Communication and Resolution Program Certification

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The Value of Collaboration to Improve Patient Safety after Adverse Events

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Despite the best efforts of healthcare professionals, systemic faults leave a chance that a medical error may occur. Adverse events where a patient is unintentionally harmed during their care can be dangerous, leading to injury or even death. Medical errors are preventable and may require systems change to reduce the risk of harm to future patients.

Over the years, momentum has been building for the adoption of a "Just Culture" in healthcare. In the Institute of Medicine's groundbreaking report, To Err is Human, the report found that the most effective way to reduce errors and enhance safety in high-risk industries is to not blame individuals. Instead, a cultural shift that promotes transparency, creates a safe environment for reporting errors, identifies the root causes, and takes action to prevent future errors can take patient safety measures to new heights.

The fear of harsh disciplinary actions can prevent healthcare workers from reporting errors made by themselves or their colleagues. However, Just Culture recognizes that medical errors often involve competent providers working in flawed systems. Just Culture replaces hostility with a team-oriented process that encourages open error reporting, responding to mistakes with enhanced training and supervision, and a drive to learn from medical errors. Communication and Resolution Programs (CRPs) provide a framework for organizations to activate Just Culture principles and contribute to state-wide learning from adverse events.

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Communication and Resolution Programs

CRPs promote a patient-centered response to adverse events. When a patient is harmed by medical care, the patient should be informed of exactly what happened, the steps that will be taken to address the event and ensure that it will not happen again. The use of CRP is a significantly different approach to handling medical error than the traditional procedure of secrecy, denial, and defensiveness.

After an adverse event, the primary things patients want are an honest explanation of what happened and a compassionate apology. Reflecting Just Culture, CRPs are characterized by transparent and prompt communication; apologizing; meeting the needs of involved patients, families, and providers; a rapid investigation of what led to the adverse event; proactive resolution; collaboration across all involved stakeholders; and system-level changes to prevent the error from happening again. In this process, CRPs save space for these important conversations to occur in order for patients to maintain a positive relationship with their provider and for organizations to improve their quality of care.

The Foundation for Health Care Quality, the Commission, and CRP Certification

The Foundation for Health Care Quality (FHCQ) is a nonprofit organization that administers quality improvement programs, including CRP Certification. With CRP Certification, FHCQ has gathered a neutral, non-judgmental panel of patients, patient advocates, physicians, surgeons, risk managers, attorneys, and other healthcare stakeholders to create the CRP Review Panel. This panel will review submitted adverse events to "certify" if the organization's response was aligned with the essential CRP principles. Organizations can apply for CRP Certification once the CRP event is complete. At the end of the CRP Certification process, applicants will receive feedback from the review panel summarized in a report with a determination of certified, not certified, or certified with contingency.

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It is important to note that CRPs do not tolerate recklessness or intentional disregard of safe practices. If evidence suggests that the provider(s) involved participated in unprofessional or unethical behavior, the event is not eligible for CRP or CRP Certification.

One benefit of undergoing the CRP Certification process is FHCQ's partnership with the Washington Medical Commission. If a complaint regarding the CRP event is filed with the Commission and the event has been certified by the CRP Review Panel, the CRP Certification report can be submitted to the Commission and will be combined with their investigation. If the Commission determines that the CRP process has thoroughly enhanced patient safety, the Commission may close the case as satisfactorily resolved.

Within the CRP Certification umbrella is CRP Validation. CRP Validation is a process that happens before CRP Certification and presents organizations with the opportunity to receive real-time feedback of their CRP response. CRP can be complex and challenging. For this reason, the review panel will be available to provide support, troubleshoot challenges, answer questions, and create additional opportunities for organizations to contribute to shared learning.

Learning from medical errors is crucial to improving patient safety. To facilitate and enhance learning, the Commission and FHCQ are committed to collaborating and developing a state-wide system to disseminate lessons learned from medical error cases to the healthcare community. To advance this work, it is encouraged for all institutions, clinics, and practices in Washington to join in the effort to encourage open communication, reduce medical error and improve patient safety through CRP. To learn more about CRP, CRP Certification, and how to apply, visit our website.

To learn more about this topic - Join us for a webinar "The Value of Collaboration to Improve Patient Safety after Adverse Events" February 7, 2024 11:00 AM PST