Overarching principles for care after an adverse event

With patients/ families

**Medical care must be safe, and patient-centered.** After an adverse event do whatever you can to assure patient safety, and to remain patient-centered. Patient-centeredness necessitates honest communication about what happened as soon as we know at the earliest appropriate time. We do this for moral reasons. It is the right thing to do. It may also improve outcomes, but that is not why we do it this way.

**Express empathy:** “We are so sorry.”

**Listen, let them tell their story, and respond to their concerns.** Avoid becoming defensive or accusatory. These unhelpful responses are more likely when providers are scared and grief stricken. Let patients have their emotional reaction. Use active listening skills. Avoid “it will be better” in an effort to “fix” emotional pain.

**Be honest with patients, but do not speculate. Avoid saying what might have happened.** Wait for the root cause analysis. Tell patients/families what you know for sure and assure them you will tell them more as that is determined. “I wish I could tell you right now why this happened. Know that the hospital will be looking very carefully at what happened and we will let you know as soon as we have answers. In the meantime we are doing everything we can to keep you safe.” Tell them what they need to know as soon as possible and appropriate from pt centered perspective.

**Remember the power of a primary care relationship developed over time.** Utilize this as a resource for healing and trust building.

With others in healthcare team

**Remember to also care for the caregivers involved. They need support from peers. And we each need to take care of ourselves.** Studies suggest caregivers benefit from early identification of suffering, ongoing emotional support from peers, coordinated institutional response that includes gossip control, and invitations to be involved in the event-related improvement team. HCMC provides free mental healthcare for residents involved with adverse events. Attending MDs are sometimes the worst at getting help. We all need to take care of ourselves.

**Gather team** to clarify goals and designate facilitator/ spokesperson.

**Offer condolences** (“I’m so sorry to hear about...”) to colleagues who have had a bad outcome.

**Resist the tendency to blame and “fundamental attribution error”:** Assume that you do not have the whole picture and cannot be sure why the event happened. Wait for the root cause
analysis. Avoid the common human tendency to ascribe responsibility and blame solely to individuals (patient or caregivers) or an institution rather than seeing that they all may have played a part.

**Develop and maintain healthy team relationships before an event happens.** When an adverse event occurs, it is best if you already have good working relationships with other members of the team.

**This kind of work takes a lot of time:** Take care of yourself as well as the patients in your care by getting back up support to help with the regular patient care as needed.

**Stay in communication with your leadership, safety/ quality leaders,** as well as malpractice carriers as appropriate.

References:


Responding to Medical Errors: Disclosure is the Best Medicine. In CLAIMS Rx newsletter February 2001 from NORCAL Mutual Insurance Company.