

# Communicating Unanticipated Adverse Outcomes to Patients

## I. Purpose

It has long been recognized that medical care has the potential to result in unanticipated 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.

The purpose of this policy is to support implementation of \_\_\_\_\_'s commitment to communicate with patients and/or their representatives when unanticipated adverse outcomes occur. The intent of this policy is to continue creating a culture of disclosure, and to develop a system to support physicians and other caregivers through the process. The \_\_\_\_\_ documents inform patients that they are provided full information about their care, including unanticipated outcomes. This information is . . . given to patients upon admission to the hospital.

## II. Policy

\_\_\_\_\_ informs patients and their families about the outcomes of care, including unanticipated outcomes. This policy applies to all situations in which an unanticipated adverse outcome occurs, regardless of the source. \_\_\_\_\_ follows the current "Communicating with Patients about Unanticipated Adverse Outcomes Guidelines."

## Definitions

**Unanticipated Adverse Outcome:** Death, or temporary and/or permanent disability requiring intervention, or a significant event.

**Sentinel/Reportable Event:** An unexpected occurrence involving the actual or potential physical or psychological injury of a patient or otherwise adversely affects the quality of service, operations, assets or reputation of \_\_\_\_\_.

**Clinical Situation Management Team (CSMT):** A group of staff and physicians with specialized training, who can advise, coach and support an attending physician who needs to communicate with a patient/family when an unanticipated adverse outcome occurs; and who can facilitate and coordinate the process, especially when medical error is a complicating factor.

## III. Procedure

\_\_\_\_\_ shall establish and maintain processes to communicate unanticipated adverse outcomes.

- A. Administration shall have a plan to manage communications about unanticipated adverse outcomes for purposes of patient care, service continuity and reputation management.
- B. The \_\_\_\_\_) Continuing Medical Education (CME) department:
  1. Provides education and training for physicians and other designated staff to increase awareness of issues involved in recognizing and determining responsibility for communication; to understand attitudes and skills required for constructive communication and to practice actual communication skills.
  2. Offers the *Communicating Unanticipated Adverse Outcomes Workshop* regularly to physicians, including \_\_\_\_\_ leadership, affiliated clinicians and departments, with an expectation that all practitioners will attend as courses become available. All new practitioners participate in the *Communicating Unanticipated Adverse Outcomes Workshop* as part of their new clinician orientation.
- C. Clinical Situation Management Team (CSMT) procedure supports the physician and coordinates the communication process. CSMT members may include representatives from the medical group, administration, risk management, quality management, legal counsel, health plan, public affairs, and others.
- D. There is a process in place for clinicians and staff to know who to contact in the event of unanticipated adverse outcomes to patients . . .
- E. The responsible physician and/or team designee:

1. Shall manage the response to the unanticipated adverse event. The first priority shall be to address the current and immediate health care needs of the patient.
2. After caring for the patient's immediate clinical needs, a plan shall be developed to communicate with the patient and/or the patient's representative. The responsible physician and/or team designee shall inform the patient, and when appropriate the patient's family, about the outcomes of care they must be knowledgeable about in order to make current or future decisions about care and treatment.
3. Internal communication and reporting shall be done by the responsible physician and/or team designee in accordance with established procedures or processes.
4. The responsible physician and/or team designee shall document a complete, accurate record of the clinical information pertaining to the unanticipated adverse outcome in the medical record. Event analysis/reports shall not be included or referred to in the medical record.
5. After initial management of the event and until resolution, the responsible physician and/or team designee shall provide follow-up medical care to the patient and ensure clinical and emotional needs are met.
- F. Throughout event analysis and until final resolution, CSMT may identify an individual to maintain an ongoing dialog between the patient and/or patient's representative and the patient's healthcare professional team, ensure emotional needs are met, and manage the care processes to ensure smooth follow-up and closure. When possible, plans to improve processes and minimize future adverse occurrences will be communicated to reassure patients and family members.
- G. Administration shall provide emotional and other support to physicians and other health care staff who were involved in the event.
- H. CSMT may discuss the content and mode of follow-up communications to other physicians and staff not directly involved in the event. This may include lessons learned.
- I. Leaders shall follow established policy in reporting to local and program office leaders and/or departments.

#### IV. References

Revised Washington Law - RCW 5.64.010 -

<http://apps.leg.wa.gov/RCW/default.aspx?cite=5.64.010>

Oregon Revised Statutes - ORS 677.082 - <http://www.leg.state.or.us/ors/677.html>

Joint Commission on Accreditation of Healthcare Organizations: *Comprehensive Accreditation Manual for Hospitals*. Oakbrook Terrace, IL: 2006 . . .

#### V. Appendix A

##### 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**

- Assess patient's condition
- Determine what needs to be done immediately
  - Request consultations
  - Determine primary physician
- Give clear explanation of the event to patient and/or patient representative and discuss necessary clinical remedies or treatment options
- Communicate changes in care plan to health care team members
- Note: The responsible 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, even if they believe that the root cause is apparent. Such discussion may further confuse the situation and may complicate future communications.

##### **2. Communicate about the unanticipated adverse outcome in a manner that is compassionate, honest and timely; plan the meeting and address the essentials of who, when, where and what.**

- Prepare for the meeting
  - May call Clinical Situation Management Team for support and assistance

- Develop a meeting plan: develop talking points; define content and facts to be discussed; discuss sequence of presentation

Plan : Who

- Usually the responsible or attending physician handles the initial communication
- Good to have at least one other person in the meeting, such as administrative physician, health plan administrator, hospital administrator, etc.
- Select leader and speakers

Plan: What

- 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 lead follow-up

Note: The following details should not be disclosed: a) names and disciplinary actions; b) root cause analysis materials or information; c) peer review materials or information; d) quality review materials or information; and e) consultations with attorneys or legal information.

Plan: When

- As soon as possible
- Consider patient's physical and emotional readiness
- May require consent from patient to discuss with representatives

Plan: Where

- Safety for patient's clinical condition
- Preserve privacy

**3. Report to appropriate entities, departments, leaders following regional policies and procedures as outlined in this policy & procedure, the \_\_\_\_\_ *Sentinel/Reportable Event P/P*, the Risk Management procedure, and your usual chain of command.**

**4. Document complete and accurate record of the clinical event in the medical record.**

Objective details in a neutral, non-judgmental language

Patient's condition prior to event

Intervention and patient response

Notification of attending physician

Information that was shared with patient and/or representatives

State why any information was withheld.

**5. After the initial discussion and throughout event analysis, maintain contact and followup until closure.**

Ongoing discussions to provide information and identify needs and issues.

- Manage health care needs of the patient
- Manage emotional responses of the patient and/or representatives

Follow through on promises made to patients and /or their representatives and to members of the health care team

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

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.**

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