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

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Introduction

Traditional litigation is slow and costly, whereas mediation can confidentially resolve legal disputes faster and less expensively, with greater satisfaction to both parties. It provides an opportunity for the healthcare provider to personalize their position directly with the patient. It also provides patients an opportunity to communicate their perspectives about care. Though healthcare providers may have a number of processes to analyze a patient safety event, these do not often include the complete patient perspective. With mediation, there is often greater satisfaction for patients, knowing they contributed to enhancing patient safety and Just Culture.

Objectives

The experiences of the UF, FSU, UCF, FAU and FIU Self-Insurance Programs with mediation was reviewed for the past 8 years, since the inception of the program in 2008. Patients agree to participate in nonbinding, confidential mediation if they have a possible claim against a covered facility or healthcare provider. The program provides, at its expense, a neutral mediator to facilitate communication in an organized setting between the patient and the healthcare provider and/or representatives of the facility. Because mediation is nonbinding, the patient retains the right to sue if mediation does not result in resolution of the claim. This evaluation was based on the asserted claims that resolved at mediation, the time and costs that were avoided, and improvements made to patient safety where possible.

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.

Contributing Factors : Administrative, Behavior Related, Clinical Environment, Clinical Judgment, Communication, Clinical System, Documentation, Electronic Health Record, Environmental, Equipment, Managed Care Related, Technical Skill, Information Related, No Insurance, No Contributing Factor, Nosocomial Infection, Patient Factors, Supervision of Housestaff

Just Culture Behavior: Unintentional Error, At Risk Behavior, Reckless Behavior, Malicious Behavior	**Just Culture Action**: Console, Coach, Peer/Review Counsel, Discipline
Process Improvements: Policy Creation/Revision, Education/Training, Individual, Process Change	**Communication Issues**: Between Physicians, Between Nurses, Between Physicians and Nurses, and Between the Physician or Nurse and the Patient

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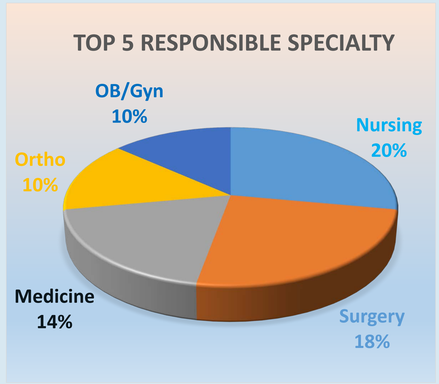
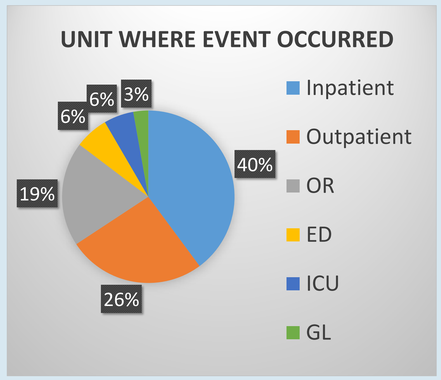
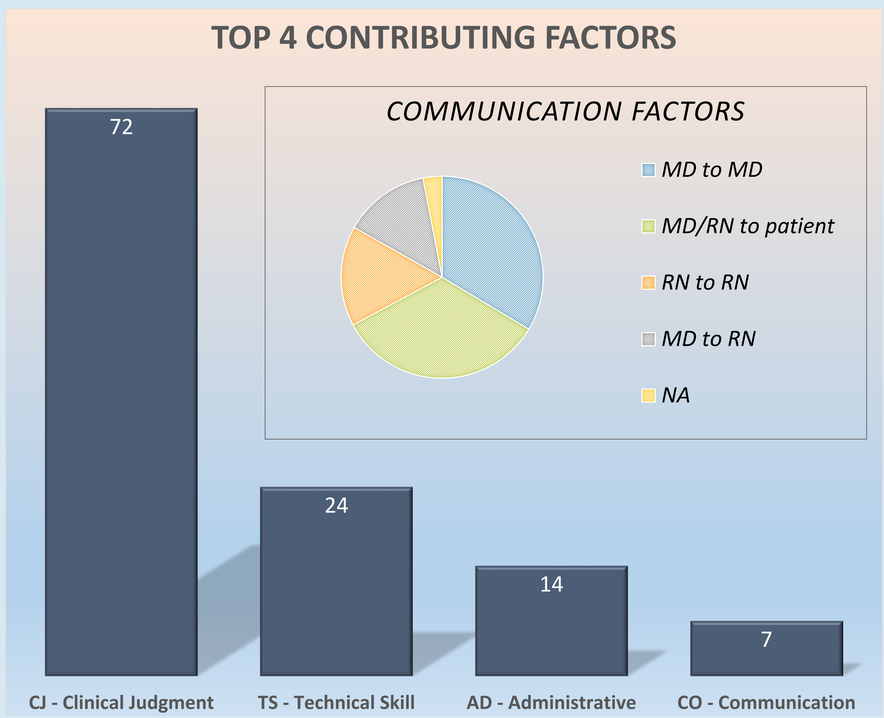
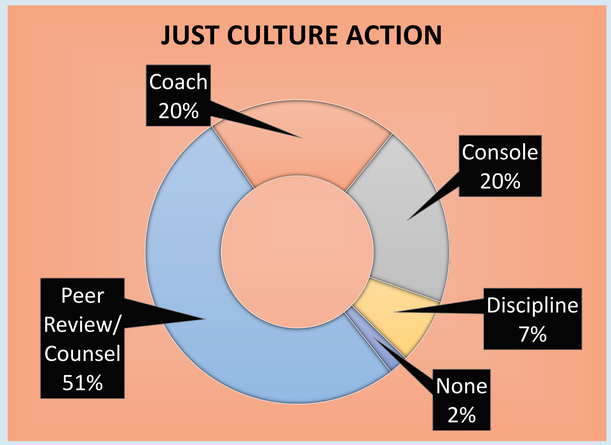


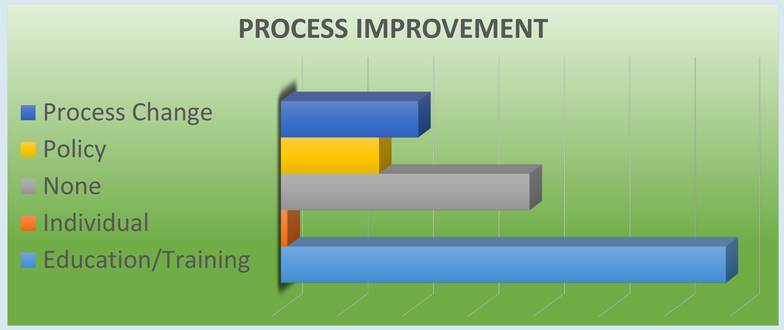






Results

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.



Conclusion

As Just Culture grows more dynamic in the healthcare environment, data supports reviewing learning processes as well as reevaluating system designs. The results suggest that in 27% of events where no process improvement was identified, there is opportunity to further evaluate the event. Implementing and utilizing presuit mediation programs resulted in faster resolution of claims, an experience that allowed the patient to feel part of the process, and the ability to interact with their healthcare provider to improve patient safety. This non-adversarial and confidential fact-finding approach allows the parties to share their concerns about care and provides an arena for a safe apology within the confines of statutory protections. It also allows for immediate learning for the healthcare providers that can be incorporated into patient safety improvements and enhancing the institution's Just Culture. Given that communication is such a crucial component of patient safety events, future innovations may include more immediate discussion with the healthcare provider of various communication components to better care for the present patient population. The educational pearls gleaned from the mediation process can be an effective teaching tool for patient safety as well as valuable information from a loss prevention perspective to reduce the likelihood of future claims.

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