker (son) to let him know about the fall is from the orthopedic surgeon calling to get operative consent for repair of the broken hip. There had been no notification to the family about the fall or the subsequent x-rays. The family is very upset.

Severity Assessment
• Patient/family: Severe
• Institution: Severe

Categorization
• Communication related to adverse events
• Uncoordinated care
Experience with emotional harm

Patient Relations & provider reports

"Noise"

"Signal"

# of incidents per year

~3500

341

63
Experience with emotional harm

Detailed example: Quarter 2, 2015

~875 Incidents

86 With possible disrespect

22 Severe & Preventable

<table>
<thead>
<tr>
<th>Domains of Respect</th>
<th># of incidents</th>
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</thead>
<tbody>
<tr>
<td>Communication</td>
<td>15</td>
</tr>
<tr>
<td>Privacy and Cleanliness</td>
<td>4</td>
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<tr>
<td>Care after Death</td>
<td>1</td>
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<tr>
<td>Personal Possessions</td>
<td>2</td>
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<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL # Determined Severe &amp; Preventable</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>
A patient posts this on the hospital’s Facebook page. “Ok...I have surgery scheduled today and the paperwork says check in @ 5 am. I wake at 3:30 to make the 1 hr. drive from [far away] only to learn that no one can ever check in B4 6 am??

The staff here states it is a little trick they do??

Hope surgery doesn’t have any little tricks or surprises!”

You investigate and determine that the surgeon’s office staff has been telling patients to get there early as the traffic in Boston is terrible and a lot of patients scheduled for the first case of the day arrive late.
Case

• A distraught family member calls to report that when they called the funeral home to check on the burial plans for their mother – it becomes obvious that the body did not make it to the funeral home. You determine that the body was released by your hospital to the wrong funeral home and embalmed there. The funeral for the patient was delayed as a result.

• You investigate and realize that for this complex process there are variable standards for managing bodies moving to and from the morgue.
Benefits of this work

• Brings rigor to emotional harm

• Raises important discussions
   Not only staff/provider → patient/family disrespect
   Patient/family → staff/provider disrespect
   Staff/provider → staff/provider disrespect

• Proactively prevents harm and fosters patient-centered care
   Communication with transgender patients
   Privacy protection systems
   Body and autopsy management
   Belongings management
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
The role of the nursing leader in setting the stage for tracking and addressing emotional harm: The BIDMC Story

Patient Care Committee

• Patient satisfaction surveys
  - RN/MD communication
  - Cleanliness
  - Food service
  - Ambulatory appointment access
  - Staff courtesy

• Patient complaints

Patient Care and Assessment Committee

• Physical harm
  - Case review – reportable events

• Publicly reported quality measures
  - Central line infections
  - Surgical site infections
  - Other clinical pay for performance measures

The soft stuff.....

The real stuff......
Leveraging the patient voice: Our Patient and Family Advisory Councils

- Hospital-wide council launched 2010
- Councils in multiple sites:
  - Critical Care
  - Primary Care
  - Psychiatry
  - Neonatal ICU
  - Universal Access
- Year over year growth – in 2015 there were 93 advisors participating in over 6 activities each, including:
  - Advance care planning
  - Environmental sustainability
  - Respect and Dignity Initiative
  - Welcome video
Integrating the full patient experience and the patient and family voice

Patient Care Committee

- Patient satisfaction surveys
  - RN/MD communication
  - Cleanliness
  - Food service
  - Ambulatory appointment access
  - Staff courtesy
- Patient complaints

Patient Care and Assessment Committee

- Patient and family advisors on the committee
- Physical harm and emotional harm
  - Case review – reportable events
- Publically reported quality measures
  - Central line infections
  - Surgical site infections
  - Other clinical pay for performance measures

Patient Care and Assessment Committee

- Physical harm
  - Case review – reportable events
- Publically reported quality measures
  - Central line infections
  - Surgical site infections
  - Other clinical pay for performance measures
Takeaways for nursing leaders

• Nursing leaders are well positioned to champion a holistic view of the patient experience.
• The patient/family voice must be integrated into care and into all levels of organizational activity.
• Capturing and addressing instances of emotional harm can be carried out using systems and mechanisms already in place in hospitals (patient complaint process, safety reporting systems).
• Nursing leaders can work to create an organizational culture that recognizes and responds to instances in which patients or families suffer emotional harm.
Questions?
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HUMAN FIRST
Before you’re a patient,
you’re a person
@BIDMCHealth