Utilizing Lessons Learned in Mediation to Enhance Patient Safety and Implement Just Culture

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Results
The majority of the events that successfully resolved at mediation involved Nursing (20%) as the primary service, with Surgery (18%) and Medicine (14%) closely following. The majority of these events occurred in the Inpatient setting (40%), followed by Outpatient (26%) and Operating Room (19%), which includes both inpatient and ambulatory ORs. The top three contributing factors to these events were Clinical Judgment (50%), Technical Skill (17%), and Administrative (10%). Communication was the next highest contributing factor (5%). Of the communication factors, communication between physicians and between physicians or nurses and the patient were tied (34% each). This was followed by communication between nurses (16%), and communication between physicians and nurses (14%). The Just Culture Behavior seen most was unintentional human error (84%) versus at risk behavior (14%). The Process Improvements initiated as a result were Education/Training (47%), Process Change (15%), and Policy Creation/Revision (10%). Just Culture actions taken were primarily Peer Review/Counsel (51%), followed by Coaching (20%) and Consoling (20%). Only 7% have resulted in Discipline, indicating a favorable inclination toward Just Culture.

Methods
A retrospective review was completed on 143 mediations that took place between January 1, 2008 through December 31, 2015. These events included only closed professional liability (139) and general liability events (4). Each mediation was evaluated by a number of factors, including the date from which the mediation claim was asserted, the date of mediation, the primary specialty responsible, the location of the event, the severity of the event, the top three factors that contributed to the event, the process improvements implemented, and the Just Culture behavior involved in the incident and the actions taken as a result. Given that communication is a central concern to a number of patient safety events, it was analyzed for all events.

TOP 5 RESPONSIBLE SPECIALTY

Nursing 20%
Ortho 10%
Medicine 14%
Surgery 18%
OB/Gyn 10%

UNIT WHERE EVENT OCCURRED

Inpatient 40%
Outpatient 26%
ED 10%
OR 6%
ICU 4%
GL 2%

TOP 4 CONTRIBUTING FACTORS

Communication Factors

MD to MD
MD/RN to patient
RN to RN
MD to RN
NA

PROCESS IMPROVEMENT

Policy
Coaching
None
Individual
Education/Training

JUST CULTURE ACTION

Discipline
Peer Review/Counsel
73%
26%
20%
10%
0%

References:
3. 2015 Hospital and Physician Professional Liability Benchmark Analysis. Aon Risk Solutions/ASHRM; October 2015