Massachusetts General Hospital
Founding Member, Mass General Brigham

Applying an Equity Framework to Patient Safety Events and Root Cause Analysis

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HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

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Outline

- New bias/discrimination pilot in patient safety event reporting system (RL solutions)
- Current trends in the reports
- Resources we can provide: Patient code of conduct policy, ending racism training and upstander training

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Outline

Accountability -New bias/discrimination pilot in patient safety event reporting system (RL solutions)

Culture –Current trends in the reports

Transparency – Annual Report on Equity in Healthcare Quality

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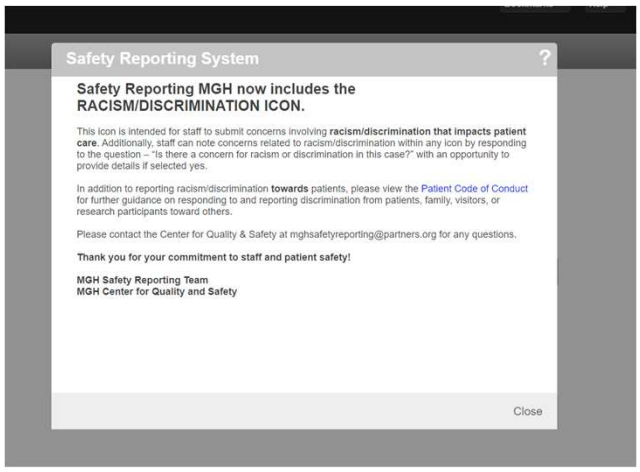

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Find a form
Please use the search above to narrow down your event results by using keywords to describe the event that you're looking for.
SCROLL DOWN TO SEE ALL ICONS
If you would like to practice entering a safety report, you can do so by clicking here.
Please note safety events submitted in the training site are not triaged/followed up.
Kind Words
peercare
Peer Support
Racism/Discrimination
Head Strike (Employee only)
Employee General Incident
Adverse Drug
Airway Management
Blood / Blood Product

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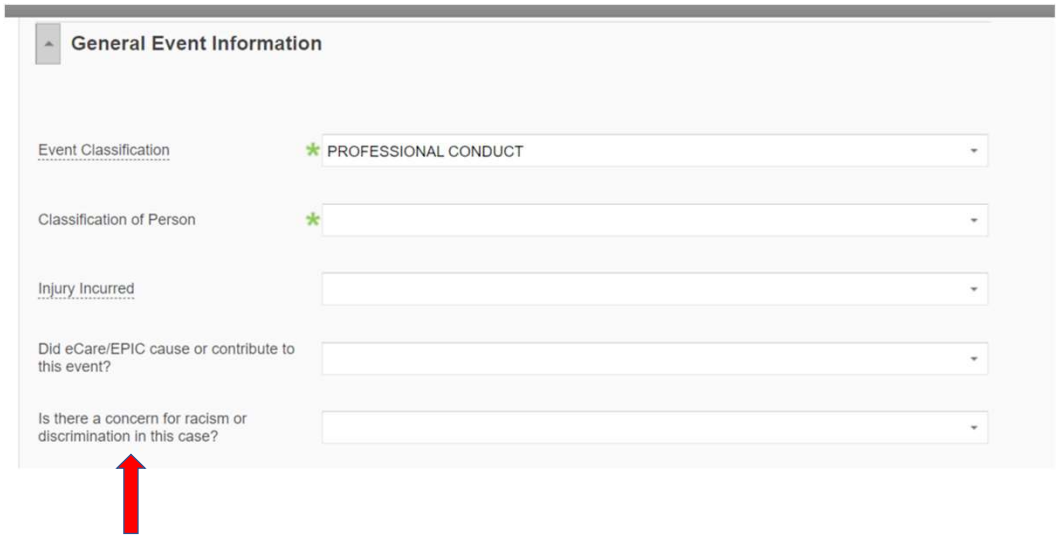
General Event Information
Event Classification
PROFESSIONAL CONDUCT
Classification of Person
Injury Incurred
Did eCare/EPIC cause or contribute to this event?
Is there a concern for racism or discrimination in this case?

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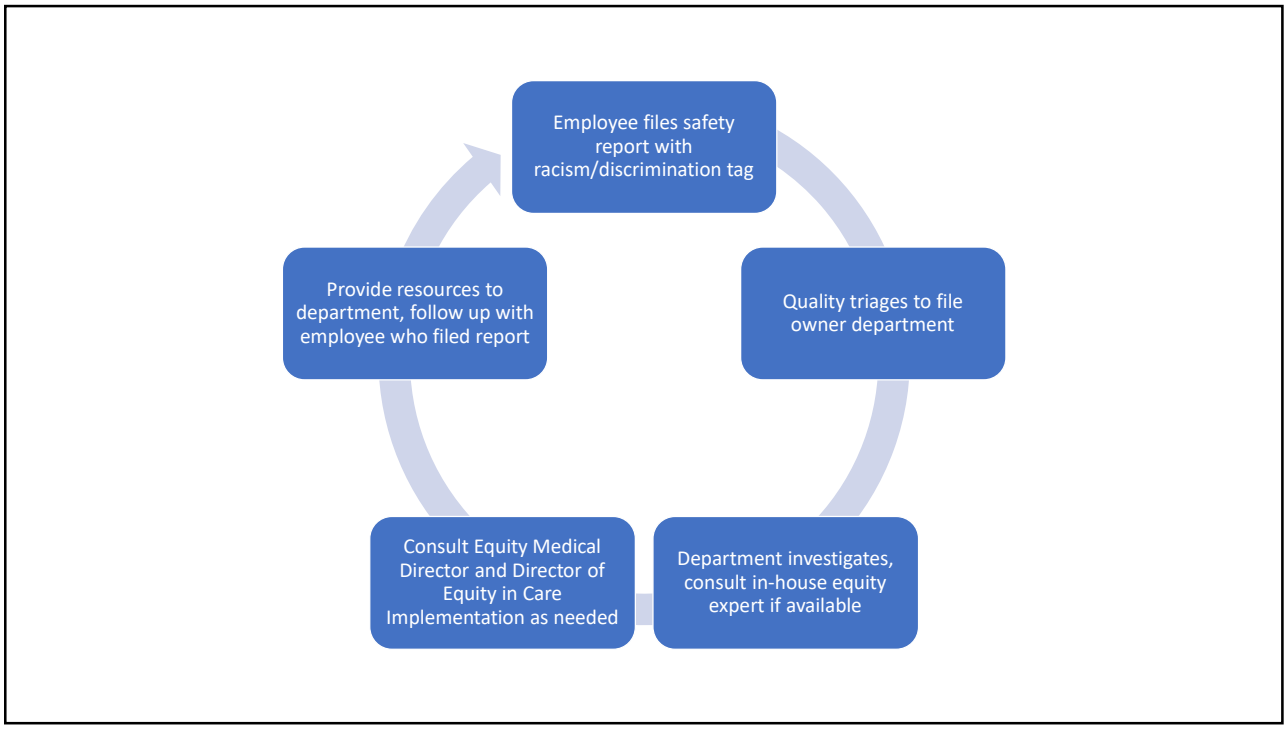
Employee files safety report with racism/discrimination tag
Quality triages to file owner department
Department investigates, consult in-house equity expert if available
Consult Equity Medical Director and Director of Equity in Care Implementation as needed
Provide resources to department, follow up with employee who filed report

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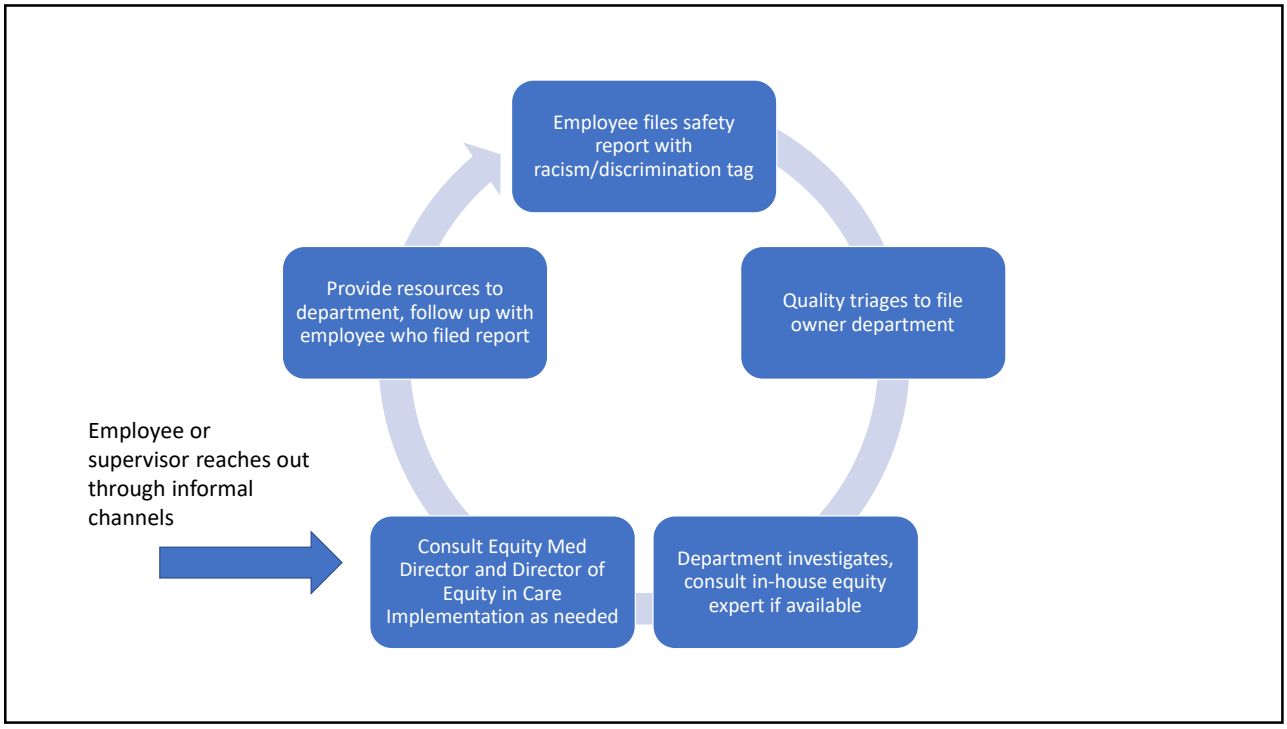
Employee files safety report with racism/discrimination tag
Quality triages to file owner department
Department investigates, consult in-house equity expert if available
Consult Equity Med Director and Director of Equity in Care Implementation as needed
Provide resources to department, follow up with employee who filed report
Employee or supervisor reaches out through informal channels

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RCA2 Timeline and Checklist

Event, Hazard, System Vulnerability Occurs

Immediate post event huddle

Goal: This debriefing is to ensure that immediate safety concerns are addressed and to begin the healing process for patients, families, and staff
Facilitator(s): Local unit staff

Immediate actions:
1. Make the situation safe
2. Care for the patient/family and identify someone to communicate with the family
3. Sequester any involved equipment, materials, capture monitors disclosure
4. Ensure staff support

Next steps:
1. File Safety Report
2. Notify key leadership
3. Notify Equity Medical Director and Director of Equity in Care Implementation
4. Plan for debriefing to occur within 12-24 hours after event

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RCA2 Timeline and Checklist

Post event debriefing, fact finding and/or interviews

Goal: This debriefing/fact-finding process is to develop the timeline of the event and to collect and analyze the facts of the event. Just culture principles will always be followed.
Facilitator(s): CQS & Quality Chair(s) and Equity Medical Director and Director of Equity in Care Implementation as needed
Fact-Finding Checklist
- Provide a brief update on the patient's condition and the status of each team member.
- Identify staff involved and conduct interviews either 1-1 or in small groups initially.
- Bring together a larger group to describe the event using a chronological flow diagram or timeline – Identify gaps in knowledge about the event.
- Evaluate equipment or products involved and visit the location of the event, if needed to understand workspace and environment
- Identify internal documents to review (i.e. policies, procedures and medical records).
- Include patients, family, or a patient representative as appropriate to ensure a thorough understanding of the facts.
- Identify and acquire appropriate expertise for RCA2 meetings.

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RCA2 Timeline and Checklist

RAC2 meetings and process

Goal: Typically, a single RCA2 team is responsible for the entire review process and becomes the "core team". This group should be multi-departmental and have subject matter experts. Multiple meetings of 1-2 meetings will be needed to develop casual statements and identify solutions and corrective actions.
Facilitator(s): CQS & Quality Chair(s)
RCA2 Meeting Checklist:
- Review the facts and timeline produced from the fact-finding meetings and debriefs.
- Apply the Equity Review process if needed
- Develop causal statements using the five rules of causation and create a cause-and-effect diagram
- Identify solutions and corrective actions

Equity Review Process: Core Equity Patient Safety Team Member will assist with facilitating and integrating into the RCA2 team discussion the following:
Optics versus intent: Everyone generally has good intentions, so rather than focusing discussion on what intent is, the discussion should focus on what optics are that we should consider for those involved (patient, family members, other care team members.)

- ❑ Trauma informed care approach: Trauma-informed care acknowledges the need to understand a patient's life experiences in order to deliver effective care and has the potential to improve patient engagement, treatment adherence, health outcomes, and provider and staff wellness.
- ❑ Adding in external context: What other external context would be helpful here to understand the case better. (Historical, cultural, language, policy, or environmental.)
- ❑ Identifying system barriers: What system barriers should be addressed here? What operationally could be improved to prevent this in the future.
- ❑ Counter factual root cause analysis: E.g., what are outcomes for different patient populations?
- ❑ Informing key stakeholders: Who are the important key stakeholders who should be informed of the summary of this discussion and next steps?
- ❑ Opportunities of measurement: Can we leverage data in some way to monitor this issue for the future?

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Ground Rules

- Value & respect the diverse perspectives and experiences in the room.
- Listen actively, with humility, empathy, & respect for the person sharing their experience.
- Speak from your own experience rather than generalizing or speaking for others. Use "I" statements instead of "they," "we," & "you."
- Avoid making assumptions about another person's identity. Do not expect others to speak on behalf of their race, ethnicity, culture, gender, sexual orientation, ability, or other groups they may identify with.
- Engage in dialogue, not debate. Dialogue involves open-ended discussion where people express & learn from one another's experiences & perspectives.

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Ground Rules

- For people who don't usually talk about racism in diverse groups, these conversations can feel uncomfortable. Remember that the goal is not for everyone to feel comfortable; it is to gain deeper understanding through listening & respectful dialogue.
- Be open to learning from others, but take responsibility for your own learning as well. Don't expect people from marginalized groups to educate you on their experiences.
- Share the air. If you tend to dominate discussions, take a step back so others' voices can be heard. If you tend to be quiet, challenge yourself to speak up so others can learn from you.

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THE NEW YORKER

A SOCIOLOGIST EXAMINES THE "WHITE FRAGILITY" THAT PREVENTS WHITE AMERICANS FROM CONFRONTING RACISM

By Katy Waldman July 23, 2018

Much of Robin DiAngelo's book is dedicated to pulling back the veil on so-called pillars of whiteness: assumptions that prop up racist beliefs without white people realizing it.

Photograph by Christopher Anderson / Magnum

In more than twenty years of running diversity-training and cultural-competency workshops for American companies, the academic and educator Robin DiAngelo has noticed that white people are sensationally, histrionically bad at discussing racism. Like waves on sand, their reactions form predictable patterns: they will insist that they "were taught to treat everyone the same," that they are "color-blind," that they "don't care if you are pink, purple, or polka-dotted." They will point to friends and family

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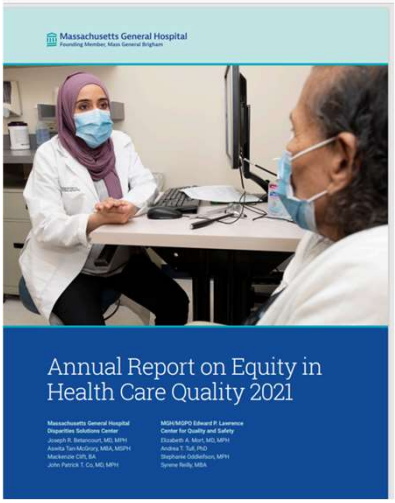
How We Have Identified Disparities in the Past – Passive Use of Data

- Collect race, ethnicity, language data
- Stratify quality metrics by REaL
- Annual Report on Equity in Healthcare Quality (AREHQ)
- Quality Improvement Project



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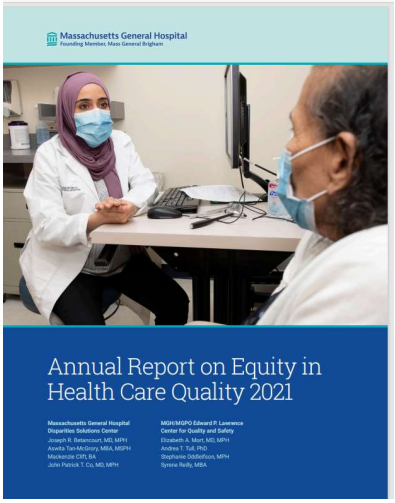
Annual Report on Equity in Health Care Quality



- Demographic Profile of MGH patients
- Improving Patient Experience: Focus on Asian Patient Experience
- Serving Patients with Limited English Proficiency
- Obstetrics/Gynecology: Improvement in C-section Rates for Black Women
- Primary Care: Addressing Disparities in Preventive Health Screenings, Chronic Disease Management

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Patient Safety Reporting Allows for More Active View on What is Happening Right Now in the Hospital

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What Are We Seeing in the Reports?

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There is bias/discrimination by a patient to staff

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There is bias/discrimination of staff to staff

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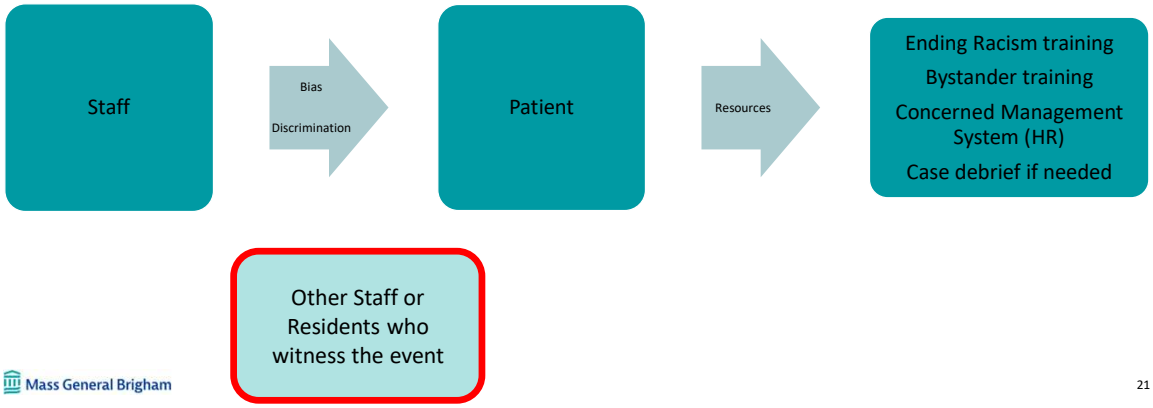
There is bias/discrimination of staff to patient



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Since the launch, most common themes:

Majority of the reports are on in-patient floors although there are some in the ambulatory space. Reports can be a mix of the previous three scenarios.

- Bias in pain management for patient who are POC (including dispensing medication in pharmacies)
- Bias in care for patients with limited English proficiency (LEP)
- Bias in pain management for patients with SUDs
- Bias/delay in providing treatment for POC
- Impact of these events on POC residents and the relationship with nursing staff
- Reluctance to report for fear of retaliation by floor staff
- We are monitoring for recurring trends

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Disclaimer

- **Case studies are intended to be used for educational purposes. These are adaptations of actual, real-life events.**
- **The patients and staff described in the case have been de-identified and anonymized.**

Inside a case:

Brief Summary:

An elder Cambodian speaking oncology patient was in the hospital for less than 48 hours. Their family members also needed assistance of an interpreter to communicate. The patient is decompensating and it was unclear if it was reversable or irreversible.

Resident concern :

Delay in rapid response due to bias for patients with LEP. Interventions that are frequently used to buy time until family can arrive, such as pressors, were contested for this patient for unclear reasons. Comments were made by nursing staff that further raised this concern.

Inside a case:

Outcome of review:

- *1:1 debrief with residents and the Director of Equity in Clinical Care Implementation*
- *Case review with multidisciplinary team including involvement with Director of Equity in Clinical Care Implementation*
- *Determination that there needs to be rapid response criteria that the entire floor/department/unit can agree on– with some leeway for varying clinical procedures*
- *Confirming that there are rapid response reminders throughout the floor*
- *Roll out of MGB wide Ending Racism Training and Upstander Training. Suggested resource is to hold debriefs with teams after the training with Director of Equity in Clinical Care Implementation as a resource.*

Patient Safety & Patients with Limited English Proficiency

Adverse events affect patients with limited English Proficiency (LEP) more frequently and severely than English speaking patients

Patients with LEP are more likely to experience medical errors due to communication problems

Patients with LEP are more likely to suffer physical harm when errors occur (49.1% vs. 29.5%)*

*Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. Int J Qual Health Care. Apr 2007;19(2):60-67.

Suggested Guidelines for Interpreter Modality

This is contingent on resources available which may vary by Mass General Brigham site

How long do you need the interpreter?	**Minimal Time** • Scheduling • Reminder calls • VRI (Inpatient menu)	**Longer time** • Family meeting • Psychological/ behavioral health assessment
Any special factors that might impede communication with the patient?	**No special factors that might impede communication**	**Yes** • Hard of hearing • Working with children • ASL • Background noise
Will this be a medically or interpersonally complex interaction?	**No complex interaction**	**Yes** • End of life • Multiple providers • Discharge • Consent for surgery/procedure

low ← Risk for miscommunication → high

Key

- Over-the-Phone Interpreting (OPI)
- Video Remote Interpreting (VRI)
- In-person with on-site staff interpreter

Multiple risk factors increase benefits of an in-person interpreter

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Patient Experience Rates, MGH Inpatient Survey by Race/Ethnicity and Language, 2021

	Providers listened	Providers explained things	Providers explained discharge	Comfortable talking with nurses	Nurses listened carefully	Nurses explained things understandably	Nurses courteous and respectful
Asian	70%	65%	71%	70%	71%	71%	73%
Black	56%	60%	63%	64%	65%	67%	65%
Hispanic	60%	62%	65%	70%	71%	69%	70%
Multiracial	63%	64%	66%	69%	71%	71%	75%
Other	66%	71%	68%	66%	72%	72%	73%
White	69%	71%	72%	77%	78%	79%	81%
English	69%	70%	72%	76%	78%	79%	80%
Other Languages	57%	57%	61%	63%	66%	63%	65%

	Good communication between staff	Understood purpose of medications	Got help as soon as wanted	Had enough input/ say in care	Clean room	Quiet at night
Asian	61%	68%	59%	62%	59%	48%
Black	59%	63%	46%	59%	56%	49%
Hispanic	65%	59%	55%	62%	59%	51%
Multiracial	63%	67%	46%	63%	62%	54%
Other	66%	70%	56%	62%	57%	42%
White	67%	70%	60%	68%	65%	43%
English	67%	70%	59%	68%	64%	44%
Other Languages	63%	56%	49%	52%	56%	49%

Significantly higher than comparison population | No different from comparison population | Significantly lower than comparison population

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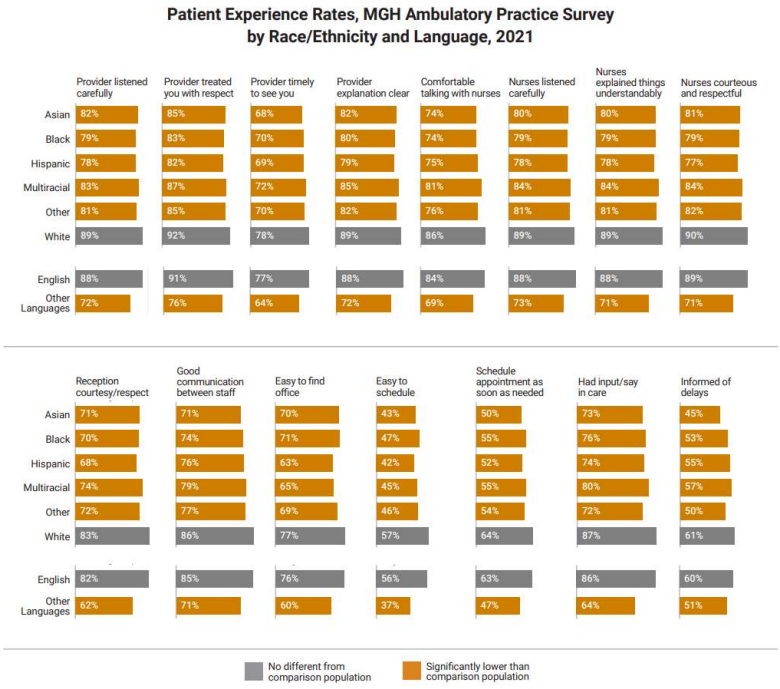

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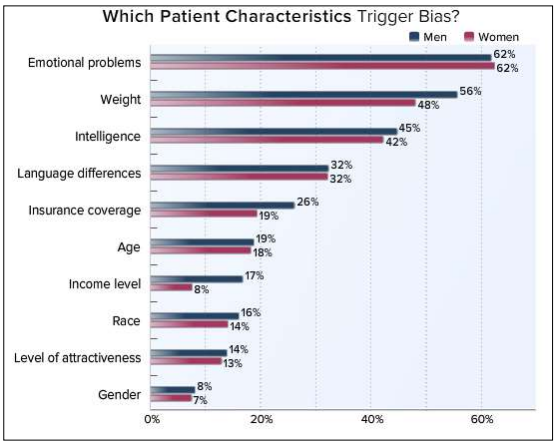
Medscape Lifestyle Report 2016: Physician Bias



Source: Medscape Lifestyle Report 2016: Bias and Burnout. https://www.medscape.com/slideshow/lifestyle-2016-overview-6007335#6

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What Resources Can we Provide

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Patient / Family / Visitor Code of Conduct – Brief Summary

1. **Purpose**
   - Define appropriate patient, family, visitor, & research participant conduct.
   - Provide a model for workforce members to respond to behavior that violates policy.

2. **Procedure**
   - Response to disrespectful, discriminatory, hostile, or harassing behaviors from patients, etc.
   - Response to discriminatory requests for specific type of clinician/workforce member based on their personal traits (race, etc.)
   - Response when patient or research participant does not adhere to expectations set by staff and continues to violate the *Code*
   - Response when family member or visitor does not adhere to expectations set by staff and continues to violate the *Code*
   - SAFER Model for responding to incidents

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Rationale for Creating the Patient* Code of Conduct

From **Mayo Clinic's 5-Step Policy for Responding to Bias Incidents,** Rahma M. Warsame, MD & Sharonne N. Hayes, MD

1. **Patient bias towards non-clinical and clinical staff is common.**
2. Silence or a "patient-first" approach may have detrimental effects on staff morale & well-being.
3. **Patients are protected from staff mistreatment by multiple policies, but staff rarely are.**
4. Lack of policy guidance leaves staff unsure of how to respond to incidents.
5. **Lack of organizational response erodes trust that reporting incidents will lead to positive change.**
6. Lack of organizational response to incidents creates legal vulnerabilities.

*Here, "patient" is shorthand for patients, family, visitors, research participants

Warsame, R.M. & Hayes, S.N. (2019). Mayo Clinic's 5-step policy for responding to bias incidents. *AMA Journal of Ethics*. 21(6):E521-529. https://www.doi.org/10.1001/amajethics.2019.521

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What is communicated to the public

Mass General Brigham is committed to providing high quality healthcare and building healthy and thriving communities. Everyone should expect a safe, caring, and inclusive environment in all our spaces.
Our Patient Code of Conduct helps us to meet this goal. Words or actions that are disrespectful, racist, discriminatory, hostile, or harassing are not welcome.

Examples of these include:
1.Offensive comments about others' race, accent, religion, gender, sexual orientation, or other personal traits
2.Refusal to see a clinician or other staff member based on these personal traits
3.Physical or verbal threats and assaults
4.Sexual or vulgar words or actions
5.Disrupting another patient's care or experience

If we believe you have violated the Code with unwelcome words or actions, you will be given the chance to explain your point of view. We will always carefully consider your response before we make any decisions about future care at Mass General Brigham. Some violations of this Code may lead to patients being asked to make other plans for their care and future non-emergency care at Mass General Brigham may require review, though we expect this to be rare.
If you *witness or are the target of* any of these behaviors, please report it to a member of your care team.
Many healthcare systems across the country have similar codes of conduct.

Patient Code of Conduct | Mass General Brigham

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Upstander Training

Ending Racism Training

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In Summary Consider….

- Community mistrust
- Language barriers and immigration issues
- Bias (who we screen for what, who we deem “non-compliant”, the idea that patient is only single diagnosis, are we doing SDoH screening, initiating care or rapid response)
- Having policies or check lists in place will help remove some of the subjectivity which is an opportunity for bias (e.g. initiating rapid response)
- Policies only work if there is a deliberate plan for implementation on floors, in practices, across divisions/departments (e.g. patient code of conduct)
- Answers to why someone reported bias/discrimination will not be in the medical chart
- Everything we see in the reports has evidence in the research literature
- While intent matters, also consider optics
- Importance of diverse team with lived experience

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Thank You

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One Goal – High Quality Care for All

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