ASHRM AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT

Monograph

Disclosure
of unanticipated events:

Creating an effective patient **communication policy**

second of three parts

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TABLE OF CONTENTS

FOREWORD

In this three-part series on disclosure, Part 1 – "The Next Step in Better Communication with Patients" – described the initial impact of the 2001 National Patient Safety Standards established by the Joint Commission on Accreditation of Health Care Organizations; the psychological and legal barriers of open communication; models used by organizations to support and influence communication; and an analysis of some disclosure experiences.

With this broad overview of the philosophy of disclosure, the challenges to nurturing a culture of open communication and the approaches some organizations have taken to work the practice of disclosure into the operation, the stage is set for analyzing the value, structure and challenges inherent in developing a disclosure policy for the organization.

This paper, Part 2 in the series, addresses:

- Considerations for developing policies and procedures regarding disclosure.
- Suggestions for building an effective policy.
- Special considerations for developing policies in specific settings such as acute care, long-term care and pediatric care.
- The effect of disclosure policies on litigation, including ways to define harm for the purpose of policy development.
- Ideas for staff and provider training and policy considerations in specific patient settings.

The third paper, titled "Effective Disclosure: What works now and what can work even better," focuses on techniques to improve effective disclosure and how they can be applied.

In addition, the third monograph analyzes different disclosure situations, providing discussion on the issues to consider and the techniques to enhance the potential for effective communication with patients and families (however patients define them). It further discusses the ramifications of disclosure on litigation and in acute, long-term care and pediatric care settings.

INTRODUCTION

Historically, organizations developed policies and procedures for regulatory and accreditation compliance purposes. From a risk management standpoint, a fear was that lack of effective implementation/enforcement of the policies and procedures could create liability exposures for the organization.

For example, if a policy required that a patient be checked every 15 minutes while under observation and, due to staffing shortages, staff members could only check the patient every 30 minutes, they are held to be in violation of their own policy by plaintiff's attorneys and juries. The reasoning: If the organization established the policy, it should be followed at all times. This was deemed true even if there was a logical reason in a particular situation for non-compliance.

The development of policies and procedures in healthcare has sometimes substituted for the arduous task of identifying and addressing latent failures in a process.

For example, when an unanticipated event occurs, it's not unusual to see the creation of a new policy or procedure to address the very specific situation that resulted in that one event. The reactionary development of policies and procedures often results in extremely detailed and proscriptive procedures that do, in fact, create a narrow window of appropriate behavior in a given circumstance. Due to the inherent variability of factors in any given situation, there is likelihood of compliance failure and thereby increased liability exposure. The more specific the policy to a situation, the less likely it is the policy will have general applicability and be followed on regular basis.

Instead, policies and procedures should reflect the values and principles of the organization, including its care philosophy. Accompanying procedures should provide guidance about implementation of the policy, and those procedures should not be so restrictive as to be prohibitive in actual practice.

BUILDING AN EFFECTIVE POLICY

Semantics: Mistake management, informing patients, disclosure and communication

When drafting a policy, it is important to determine the language that will be used and the effect of that language.

Using the word "disclosure" can often give the impression that the consequences of not having such a policy would indicate "non-disclosure." Instead, using proactive terms such as "communication" may avoid this impression and convey a positive cultural statement.

Note, for instance, how a patient disclosure/communication policy statement that reads *"It is XY Hospital's goal to always have open, honest and constant communication with our patients"* is much more positive than one that says *"It is the policy of XY Hospital to disclose any unanticipated outcomes."*

While this may seem too basic, the policy may be produced in a lawsuit in the future and a jury may try to interpret its meaning and application. The focal point becomes the interests of the patient versus protection of the organization from litigation. The policy should be stated in positive and proactive terms.

Example:

> Hospital XXX Policy & Procedure Manual
>
> Policy for Effective Patient Communication
>
> Purpose: It is the goal of Hospital XXX that all patients feel involved in their care and treatment through frequent and effective communication. This communication may take the form of informed consent, communication of an unanticipated event, and the daily talks with physicians and staff on how their treatment plan is progressing.

In addition, the language used in the policy needs to be the same as language employed throughout the organization to help ensure consistency of the message. Using language that is not consistent with the safety philosophy will create confusion. Language communicates not only the content message, it conveys and reinforces the culture, too.

Consistent communication, informed consent through disclosure

Effective disclosure/communication begins with informed consent, which is basically a proactive form of disclosure of an unanticipated or undesired outcome.

The disclosure should be considered part of the informed consent process between the patient and practitioner. This process includes much more than just the informed consent for a single procedure. It includes involving the patient in daily decisions that affect the overall treatment plan, obtaining his or her cooperation in their own well-being and facilitating an open forum for patient or family questions or concerns.

Moreover, risk management professionals can use documentation of the informed consent to guide practitioners during the disclosure of an unanticipated or undesired outcome, so that the message to the patient remains consistent.

Ultimately, the communication or disclosure policy should be drafted to be consistent with the organization's informed consent policy, but also with the goal of instilling a culture of constant communication between hospital staff and patients and their spouses, partners, children or any others they consider "family."

Medical staff approval

Obtaining approval for the policy from the medical staff may require some education before support will be given. Actually, the physician leadership should be engaged in establishment of the policy. For example, they might be involved in identifying the expected role of the physician membership in disclosure conversations.

To be consistent with the spirit of a safety culture, discussion should focus on the issue of the organization's care philosophy and how physicians can support that philosophy. If the policy has been worded with that philosophy in mind, the "sell" to the medical staff will be facilitated and the willingness to support the policy will likely be increased.

Very often, physicians are concerned that they will be the targets of blame in disclosure situations. They need to be assured of support in their efforts – before, during and after the conversation itself and in the followup investigations or reporting that may be necessary as a consequence of the event.

Furthermore, physicians must be assured that although they, as attending, may take the lead in the discussion, the organization sees any occasion on which news of harm is delivered as a team occurrence for any staff that may have been involved in the event.

Therefore, a condensed training session should take place with the key medical executives in order to give them information not only about the basis and need of the policy, but also to allow them to understand (and thus communicate) the roles that they and other providers will fill.

At this time, the philosophy of patient communication is more than informed consent for a procedure or the disclosure of an unanticipated outcome. The involvement of the patient in daily decisions that affect the overall treatment plan builds a framework in which discussions about bad news (poor prognosis, complications of treatment, medication reactions, medication errors, less than optimal outcome of treatment, treatment error, etc.) are as natural as discussions about good outcomes and routine care.

Policy contents

A complete policy should include the following:

- Policy statement/objectives. This should be a brief statement that describes what the policy is, when it applies and what it is intended to do. Policy statements are most effective when they are limited to a single sentence. The policy statement is the quick guide to staff and employees that indicates the relevance of the policy to the situation about which they are concerned.

  Example:

> Hospital XXX Policy & Procedure Manual
>
> Policy for Effective Patient Communication
>
> Objective: "Hospital XX believes that patients are entitled to information about the outcomes of diagnostic tests, medical treatment, and surgical intervention. Hospital XX and its providers recognize the importance of maintaining good communication with patients and when appropriate their family by providing information that fosters informed decision-making."(1)

  Note that the language of the policy ideally is stated in the affirmative, rather than the negative. For example: *"Only factual medical information about the patient's direct care and status should be documented in the chart"* is a better way to state that information about discussions with risk management should be eliminated from the documentation. If the policy were to state *"Do not document that risk management was notified,"* a plaintiff's

attorney or jury is likely to interpret the message as one of the organization discouraging communication and possibly trying to cover up information.

- Definitions. The policy should give definitions for any terms used within the policy and procedure that may be unclear. Although many organizations use definitions that come from Joint Commission standards or the literature, other organizations create definitions that address the specific structure of their organizations.

  Terms listed below generally are defined in a comprehensive disclosure/communication policy. Not all need to be included if they are not terms used at a specific facility (and some may be duplicative), but all are listed here for suggestion of inclusion:

  Adverse Event or Error or Unanticipated Event
  Near Miss
  Sentinel Event
  Significant Adverse Event
  Disclosure
  Patient Safety Committee or Officer
  Informed Consent
  Primary Caregiver
  Outcome
  Patient Care or Treatment Plan

  Furthermore, if the organization uses terms that differ from those used by other organizations or reflect the unique culture of the organization, then those terms should be defined in the body of the policy.

- Criteria of an event warranting "disclosure." This statement should also be brief, and should include language general enough to allow for the inclusion of multiple situations. An example statement may be: "*Discussions with the patient or family may be warranted if there is a change in the treatment plan or unanticipated event or outcome of which the patient may not otherwise be aware.*"

  Some organizations are choosing to move to statements of disclosure/communication when "harm," however it is defined, has occurred to the patient. Many organizations are indicating the need for "disclosure" with a stepped analysis of harm moving from errors that never reached the patient (no obligation to discuss) to outcomes such as natural sub-optimal results to treatment or from medical error (must be discussed).

- Process steps for disclosure conversations. The policy should then give guidance on steps to be followed to allow for the disclosure conversation to be effective and consistent.

  Here, the policy may need to identify:

  1. Designated personnel roles. Who should be part of the conversation? An example might state: "*It is preferred that the attending physician responsible for a patient's care will fully and honestly explain the outcome of any treatments or procedures to the patient, and when appropriate, to the designated decision-maker. In most circumstances, the primary attending physician will lead this explanation. Another member of the hospital staff or medical staff (such as a nurse, consulting physician or*

physician performing a specific procedure) may explain the outcome if deemed more appropriate by the primary attending physician."(2)

2. **Conversation outlines.** Key areas to cover, but with the opening statement examples left to specific provider training sessions. An outline might include:

    a. Statement of what happened (objective statement of the event/outcome).
    b. Clear conveyance of regret.
    c. Identification of steps already taken to prevent reoccurrence.
    d. Discussion of any change in the patient's care plan and addressing of any areas of particular concern to the patient.
    e. Identification of whom the patient or family will hear from next in the organization and what (if any) steps they will need to take.
    f. An offer of support services to the patient and applicable family members. The book *What Do I Say? Communicating Intended or Unanticipated Outcomes in Obstetrics* suggests the acronym FEARED to remind providers of the steps involved in disclosure conversations. These steps include:

        Get all of the Facts.
        Express Empathy and Educate.
        Search for sources of Anger.
        Have patients Relate back their understanding of the explanation.
        Evaluate the Extended family response.
        Document the conversation.(3)

3. **Accommodations for special communication needs.** Advice on dealing with special situations where language barriers, disabilities or other communication challenges may be encountered, including the identification of accommodation resources such as interpreters.
4. **Support services available to the patient.** A list of resources that could be given to the patient or family for pastoral care, social services or other support services available in the community.
5. **Steps for followup conversations.** Advice on how to leave the door open for future conversations with the patient or family on the issues being addressed, including contact information for the patient or family plus contact information for future provider support or questions.
6. **Documentation of the conversation.** Appropriate location, timing and technique to ascertain that the documentation reflects the content of the conversation, any treatment plans discussed, the participants, the level of understanding exhibited by the patient and the next steps to be taken by the patient and any providers or the facility staff.(4)

- **Conflict resolution steps.** Periodically, a disclosure conversation will result in the need for diffusing conflict or even the need to involve pastoral care or security (depending on the degree of conflict present). It is important for the policy to indicate that appropriate steps will be taken to resolve any conflict, including when to involve staff beyond the involved providers.

- **Dates of review and implementation.** The policy needs to reflect dates when the policy was implemented, when it has been reviewed (as specified in an organizational structure) and

when it will be reviewed again. This policy should be reviewed at least twice the first year to be sure that the wording in the policy truly reflects the actions being taken.

- Circumstances where disclosure may not be appropriate. The policy may state circumstances where the harm of the disclosure outweighs the benefits, and how to handle the making and documentation of this decision. An example might include: "*In extremely rare situations where a physician can clearly demonstrate that the interests of the patient or, when appropriate, the family, are harmed by disclosure, this discussion may be withheld until the benefits of disclosure are greater than the harm. Any exceptions to the presumption of disclosure must be specifically justified and documented and reported to the hospital's peer review committee."(5)*

Staff and provider training

Any policy of disclosure/communication requires education at all levels of the organization. Implementing the policy means much more than simply drafting the language. It means communicating the goals and the steps to the involved personnel. It also means making sure that levels of management understand not only the reasons for the policy but the potential implications – including what resources are needed to effectively implement the policy – too.

Training goals should include identification of disclosure situations, staff understanding of how to implement the appropriate strategy or communication technique, and staff acceptance of their role (involved or not) in disclosure conversations. Additionally, the goals must illustrate a measurable behavior change in communication techniques and give a forum to discuss remaining barriers to change in a debrief meeting with key clinicians or administrative personnel.

Audiences and applicable topics may include:

1. Board leadership. Covers the financial exposures of litigation and the role of the crisis team. Identifies the board's role, exposures and the care philosophy that supports the need for patient-centered communication.
2. Organization leadership. Covers the financial exposures of litigation, the role of the crisis team and identification of the crisis team members. Encourages a culture of disclosure/communication by emphasizing the organization's care philosophy and mitigating litigation exposure. May include administrative team, medical staff leadership and employed providers.
3. Physician/medical staff. Covers the physician's role in actual disclosure, fostering increased patient involvement and mitigating liability exposures.
4. Hands on caregivers. Covers the hospital staff practitioner's role in actual disclosure, emphasizing the balance of finding the "appropriate time and appropriate message in the appropriate way."

The training should be centered on the policy language, both on learning the policy and understanding the cultural environment that needs to be in place in order to affect the policy. For an organization that is not yet there culturally, the training should emphasize adoption of the policy by the medical staff and board. When they adopt the policy, they make a statement that they support a patient-centered philosophy. The implementation of the policy will reinforce the culture. Training should be adapted to the audience and should include easily remembered themes and role-playing so all participants can become familiar with their roles and the intent of the policy.

POLICY CONSIDERATIONS FOR SPECIFIC POPULATIONS AND SETTINGS

When developing disclosure/communications policies for specific populations and settings, the organization should consider the unique aspects of care, types of potential unanticipated events, and unique psychologies of patients and their self-defined families.

Pediatric settings

Special attention should be paid to establishing when children should be involved in provider-family communications and when this is not appropriate. A decision tree may be referenced, outlining criteria such as the child's age, mental status, knowledge and involvement in their condition and treatment plan.

In addition, custodial issues need to be addressed, including when conversations can take place without the custodial parent present (if at all), etc.

Long-term care settings

A key issue may be the capacity of the patient to understand discussions about events in care. Policies need to state clearly how the organization determines the appropriate persons to participate in the disclosure discussions. Again, a decision tree may be referenced, outlining the patient's mental status, involvement in his or her condition and treatment plan, family requests for involvement, patient confidentiality, etc.

Special attention needs to be paid to telephone notification about the need for a discussion. In some instances, the appropriate parties to participate will be unable to come to the facility for a face-to-face discussion. How those situations are to be handled must be addressed in such a way that the communication plan does not create undue hardship on the family.

Psychiatric settings

Much as in long-term care settings, the psychiatric setting policy should address when the patient is involved in the discussion and include a decision tree for patients without current or permanent capacity. The notification of family or custodians may bring confidentiality issues if communication channels are not identified early in the patient's care.

Finally, the policy needs to address to whom disclosure should be made if the patient has no family or next of kin.

SPECIAL CONSIDERATIONS FOR THE RISK MANAGER

Policies and litigation

It is not unusual early in a malpractice case to receive a request for policies and procedures that may have relevance to the event being litigated. Before simply turning over the entire policy manual, it is best to think about just which policies may apply to the event in question.

There may be policies that actually help the defense of the case, and those should be provided. An effective policy may be one that is produced in any situation that has an unexpected outcome or

disclosure conversation. This can help ensure that the jury hears that the organization does believe in open and constant communication.

At the same time, it should be realized that a feeling of frustration with either the care rendered or the lack of information surrounding an event or outcome is the reason most cases result in litigation. Therefore, when producing the disclosure/communication policy in a pending malpractice case, be sure you have identified who may have been involved in communications with the patient on the issue at question and how those conversations went toward involving the patient in care and treatment as well as communicating any difficulty or unanticipated event. It would also be beneficial to show documentation of all communication in the patient's chart.

Reconcile how the situation was handled with the policy/procedure to prepare the defense, and examine documentation of reasons that could explain why the policy may not have been specifically followed.

Always consult with defense counsel on just what policies to produce in response to a Request for Production. Talk about the policies, their applicability to the case at hand and how they can assist in the defense of the case.

The effect of disclosure discussions (as distinct from policies) on litigation and claims is discussed in more detail in Part 3 of this ASHRM monograph series, where it can be analyzed in light of the skills for effective disclosure.

Support services for involved staff members

The occurrence of an unanticipated event can have significant emotional and psychological impact on the involved providers and staff caring for the patient. Any providers or staff who need support services should be given those through the facility.

Required reporting or necessary investigations

Depending on the situation, state or federal reporting may be necessary.

Training for staff

Training in communication skills should be provided for staff on an ongoing basis to be sure that any and all communication with patients and families is as efficient as possible (and therefore complies with the overall organization goals and vision). Specific training in disclosure may be provided. However, training should also be provided for improving the consent process across the spectrum of care (not just for invasive procedures), methods for engaging patients and their families as collaborative partners in the care process, and dealing with patients who may present challenges to us because of their communication style, demeanor, or other attributes.

Communication skills that are needed in the healthcare organization are varied and complex. Training should be provided for any hospital staff that works with patients and families.

SUMMARY AND CONCLUSION

A well thought-out disclosure/communication policy will provide the healthcare facility with a means to prove the organization's values about communication with patients and their self-defined families.

A good policy also will provide a guideline to ensure that the rights and needs of patients are met during that encounter.

Policies should be simply stated expressions of organizational values. A helpful procedure is short and easy to understand. It addresses the key question in the mind of the practitioner who is managing the difficult situation and is broad enough to allow room for applying situationally based judgment.

All staff should be trained on the existence and purpose of the policy. All staff and employees – from the attending physician to the hands-on caregivers – must be aware that open and honest communication is not an option, but rather is integral to the value system and culture that the organization is striving to maintain. Training on the techniques of disclosing unanticipated events should be provided regularly to staff members who may need to be involved in such communication.

Policies created for special population group settings should address potential difficulties in creating an atmosphere of open communication. Common issues concern patient participation in the discussion, the appropriate parties to be part of the discussion, the ethnicity of the predominant patient group/self-defined family, and the lack of availability of family in proximity to the facility. Each organization should look at the unique characteristics of its facility's setting to determine what potential situations are likely to occur.

While policies will not protect against liability, a well-designed policy can be an ally in a court of law. A policy that addresses key issues and is followed is better evidence of good faith than a highly detailed policy that is ignored. On balance, a short policy that everyone knows about and strives to adhere to is better than an either overly comprehensive policy or none at all.

Effective patient communication is a process. It begins with the initial meeting and ends only when the therapeutic relationship is over. Policies supporting disclosure are only the first step. The ultimate result of an organization's embrace of honest communication is patient/customer satisfaction and well-being – as ASHRM's vision statement puts it: "Safe and trusted healthcare."

REFERENCES

1. HealthEast Policy and Procedure, Disclosure of Outcomes to Patients.

2. HealthEst.

3. Woods Jr., James R. and Rozovsky, Fay A. What Do I Say? Communicating Intended or Unanticipated Outcomes in Obstetrics. San Francisco: Jossey-Bass, 2003; p 45.

4. Perspective on Disclosure of Unanticipated Outcome Information, ASHRM whitepaper/monograph, www.ashrm.org, April 2001

5. HealthEast.

ADDITIONAL RESOURCES

The Risk Management Handbook for Healthcare Organizations. San Francisco: Jossey-Bass. www.ashrm.org/store or call (800) AHA-2626.

Risk Management Pearls on Disclosure of Adverse Events. Chicago: ASHRM. www.ashrm.org/store or call (800) AHA-2626.

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