IHI Open School Course Summary Sheet

PS 105: Responding to Adverse Events

Lesson 1: Responding to an Adverse Event: A Step-by-Step Approach

- Communicating with patients and families after something serious goes wrong is the right thing to do — and the best thing for them and the caregivers involved.

- Four steps to follow immediately after an adverse event include:
  - Step 1: Care for the patient.
  - Step 2: Communicate with the patient.
  - Step 3: Report the event to appropriate parties.
  - Step 4: Document in the medical record.

- The best person to have an initial conversation with a patient after something goes wrong is the physician who is responsible for the patient’s care or someone who is familiar with the patient, his or her clinical condition, and future treatment options.
  - When you initially communicate, keep it simple, express empathy and compassion, and don’t place blame.

- Providers and organizations often assume that communicating with patients after adverse events increases the risk of lawsuits; however, many hospital risk managers are starting to view open communication as a way to reduce malpractice claims.

Lesson 2: When and How to Apologize to Patients

- A sincere apology after an adverse event leads to patient harm can be healing to the patient, the family, and the caregivers involved.
  - Apologizing effectively is a skill to be learned and practiced.

- Four components of an effective apology, according to psychiatrist and researcher Aaron Lazare, include:
  - Acknowledgment
  - Explanation
  - Expression of remorse, shame, and humility
- Reparation

- Although it depends on the situation, the physician responsible for the patient’s care is typically the best person to apologize.

Lesson 3: The Impact of Adverse Events on Caregivers: The Second Victim

- Although many health care providers adjust well to the difficulty of an unexpected or traumatic clinical event, for others, the long-term effects can be devastating.
  - After an adverse event, clinicians can feel upset, guilty, self-critical, depressed, or scared.
  - Caregivers involved in an adverse event are sometimes called second victims.
- Research has found caregivers ask for the following support after an adverse event:
  - Early identification of suffering
  - Provision of ongoing emotional support from peers
  - Gossip control
  - Involvement in improvement efforts
- Assigning disproportionate blame to the individuals involved in an adverse event is a common type of mistake that psychologists call fundamental attribution error.
- Second victims should take advantage of resources within their organizations to whatever extent they exist and seek out ways to address their feelings.

Lesson 4: Learning from Errors Through Root Cause Analysis

- A root cause analysis (RCA) is a systematic approach to understanding the causes of an adverse event and identifying system flaws that can be corrected to prevent the error from happening again.
- Accidents in health care almost never stem from a single, linear cause. They come from a mix of contributory factors.
- There are six steps common to most RCAs:
  - Step 1: Identify what happened.
  - Step 2: Determine what should have happened.
  - Step 3: Determine causes (“Ask why five times”).
  - Step 4: Develop causal statements.
  - Step 5: Generate a list of actions to prevent the recurrence of the event.
  - Step 6: Share the findings.