Legal and Ethical Accountability for Nursing Errors: Disclosure and Apology

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Landscape

- ***Increased public awareness of medical errors- increased emphasis on patient safety***
- ***Ethical, legal expectations to disclose errors- transparency in all patient care actions***
- ***Professional and regulatory supports***
- ***Nursing has been slow to respond to these challenges***

Professional/Regulatory Perspectives

- **JACHO (now the Joint Commission) 1st to require disclosure in United States (U.S.)**

- **National Quality Forum (2006)safe practice guideline**

ANA Code of Ethics –U.S.(2015)

- ***The nurse has a professional responsibility to promote a culture of safety***

- ***Nurses are responsible for the care patients receive and accountable for their practice***

- ***Nurses and advanced practice nurses are increasing their involvement in error-prone procedures and processes***

Source: American Nurses Association. 2015. Code of Ethics for Nurses. Washington, DC: Author

QSEN Standards

- ***Quality and Safety Standards for Nurses (QSEN)***
- ***Pre licensure standards-knowledge, skills and attitudes***
- ***Graduate standards- knowledge, skills and attitudes***

Benefits of Error Disclosure

- ***Studies show apologies can decrease monetary losses from litigation***

- ***Psychological benefit for patient and practitioner- satisfaction, closure, and emotional healing***

Barriers to disclosure of errors

- Attorneys and insurers may discourage disclosure- fear of litigation
- Practitioner should consult attorney in U.S. if any question about implications of disclosure
- Legal and Cultural barriers: “deny and defend”

- Confusion of what to disclose may prevent full disclosure- lack of training in nursing and other health professions

Successful U.S. Disclosure Programs

- ***VA hospital in Lexington, KY- program in effect since 1987 has resulted in improved relationships, faster settlements and smaller claim payouts***

- ***"Michigan Model" since 2001 has shown decreases in number of new malpractice claims, estimated cost savings of 2.2 million (1195- 2007)***

Disclosure, Apology and Offer D,A &O

- Model advocates disclosure of adverse events, including an apology when appropriate
- Patent safety is improved by using information for safety –enhancing interventions
- Offer compensation when care was unreasonable, defend vigorously when care was reasonable

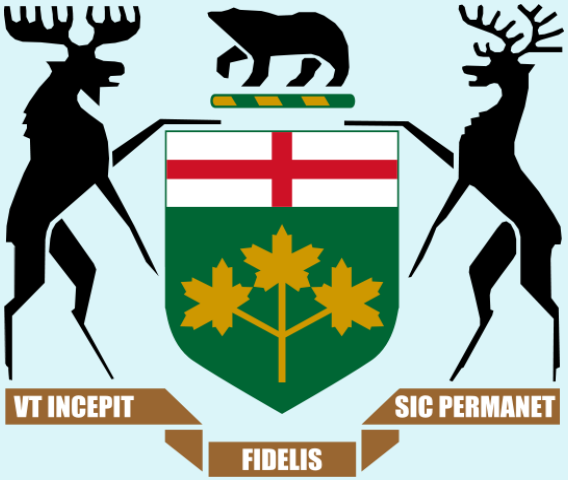
Responses in Other Countries

Australia

Open Disclosure Standard (2003), now called Open Disclosure Framework

Canada

Saying "Sorry" does not constitute an admission of fault or civil liability



United Kingdom

- A professional "Duty of Candour" for health professionals including nurses, includes an apology
- Required by the General Medical (GMC) Council and Nursing and Midwifery Council (MWC)
- Compensation Act of 2006, Chapter 29 "An apology, offer of treatment or other redress shall not of itself amount to an admission of negligence…"

U.S. Apology Laws (Statutes)

Protect expressions of regret

Apologies are then inadmissible in civil actions arising from alleged medical errors

Acknowledge mistake " I am sorry this happened to you"

Typically do not protect information related to causality or fault- would not protect "I'm sorry I hurt you"

U.S.States With Apology Statutes (Laws)

Arizona (2009)
California (2001)
Colorado (2003)
Connecticut (2006)
Delaware (2006)
Dist. of Columbia(2007)
Florida (2001)
Georgia (2006)
Hawaii (2007)
Idaho (2006)
Illinois (2005)
Indiana (2006)
Iowa (2007)
Louisiana (2005)
Maine (2009)
Maryland (2005)
Massachusetts (2000)
Michigan (2011)
Missouri (2010)
Montana (2010)
Nebraska (2010)
New Hampshire (2010)
North Carolina (2004)
North Dakota (2010)
Ohio (2004)
Oklahoma (2010)
Oregon (2010)
Pennsylvania (2013)
South Carolina (2010)
South Dakota (2005)
Tennessee (2003)
Texas (2009)
Utah (2010)
Vermont (2010)
Virginia 2011
Washington (2010)
West Virginia (2005)
Wyoming (2004)

Case Law decided under Apology Statutes

- ***Airasian v Shaak (2008). MD accidently removed part of patient's colon. "This was my fault" protected under broadly worded Georgia statute, as an expression of remorseful wrongdoing***

- ***Davis v. Wooster Orthopaedics & Sports Medicine (2011). Patient died after lumbar surgery- MD conduct found below the standard of care. Jury did not hear statement that he was sorry for his mistake- did hear he took full responsibility for his mistake. Ohio statute***

Facilitating Error Disclosure

- ***Sorry Works! Coalition (2005)- advocacy organization for apology and compensation for medical errors- resources/toolkits/training materials***

http://sorryworkssite.bondwaresite.com/online-disclosure-training-for-front-line-staff-cms-126

Institute for Healthcare Improvement (IHI)

- ***Not-for-profit organization leading the improvement of HC throughout the world***
- ***Works on accelerating change to improve patient care***
- ***White paper on "Respectful Management of Serious Clinical Events" (2011) with tools, online courses, bibliographies, checklist etc. on website***

Source- http:/www.ihi.org

Prioritized Organizational Response

Priority 1: The patient and family

- ***Honest communication, most often a team of 2, including someone with a pre-established relationship with them***
- ***Apology issued " I'm sorry this happened"***
- ***Ongoing support for family, including reimbursement for out-of-pocket expenses***

Source- IHI White Paper (2011)

Priority 2: The frontline staff

- ***Resources available for on-the-spot coaching for empathetic communication, disclosure of the event- ongoing support***
- ***Mechanisms to ensure learning and healing***
- ***Focus on "What happened" rather than "Who did it", "We'll figure this out together"***

Source IHI

Priority 3: The organization

- ***Visible management " I care" call to action grounded in values of integrity and doing the right thing***
- ***Crisis management team activated if serious event- clear chain of command***
- ***RCA- focus on learning and improvement, clear internal and external communication***

Source- IHI

U.S.Malpractice Carrier

- There is a commitment to rapid disclosure, compensation, and support.
- There is a written understanding of how cases will be managed with carrier.
- Mechanisms are in place for rapid, respectful resolution

Words of Compassion, Concern, Empathy, and Remorse

Concerned
Disappointed
Embarrassed
Empathized
Failed/Failure
Let you down
Regret
Sad/Saddened
Sorrow/Sorrowful
Sympathetic
Tragic
Unfortunate
Unintended
Unnecessary
Unsatisfactory

The Disclosure

- The organization is transparent and honest. Responsibility is taken.
- We are empathetic, apologize and/or acknowledge.
- There is a commitment to providing follow-up information.
- The caregiver is supported throughout the process.
- Ongoing support is provided for the patient and family.

Ongoing Support

- Resources are available to assist families experiencing unanticipated outcomes—support is defined by the **patient and family**.

- Resources are available to assist staff at the front line of unanticipated outcomes—support is defined by needs of the **clinician**.

- Procedures are in place and are known to ensure ongoing communications with patients, families, and staff over **months and possibly years**.

IHI Open School Online Courses

PS 105 Responding to Adverse Events (1 hr. 45 min.)

- Lesson 1- Responding to an adverse event: Step by step Approach
- Lesson 2- When and How to Apologize to Patients
- Lesson 3- The Impact of Adverse event on caregivers: The second Victim
- Lesson 4- Learning from Errors Through Root Cause Analysis

Healthcare Professionals & Nurses

- Research reveals nurses and other HP fear repercussions for reporting errors

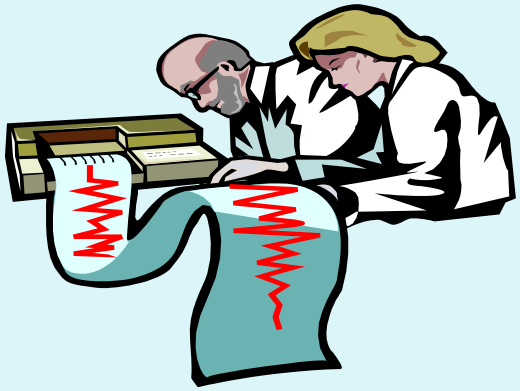
- Leads to underreporting, missed opportunities for learning from errors and near misses

- Second victim (HC practitioner) and Third victim (Organization)

Nurses as Second Victims

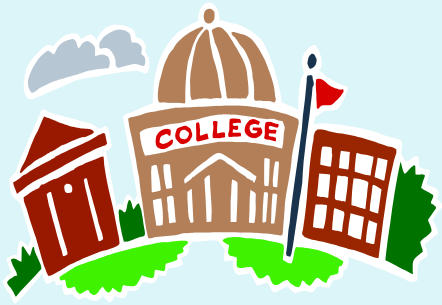
- U.S. American Nurses Association focus on "Culture of Safety"
- Literature validates this phenomenon- introduced by Dr. Albert Wu (2000) related to MDs who make professional errors
- Appropriate support mechanisms and interventions must be in place

Nurses and Disclosure



- Patients need to be informed of system changes made to prevent recurrence, plans to investigate
- Institution must have policies where nurses feel supported
- Nurse manager and risk managers must be trained to assist in the disclosure process

Education/Training



- Obligation of nurse educators to include patient safety and error disclosure focus in curriculums

- Simulated experiences can be used to provide case studies, role playing for error disclosure and difficult conversations with patients

Learning to Apologize

- IHI Open School Courses- Colleen Hayes, MHS, RN, Western Carolina University
- case study where a patient was harmed, small groups to craft apologies to patients and families.
- pretend they are the nursing director, charge nurse, or medical director delivering an apology,"
- "The class then evaluates the group on whether they hit all the components of an apology-more than just saying 'I'm sorry.' "

Conclusion/Questions

Clear mandate for nurses to participate in error disclosure and transparency in adhering to professional standards and as part of enabling a “Culture of Safety”

Thank You!!

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Selected References/Resources

ANA Code of Ethics for Nurses. (2015).

Institute of Safe Medication Practices: www.ismp.org

Institute for Healthcare Improvement: www.ihi.org

Nursing & Midwifery Council, General Medical Council. (2015). Openness and honesty when things go wrong: The professional duty of candour. https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf

Nursing and Midwifery Council. (2015). The Code- Professional standards of practice and behavior for nurses and midwives. https://www.nmc.org.uk/standards/code

Sorry Works! ***http://sorryworkssite.bondwaresite.com/online-disclosure-training-for-front-line-staff-cms-126***

Westrick, S. and Jacobs, N. (2016). Disclosure of Errors and Apology. *Journal for Nurse Practitioners*, *12*(2), 120-126.

Westrick , S. (2014). Essentials of nursing law and ethics, 2nd Ed. . Burlington, MA: Jones and Bartlett Learning.