Partnering with Patients and Families in Patient Safety Incident Reviews

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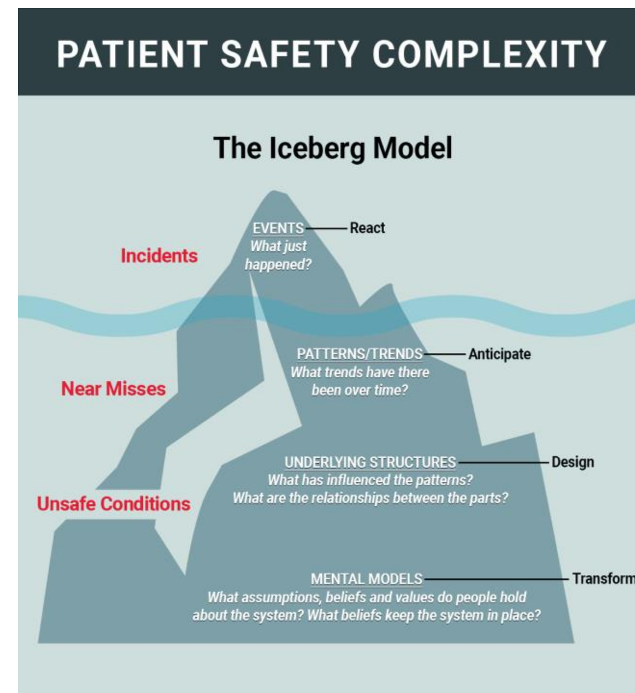
Learning Objectives

- Describe why the patient and family voice is essential in reviewing patient safety incidents and developing recommendations to support changes at the system level and ultimately support the delivery of quality health care.
- Reflect on the tangible ways to engage patients and families in the quality review process to enable development of recommendations that will truly mitigate the harm patients experience

Patient Safety Incident Reviews

Patient safety incident review are activities oriented toward quality improvement and system-based analysis, rather than individual accountability or performance.

The process includes identifying factors that contributed to the incident through a system-based analysis.



Patients and Family Involvement

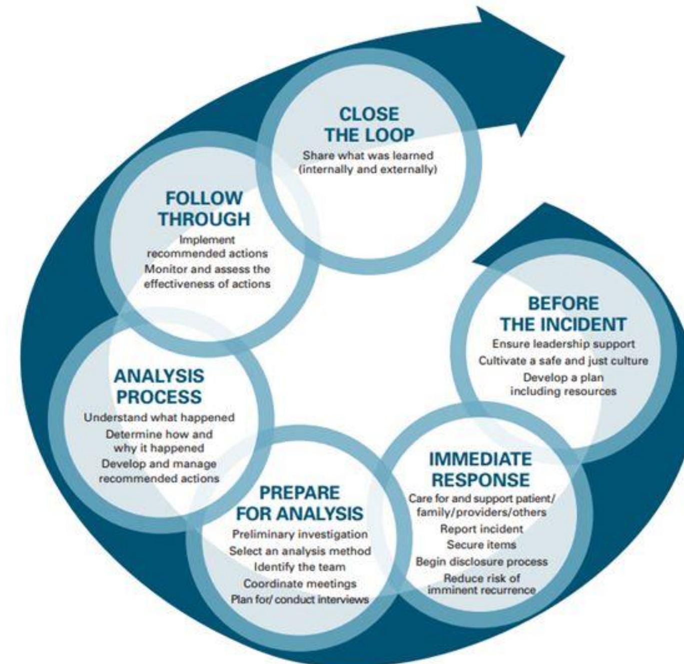
- Patient and family involvement in considered essential in quality and safety research and practice
- Health Standards organization and Accreditation Canada recognize and focus their National Framework to include a goal of Safe Care to include an outcome that “Patient safety events are analyzed and acted upon by interdisciplinary teams which includes patients”

Examples of Patient/Family Roles in Incident Analysis

- Share a personal story to humanize the person impacted and centre the team in the lived experience of the patient and family
- Identify pieces of the process that are confusing or missing from a patient and family perspective
- Participate in information/data gathering
- Discuss and analyze findings
- Assist in developing action plans and recommendations

Analysis

The analysis includes identifying factors that contributed to the patient safety incident, determining actions or recommendations to reduce the risk of future recurrence, and developing an implementation plan along with associated measurement strategies to evaluate their effectiveness.



Embedding the Patient Experience in transformative healthcare delivery

Guidelines

How Do We Review Patient Safety Events?

The legal stuff you and patient representatives will need to know

Quality Reviews- Section 51 *BC Evidence Act*

- Patient safety event reviews are often conducted under Section 51 of the *BC Evidence Act*.
- Section 51 sets out criteria that restrict information (documents and deliberations) concerning patient care quality reviews and activities from being admissible in court proceedings.
- This prohibition on disclosure is intended to facilitate open and honest communication by encouraging health care professionals to share information about patient care and safety without the risk that the information will be used against them in legal proceedings.

Section 51 cont'd

- This protection, however, only covers hospital based and BC Emergency Health Services activities under the current interpretation of section 51 of the *Evidence Act* – Not all health care facilities have section 51 protection.

- If reviews do not occur within a committee constituted in accordance with the *Evidence Act*, information generated through the quality of care review process will not be restricted from release and may be admissible as evidence in legal proceedings, in BC via Freedom of Information and Protection of Privacy Act (FOIPPA) requests.

Key Compliance Obligations

Central compliance requirements under section 51 of the *Evidence Act* are that:

- A person participating in a Section 51-protected review must not give evidence concerning the deliberations of the committee or produce any document used by or prepared for the committee
- Staff and the patient advisor may need to sign a document to that effect.
- There maybe letters written that outline the expectations and a signature may be needed to confirm it has been read and understood

Sample Confidentiality Agreement

- I AGREE THAT:

- I shall only use the Confidential Information for internal purposes in considering and working on the Project. Any Confidential Information that I may see, hear, collect, record or use when I am at an VCH facility or otherwise observing its systems, processes, and procedures is strictly private and confidential and may not be shared or disclosed to any other individual. Any Confidential Information shall remain the sole property of VCH.
- I will take all reasonable steps to prevent the unauthorized collection, use and/or disclosure of any Confidential Information, including taking precautions against such risks as loss, theft or improper access to such information by unauthorized individuals.
- I will securely destroy any and all Confidential Information in my possession when I no longer need this information for the Project.
- I agree to notify VCH as soon as possible if I am aware of a breach of this agreement.
- By signing below I accept the terms of this agreement and intend to be legally bound by them.

Name: _________________________________

Signature: ______________________________

Date: __________________________________

Witness Name: __________________________

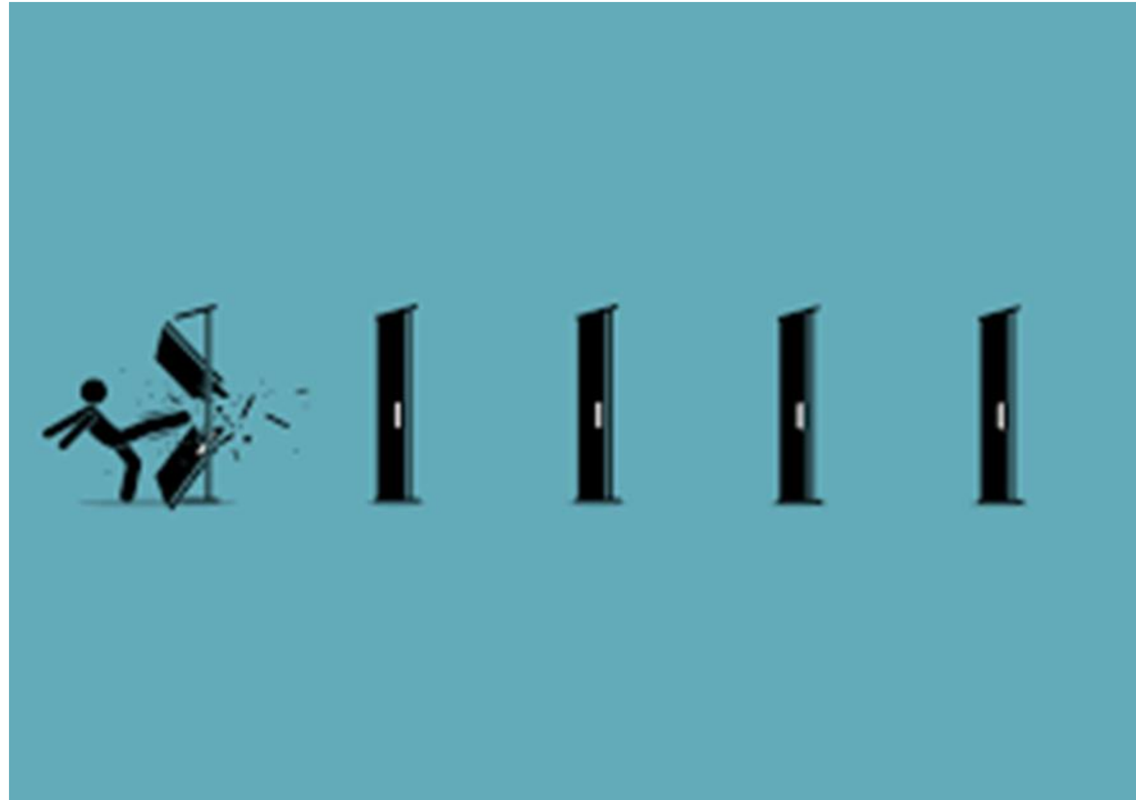
Phone Number: __________________________

Signature: _______________________________

Date: ___________________________________

Organization: ____________________________

It’s That Simple!



Why Include Patients and Families?

- It brings us back to the deeper meaning of what we should be doing in a health organization. We talk a lot about our patients and we work for the patients, but now we do things with the patients, and that changes the dynamic." Ibid., Pomey, 2016.
- Many people may come together to partner in quality and safety improvement processes. Patients, partners and providers each bring a unique role and perspective but share responsibility for working together in partnership effectively.
- Patients are experts in their illness and care experience. Their experiential knowledge and perspectives are critical in improving quality and safety processes.
- Patients and families may choose to be involved in organizational change for their own personal healing.

Why Include Patients and Families cont’d

- Safe care is critical for patients and families, providers and organizations to realize improvements in care safety. Healthcare organizations and providers need to partner with patients in all aspects of patient safety, from prevention to incident response.
- Partnering with patients and families for quality and safety in organizations and systems helps:
  - Inform changes to processes and policies that shift to safer, more patient centred care
  - Build structures and processes for safer, better quality care

Engaging Patients in Patient Safety: A Canadian Guide. Patient Engagement Action Team – February 2018.

How to Engage Patients and Families Following an Incident

- The patient and family directly affected should receive information through the disclosure process, and be invited to participate in the incident analysis review. They should continue to receive updates and further disclosure information as things evolve.
- Etchegaray et al found that patients and families are somewhat aware about what contributed to their incidents.

How to Involve Patients and Families in the Analysis Process

- Ensure the patient and/or family involved in the patient safety incident are interviewed for their perspective and then invited to suggest what recommendations they feel should be put in place to prevent the incident or improve patient safety, if they are comfortable and able;
- Include patient partners on the analysis team throughout the analysis process; and
- Apply a broad system lens to the analysis by focusing on the patient journey and selecting a time frame for review that captures the relevant experiences.

❖ BC guidelines for patient safety incident reviews 2020

Including Patients and Families Individually and Organizationally

- Patient partner participation can range from sharing personal experiences to providing feedback on processes. They may help determine what went wrong and why and contribute the patient perspective on improvement initiatives (e.g. reducing falls in LTC, improving discharge processes and reducing readmissions etc.).
- Some organizations have a formal structure to help identify priorities that matter to patients and families and to act as a resource for providers on improvement initiatives. E.g. (Patient and Family Advisory Councils (PFACs) or resident/family councils in LTC)

Still a New Concept…

- Patient engagement in safety and quality is still not common in all organizations. One of the challenges is the readiness of providers to partner which is shaped by their perception of the value of patient involvement.
- Seattle Children's Hospital has shifted it's expectation from asking "Should we involve parents in this serious safety event?" to "Why wouldn't we involve a parent in this serious safety event?" This has presented a major culture shift for providers, patients and families.

Healthcare Providers – Perceived Barriers to Involving Patients in Safety Reviews

- Patient perspectives might differ from their own creating conflict
- Inadequate healthcare provider time, resources, and expertise to support patient engagement
- Lack of diversity in the patients engaged (not representative of the populations served)
- Patients might not have the required knowledge to participate meaningfully
- Patients might lose confidence in the healthcare organization
- Patients may not respect privacy and information confidentiality

Patient Perceived Barriers to Becoming Involved in a Patient Safety Incident Review

- Fear that speaking up could impact relationships
- A belief that they may not be qualified enough to contribute
- Patient engagement to “tokenism” and their input will not be used to make decisions

How are Patients and Families Engaged Elsewhere in Canada?

In Alberta, patients and families are involved in two steps of patient safety incident reviews and we are now moving to this approach in many health authorities within BC:

- Interviewed at the information-gathering stage to gain their understanding of the incident’s cause, what could have prevented it, and any actions they think the organization should take to improve the safety of the system
- Invited to review draft recommendations for feedback and refinement

What Other Countries are Doing

- Netherlands, Australia and Norway have regulation enabling users of the health care system, or next of kin, to file complaints to the regulator or an ombudsperson or both.
- BC has similar legislation to address patient care quality complaints which may lead to a patient safety incident review. *BC Patient Care Quality Review Board Act*
- Norway has recently made it mandatory for health service providers to invite patients and users to a meeting after a severe adverse event and in Long term care settings they audit to ensure that this has occurred.

❖Wilig et al. BMC Health Services Research (2020) 20:616

What are Patients and Families Telling Us?

A patient experience might uncover certain practices that are unknowingly hurtful to the sensitivities of patients and their families. It is acknowledged that the systemic racial bias exists in the delivery of services and is a major detriment that is often ignored.

I think it is a matter of building public trust and transparency.

The inclusion of the patient and family is critical in the review process as it offers the opportunity to hear their lived experience during the unexpected care incident. It offers opportunities for improvement from the health care side but also healing and understanding the patient and caregiver side as well as rebuilding trust.

It can also support resolving the feelings of distrust that will have emerged in the incident.

What are Patients and Families Telling Us?

Both patients and caregivers have a vested interest in better quality of care and better outcomes.

It gives the space for a patient to forgive providers personally, which would be of the greatest benefit to all.

You will not only get the FACTS of the error or incident, but you will learn of the ripple effects such as loss of trust in staff, loss of respect for the health care system.

Patients and caregivers offer insight into the other side of the gurney - what it feels like and what errors they may think affect or affected their care.

It allows for building of trust or rebuilding of trust between patients, caregivers and the health care system especially if the trust has been broken during a care episode.

What are Patients and Families Telling Us?

Patients should be included from the start…the family/patient must feel supported.

The family/patient must be assured that there has been a learning from the experience.

The way in which patients and families are included needs to be done in a safe and respectful manner.

Need a process that allows patients and families to contribute in a way that works for them, that does not trigger the trauma of the incident.

Consider including a member from the indigenous community be part of a review panel due to systemic racism existing in the healthcare system.

Patient Transported Down for Possible Transplant

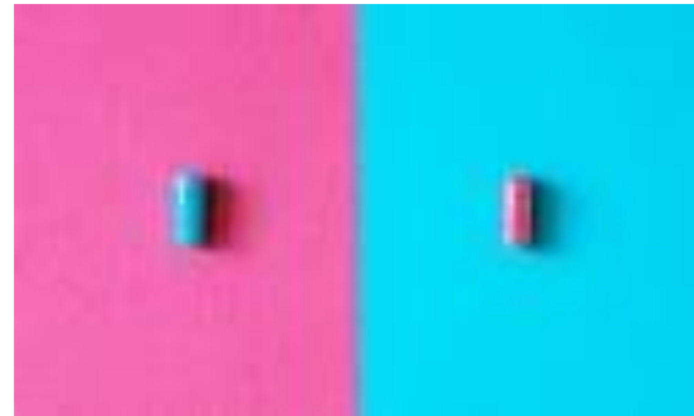
- Patient transported from a remote indigenous community as the care team was exploring possible transplant.
- On arrival patient is assessed by care team and deemed not appropriate for a transplant this is not communicated to the family for a week, ultimately patient deteriorates and dies and family upset as they were expecting a transplant to have occurred.
- Interview with family indicates misaligned expectations. Family were not told that it was only a possibility, nor were they informed or aware of severity of situation..
- Family makes a decision to come to Vancouver to be with their relative, optimistic about transplant and shortly after patient deteriorates and dies. Extended family not present as not aware of severity and therefore were not able to practice some of their cultural traditions around end of life.

Open Wounds Following Cast Removal

- Chart indicates "no problems, fracture healing well" on 4 separate visits to see an orthopedic team following surgery.
- Family provides information as to their discussions with the care team providing that they had called and left messages on 3 separate occasions related to their concerns with pain, swelling and foul smelling cast.
- On removal of cast patient had extensive infection to surgical site that was not identified requiring additional surgeries, hospitalization and extensive antibiotic treatment.

Why is the Pill a Different Color?

- The review for a medication error with the care team provides all the system issues related to a medication error
- The family interview indicates that they questioned why the pill was a different color and shape, and this was dismissed by the health care provider, saying that often different manufacturers pills look different, the medication was given to the patient without double checking, resulting in an adverse drug event.



Closing the Loop with Patients and Families

- Ensure that the patient and/or family involved in the patient safety incident have the opportunity to provide feedback on their experience of the patient safety incident management.
- Once there is approval within your organization to implement the recommendations coming from the review, then those actions should be shared with those involved in the review including the patient or family.
- There maybe limitations to what can be shared and requires Risk Management or Legal Services for your organization to provide advice about what can be shared and timing specifically if done under legislative restriction e.g. section 51 of the *BC Evidence Act.*

“Putting patients in a position of real power and influence and using their wisdom and experience to identify issues and to inform and redesign care…provides the most important force for driving change and has the greatest potential for achieving long- term transformation in the healthcare system.”

Reinerston,J.R., M. Bisognano and M.D. Pugh. Seven Leadership Leverage Points for Organization–Level Improvement in Health Care. Cambridge, MA: Insititute for Healthcare Improvement, 2008, 39. In Baker G.R., et all, 2016.

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