SPRING/SUMMER 2020

First Do No Harm

Quality and Patient Safety Division, Massachusetts Board of Registration in Medicine

Message from QPSD Leadership

Julian N. Robinson, MD
Chairperson QPSC

Daniela Brown, MSN, RN, CIC
Director QPSD

Dear Colleagues,

As we navigate through these extraordinary times, we are able to reflect upon how health care has adapted and how we have continued to move forward despite the many challenges. The Covid-19 crisis has required us to change how we function in many areas. Innovation and resourcefulness have helped us to approach aspects of the care we provide and decisions that we have made. What has remained at the forefront continues to be the dedication and commitment to our patients. Day after day, clinicians and administrators 'showed up' to provide our patients with the best care possible. For our next issue, we hope to highlight some examples of strategies and plans for moving forward. We hope to share not only stories of inspiration, but also new protocols, ideas, and what has worked during the crisis so that we might continue to learn from each other.

This issue will focus on the patient experience. The importance of providing compassionate care and involving our patients in their plan of care has perhaps never been as important as it is now. Our own Quality & Patient Safety Committee (QPSC) member and Patient Advocate, Zoe Burns, provides her perspective on the importance of inclusion and empathy in healthcare. We also share information regarding programs from three hospitals in the Commonwealth and their approaches to improving the patient experience.

As the QPSD moves forward, I'd like to announce a change in leadership. Daniela Brown, who has been with QPSD for three years, has transitioned to Director. I look forward immensely to Daniela taking a lead, as the last three years have demonstrated her knowledge, passion, and experience in the field of Patient Safety. I feel that we will all benefit greatly from her adept touch. We will continue to expand the division, and as the Commonwealth moves forward with Reopening Massachusetts, we will plan to once again offer conferences, workshops, and educational visits. Updated guidance for reporting to QPSD in CY 2020 was provided to PCA Coordinators at the beginning of June and may also be found on the last page of this newsletter.

Finally, I'd like to provide an update regarding our plan to transition to electronic reporting. We are in the final stages of selecting a vendor and are rapidly moving forward in this process. More information will be available in our next newsletter regarding timelines, training, and onboarding. The QPSD wishes to thank the Board for its support in this endeavor. This transition will be a positive change towards efficiency and ease of reporting.
Best,

Julian N. Robinson, MD

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QPSD Mission is to assist Massachusetts healthcare facilities in maintaining and improving systems for patient care that are evidence and team based, sustainable, safe and inclusive. We achieve this by reviewing data, listening, collaborating and educating teams in healthcare facilities throughout the state.

A Patient's Perspective

Prepared by: Zoe Burns, Patient Representative,
Quality & Patient Safety Division Committee Member

In a recent appointment with my ophthalmologist, she turned to the technician who was assisting her and advised, "Always listen to your patients, they know what's going on with their bodies better than anyone".

I spent most of my teenage years fighting recurrent Hodgkin's lymphoma. I was treated at stellar hospitals by exceptional staff. I also had several near misses and safety events that taught me continual quality improvement is not beyond any health system. It also taught me the importance of patient activation.

I am a member of the Pediatric Patient and Family Advisory Council (PFAC) at Dana-Farber Cancer Institute (DFCI), where the value of the patient voice is recognized and embedded in the culture of quality and safety. As patients and caregivers, PFAC members volunteer to incorporate the patient perspective into policies, programs, and projects throughout the hospital. This is done through our attendance at standing meetings, providing feedback to staff partners on the council, by speaking with other patients and families, and empowering them to advocate for themselves and become actively involved in their healthcare.

"I am treated the same as any staff member in attendance, and I leave feeling confident that I am in the capable hands of professionals who truly embrace patient-centered care, quality, and safety".

While each of us have our own unique experiences and reasons for volunteering, all of us have gained much insight into what works well for patients and what could be improved in our hospitals and in our healthcare system. All of us have a passion for ensuring a consistent positive patient experience, which I believe is strongly tethered to quality and patient safety.

Hospital staff approach the PFAC for a variety of reasons: to gain feedback on patient satisfaction surveys, to inform the redesign of the pediatric outpatient clinic waiting room, to brainstorm topics for parent support groups, and many more. As part of my role on PFAC, I attend several of DFCI's standing meetings. A highlight for me is the Grievance Committee, where we discuss patient complaints, grievances, and resolutions. Here, I can feel that I am not simply fulfilling a regulatory requirement, but that as a patient, I am a valued member of the committee. My questions are always answered, I am treated the same as any staff member in attendance, and I leave feeling confident that I am in the capable hands of professionals who truly embrace patient-centered care, quality, and safety.

As patients, we know more about our bodies, hospitals, and our complex healthcare system than we ever wanted. Through inclusion in decisions that affect us and other patients, you can help us put our unsolicited expertise to good use. Whether through working with patients to make sure they are fully involved in creating and understand their care plans, or whether you decide to elicit feedback on a research project from your organization's PFAC, on behalf of the patients, thank you for listening to our voice.

Communication, Apology and Resolution (CARe) at Beth Israel Deaconess Medical Center

Prepared by: Pat Folcarelli, RN, MA, PhD
Vice President for Health Care Quality

Communication, Apology and Resolution (CARe) is a program that was developed by several hospitals and health care organizations in Massachusetts as an alternative to costly, lengthy, and emotionally difficult lawsuits after medical injuries. It is a way to proactively respond to cases of preventable harm – a better way for the patient to receive information, an apology, support, and compensation if appropriate.

At BIDMC, we have been working toward the elimination of preventable harms since 2007. This focus helped to create improved processes for detection, review, categorization, process improvement and transparency in communication among our physicians, staff, and patients. CARe builds on that base and adds a commitment to a fair, just, and supportive approach for our caregivers and work to more deeply engage patients and families. The building blocks for success also included building strong collaboration among the members of our patient safety, patient relations, physicians, staff, and malpractice colleagues.

"It is a way to proactively respond to cases of preventable harm – a better way for the patient to receive information, an apology, support, and compensation if appropriate".

Following an adverse event the **communication** process begins, with staff promptly conveying what is known at the time about what happened, how it will affect the patient's care, and how the hospital will support the patient and family. The communication is a process that continues with the patient and family after our **investigation** into the injury, when we determine what happened. In the **resolution** stage of the CARe process, we **explain** what led to the adverse outcome, and whether a medical error was involved. If there was an error that caused the injury, our communication with the patient/family includes a conversation about **financial compensation.** These subsequent meetings with the patient/family are coordinated in collaboration with the hospitals malpractice insurance company. The patient may bring an attorney to any meetings, particularly those in which there is a discussion of financial compensation, but an attorney is not required. If we determine that our care leading up to the injury was reasonable, the patient and/or family are given a **thorough explanation and a chance to ask questions** to help them understand what occurred.

We also believe CARe helps us continue to improve patient safety, so we also strive to describe in our communication with the patient and family the patient safety improvements that we are taking on to prevent such events from happening in the future. Our experience with CARe has been supported by the Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI) and our support from BORM, the Mass Medical Society, the Mass Bar Association, the Mass Hospital Association, the Massachusetts Coalition for the Prevention of Medical Errors, Coverys and CRICO. In addition, the collaboration with other hospitals participating in this important work include Baystate Health, Brigham and Women's Hospital, Newton Wellesley Hospital, Atrius Health, and Sturdy Memorial Hospital has been invaluable. The MACMRI website (https://www.macrmi.info/) is a wonderful source of additional information about CARe, including peer-reviewed studies that demonstrate that CARe can be rigorously implemented without an increase in costs or claims (and in some cases decreases both of these), while improving provider satisfaction and patient safety.

We would encourage other hospitals to use the MACRMI resources and to join forces with us to improve the safety of patients and the support of clinicians through this approach.

C.A.R.E.S. For You Program-Steward Health Care

Prepared by: Darren Grubb, Vice President, Communications, Steward Health Care
Melissa Kupiec, Executive Director, Patient Experience, Steward Health Care
Deborah Chiaravalloti , Director, Marketing and Community Relations , Holy Family Hospital

Steward Health Care's highest priority is the care, safety and well-being of our patients and staff. To help us always stay mindful of this commitment, Steward has implemented a best practices program across the entire system called *C.A.R.E.S. For You* – which stands for **C**ompassion, **A**ccountability, **R**espect, **E**xcellence, and **S**tewardship. This program is an employee and patient experience philosophy and serves as a value system that informs our approach to our work with patients, families, and co-workers.

At Holy Family Hospital (HFH) in Methuen and Haverhill, C.A.R.E.S. values guide employees as they make daily decisions for patient care, business operations, and relationships with coworkers; fostering empathy, responsibility, respect, teamwork, and the responsible management of resources. The program begins during New Hire Orientation where every employee receives standard education developed by the Corporate Patient Experience Department about C.A.R.E.S. values and behaviors. Department leaders along with the Patient Experience Committee and the Employee Engagement and Recognition Committee continue to drive implementation and sustainability of the program locally across the two HFH campuses.

C.A.R.E.S. For You – which stands for Compassion, Accountability, Respect, Excellence, and Stewardship.

Ingraining the program into the culture and decision-making processes of the hospital requires constant attention. The hospital president has made attendance at monthly patient experience committee meetings mandatory, and his monthly column in the employee newsletter focuses on one detail of C.A.R.E.S. each month. Accompanying newsletter articles and resources developed by the Corporate Patient Experience Department delve into the details of daily practice, relate patient comments from Patient Experience surveys, illustrate hospital progress on patient experience performance, and provide learning tools on evidence-based practices related to safe, high-quality, patient centered care. Several departments have created C.A.R.E.S. bulletin boards to reinforce the value of "doing good work" and the importance of positive feedback for a job well done. For example, department directors carry $5 cafeteria gift cards at all times for on-the-spot recognition of C.A.R.E.S. moments. "Appreciative Coaching" is a key piece to the sustainability of the program's behaviors and includes the observation and coaching of employees in real time by department leaders to reinforce expected behaviors taught in New Hire Orientation.

Many hospitals across the System including HFH also highlight peer-to-peer recognition and encourage C.A.R.E.S. Awards where employees can nominate fellow employees in recognition of exceptional C.A.R.E.S. behavior. Quarterly winners receive hospital wide recognition and department celebrations.

This is important work, because the implementation of C.A.R.E.S. values builds a hospital and health system of excellence and increases patient and employee experience.

Patient Engagement in Multidisciplinary Rounds in the Pediatric Setting at Franciscan Children's

Prepared By: Jennifer Fexis, CPHQ, Vice President, Quality & Safety
Amanda Voysey, BCPA, Patient Advocate and Human Rights Officer

Based on the supposition that parents of hospitalized pediatric patients have an essential knowledge base necessary in considering treatment for the whole child, Franciscan Children's developed a systematic approach to include parents as integral members of the Multidisciplinary Team at Franciscan Children's Hospital. Integration into the treatment team begins prior to admission. All parents are encouraged to participate in a tour prior to accepting admission to the hospital. During the tours the parents meet all disciplines who will be forming the treatment plan including but not limited to an attending physician, respiratory therapist, physical, speech and occupational therapists, nursing manager, patient advocate and social worker.

Within 24 hours of admission to the hospital, the multidisciplinary team again meets with the parents and reviews the plans for assessment and treatment. Parents are encouraged to be interactive members by attending the team's daily bedside rounding discussion. During this meeting the Home and Hospital Teacher assesses the patient's educational needs and requirements and subsequently works with the parents and patient's school system to provide the appropriate educational services.

Parents are encouraged to be interactive members by attending the team's daily bedside rounding discussion.

Multidisciplinary Rounds are conducted daily at the patient's bedside. Parents are invited to participate in the rounds and encouraged to share any questions or concerns they might have regarding the daily treatment and educational plan. If parents have questions or concerns requiring a comprehensive response the responsible team member will meet with the parent immediately after rounding has ended.
This systematic approach of engaging parents as members of the Multidisciplinary Team has led to several positive outcomes:

- Reduction of parent's anxiety when considering admission to the hospital.
- Increased parental understanding and participation in the development of assessment and treatment plans.
- Decrease in concerns expressed regarding frequency of provider communication
- Standardization of obtaining and providing educational services to the patient.

Calendar

June

M	T	W	T	F
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30			

July

M	T	W	T	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	31

August

M	T	W	T	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

7/31/20:
Q1 & Q2 PI and Patient Falls Reports due
*Reporting of events occurring between March 1, 2020 and May 31, 2020 is optional-see guidance on reporting

8/14/20:
Semi-Annual Report Narrative due

Addendum:

Teaching Standard at Newton Wellesley Hospital

In the Quality and Patient Safety Division's Winter Newsletter, we published an article on *The Teaching Standard* which is used to engage the Newton-Wellesley Hospital medical staff in a non-punitive peer review process as an essential component of their quality and patient safety improvement programs. In the event that individuals would like to know more about this principle and maybe incorporate it into their own system, we would like to draw attention to the fact that **Leslie G. Selbovitz, MD**, founded this concept and has been lecturing and consulting to organizations on this principle since 1998. Les was the first and longstanding Chief Medical Officer at Newton-Wellesley Hospital and now serves in a similar role at Milford Regional Medical Center. We are indeed very lucky to have Les now join us as a committee member at QPSD.

Les did his first statewide conference on *The Teaching Principle*, the basis of the Standard, in 2007 for the Board of Registration in Medicine's Patient Care Assessment Program, now known as the Quality and Patient Safety Division, and has done additional conferences since then for QPSD, and jointly with MHA, as well as numerous Grand Rounds in the state on *The Teaching Principle*. As Les states, the foundation of the *Principle* is: *Unless each component of care is delivered in the exact fashion in which you would teach it, there is opportunity for improvement*. This charges a structured process which allows for the correlation of processes with outcomes of care and to provide a continuous feedback loop emphasizing professionalism. Les emphasizes that by policy, no peer review body using this educational approach to drive improvement has any disciplinary authority. Those who have seen Les run PCAC meetings have commented they are like M&M rounds on steroids but without rancor. As a fan of the Case Records of the Massachusetts General Hospital in *The New England Journal of Medicine,* Les states this is by intention as a way to engage his colleagues in a framework that feels familiar and is clinically driven while assessing the interplay of professional performance with systems of care. *The Teaching Principle* also provides a vehicle to try to improve diagnosis in medicine, a key national focus of patient safety.

Questions and comments may be directed to
Mali Gunaratne,
Administrative Assistant
Mali.Gunaratne@MassMail.State.Ma.us

"Unless each component of care is delivered in the exact fashion in which you would teach it, there is opportunity for improvement".

Guidance for CY 2020 Reporting to QPSD:

Safety and Quality Review (SQR) Reporting:

HCFs are required to report Major Incidents as defined in 243 CMR 3.08(2)(a) through (d) to the Board of Registration in Medicine (BORiM). The following events, or major incidents, must be reported on a quarterly basis to the BORiM's Quality and Patient Safety Division (QPSD):

I. Maternal deaths that are related to delivery
II. Death in the course of, or resulting from, elective ambulatory procedures
III. Any invasive diagnostic procedure or surgical intervention performed on the wrong organ, extremity or body part
IV. All deaths ***or*** major ***or*** permanent impairments of bodily functions (other than those reported above) that are not ordinarily expected as a result of the patient's condition on presentation.

Reporting of events that met criteria for Type I-Type IV reporting that occurred between March 1, 2020 and May 31, 2020 is optional. This means if an event date is between March 1, 2020 and May 31, 2020, reporting of that event to QPSD is optional.

Events that met criteria and occurred before or after this time period would still require reporting to QPSD. If QPSD requested an additional response for an event that occurred before March 1, 2020, the response is still required. The quarterly report for patient fall events and pressure injury events is still due each quarter. The report for quarter one (Jan-Mar) was due on April 30th, but this has been extended to July 31st when both quarter one and quarter two (April-Jun) will be due. Reporting of patient falls and pressure injury-related events that occurred between March 1, 2020 and May 31, 2020 is optional as noted above. Please contact QPSD if you require information regarding how to complete these quarterly reports.

Annual Reports (AR):

The PCA Annual Report requires specific information to be submitted to the QPSD as defined in the PCA regulations 243 CMR 3.12(4).

The Annual Report is typically due in the spring of every year. For 2020, the Annual Report was deferred until the fall. This report will be optional for 2020. The next required Annual Report will be due spring of 2021.

Semi-annual Reports (SAR):

The PCA Semi-Annual Report is essentially a progress report on quality assurance data and activities. It is required by the PCA regulations at 243 CMR 3.07(3)(g).

The Semi-annual Reports are typically due in the spring and fall of every year. For spring 2020, all HCFs were excused from submitting the Semi-annual Report. There are two options for submission of the fall 2020 Semi-annual Report.

1. *In lieu of the usual Semi-annual Report, HCFs may submit a narrative* regarding plans for moving forward and/or a reflection on experiences with Covid-19. This may include, but is not limited to, clinical management, administrative management, new protocols, new learnings, and/or inspirational stories regarding staff and patients. Each narrative should be no more than 350 words. QPSD may contact HCFs for permission to include the narrative in a future edition of the QPSD newsletter in an effort to share learnings and inspirational stories with other HCFs in the Commonwealth. More than one submission may be sent. Submissions are due by August 14, 2020 by email to Daniela.Brown@state.ma.us*
   **Please do not include confidential information in the narrative or send any confidential reports by email.*
2. *HCFs may contact QPSD to request to be excused from the fall 2020 Semi-annual Report submission. The request must be made in writing to QPSD by September 1, 2020. HCFs are encouraged to select option one, however, this option may be requested by emailing Mali Gunaratne, Administrative Assistant, at* Mali.Gunaratne@MassMail.State.Ma.us