Appendix A:

Respectful Management of Serious Clinical Adverse Events Checklist

Element	Dimension	Started ☑	Completed ☑
Organizational Culture of Safety	Have expectations been set? Are board and leadership accountable?		
	Are there established systems, policies, and a crisis management plan?		
Internal Notification	Have the CEO, Executive Leaders, Risk Management, QI and Patient Safety, PR, Legal Counsel, and other relevant leaders been notified of the event?		
	Has the board of trustees been notified?		
Crisis Management Team (CMT)	Has the threshold been met for activation of the CMT?		
	Is the team membership in place?		
	What executive leadership will chair the team?		
	Is there a need for an independent facilitator?		
Priority 1: The Patient and Family	Who is the organizational 24/7 contact person for the patient and family?		
	Has the organization acknowledged the pain, expressed empathy and regret?		
	Are the immediate needs of the patient and family met?		
	Has the patient had a full clinical assessment?		
	Has the organization assessed the personal safety of the patient and family?		
	Has the patient's primary care physician and extended care team been notified?		
	What is being heard from the patient and family?		
	Has the organization apologized, as appropriate?		
	Does the organization understand what the patient and family want said to others about the event?		
	Is the organization providing ongoing support to the patient and family, including reimbursement of out-of-pocket expenses?		
	Is the organization prepared to have open discussions about compensation, if deemed appropriate?		
	Has the family been engaged in the immediate investigation and then invited to participate in the root cause analysis (RCA) of the event?		
	Has the organization suppressed all normal PR and other communications to the patient or family that could inflict further pain?		

NOTE: This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

(continued on next page)

Source: Conway J, Federico F, Stewart K, Campbell M. *Respectful Management of Serious Clinical Adverse Events* (Second Edition). IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)

Appendix A: Respectful Management of Serious Clinical Adverse Events Checklist (continued)

Element	Dimension	Started ✔	Completed ✔
Priority 2: The Frontline Staff	Who is the organizational 24/7 contact person for staff involved in the event?		
	Has the personal safety of frontline staff been assessed?		
	What is being heard from the frontline staff?		
	Has the organization expressed empathy and been visible?		
	Have frontline staff been invited to participate in any investigation and the RCA?		
Priority 3: The Organization	**The Event**		
	Has an overall organizational point person been established?		
	What is known about what happened? What is the system for updates?		
	Is there clear and present danger to other patients, given what we know?		
	Has the root cause analysis been initiated? Is there an executive sponsor?		
	What about the event is known internally and externally?		
	What is being heard internally and externally in response?		
	What are the priorities to be addressed and who is the point person?		
	Are there materials that need to be sequestered?		
	What is the system to be used for urgent updates?		
	Has billing stopped per hospital-acquired condition policy?		
	Internal and External Communications		
	What is the organization prepared to say internally and externally?		
	Who is (are) on point for communications?		
	Is there clarity on what the patient and family want said to others? Have they had input into all communications materials?		
	Has a press release been prepared in case it is needed?		
	Have there been communications to trustees, patients, families, staff, and internal/external members of the patient's extended care team?		
	Have there been external communications to the media, the community?		
	Are there "friendly" experts available?		
	Should outside media help be obtained?		

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Appendix A: Respectful Management of Serious Clinical Adverse Events Checklist (continued)

Element	Dimension	Started ✔	Completed ✔
Priority 3: The Organization (continued)	**External Notifications and Unannounced Visits**		
	Are there required notifications to state public health, Centers for Medicare & Medicaid Services?		
	Is this event being reported to The Joint Commission, others?		
	Have risk insurers/outside legal counsel been notified?		
	Are there federal agencies to be notified (e.g., Health and Human Services, National Institutes of Health)? Does the Food and Drug Administration need to be contacted?		
	Do law enforcement agencies need to be notified?		
	Are there others that would benefit from learning from this event (e.g., Institute for Safe Medication Practices)?		

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