

COMMUNICATING UNANTICIPATED ADVERSE OUTCOMES

Kaiser Permanente Statement of Principle

Patient care should be reliable, effective, and safe. Patient safety is every patient's right and every leader's, employee's and clinician's responsibility. It is an ongoing and relentless commitment to continuing to build safer systems. Despite constant and committed efforts to provide safe health care, from time to time, patients experience unanticipated outcomes that are adverse.

To fulfill our commitment to our patients, "Quality You Can Trust," we embrace our responsibility and acknowledge our ethical obligation to communicate with our patients when unanticipated outcomes have occurred. When such an outcome occurs, the patient, or the patient's health care representative, has a right to an explanation of the outcome and its effects, provided in a timely, truthful, and compassionate nature.

Human error and systems conditions periodically align and combine to contribute to unanticipated adverse outcomes for patients. The decisive factor will be the manner in which we handle these adverse outcomes. Patient safety and clinical welfare will be best served if we are honest about unanticipated adverse outcomes with our patient and open with our colleagues and ourselves, and if we handle such occurrences with sympathy and empathy for our patients and our colleagues.

Guidelines for Response to Unanticipated Events

It has long been recognized that medical care has the potential to result in anticipated adverse outcomes, and physicians have always had an ethical obligation to communicate with patients when such outcomes occur. Yet, communicating with patients about adverse outcomes can be a difficult and challenging process. This process should be guided by the following five principles:

1. Address the patient's health care needs immediately, as the patient's medical condition is the highest priority.
2. Communicate in a manner that is compassionate, honest, and timely.
3. Follow through on promises made to patients and/or their representatives and to members of the health care team.
4. Avoid casting blame to foster a mutually supportive environment where lessons learned and improved reporting enable better care delivery.
5. Create or sustain trust by providing patients with a truthful and understandable explanation of the event and how future occurrences will be prevented or minimized.

Response to Unanticipated Adverse Outcomes—Checklist

1. ADDRESS THE PATIENT’S HEALTH CARE NEEDS IMMEDIATELY, as the patient’s medical condition is the highest priority.
 - a. assess patient’s condition
 - b. determine what needs to be done immediately (consultations?, designating primary physician?)
 - c. give clear explanation of medical event to the patient and/or patient representative and discuss necessary clinical remedies or treatment options
 - d. communicate changes in care plan to health care team members

NOTE: The physician and members of the health care team should refrain from offering subjective information, conjecture, or beliefs relating to possible causes of the adverse event, if they believe that the root cause is apparent. Such discussion may be inaccurate and may further confuse the situation, complicating future communications.

2. COMMUNICATE about the unanticipated adverse outcome in a manner that is compassionate, honest, and timely.
 - a. PREPARE for the meeting:
 - During business hours, call the Med Legal Department at (503) 813-4835 or 49-4835
 - After hours and on weekends, page the Quality pager at (503) 904-8475
 - Develop a meeting plan: talking points, sequence of presentation, content and facts to be discussed
 - b. Plan WHO should be there:
 - Usually the responsible or attending physician handles the initial communication
 - Advisable to have at least one other person in the meeting, such as an administrative physician, health plan administrator, hospital administrator, etc.
 - c. Plan WHAT should be said:
 - Identify facts
 - Develop talking points
 - Discuss sequence of presentation
 - Anticipate questions and plan answers
 - Express sympathy and empathy
 - Offer support and counseling
 - Identify who will communicate or provide follow-up

NOTE: The following details should not be disclosed:

1. *Names and disciplinary actions;*
2. *Root cause analysis Materials or information;*
3. *Peer review materials or information;*
4. *Quality review materials or Information; and*
5. *Consultations with attorneys or legal information.*

- d. Plan WHEN meeting should occur:
 - As soon as possible
 - Consider patient's physical and emotional readiness
 - May require consent from patient to discuss with representatives
- e. Plan WHERE meeting should occur:
 - Consider safety for patient's clinical condition
 - Preserve privacy
 - Provide for comfort of participants
3. REPORT to appropriate entities, departments, leaders, following regional policies and procedures as outlined in KPNW Significant Event Management Policy, Risk Management procedure, and your usual chain of command.
4. DOCUMENT complete and accurate record of the clinical event and subsequent communication in the medical record.
 - a. Include objective details in neutral, non-judgmental language
 - b. Description of patient's condition prior to the event
 - c. Intervention and patient response
 - d. Notification of the attending physician
 - e. Information that was shared with patient and/or representatives following the event
 - f. If applicable, state in neutral terms why any information was withheld

NOTE:

- i. *Documentation in the medical record should not include speculation about causes or blame of individuals.*
 - ii. *Incident reports, event analysis, or notification of med legal department should NOT be included or referred to in the medical record in order to avoid waiver of privileges that attach to those documents and processes.*
5. After the initial discussion and throughout event analysis, MAINTAIN CONTACT and follow-up until closure.
 - a. Allow for ongoing discussions to provide information and identify needs and issues.
 - b. Manage health care needs of the patient
 - c. Address emotional responses of the patient and/or representatives
 - d. Follow through on promises made to patients and/or their representatives and to members of the health care team.
 - e. Create or sustain trust by providing patients with a truthful and understandable explanation of the event and how future occurrences will be prevented or minimized.
 - f. Manage patient's contacts with health care system to ensure timely and complete response.

6. Provide emotional and other SUPPORT to the health care team members involved.
 - Consider referrals to PAR (Physician Advocate Resource) or EAP (Employee Assistance Program)

NOTE: Avoid casting blame in order to foster a mutually supportive environment where lessons learned and improved reporting enables better care delivery.

What about apology?

Under Oregon and Washington law, a statement of sympathy or benevolence relating to pain, suffering, or death that are made to a patient or family member are inadmissible as evidence of an admission of guilt or liability.

For Example: “I am so sorry that you and your family have been through so much pain and worry since the surgery.”

By contrast, statements of fault which are part of, or in addition to, expressions of sympathy or general benevolence are admissible as evidence of liability in a civil lawsuit. Thus, unless one is absolutely clear that negligence has occurred (e.g.: surgery on the wrong limb), an expression of sympathy or benevolence should be used. In the event that clear negligence has occurred, it is appropriate to make an apology and document that you have done so in the medical record. In this case, you should first contact your supervisor or a quality or risk professional to discuss the event and develop a communication plan as above.

Training and resources

Training in communicating unanticipated adverse outcomes is now provided during KPNW New Clinician Orientation. For more information about these biannual courses, contact Fran Jackson in NWP CME at 503-813-2661, 49-2661.

Special sessions in communicating unanticipated adverse outcomes can be scheduled for departments or groups. For more information, contact Amy Lawrence, MD at 503-813-2290, 49-2290, or Rick Woods, MD at 503-813-4831, 49-4831.

Just in time training is available from risk management professionals in the med legal department during business hours. Confidential voice mail messages may be left at any time at 503-813-4835, 49-4835.

KPNW Patient Safety website:

http://internal.or.kp.org/patientsfty/tools-commun_unanticip_outcomes.htm

Permanente Federation national information about Communicating Unanticipated Adverse Outcomes (CUAO) and Situation Management:

http://kpnet.kp.org/permfed/Quality/risk_mgmt_CUAO_SMT.html