This presentation will introduce you to Communication and Optimal Resolution, or the CANDOR process. Some organizations struggle to improve the way they and their care teams respond to medical harm. The CANDOR process aims to change that.

To get started, let’s watch this video.

Video: Do Less Harm

Today’s Presentation Goals are to:

- Highlight the gap between optimal response to medical injury and current practices, and identify the reasons for this gap.
- Describe the CANDOR process and how this toolkit will help organizations improve their response to medical injury.
- Discuss next steps in the CANDOR implementation process.
All of us in health care want to provide excellent, high-quality medical care, but despite all of our patient safety work, patient harm is too common.

Organizations have quality and safety programs, but many struggle to ensure that solutions to errors are really addressing the cause of the error and not just checking the box on their process when they do their analysis of the error.

Patients want a health care organization, physician, and/or care provider to be fully transparent when an error occurs, but often this doesn’t happen.

From the book “To Err is Human,” as reported from the 2010 Medicare data:
- 13.5% of hospitalized beneficiaries experienced an adverse event.
- 1.5% experienced harm that contributed to their death.
- 44% of adverse events were preventable.

We haven’t made headway on safety, in part because we’ve struggled with transparency. In this Health Affairs article, doctors report they don’t always disclose medical errors.

In Rosemary Gibson’s book: Responding to medical error is a part of health care where we should be most patient centered (true stress test), but where we are perhaps the least.

Consequences are high when organizations and health care providers don’t respond to medical injury.

As we saw in the Do No Harm video, families reported how the silence they experienced after the adverse event actually compounded the injury from the event itself.

When an organization or a care provider doesn’t communicate, or the communication doesn’t meet the patients’ or families’ expectations, it may lead to litigation as patients and families see this as their only way of getting answers to their questions.
Say:
Open and honest communication after an adverse event is not easy and does require training and support.

It starts with answering the question: “What do we know?”

■ This is not always easy, as we may not have all the answers.

■ It is important to understand that communication doesn’t happen just once and then you are done; rather, it is a **process**. During the first communication with patients and families, we need to set the stage for this as well, by telling them the facts that we know at the time and promising them more information later.

It is also important to recognize not only patients’ and families’ emotions at the time, but also the caregivers’ emotions, and to provide emotional support.

It is important to remember what patients want in our communication with them:

1. An explicit statement that an error occurred.
2. What happened and the implications it has on their health.
3. Why it happened:
   - This might be hard to answer at the time; but again, this is to stress that as the investigation occurs, we will meet with patients and families and update them on everything the organization and care team discovers during the investigation.
4. How recurrences will be prevented:
   - This will be part of the investigation and conversations with patients and families later.
5. Most importantly, the patient and family want to hear the organization and the caregivers apologize with sincerity.

Say:
It is important to recognize why organizations and care providers are resistant to this type of open and transparent communication.

Fear of:

■ Loss of reputation and trust.
■ Being sued.
■ Reporting issues, for example, State reporting requirements and the physician data bank.
■ Being shamed or blamed for the error.
■ Revealing poor skills/abilities.
■ Lacking an organizational process related to open and transparent communication that is fair and just.
Benefits from an open and transparent culture include:

- Organizational learning that leads to improvements.
- Potential decrease in adverse events being litigated, which can potentially lead to lower malpractice expenses and claims.
- Improved morale and trust amongst the organization and care providers as they see that this entire process is core to everyone's mission, which is to improve quality and safety.

**Example case.**

*If you like, you can also insert a picture of a case at your own organization.*

Michelle Malizzo-Balog, pictured here with her mother and father.

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Michelle Malizzo-Balog

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**Story of Michelle Malizzo-Balog**

- 39-year-old presents for endoscopic GI procedure under heavy-moderate sedation.
  - Had failed stent placement 2 weeks prior due to discomfort, despite large amounts of narcotics
  - Repeat scheduled for 1 p.m. with anesthesia present
  - GI physician delayed. Arrives at 4 p.m., at which point anesthesia not available for elective case
  - Twice the dose of fentanyl, midazolam used
  - Standard monitors for HR, BP, O2 Sat used.
  - Dark room, patient on side, unable to auscultate.
  - Physician asks monitoring nurse to get different stent. Nurse leaves the room.

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**...Case Continued**

- Upon return, patient found to be in respiratory distress.
- Code called.
- No response to reversal agents.
- Team assumes allergic reaction to medication as etiology of arrest.
- Michelle resuscitated but brain dead.
The response to medical injury involves more than just what to do and what we say to the patient. The CANDOR process is an integrated approach that involves different pieces; but for the process to work well, it centers on communication.

The CANDOR process is an approach that health care institutions and practitioners can use to respond in a timely, thorough, and just way to unexpected patient harm events.

The first step in implementing the CANDOR process is for the organization to assess organizational readiness for change.

To assess readiness for change, the organization should conduct a Gap Analysis. The Gap Analysis is a review of the organization to determine what processes, policies, and systems are currently in place and what will need to be changed or created to implement the CANDOR process.
A good response to adverse events really hinges on knowing about them immediately. Our typical human reflex is not only to not necessarily be open with patients but also not to be honest with the organization when an adverse event occurs.

The statement “We can’t fix what we don’t know about” is never more true than when implementing the CANDOR process. The process starts with identifying and reporting the event.

Organizations that are implementing the CANDOR process need to emphasize the importance of reporting and remove the stigma attached to reporting. Once the report is received, the organization that has implemented the CANDOR process will activate the CANDOR system to ensure that:

1. Designated staff respond to the scene and provide an initial disclosure to the patient and family.
   - It involves the activation of the Care for Caregiver program for the organization.

2. An event report is completed, which will trigger analysis of the event. This will include holding all facility and professional fees related to the patient's care until the analysis of the event is completed.

Readiness requires both the capability to make changes and the motivation to change. Items for discussion:

- How can you link event reporting to your culture?
- How can you engage learners (i.e., residents) to become champions of this process?
- What other barriers must your organization overcome?

Once the CANDOR system is activated, two processes are occurring at the same time:

The Response to the adverse event: stabilization of the patient, care for the caregivers, and initial communication with the patient/family.

The Investigation: to determine how the event occurred, and how to mitigate that event or even prevent it from occurring again.
The CANDOR process involves a thorough investigation of the adverse event; but in the old paradigm, the goal of investigation was “who/what can we blame for this error?” In this new paradigm, the focus of the event investigation is process improvement and conducting the investigation with a human factors approach.

Best practices related to event investigations are:

- Results are protected.
- The team is interdisciplinary and has human factors expertise.
- Process is conducted timely, fairly, and comprehensively.

The goal of these investigations is to:

- Develop broad process improvements.
- Provide all those involved, as well as the organization as a whole, with feedback on the investigation and its plans to prevent the adverse harm from occurring again.

Example case.

[You can also insert information from a case at your own organization.]

In the old paradigm, it is about finding a person or persons to blame. In this case, the organization could blame:

- Nurse
- Physician
- Others?

For an organization to be successful in getting event reports, the organization must have a Just Culture.

Just Culture principles are a crucial accompaniment to the CANDOR process framework and will spark the shared accountability that is necessary for the CANDOR process implementation to be successful.

If a Just Culture is so important to an organization’s culture, why do we still focus on blame?

In a Just Culture, not only is shared responsibility the norm, but a commitment to eliminating harm resulting from error is widespread within the culture. This is a cornerstone of the CANDOR process of investigating the root cause of how an error occurred, including the human factors. The entire organization must support this culture change.
Safety Attitudes:

1. Dr. Lucian Leape stated, “The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.”

2. James Reason stated, “Fallibility is part of the human condition. We cannot change the human condition. But we can change the conditions under which people work.”

Eliminating human error is a futile goal, as it is not a realistic approach. The CANDOR process recommends that organizations take a systems approach with human factors integrated into the event analysis of an adverse event. In this approach, the goal is to:

Ask what is responsible, not who is responsible, and focus on system solutions.

Human factors engineering is about redesigning the system within which humans work, as we don’t redesign humans. This approach is used in the aviation industry, and it is part of the safety culture in health care organizations. Another example of redesigning systems within which humans work is the field of ergonomics; as we work more at desks and computers, these areas are redesigned to help prevent injuries from working in this environment. This approach should be part of the safety culture in health care organizations.

The CANDOR process promotes the involvement of patients and families throughout the process. This concept can be very concerning for organizations, but the CANDOR process will help to address these issues.

**Issues/Concerns:**

- Patients may not know enough about health care systems — The CANDOR process encourages you not to make assumptions, and to interview patients and families to get their perspective on the event.
Concerns about legal protections—Invite patients in appropriate settings (i.e., patient safety committees), determine local QI privileges, and share this information with caregivers.

Further distress to the family—Timing matters; but if you are open and continuously communicating with the patient and family, the organization will know the right time to approach them.

Best way to involve patients and family—Provide various options, because not every patient/family will want the same thing. Having options allows them to select what works best.

Say:
The culture of the CANDOR process provides the opportunity for continuous learning after the resolution of a CANDOR event. The information feeds into the organization’s metrics, allowing for clarification and improvement of the CANDOR processes and preventing similar harm events from occurring in the future.

Communication is at the heart of the CANDOR process. But the communication needs to be tailored for the audience and engaged in by individuals who understand the art of communication and have received communication training. Communication with the patient and family needs to be honest, open, and truthful and contain the facts of what is known at that moment. But it has to convey empathy and sincerity. Communication with the caregivers involved in the event needs to be supportive and ongoing.

In the CANDOR process, there is training for CANDOR Communication Leads, as not everyone is a good communicator. We all can identify who is a good communicator and who we would want to give us difficult or bad news. These disclosure conversations can be emotionally difficult, not only for the patient and family, but also for clinician communicating with the patient/family. Not all clinicians should be conducting this initial communication with patients/families. It is important that, as part of the CANDOR process, clinicians reach out to the CANDOR Communication Leads to enlist help with these conversations.
Say:
Let’s watch this video, as it demonstrates what happens when communication is not handled well.

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What we have learned from patients and families after a serious harm event is that every hour that goes by without effective communication results in additional harm to the patient/family. It is important that communication with the patient and family is planned and structured to meet the goals of the patient and family.

Keys to remember about the disclosure:
■ Disclosure is a **process**, not a single event.
■ Explain what happened, and reveal the facts known at the time.
■ Explain to the patient and family how the event could affect their treatment plan.
■ Offer a genuine expression of regret/apology for the event.
■ Explain how the event will undergo an investigation, and as more information is discovered, information will be shared with the patient and family.
■ Establish a hospital contact person for the patient and family to contact with questions/concerns.

Organizational leadership and support for the CANDOR process are key to ensure that it occurs.

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Additional tips to help the disclosure conversation:
■ Be yourself—Let them see your emotions/empathy.
■ Prepare for the conversation, and consider their potential reactions or questions.
■ Avoid blaming other people, departments, or systems.
■ As a team, discuss who should be in the room when having conversations with the patient and family.
■ Use your resources, and get help in preparing for these conversations—Your organization may develop a process related to disclosure, and it is important to follow that process.

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**Additional Tips**
- Be yourself—authenticity matters.
- Anticipate potential reactions and questions.
- Avoid blame.
  - “The lab always does this.”
  - “If only radiology had called me...”
  - Blaming other providers, “system.”
- Weigh pros and cons of who goes in the room.
- Take advantage of coaching and consultation.
- Involve trainees, team members when appropriate.
- Follow organizational processes.
As we can see from the data, there is still work to be done in open and transparent communication. The CANDOR process can help clinicians and organizations feel more comfortable with the act of disclosure, and patients and families will have communication that meets their expectations.

When the organization responds to the event, part of the CANDOR process Response is the activation of the organization’s Care for the Caregiver program.

Involvement in a medical error can increase a clinician’s:
- Chance for burnout.
- Likelihood of involvement in future errors.
- Risk of depression.
- Risk of suicide.
- Leaving the practice of medicine, nursing, or other practice area.

In addition to the organization Medically Induced Trauma Support Services (MITSS), the National Quality Forum has published guidance in a “safe practice” on caring for caregivers after an adverse event. It explains that after an adverse event, regardless of whether it is due to human or system error, all employees involved (including administrators, clinical providers, and other staff), should receive care. It should be timely, systematic, just, respectful, and compassionate. If needed, supportive medical care should be offered, and the involved employees should be offered the ability to meaningfully participate in the event investigation, in hopes that they contribute to efforts designed to prevent future events.

An organization that implements the CANDOR process must support not only the patients/families affected by an adverse event, but also the providers who care for patients/families.
Resolution can be defined as the act of solving a problem, dispute, or contentious matter. In the CANDOR process, this definition applies as well, but resolution does not equate to a financial settlement. Rather, resolution is a process that addresses patients’ expectations. Resolution should lead to a settlement of issues related to the adverse event, but doesn’t always lead to a financial settlement.

In a September 27, 2013, column in Elle, journalist Celia Barbour chronicled her experience having a vein nicked during arm surgery, an injury that nearly killed her (http://www.elle.com/beauty/health-fitness/medical-malpractice-personal-essay). The surgeon gave her an immediate and sensitive apology for the error, accepting full responsibility. But no one offered her compensation, beyond the surgeon waiving his portion of the bill. She hasn’t sued—yet—but months later, she still struggles with whether the apology was enough.

This story illustrates the progress we’ve made toward accountability for error in medical care…and also what we haven’t yet been able to do for injured patients, which is to proactively offer just compensation.

The concept of accountability relates to what patients want, following an adverse event, from their care providers and from the organization. Patients want:
- An explanation.
- An apology.
- An understanding of the changes that have been made to prevent harm to another patient.

Patients are looking for the actions the organization is taking to prevent and learn from the adverse event.

Resolution can truly occur only after the organization has completed its investigation and analysis of the event. Remember that disclosure is a process, and the first step is to:
- Let the patient and family know an adverse event occurred and then:
  - After the organization investigates the event, present the results to the patient/family, along with information as to what action the organization is taking to prevent a similar event from occurring again.
  - After the family receives this information, the organization convenes another meeting with the patient and family to discuss:
    - Whether the care provided met the standard of care or not.
- Whether the organization has determined, based on the analysis of the event and other factors, that the event warrants compensation for the patient/family.

- Understand that this part of the CANDOR process can also be very emotionally charged, but for different reasons. The organization needs to select individuals for these conversations who can effectively communicate with patients and families. As part of the CANDOR implementation process, these skills will be discussed, and tools will be presented to help the organization implement the resolution component of the CANDOR process at their organization.

Say:
The implementation of the CANDOR process can be broken down into three major buckets:

1. Assessments—We set the stage for this organizational change.
2. The CANDOR process—Once implemented, the organization responds to an event in a timely and thorough way.
3. Organizational learning and sustainment—The organization takes what they have learned from the event to improve and sustain the CANDOR process culture change and to help prevent a similar event from recurring in the future.

Say:
It is important to keep patients and families who were involved in a medical error at your organization involved in the process of improving patient safety at the organization.

Say:
Example case.
You can also insert information from a case at your own organization.

As a result of the investigation and analysis of Michelle’s case, the following patient safety changes occurred:

- The American Society of Anesthesiology adopted the standard that capnography be used in heavy sedation cases. (Capnography is the measurement and graphic display of carbon dioxide levels in the airways.)

- The University of Illinois at Chicago adopted improved policies regarding anesthesia coverage for cases involving heavy sedation.
The University of Illinois at Chicago also developed environmental strategies for patient monitoring that took into account:
- Where equipment is placed to ensure providers are able to see patient monitoring screens.
- Lighting in procedure rooms.
- Alarm settings.

Next steps for your organization:
- Conduct a Gap Analysis review.
- Conduct communication training for your selected CANDOR Communication Leads.
- Host event analysis training using tools from CANDOR.
- Monitor progress by capturing data and providing feedback to the organization on this information.
- Encourage and support the CANDOR process throughout the organization.

Questions?