

## **\*Stepping Into Transparency\***

Rogue Valley Medical Center recently made a major decision to add a new facet to improving the quality and safety of care within our facility. After a Sentinel Event occurred in our hospital, resulting in a patient's death, Risk Management approached the Administrative Team with a request that we move forward in becoming transparent regarding what had occurred and include the patient's family in our Root Cause Analysis process.

The decision to proceed with this level of involvement from a family was new and concerning to all involved from the hospital, but it was also recognized as the right thing to do. We tried to ask ourselves what we would want done if it had involved our own family member.

During the full disclosure meeting, attended by the patient's family, Hospital CEO, VP of Patient Care Services, attending physician, and Risk Manager, an invitation was extended and accepted by the family to attend the RCA meeting. The family's request for a copy of the complete medical record was also honored.

Risk Management met with the family prior to the formal meeting, to provide an orientation to the RCA process and to answer any questions the family had regarding the meeting. Key points were:

- Emotions are OK; don't be afraid to express them.
- This is a new process for us as well so we will be learning together.
- Oregon law protects everything discussed in the meeting and no notes can be taken.
- Family would be signing a confidentiality statement just as all attendees do.

Lessons learned from involving family in our Root Cause Analysis:

- Acknowledge Emotions: There was awkwardness and vulnerability on the part of the patient's family as well as our staff. Recognizing this helped us to move forward and allowed us to focus on the human aspect of this adverse event.
- Benefit to staff: There was value in the transparency for the members of our staff. It allowed key employees to apologize and grieve with the family and forgive themselves for what had happened.
- Family contribution: We found that this family provided valuable insight into our systems and ways that they could be improved.
- Establish a single contact person: Risk Management had established a close relationship with this family at an early stage and it was therefore appropriate for this individual to be the contact person for the family.
- Have key people in attendance: Even though we had carefully arranged schedules and reminders, the patient's physician was unable to attend due to a difficult extended surgery. This was very disturbing to the family and even though he was able to meet with family immediately following the meeting, they voiced afterward that it would have been better to have him present to provide support for them.

Rogue Valley Medical Center believes that we are making a healthy start toward improving both quality and safety through transparency. Your process may differ because of the personalities of people in each of your key roles, but it is worth taking the step. We also recognize that involvement is not appropriate for every family and some may decline participation. For our part, we plan to extend the invitation whenever we can.

Bobbi Higgins, Risk Management Supervisor  
Rogue Valley Medical Center