



# Communicating Outcomes to Patients



*Minnesota Hospital Association*



*The Minnesota Hospital Association is charged to lead a coalition of Minnesota's health care community to improve public trust and enhance patient safety. We are pleased to share the groundbreaking MHA model communication policy which was created through the collaborative work of MHA Patient Safety Committee members. Committee Chair Steven Kleinglass, Director, Veterans Affairs Medical Center, states that "this is one example of the great work that is being accomplished through collaborative efforts of MHA members. The members have come together and have shaped patient safety best practices to create this gold standard communication policy for communicating with patients and families."*

**T**his document serves as a resource for Minnesota Hospital Association facilities. It is recommended that health care organizations establish a separate policy that specifically addresses communication with patients, especially during times of unanticipated outcomes. Facilities may choose to incorporate this language into their organizational patient safety philosophy statements, policies, and procedures. The language may be modified to meet the needs of specific organizations. It is recommended to review this policy with your individual malpractice insurance carrier.

This model policy is intended to provide communication principles and provide reliable resources for definitions.

## Terminology

**Outcome:** The result of the performance (or non-performance) of a function(s) or process(es). (*JCAHO*)

**Unanticipated Outcomes:** A result that differs significantly from what was anticipated to be the result of a treatment or procedure (*American Society for Healthcare Risk Management, 2003*). Note: An unanticipated outcome is associated with the performance of a treatment or procedure and may be negative or positive. It may or may not be associated with an error.

**Medical Accident:** Any unintended event in the system of care with actual or potential negative consequences to the patient. (*Children's Hospitals and Clinics of Minnesota Medical Accident and Disclosure Policy*)

**Near Miss Medical Accident / Good Catch / Accident Waiting to Happen:** Any unintended event in the system of care which would have constituted a medical accident but which was intercepted before it actually reached the patient. (*Children's Hospitals and Clinics of Minnesota Medical Accident and Disclosure Policy*)

## Philosophy

Open and ongoing communication with patients about their care and the outcomes of such care is critical so that patients can be full partners in their health care. Patients have the right to receive accurate, timely, and easily understood information so that they can make informed decisions about their care. Health care institutions and

providers have an obligation to inform patients and, when appropriate, their families about the outcomes of care, treatment and services that have been provided, including unanticipated outcomes (*JCAHO - RR 2.90*). Institutions and providers have a legal and ethical duty to disclose medical accidents when there are clinical consequences<sup>1</sup> resulting from the medical accidents or when a reasonable person<sup>2</sup> would want to know, regardless of whether any negative clinical consequences resulted from the medical accident.

## Purpose

To clarify the philosophy and approach to patient communication, by providing policy guidelines for communicating unanticipated outcomes and medical accidents.

## Policy Statement

Patients or the appropriate guardian or representative will be provided relevant, easy to understand information about all outcomes of care in a timely manner.

Patients will receive a truthful and compassionate explanation when:

- ▶ Outcome of care varies significantly from what was anticipated;
- ▶ A medical accident has occurred resulting in clear or potential clinical consequences;
- ▶ A medical accident has occurred that has not resulted in clinical consequences, but a reasonable person would want information about the accident because it might assist them in planning future care; and
- ▶ A near medical accident has occurred that has reached the patient's awareness.

When a medical accident has occurred, open dialogue of the resolution available to the patient will occur. Patients or the appropriate guardian or representative will receive information on the steps taken to ameliorate the clinical consequences of the medical accident. There will also be open dialogue of non-clinical resolutions available to the patient, such as financial compensation if such remedies are appropriate.

## Procedure

- ▶ The responsible licensed independent practitioner<sup>3</sup> or his/her designee<sup>4</sup> explains the outcomes of all care to the patient, or appropriate guardian or representative, whether the outcomes are anticipated or differ significantly from the anticipated outcomes.
- ▶ Medical accidents are communicated to the patient, or appropriate guardian or representative if there are clinical consequences or, if a reasonable person would want to know, regardless of whether any negative clinical consequences resulted. The responsible licensed independent practitioner caring for the patient at the time of the event or his or her designee is responsible for ongoing communication with the patient or appropriate guardian or representative.
- ▶ When a medical accident occurs, the responsible licensed independent practitioner will be guided by the procedure for disclosure of medical accidents outlined below.
- ▶ It is recommended to include the statements below in your communication policy or reference other facility policies that include the language.
  - The health care institution will provide necessary tools when special types of communication are needed. Persons with limited English proficiency, individuals with a dramatically different cultural framework for health care services, persons with language, auditory or visual challenges and those with diminished or cognitive impairment fall into this category.
  - Health care institutions will protect the privacy of patient identifiable information. When it is deemed appropriate for family members to participate in discussion about outcomes, the patient's permission will be obtained. When a patient is deemed to be unable to understand information about his or her outcomes, or when the patient is an unemancipated minor, a legal or otherwise appropriate surrogate decision-maker will be informed.

## Procedure for Disclosure of Medical Accidents

Patients or the appropriate guardian or representative have the right to a prompt and truthful conversation when a medical accident has occurred.

- ▶ To assure continuity and appropriate perspective in discussion, the disclosure of information and subsequent discussions with the patient or his/her guardian or representative will be handled by the responsible licensed independent practitioner or his/her designee. In most cases, the licensed practitioner caring for the patient is the preferred communicator in the disclosure of unanticipated outcomes.

- ▶ Organizations may wish to have the practitioner inform appropriate administrative personnel before discussing such outcomes with the patient for the purposes of mentoring the individual on how to handle the discussion, reviewing what should be discussed, and the initiation of the organization's support, risk management, and quality assurance functions as may be required.
- ▶ Consideration should be given to having a second individual present during the initial conversation with the patient or the appropriate guardian or representative of the patient to assist with documentation of the conversation and to provide continuity and clarity.
- ▶ Facts will be reviewed and shared with the patient or appropriate guardian or representative without unnecessary delay.
- ▶ In rare instances where disclosure of a medical accident will have a deleterious effect on the patient's well being, disclosure may be withheld until such a time that the benefits of disclosure are greater than the harm.
- ▶ For discussions anticipated to be complex or difficult, patients or appropriate guardians or representatives should be given the option of having another person with them as support during the discussion.
- ▶ During initial and follow-up discussion the following subjects may be discussed, although discussion of each subject on the list is not required nor is discussion limited to these topics:
  - The hospital and its staff regret and apologize that a medical accident has occurred.
  - The nature of the medical accident.
  - The time, place, and circumstances of the medical accident.
  - The proximate cause of the medical accident, if known.
  - The known, definite consequences of the medical accident for the patient and potential consequences.
  - Actions taken to treat or ameliorate the consequences of the medical accident.
  - Who will manage ongoing care of the patient.
  - Planned investigation or review of the medical accident.
  - Who else has been informed of the medical accident (in the hospital, review organizations, etc.) and the facility's confidentiality policy.
  - Actions taken to identify systems issues that may have contributed to the medical accident and to prevent the same or similar medical accident from recurring.



- Who will manage ongoing communication with the patient or appropriate guardian or representative.
  - The names and phone numbers of individuals in the hospital to whom the patient or appropriate guardian or representative may address complaints or concerns about the process around the medical accident.
  - The names and phone numbers of agencies to whom the patient or appropriate guardian or representative could communicate about the medical accident.
  - How to obtain support and counseling regarding the medical accident and its consequences both within the hospital and from outside.
  - The organization's process to establish compensation for harm, as appropriate — or contact person's name.
  - As applicable, the medical accident will be reported to appropriate agencies so that organizations can learn and prevent a similar event from recurring (e.g., MDH, JCAHO).
  - If the medical accident is determined to be one of the 27 Minnesota Adverse Health Care Events, non-identifiable information will be included in the MDH annual public report. (Points to consider prior to discussing this include, but are not limited to, whether the event is in litigation or the discussion might have a negative effect on the patient/family.)
- ▶ The facts and pertinent points of the conversation with the patient and or family will be recorded in the medical record.
- ▶ Appropriate communications are made internally within the health care facility and are consistent with organizational practices such as public relations, risk management, and media policies.

### Endnotes

1. These are consequences that result in any temporary or permanent change in the patient's current condition and/or result in a change of treatment plan.
2. The reasonable person standard is an ethical/legal standard that calls for the disclosure of information to patients based on what a hypothetical reasonable person would want to know (*Principles of Biomedical Ethics*, Bechum).
3. JCAHO defines "licensed independent practitioner" as any individual permitted by law and regulation and by the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges (*Jan. 2005*). Licensed independent practitioners include physicians, nurse practitioners, physician assistants, radiologists, on-call physicians, and other designated alternate physicians.
4. If the responsible licensed, independent practitioner is unable or unwilling to explain the outcomes, a designated physician leader will provide such explanation. In instances where there is negligible harm to the patient, another individual may be designated as the primary person to communicate the event.

### References

- Allina Hospitals & Clinics' Patient and Visitor Safety Reporting Draft policy
- American Society for Healthcare Risk Management Perspectives on Disclosure of Unanticipated Outcome Information'
- Children's Hospitals and Clinics of Minnesota's Medical Accident and Disclosure Policy
- JCAHO Patient Safety Standards, Effective July 1, 2001
- National Patient Safety Foundation Statement of Principle Patients' Bill of Rights
- Avera Marshall Regional Medical Center, Marshall, Draft Communication Policy

To order copies of this brochure or for more information, contact the Minnesota Hospital Association.



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