

## Testing the Limits of Transparency

By Patrice Spath

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*A few hospitals are inviting patients' families to join them in root cause analysis discussions.*



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Partnering with patients to improve safety is fast becoming an essential element of health care transparency. Patients expect to be actively involved in their own care and given opportunities to speak up if something doesn't seem right. Some organizations have taken patient involvement a step further by adding laypeople to patient safety committees. A few are testing the limits of transparency by incorporating the patient's experience and perception into adverse event investigations.

In 2001 when Sorrel and Tony King, whose daughter Josie died from a medical error, were invited to tell their story to the whole investigation team at Johns Hopkins Hospital, it was rare for laypeople to attend what is considered a confidential meeting. Organizations were fearful of compromising the privacy of the investigation process and jeopardizing state law peer review protections by inviting outsiders to the meeting. If a family's personal experiences were shared at all, it was done one on one with the risk manager or another hospital representative.

"My husband, Tony, and I attended the root cause meeting at Hopkins following the death of our child," says Sorrel King, consumer patient safety advocate and founder of the Josie King Foundation (<http://www.josieking.org>). "We told them what we saw and what happened. It was important for them to hear our perspective." Since then King has joined forces with the hospital to implement changes that will make future errors less likely.

The media coverage of the Kings' experience at Hopkins caught the attention of health care organizations throughout the country, prompting some to engage more patients and families in safety partnerships. (See "[Involving Patients in Safety Improvement](http://www.myschospital.org/docs/h&h2-19-08.pdf)," *H&HN OnLine*, Feb. 19, 2008. <http://www.myschospital.org/docs/h&h2-19-08.pdf> ) Only recently have a few organizations taken a step that many would still view as being radical: include the patient or family in root cause analysis (RCA) discussions.

### One Hospital's Journey

Following a 2007 sentinel event in which a patient died, Rogue Valley Medical Center in Medford, Ore., invited the patient's widow to be part of the RCA team. The decision to involve her in the investigation process was not made lightly. "I was approached by our risk manager with a request that we include the patient's family in the RCA," says Kent Brown, CEO at Rogue Valley. "My first reaction was one of horror. I was concerned that we would have significant liability risks."

"Hospital attorneys fear that opening an RCA to people outside of the organization may act as a waiver of certain privileges that would allow otherwise confidential information to be used against the health care provider during subsequent litigation," says Terie Zimmerman, a patient safety officer at Catholic Healthcare Partners in Cincinnati. "There is some legitimacy to these liability concerns; however, by systematically addressing these fears, it is possible for health care teams to successfully partner with patients during an RCA."

Not surprisingly, attorneys in the Rogue Valley community cautioned against including family members on the RCA team. Yet the administrative team ultimately decided to take the risk. "We could not undo what had happened to the patient," says Bobbi Higgins, risk manager at Rogue Valley. "However, we could offer the wife an opportunity to be an advocate for her husband and for future patients. Involving the family member is consistent with our philosophy of transparency."

During the full disclosure meeting immediately after the event occurred, an invitation to attend the RCA meeting was extended and accepted by the family. The family's request for a copy of the patient's complete medical record was also honored.

### **Meeting Preparation**

Preparing the family for RCA participation is an important step. "We knew we were being invited to a meeting to tell our story to a group of people whose job it was to investigate what happened," says King. "But we didn't know who the people were or what they would be doing with the information we gave them."

At Rogue Valley, Higgins met with the patient's widow before the RCA meeting to discuss the purpose of the investigation process, and to describe who would be at the meeting and what would happen. Issues of confidentiality were also discussed. "I explained that everyone on our RCA teams is asked to sign confidentiality statements and not to take any notes during the meeting. She was agreeable to that," says Higgins. "We'd developed an open and trusting relationship with the family from the very beginning. Knowing that we welcomed her input during the investigation reinforced that relationship."

The health care professionals attending the RCA meeting also need to come prepared. "It was essential that everyone be briefed before the meeting," says Jo Lynn Wallace, vice president of patient care services at Rogue Valley. "Our biggest fear was that we'd say the wrong thing in front of the family. We wanted everyone to have a good understanding of what actually happened before we went into the meeting."

"All parties must be adequately prepared prior to the RCA meeting," says Zimmerman. "Otherwise the process can do more harm than good for the laypeople as well as the caregivers." Considerations in the selection of people for the RCA team and recommended preparation steps are detailed by Zimmerman and her co-author, Geri Amori, in a chapter in the book [\*Engaging Patients as Safety Partners: A Guide for Reducing Errors and Improving Satisfaction\*](#) (Chicago: AHA Press, 2008).

### **The Meeting**

Less than a month after the sentinel event, the RCA team at Rogue Valley met for two hours to conduct the review. "The patient's wife was upset at the beginning and expressed her anger at the caregivers," says Brown. "We listened respectfully to her concerns and individually expressed our apologies. As the meeting progressed, she added her perspective to our

discussions of what happened. Without the family member's input, we would not have known about one of our processes that didn't function as it should."

When the Kings met with the RCA team at Johns Hopkins, they remained in the room long enough to tell their story and were then dismissed. The family member attending the RCA investigation at Rogue Valley stayed for the entire meeting. "After determining what went wrong, we discussed our plan of correction," says Brown. "It was important for the family member to witness our commitment to follow through on the plan. Having her there reinforced our determination to prevent a similar incident from happening again."

The RCA at Rogue Valley yielded valuable information that will improve the safety of future patients. It also helped those involved in the event come to some emotional closure. "The staff members had a chance to forgive themselves for what happened," says Wallace. "We grieved together with the family member and expressed our sorrow."

The RCA meeting must be a psychologically safe environment for everyone, including family members or patients who may be in attendance. "People must feel comfortable showing emotions and expressing opinions," says Zimmerman. "When everyone has been carefully prepared for patient or family participation in an RCA, the process can be a truly valuable and enlightening experience for those involved."

### **Learning from the Process**

"Would we do it again? The answer is a resounding *yes*," says Brown. "It's just one more element of transparency. It's something we owe to our patients and family members. Having now participated in an RCA that involved the family, I know we did the right thing."

What did Rogue Valley gain from involving a family member in an adverse event investigation? Below are some key learning points identified by senior leaders and the management team:

- Both family members (or patients) and the health care professionals involved in the incident need to be supported and adequately prepared. Everyone must be informed and feel that they have an equal and important role to play in the investigation.
- One person at the hospital should be designated as a contact for the family. The risk manager had established a close relationship with this family at an early stage, and she therefore continued as the contact person. Each situation will be different; the designated hospital contact may vary.
- Laypeople as well as staff members will feel awkward and vulnerable during the face-to-face discussions. It is important to recognize the human aspects of the event and to create a safe atmosphere where everyone can express emotions.
- There is value in transparency for staff members. It allows key employees to apologize and grieve with the family and forgive themselves for what happened.
- There is value in transparency for sustainable quality and safety improvement. Understanding and agreeing that change is needed in a very public way generates a strong commitment among staff members to make sure that improvements actually happen.

"I don't know whether involving the family member in the RCA will prevent a claim from being filed, but that was not our goal," says Higgins. "I've always felt that transparency was the right thing to do. It would not have happened, however, without strong support from senior leadership here at Rogue Valley."

Rogue Valley increased the number of RCAs over the past two years and now conducts them on significant events and near misses as well as sentinel events. Not every situation is the same. On some occasions families will not wish to be involved in the RCA, or the circumstances may be such that layperson participation would not be appropriate. "For our part, we plan to extend the invitation whenever we can," says Higgins.

At the very least, providers should interview the family outside of the RCA meeting. "Our input is important to the investigation process," says King. "What matters most is that caregivers hear and pay attention to our side of the story."

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