UCSF Benioff Children's Hospital Oakland

UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND

NEVER WORRY ALONE

A TOOLKIT FOR ADVERSE EVENTS/OUTCOMES

These tools were created by the combined efforts of a UCSF Benioff Children's Hospital Oakland QBI Kaizen Team in May 2014.

Thanks are extended to all those involved in this important improvement project.

For questions or additional information contact UCSF Benioff Children's Hospital Oakland Institutional Quality and Patient Safety at ext. 4784 or Risk Management at ext. 3455.

Communicating Serious Unanticipated Adverse Medical Events/Outcomes

Steps for Unanticipated Adverse Events

1. **Call Patient Safety Specialist On-Call 24/7**
   or activate a Patient Safety Stat per criteria

2. **Patient Safety Specialist Decides**
   - » Whether or not to call PS-STAT
   - » Crisis Management Team Activation or PSS
   - » AOC on-call as leader

3. **Crisis Management Team Huddles with Care Team**
   - » Decides how to deploy initial disclosure
   - » Use Toolkit

4. **Crisis Management Team/Care Team Decides Family Ongoing Contact Person(s)**

5. **Crisis Management Team/Care Team Identifies All Second Victims**
   - » Use Toolkit

6. **Post Event Actions (or activities)**
   - » Investigation by Patient Safety Team
   - » Ongoing Crisis Management Team support

UNANTICIPATED ADVERSE EVENT

- Stabilize patient, mitigate harm. Sequester any items used if death.
- Immediately notify RN supervisor and attending, if not already aware.

Tip/Reminders

» Not necessarily error; just not expected
» Attending should be informed prior to contacting Patient Safety Specialist

» If serious outcome proceed through all steps; if not, Patient Safety Specialist may arrange other follow-up as appropriate

» Say “What” not “Why.”
» Use “Act With Heart” tool as general guideline for what we do

» **Goal:** 24/7 availability for the family if needed

» Use assessment tool for second victim screening
» Take off duty ASAP, and schedule replacement(s)
» Do clinician de-briefing
» Offer support using “second victim support card” for guidance
» Review levels of support diagram; refer to EAP as needed

» RCA or other investigation as decided by Patient Safety
» Crisis Management Team makes decision regarding need for formal apology with disclosure.

What is an Adverse Event?

An adverse event/outcome can be:

» A complication—a known risk of the procedure that is not always preventable at the current state of medical knowledge

» A medical error—generally, a preventable adverse outcome.

Therefore, an adverse event is:

» The whole universe of negative outcomes of care

» An injury caused by medical care rather than the patient's underlying disease. May or may not be the result of a medical error.

What do you say?

» It depends on the situation, but supporting the family is always appropriate.

Apology/Disclosure Preparation Checklist for Attending/Leader

Initial Apology or Disclosure Communication:

Use BCHO **Adverse-Event Communication Tool ("ACT with HEART")**; review/ rehearse the following checklist prior to commencing any apology or disclosure whenever possible

» Report only the facts of the incident—what occurred, not how or why you believe the outcome occurred
» Disclose reliable information in a timely fashion as it becomes available
» Explain your recommendations for further diagnostics and therapeutics; attend to all medical needs of pt
» Explain the implications for prognosis if known, and tell them you will continue to update them

Who and How to Communicate

» A trusted caregiver should lead initial communication (usually attending), but the care team should also be there
» The person responsible for next steps in care should lead subsequent communication (if different attending)
» Include patient's primary nurse in communications
» Provide staff with coaching in communication techniques prior to disclosure (must rehearse at least once)
» Choose a quiet private area for all communication

Full Disclosure Communication

(Risk Manager and senior team including attending must agree in advance):

» Tell the patient and family what happened; present results of event analysis without using jargon, if possible
» Accept responsibility for event based on investigation if agreed by hospital and attending(s) involved
» Apologize once again with empathy, acknowledging the effect it may have had on the patient and family
» Explain what will be done to prevent future events
» Respond to patient questions
» Prepare "a priori" a response to questions about financial compensation

Follow-up Communication

» Assign one person as contact for family 24/7
» Conduct follow-up sessions promptly
» Primary attending or team members should lead sessions
» Involve CME or CEO in serious or difficult cases

General reference: When Things Go Wrong: Responding to Adverse Events, Harvard Hospitals

Adverse Event Communication Tool (ACT)
"Act with Heart"

HOW TO APOLOGIZE OR DISCLOSE

HEAR (and Listen)

"Has anyone spoken to you recently?"
"What do you understand about the current .....?"
"Do you have any questions?"
"What would you like to know?"

EMPATHIZE

"This must be very (or extremely) difficult"
"I can't even imagine how difficult this must be right now"
"Is there anything you need right now?"

APOLOGIZE for the Event
("Blameless" apology, until Risk consulted)

"We are sorry.. (event) happened (or is happening)"
"Again, I am so very sorry this happened to your child"

RESPONSE (if error)

"We take this ..(event)....extremely seriously. We want you to know we will conduct a full investigation and put measures into place to ensure this doesn't happen again."
[No "WHYs" yet, no blame]

THANK YOU

"Thank you for your patience/(or)/understanding"
"Thank you for letting us care for your child."

Discussion Points with Family

Patient Name _____ ☐ F ☐ M ☐ _____

Family Names

Mother _____

Father _____

Other _____

Culture/Language _____

What do we know?

_____

_____

Hx _____

Event _____

_____

Current status

_____

_____

What can we expect?

_____

_____

_____

Investigation (we will continue to care for your child)

_____

_____

Next steps and what we can offer for support

_____

_____

Questions

_____

_____

_____

Second Victim Assessment Tool

This tool is to be used to assess second victims following serious adverse patient safety events. It may be used by back up physician, chief residents, charge nurse, nursing supervisor, RT team leader.

Initial emotional assessment:

- What can we do for you?
- How are you feeling (nauseous, shaky, light headed, dizzy, blurry vision, headache)?
- Are you taking any regular medications?
- Who can we call for you?

After a period of about 30 minutes of quiet time, begin secondary assessment:

- Would you like to complete your shift, or would you like to be relieved?
- Assess transportation needs: if patient assessed not to be safe to drive, arrange alternate transportation
- Based on observation of team of responders, assess for immediate safety concerns:
  - Clear inability to function (tearfulness, shock, catatonia)
  - Perseveration
  - Suicidal ideation or other expressions of extreme anxiety or despair
- If any of the above situations exist, social worker should assess immediately and initiate appropriate referral. Social worker may utilize EAP hotline (1-800-834-3773) or other resources as indicated. Notify emergency contact.

Second Victim Support Card

DO:

- **Care for the patient** until patient medically stable and/or care handed off to another provider
- **Call for help** from a colleague
- **Document the facts** carefully in the medical record. Avoid speculation.
- **Recognize** that patient harm events can affect you, the caregiver. Take care of yourself.
- **Communicate** with family in a timely and truthful way.
- **Notify risk management** as well as your malpractice carrier if appropriate (physicians)

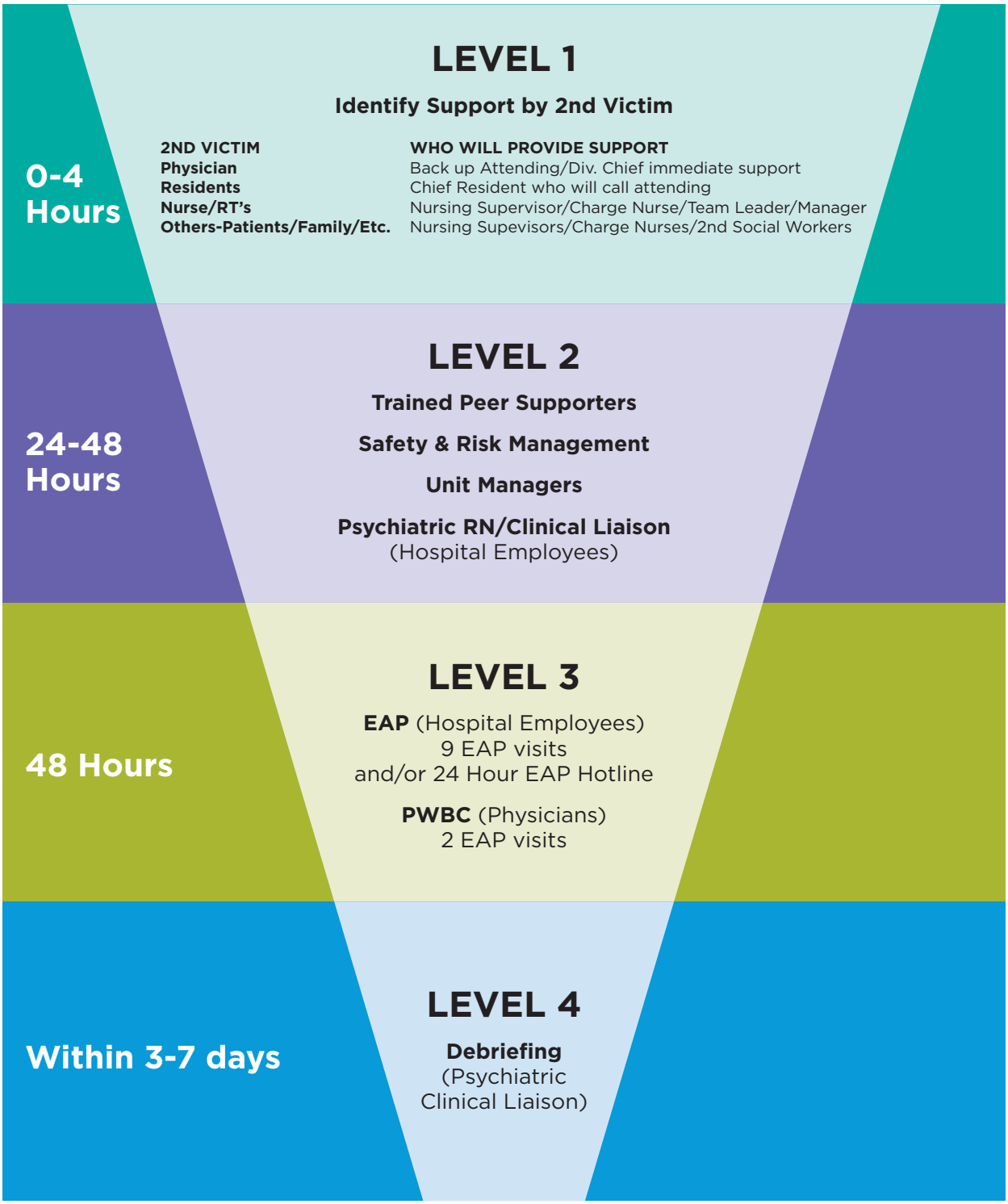
DON'T

- **Speculate or offer opinions** in the medical record about cause or culpability
- **Push yourself** to keep going. Stop working if you are upset, fatigued or otherwise not feeling 100%
- **Have conversations regarding the specifics of the case in the hallway, cafeteria, doctor's lounge or parking lot**

Who Can I Talk to?

- Discussions about specifics of the case are discoverable by the court except in certain situations. Speak about the specifics of the case only in the following forums or with the following individuals:
  - Your division chief, department chair or chief resident, in a scheduled medical staff meeting for that purpose (physicians)
  - Any other officially sanctioned medical staff forum, such as an official peer review meeting, root cause analysis (RCA) or with a member of the Physician Well Being Committee (physicians)
  - Hospital Risk Manager
  - Any debriefing held with mental health professionals at the hospital
  - Your spouse, clergy or mental health professional
- It's okay to talk about **HOW** you are feeling to peers, close friends, or family members.

Levels of Support for Second Victim



Apology & Disclosure

Medical Record Documentation for all providers

- Time, date and place of discussion
- Names and relationships of all present at meeting
- Nature and discussion of unanticipated event/outcome
- Offer and type of assistance and response to it
- Questions posed by patient, family or legally authorized representative, and answers by caregivers
- Consults with psychiatry, ethics committee per hospital policy
- All follow-up discussions to be documented as above

NOTES