Reporting and Disclosing Adverse Events

Objectives

- Review definition of errors and adverse events.
- Examine the difference between disclosure and apology.
- Discuss the recognition of and care for “second victims” of medical error.

Adverse Event

- Key Terms:
  - Adverse event or incident: negative or unexpected results.
  - Adverse drug reaction: A noxious and unintended response to a medicinal product.
- Not all adverse events are due to error.

Event

- Key Terms:
  - Medical error: error by physician or team.
  - Medication error: A preventable event that may cause or lead to inappropriate medication use or patient harm.
- Several different types of errors, including:
  - Errors of planning.
  - Errors of execution.
  - Commission vs. omission.


1. Report
2. Assess
3. Disclose

Reporting Events or Incidents

Who?

- Reporters: any and every hospital staff member.
- Reported to: Quality, Safety and Risk Management departments and Administration.

When?

- As soon as possible after event occurs and situation is stabilized.

Why?

- Identify sentinel events.
- Signal trends.
- Help allocate needed resources.
- Help avoid similar events.

Reporting Events or Incidents

What?

- Sentinel Events
- Adverse drug events (reactions)
- Medication errors
  - Wrong drug or dose administered
  - Failure to administer drugs as prescribed
- Blood product complication
  - Wrong blood product given to patient
- Falls
- Safety concerns
- AMAs
- Hospital-acquired infections
- Disruptive or violent behavior (patient or staff)
- Resource or organization problems
- Equipment malfunction
- Procedure complications

See Something,
Say Something.

Joint Commission, www.jointcommission.org and
de Feijter JM, *et. al*, PLoS ONE February 2012;7(2):e31125.

Reporting Events or Incidents

Interim LSU Hospital (ILH)

- Voicemail: (504) 903-SAFE (7899)
- Email: ILHSafe@lsuhsc.edu

Questions? Contact Quality Department – 903-4925 or 903-3665

Children's Hospital

- Voicemail: ext. 2727
- ASAP@chnola.org
- Paper Safety Report
  - Forward to QA/QI Office

How?

- Each member of the team hierarchy should take responsibility for reporting an incident.

Our Lady of the Lake (OLOL)

- Patient Safety Speak Up Hotline: (225) 765-1734
- Online: Quantros
  - LakeLink >> "Applications"
  - Use OLOL username and password
- Compliance Hotline: (888) 400-4517
  - Or FMOLHSintegritylink.com

Reporting Events or Incidents

- What happens to reports?
  - Performance Improvement (PI) receives email/phone notification.
  - PI Analysts enter incident into Risk Plus.
  - Follow-up by PI Analysts.
  - PI Analysts send email to reporting physician(s) with copies to hospital and hospital center administrators.

Reporting Events or Incidents

- Only *54%* of residents reported their most significant error of the previous year with the attending.
  - Residents who accepted responsibility for their errors and disclosed them were more likely to report constructive changes in their practice.
- Residents discussed the error with family members in only *24%* of cases.
  - Of the errors reported – *90%* had an adverse outcome, *31%* resulted in death.

Wu A, Folkman S, McPhee S, Lo B. *Qual Saf Health Care* 2003;12:221-227.

Reporting Events or Incidents

- Challenges:
  - Learn from incident reports.
  - Disseminate lessons learned.
  - Leadership and follow-through to make necessary changes.
- New culture:
  - Move away from “shame and blame.”
  - Open reporting (including residents and fellows).
  - No retaliation.
  - Standardized peer reviews and root cause analyses.
  - Close the feedback loop on error reports.

Hastie IR and Paice E. *Qual Saf Health Care* 2003;12:227-228.


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Disclosing an Adverse Event

- What to do:
  - Be honest, fearless – and don't blame.
  - Think multifactorial – "system" rather than individual.
  - Reward positive contributors to change.
  - Participate in prevention efforts.
  - Read, stay informed, innovate.
  - Educate others.
- Patients need:
  - To know what happened.
  - To hear a sincere apology.
  - To know what is being done to prevent a reoccurrence.

Disclosing an Adverse Event

- BEFORE disclosure:
  - Consult with Risk Management and insurance carrier.
  - Establish the facts of the event.
  - Evaluate patient and family's readiness, health literacy and cultural issues.
  - Address patient privacy needs and concerns.

Disclosure vs. Apology

Disclosure is ethically correct and required by some regulatory agencies.

Disclosure

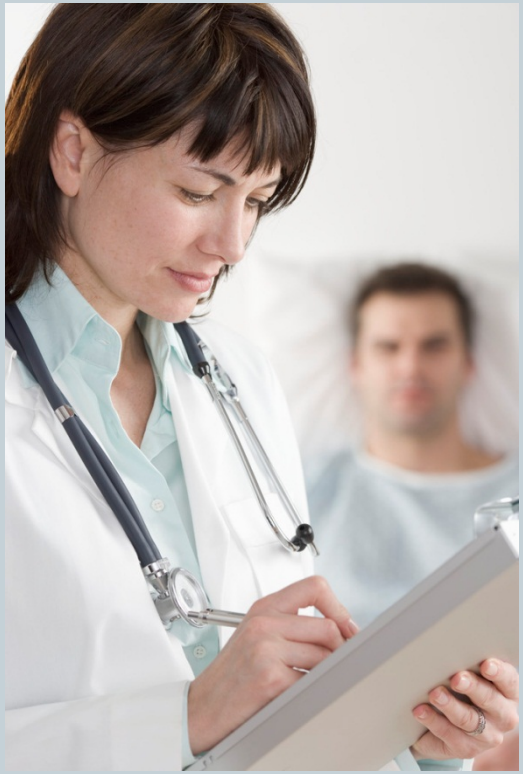
Providing information to patient and/family about an incident while conveying a sense of openness and reciprocity.

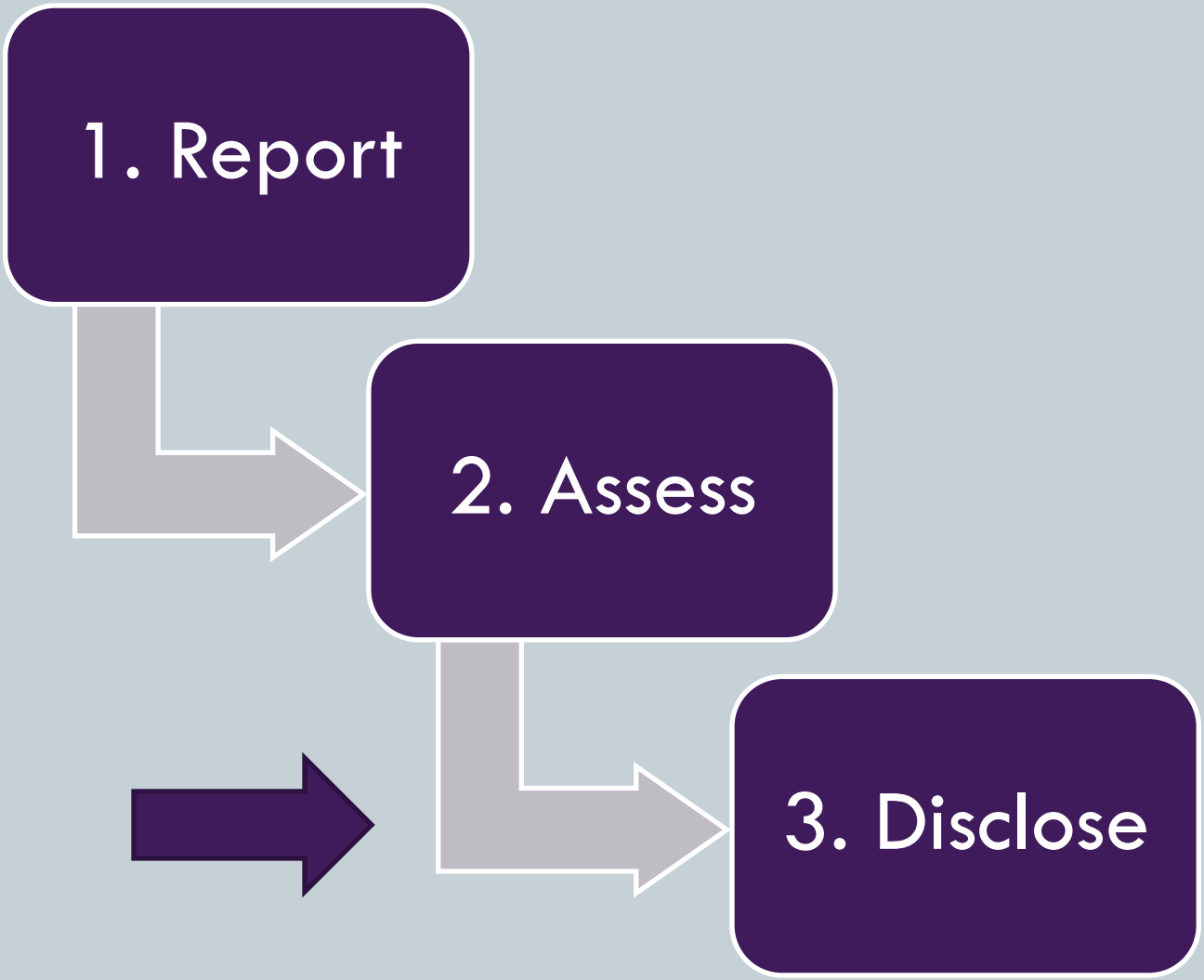
Apology

Acknowledgement of responsibility for an event coupled with an expression of remorse.

Disclosing an Adverse Event

- Common barriers:
  - Deficiencies in communication skills.
  - Lack of training in disclosure.
  - Culture of infallibility.
  - Fear of litigation, disciplinary action, sanctions.
  - Fear for professional reputation.
  - Fear of scapegoating, retribution.

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Disclosing an Adverse Event

1. Determine appropriate time, location for meeting with family.
   - Organize a team meeting prior to disclosure.
2. Coordinate who should speak with patient or family.
3. Speak honestly and straightforwardly.
   - Don't use jargon.
   - Establish plans for follow-up communications.
4. Support emotional well-being of patient and care team.
5. Document disclosure conference in medical record.
   - Report incident per organizational procedure.

The Second Victim

- First victim: patient.
- Second victim: Physician/health care professional who makes a mistake.

- 3-fold increase in depression.
- Increased burnout.
- Decreased quality of life.
- Increased anxiety.
- Loss of confidence.
- Sleep disturbances.
- Reduced job satisfaction.
- Substance abuse.
- Inhibited learning.
- Fear – reputation, license suspension, litigation.

Albert Wu BMJ 2000.

The Second Victim

Classical Approach

- Name/Blame/Shame Game.

Safety Approach

- Focus on Prevention.
- Accept responsibility.
- Understand error event.
- Need for support not a sign of weakness.
- Discussions with family and colleagues.
- Participation in disclosure.

Wu AW et al. West J Med 1993; 159:565-569;
www.webmm.ahrq.gov Jan 2008.

The Second Victim

- Recognize need to support entire team.
- Avoid conspiracy of silence.
- Encourage peers to share their stories.
- Understand guilt associated with medical error.
- Eliminate culture of shame and blame.
- Reject notion of physician infallibility.

The Second Victim

- Conferences useful if framed differently.
  - Morning report
  - M&M conferences
  - Performance improvement
  - Peer review
  - Root Cause Analyses
- Role modeling.
- Error acknowledgement – system and individual.
- Attention to personal impact, not just clinical.

Summary

- Not all adverse events are due to error.
- All hospital staff members – including residents and fellows – should report any and all incidents and safety concerns.
- Patients and families should be told of adverse events or incidents.
- Second victims of medical error – team members involved in the case – should be supported and helped.

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