PATIENT SAFETY CONFERENCE

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Chief Concern

86-year-old male with PMH proteinuric CKD4, presumed IgA nephropathy, HTN, HLD, and sinus bradycardia who was referred to the ER by outpatient nephrologist for initiation of dialysis

History of Present Illness

- Patient had multiple admissions and ER visits for complications of CKD, such as hypervolemia, pericardial effusion, pruritis 2/2 uremia, fatigue
- Follows with many providers at UCSD (allergy, dermatology, nephrology, family medicine)
- Many outpatient and inpatient notes comment on language barrier and hearing loss resulting in poor communication

“The language barrier and being hard of hearing made his understanding of what was happening very difficult with prior hospitalization”

“Difficult communication as patient is extremely hard of hearing and has trouble understanding MARTTI interpreter”

“Initially, it was thought that he only understood a certain dialect of Mandarin, but we eventually communicated well with the help of team members who speak Mandarin and with an electronic translation app”

“His wife's caregiver was able to come to the bedside a few times to help translate, although her English was not great, at least patient could hear her and understand more using the MARTTI”

History of Present Illness

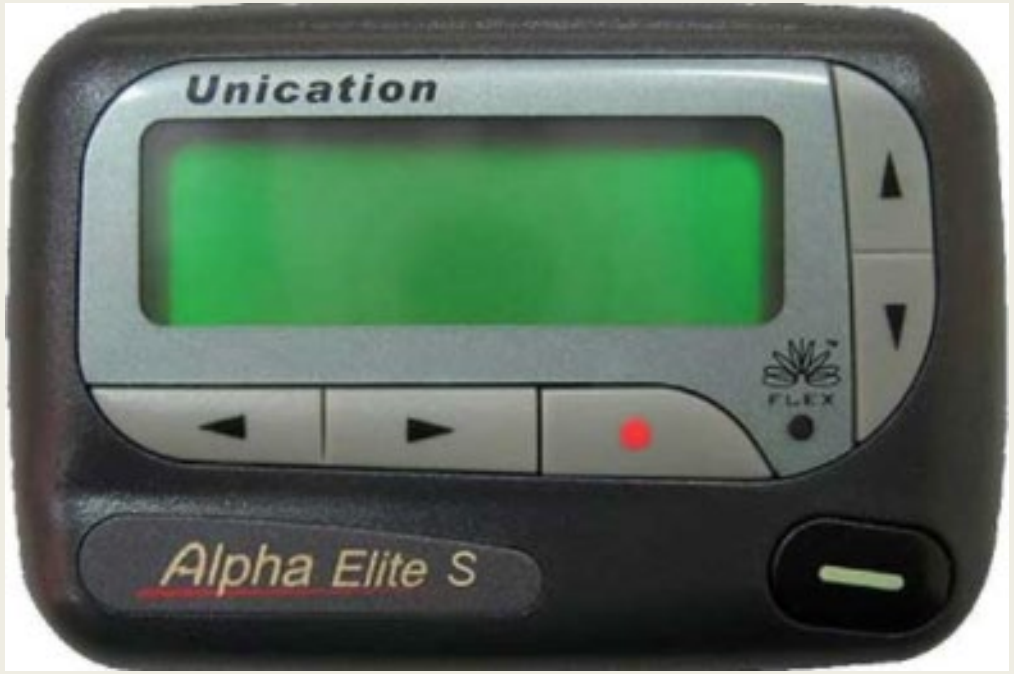
- Notes also comment on how patient was encouraged to bring “English-speaking family member to appointments” due to poor communication even with MARTTI
- Family member brought to appointments was usually patient’s daughter (healthcare proxy)
- Goals of care conversations regarding dialysis held inpatient and outpatient, which commented on reservations with dialysis (reservations not elaborated on)

History of Present Illness

- On day of presentation to ER, patient had appointment with nephrologist, in which worsening pericardial effusion and uremic symptoms noted
- That day, the internal medicine resident rotating through nephrology clinic happened to be fluent in Mandarin and English, so she saw the patient
- Lengthy discussion was had regarding dialysis vs hospice treatment
- Per attending note, this particular visit/conversation was the ”most productive ever had”. Patient opted for dialysis and thus was referred to ER for initiation

Back to the hospital…nephrology fellow gets a page

- Nephrology fellow: Can you see this patient and consent him for dialysis?
- Me: Sure!



Reviewing the chart

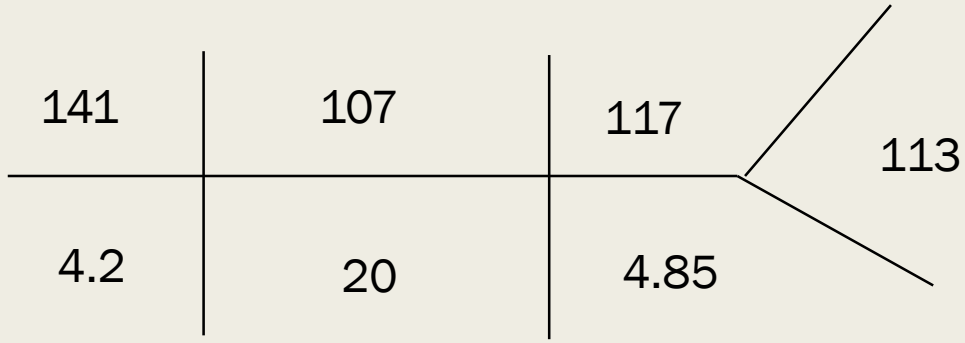
- PMH
  - *Proteinuric CKD4 (received short-term dialysis in China at some point)*
  - *Presumed IgA nephropathy*
  - *HTN*
  - *HLD*
  - *sinus bradycardia*
  - *Carotid artery stenosis*
  - *Pericardial effusion (recent diagnosis)*
- Allergies: None per chart
- Social History:
  - *Former smoker, quit in 2012*
  - *No alcohol or drug use*
  - *Lives with wife and caregiver, daughter is healthcare proxy*

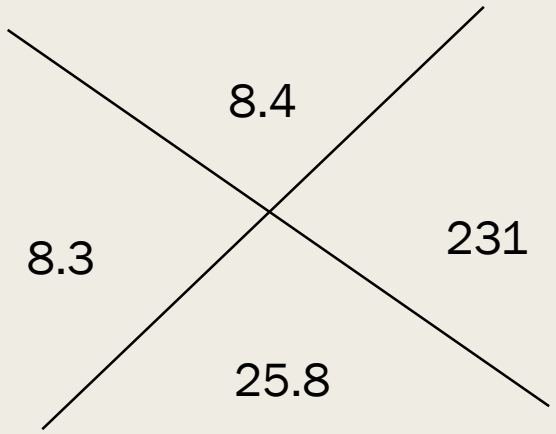
Medications

- Allopurinol 100 mg daily
- ASA 81 mg daily
- Atorvastatin 10 mg daily
- Bumetanide 2 mg BID
- Carvedilol 6.25 mg BID
- Cetirizine 10 mg daily
- Darbepoetin alfa (40 mcg) qweekly
- Hydroxyzine 25 mg PRN for itching
- Nifedipine 60 mg qAM and at bedtime

More info

- Vitals:
  - *Temp 98.1*
  - *HR 75*
  - *BP 160/52*
  - *SpO2 95% on room air*





Physical exam

- Gen: NAD
- HEENT: NC/AT, MMM, PERRL, Anicteric sclera, no conjunctival injection
- Neck: Neck supple. No thyromegaly. No JVD
- Cardiac: RRR, no m/r/g. No friction rub
- Lungs: Crackles at bases bilaterally but no wheezing, rales, rhonchi
- Abd: soft, non-tender, non-distended. Bowel sounds normoactive
- Extremities: 2+ pitting edema up to thighs. DP pulses intact
- Skin: Xerosis of the skin but no rash present

The consent process

- Consent is required for:
  - *Any new iHD*
  - *Any new peritoneal dialysis*
  - *Any NEW CRRT*
  - *Any existing dialysis patient with no consent in the chart for the past 30 days*
  - *Of note, consent forms provided in English and Spanish but no other languages readily available*

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CONSENT TO HEMODIALYSIS INTERMITTENT OR CONTINUOUS

Patient Identification

1. Your doctors have recommended the following procedure:

Hemodialysis Intermittent or Continuous and the possible administration of anesthesia. If anesthesia is requi
anesthesia and its associated risks will be discussed with you by an anesthesiologist.

STOP

PROVIDER(S): ***Listing of material risks discussed with patient AND other comments as applicable:*** *(Informed*

I understand hemodialysis involves pumping my blood through a filter to remove waste products while my kidneys
working correctly. The doctors may have to use blood thinners to keep my blood from clotting in the filter. I under
the procedure may be either continuous or intermittent as my condition warrants. I understand that dialysis provic
limited replacement of kidney function. It will not heal my kidneys. Possible complications include, and are not lim
the following: Bleeding from disconnection of tubes, bleeding from use of blood thinners, some loss of blood from
in the filter, air entering my veins from failure or disconnection of tubes, infection, drop in blood pressure, and irre
heartbeats. I understand that I could suffer injury or death as a result of these complications. I further understand th
procedure may fail because of technical problems involving the dialysis catheter or low blood pressure.

☐ ***OR, see informed consent discussion in progress note of _____ /_____ /_____ (date)***

Your procedure will be performed by: _____, Attending Physician
associates.

If there is an emergency during your procedure, your doctor may have to provide additional care or do more proce

2. All procedures carry the risk of unsuccessful results, complications, injury, or even death, from both known and ur
causes. No guarantee is made as to a result or cure. You have the right to be informed of:
   a. The nature of the procedure, including other care, treatment or medications.
   b. Potential benefits, risks or side effects of the procedure.
   c. The chance of reaching your treatment goals.
   d. Reasonable alternatives to the procedure and relevant risks, benefits and side effects related to such alternati
   including the possible results of not receiving care or treatment.
3. If there is a reasonable possibility that you may require a blood transfusion, your doctor will tell you and give you
information about the benefits and risks of the various options for blood transfusion. If a blood transfusion is likel
will be asked to sign a separate blood transfusion consent form. ***If you are unwilling to receive blood produ***
should discuss this with your doctor prior to your procedure.
4. You have the right to give or refuse consent to any proposed procedure at any time before it happens.
5. You authorize the pathologist(s) to choose whether to keep, use or dispose of any specimens (bodily fluids, blood
components) removed during your procedure. You understand that you have no property ownership or interest in s
specimens or data derived from those specimens and no right or entitlement in any research or research product u
derived from the specimens.
6. You understand that as a part of its teaching mission, UC San Diego Health (UCSDH) may permit the viewing of th
procedure, use of closed-circuit television, taking of photos (including video), and drawing of pictures. The films, p
and drawings may also be used to document your care. Use (for reasons other than to document your care) or disc
films, photos or drawings that identify you will not be allowed unless UCSDH gets your or your representative's pe
7. You consent to the possible presence of a vendor's (product) representative, who may be in the room at the time c
procedure.
8. Your doctor (or licensed provider) may have a financial interest(s) with a company that makes a product intended t
in your procedure. You may request more information about financial interest(s) that may exist at the time of, or p
your agreeing to the procedure.

UC San Diego Health

CONSENT TO HEMODIALYSIS INTERMITTENT OR CONTINUOUS

Patient Identification

PATIENT SECTION CONTINUED

STOP

9. Your signature on this form means:
   a. You have read and understand the information given in this form.
   b. Your doctor has explained the (1) procedure; (2) associated risks, benefits and alternatives; and (3) other written information in this form.
   c. You have had a chance to ask your doctor(s) about any financial interests related to the proposed operation or procedure.
   d. You discussed your resuscitation wishes with your doctor(s) and you disclosed your preferences.
   e. You further understand that the explanations you have received may not be exhaustive and all-inclusive and that other more remote risks may be involved; however, the information that you have received is sufficient for you to consent to the operation or procedure described above. You have had full opportunity to ask questions concerning your condition, the authorized operation(s) or procedure(s), the alternatives, and the risks and consequences associated with it. All of the questions you have asked have been answered to your satisfaction.
   f. You agree to have the procedure.

STOP

10. It is presumed that, in the event of an emergency during your procedure that it is your wish is to be resuscitated.
    If you **DO NOT** wish to be resuscitated, please initial here: _____ Date: _____ Time: _____ AM / PM

STOP

11. **I do not wish to receive blood products/transfusions.**
    Initial here: _____ Date: _____ Time: _____ AM / PM

_____ Date: _____ Time: _____ AM / PM
Patient or Patient's Representative Signature

Relationship to Patient: _____ Reason for non-patient signature: _____

_____ _____ Date: _____ Time: _____ AM / PM
Witness Signature Witness Print Name

If Interpreted: _____ _____ Date: _____ Time: _____ AM / PM
☐ Telephonic ☐ Video Interpreter **OR** ID# Language

The consent process

- Did not go smoothly
- Patient looking for hearing aids, eventually found
- Patient very fixated on the on his limited trial of dialysis in China
- Interpreter was getting frustrated because patient would speak for 5-10 minutes before pausing for interpreter to translate
- Spent ~50 minutes with the patient but still left with uncertainty
- I left thinking: Does he really understand what just happened? What could I have done better? What resources does UCSD have in place for language barriers?

Categories of Errors

- Diagnostic
- Treatment
- Preventative
- Other
  - *Failure of communication*
  - *Maybe equipment failure?*

Safety Assessment Code

Probability/Severity	Catastrophic	Major	Moderate	Minor
Frequent	3	3	2	1
Occasional	3	2	1	1
Uncommon	3	2	1	1
Remote	3	2	1	1

Impact of language barriers on patient safety

- According to the 2000 Census, over 20 million people in the USA are limited English proficient (LEP)
- 1990 and 2000, the LEP population grew by one-third, from 6.1 to 8.1%
- In a study done in 2007, in which they examined differences in the characteristics of adverse events between English speaking patients and patients with limited English proficiency in US hospitals

Impact of language barriers on patient safety

- About 49.1% of limited English proficient patient adverse events involved some physical harm whereas only 29.5% of adverse events for patients who speak English resulted in physical harm
- Of those adverse events resulting in physical harm, 46.8% of the limited English proficient patient adverse events had a level of harm ranging from *moderate temporary harm* to *death*, compared with 24.4% of English speaking patient adverse events
- The adverse events that occurred to limited English proficient patients were also more likely to be the result of communication errors (52.4%) than adverse events for English speaking patients (35.9%)

Limited health literacy and hearing loss

- In a study conducted in 2020, adults ages 65 and older completed a health survey that was linked to his or her medical claims
- Seven percent reported low health literacy (LHL) and 41% reported hearing loss
- Hearing loss, especially unaided severe, was associated with LHL
- People with aided severe hearing loss and LHL had higher annual medical costs than those with adequate health literacy

Alterations within medical interpretation

- LEP patients are often less satisfied with their healthcare when compared with patients who speak English as a first language
- However, there is evidence of important limitations in medical care for patients with LEP even if that care is provided with the aid of medical interpreters
- In a study published in 2008, they looked at family conferences in the ICU that occurred with families of patients with limited English proficiency requiring a medical interpreter
- Categorized the alterations

Table 3

Frequencies, average number per conference, and average number across conferences of first and second tier codes.

Code	# of Alteration Codes	# of Conferences with these Alteration Codes (n=10)	#Alteration Codes per Conference
TYPE OF ALTERATIONS			
Addition	20	7	2
Omission	100	10	10
Substitution	65	9	6.5
Editorialization	137	10	13.7
POTENTIALLY CLINICALLY SIGNIFICANT ALTERATIONS			
INFORMATION			
Positive alterations	16	6	1.6
Negative alterations	129	10	12.9
TREATMENT DECISIONS			
Negative alterations	157	10	15.7
EMOTIONAL SUPPORT			
Positive alterations	5	3	0.5
Negative alterations	23	8	2.3
RAPPORT			
Positive alterations	6	5	0.6
Negative alterations	24	8	2.4

Examples

Potentially positive alteration

MD: I don't know what else to say to you. I mean, I told you yesterday that he's essentially brain dead. I don't know what you expected from that. I also said yesterday that there's no recovery from this.

Interpreter (translating) I told {you} that his brain was dead and it wasn't going to recover.

- Sounds less confrontational

Potentially negative alteration

MD: The problem with this option is that he may have to stay on this machine for the rest of his life.

Interpreter (translating) But the problem with this option is that he will have to stay on this machine for the rest of his life.

- The substitution of of one word ("may" vs "will") changes the everything!

MD: Does that sound like a good plan to you? Do you have any more questions?

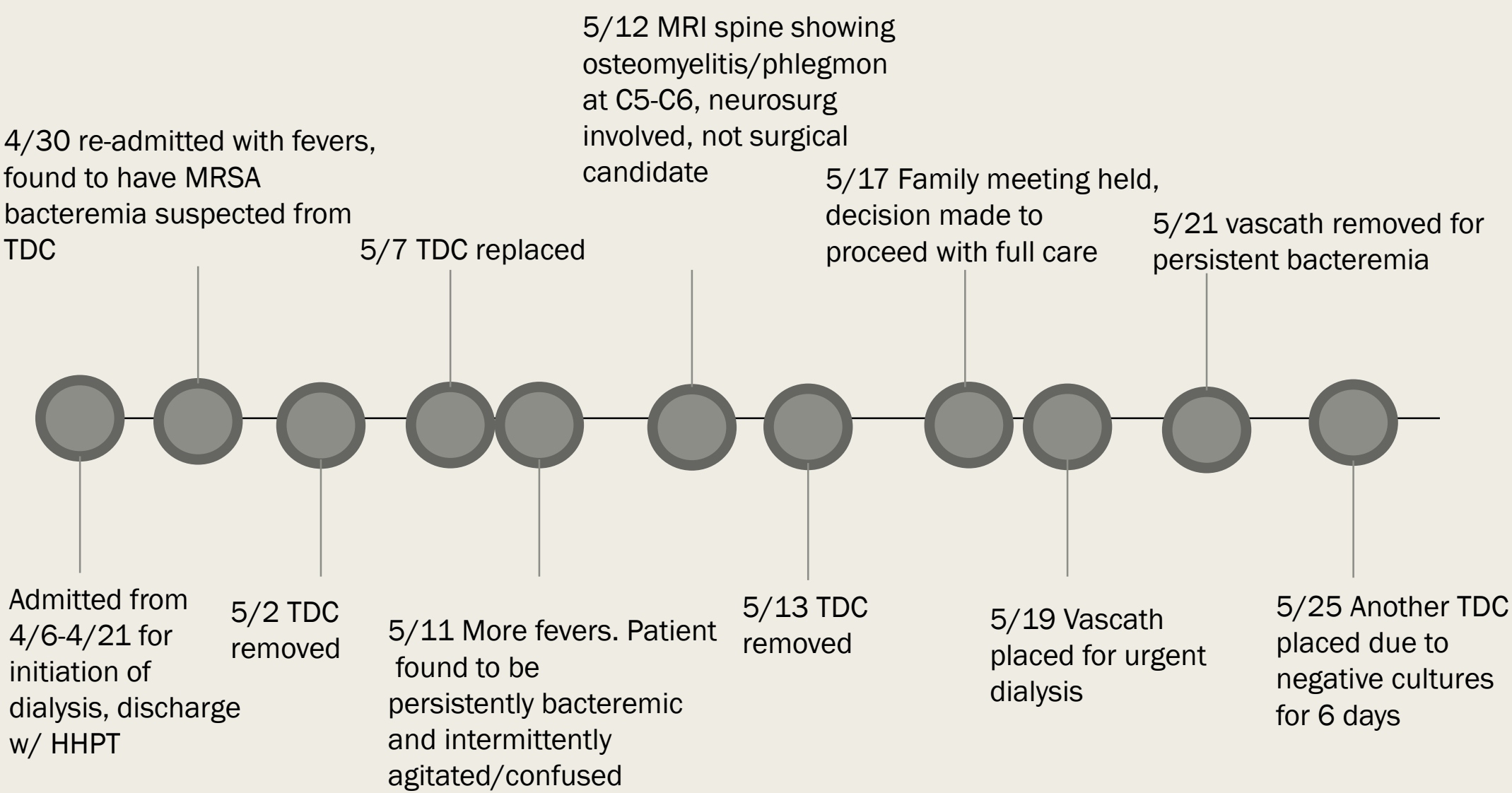
Interpreter (translating) Do you agree?

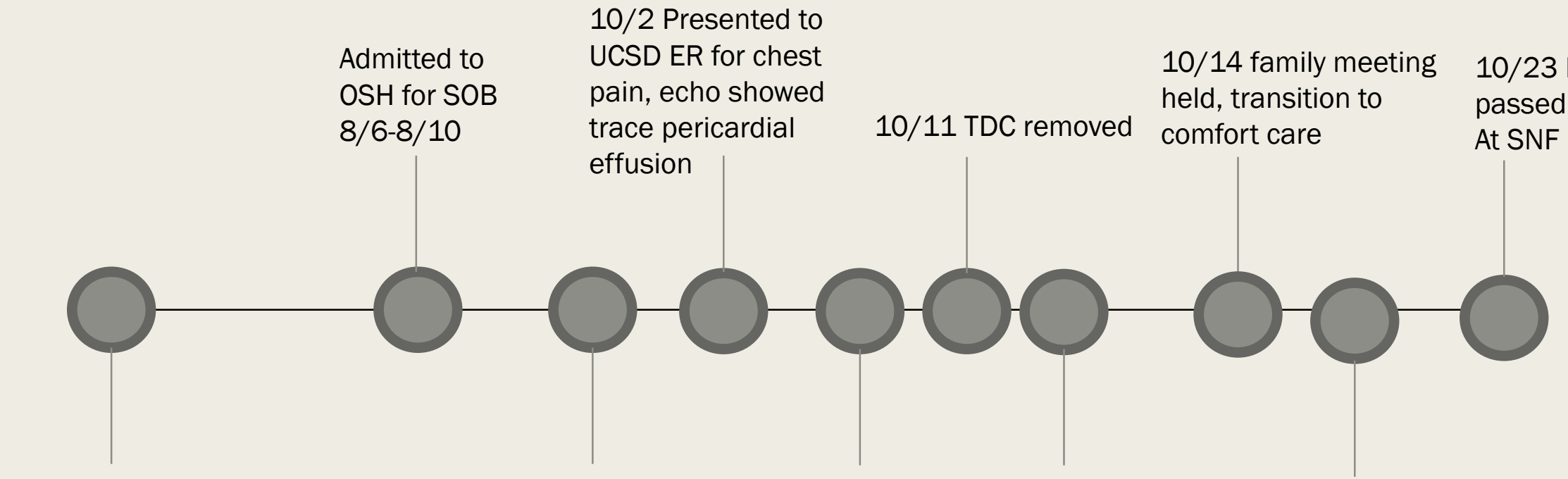
- The interpretation sounds less open ended

Back to our patient

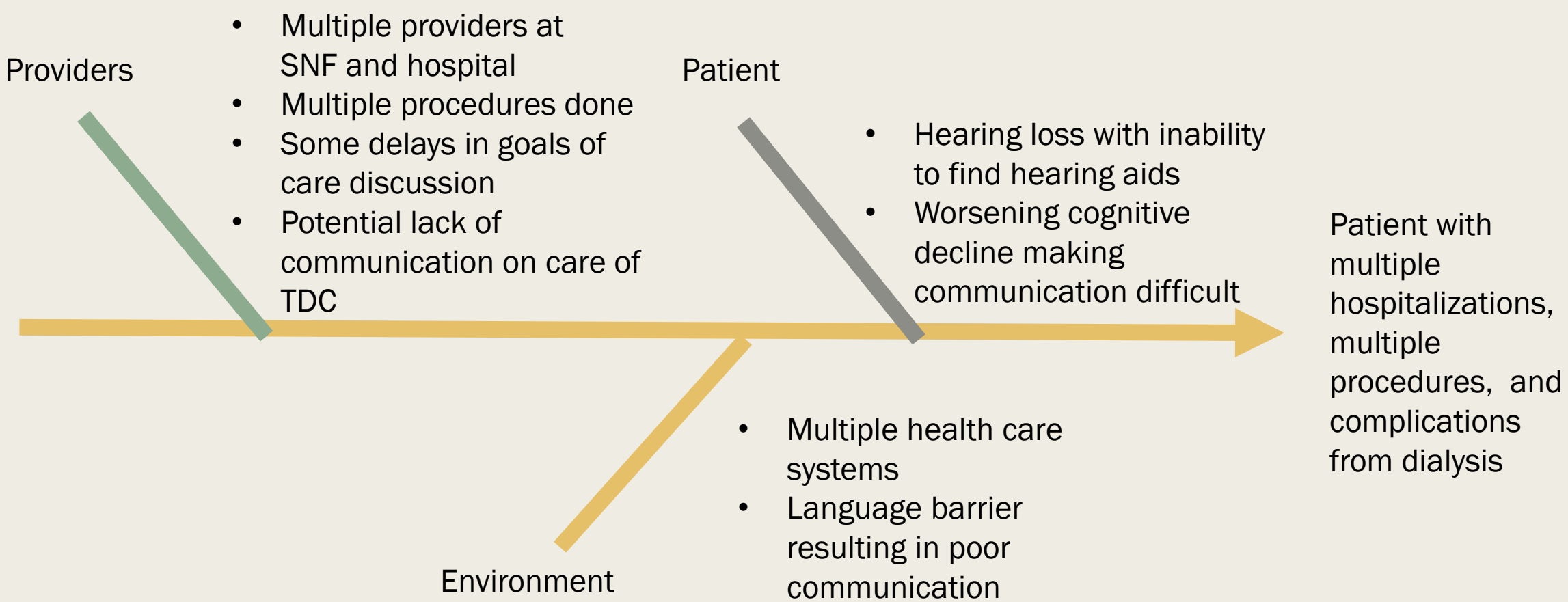
- Patient consented for dialysis, underwent tunneled catheter placement with IR
- Started dialysis and seemingly tolerated well, discharged once dialysis center found

BUT…


Admitted from 4/6-4/21 for initiation of dialysis, discharge w/ HHPT
4/30 re-admitted with fevers, found to have MRSA bacteremia suspected from TDC
5/2 TDC removed
5/7 TDC replaced
5/11 More fevers. Patient found to be persistently bacteremic and intermittently agitated/confused
5/12 MRI spine showing osteomyelitis/phlegmon at C5-C6, neurosurg involved, not surgical candidate
5/13 TDC removed
5/17 Family meeting held, decision made to proceed with full care
5/19 Vascath placed for urgent dialysis
5/21 vascath removed for persistent bacteremia
5/25 Another TDC placed due to negative cultures for 6 days


6/6 Discharged to SNF with plan to continue IV Daptomycin for 6 weeks (until 6/28)
Admitted to OSH for SOB 8/6-8/10
Admitted to OSH unclear reason 8/23-8/30, discharged to SNF
10/2 Presented to UCSD ER for chest pain, echo showed trace pericardial effusion
10/7 Febrile. Found to be bacteremic again with MRSA
10/11 TDC removed
10/12 MRI spine survey showed extensive osteomyelitis (C and T spine) and multiple epidural and paravertebral abscesses. Multiple services involved
10/14 family meeting held, transition to comfort care
10/15 Discharged to SNF with hospice
10/23 Patien
passed away
At SNF

Root Cause Analysis



Medical interpretation resources at UCSD

- Services include: in-person, telephone, and video
- Telephone and video are 24/7
- In-person interpreters for Spanish available M-F 8:00 AM-4:30 PM
- For in-person interpreter for languages other than Spanish, request must be submitted at least 48 hours in advance. Unclear if there are language limitations
  - *Form located on pulse website (pulse.ucsd.edu)*

Discussion

- Would this patient have undergone dialysis if he had a Mandarin-speaking provider? (interestingly, he did decide to start dialysis the day that he had a Mandarin-speaking provider)
- Are there any other resources at UCSD for LEP and their families?
- What more can we do as physicians to help with language barriers?
- Is there any standard protocol for prognostication prior to initiation of dialysis?
- There was some concern of cognitive impairment (but potentially thought to be 2/2 uremia). Was he every formally assessed?

QUESTIONS

THANK YOU!

References

1. Divi C, Koss RG, Schmaltz SP, Loeb JM. *Language proficiency and adverse events in US hospitals: a pilot study.* Int J Qual Health Care. 2007 Apr;19(2):60-7.
2. Wells TS, Rush SR, Nickels LD, Wu L, Bhattarai GR, Yeh CS. Limited Health Literacy and Hearing Loss Among Older Adults. *Health Lit Res Pract*. 2020;4(2):e129-e137.
3. Pham K, Thornton JD, Engelberg RA, Jackson JC, Curtis JR. *Alterations during medical interpretation of ICU family conferences that interfere with or enhance communication.* Chest. 2008 Jul;134(1):109-16.