Communication with Patients & Families after an Adverse Event
Communication, including disclosure and apology, with patients and families after an adverse event is ethical, patient-centered, and essential to mitigating the impact of the event.

Domain

Patient Care Processes:
Clinical processes that ensure delivery of high-quality care to individual patients

Aims

Patient Centered:
Care throughout a patient’s experience that is coordinated, informed, and grounded in respectful interactions with care providers that are consistent with the patient's values, expectations, and care decisions

Safe:
Delivery of care in a manner that minimizes any risk of harm to a patient

Process Attributes

$ Cost to Implement
The monetary resources required to implement this process

Minimal: Just the cost of the improvement effort itself

Time to Implement
The amount of time, from months to years, it will take on average to establish this process

1 to 2 years

Difficulty to Implement
The challenges of implementing this process

Most Challenging: Involves multiple units or disciplines AND requires a substantial shift in culture and/or operations

Level of Evidence
The degree to which the actions in this process are supported by research and experience; based on the Cochrane scale

Opinion: Level IV — Experience in a few organizations, case studies
Details

Elements

- Provide immediate care for the patient
- Identify an adverse event
- Use a standard approach to communicate with the patient and family
  - Support collaboration among the physicians, if there is more than one, about the disclosure conversation.
  - Communicate directly with the patient and family about the event (what happened and plans for continuing care and financial support, as needed).
  - Apologize, if the event meets the criteria for doing so.
  - Promise to investigate and follow up.
- Make sure communication is with appropriate family members and addresses language and health literacy barriers
  Apologize if indicated

Outcomes

- Patient Satisfaction: Increased patient satisfaction (e.g., HCAHPS Willingness to Recommend, HCAHPS Hospital Rating)

Service Lines and Critical Functions

- Hospital Medicine, Adult
- Intensive Care
- Surgical

Key Measures

- Number of adverse events for which full apology and disclosure are performed
- Number of associated malpractice claims and suits before and after program implementation
- Percent of health care providers trained in communication after an adverse event

Reasons and Implications

Importance for Patients and Families
Patients and families expect and deserve honest and timely communication from health care providers about an adverse event.

Requirement, Standards, Policies, and Guidelines

- Institute of Medicine (IOM)
- National Priorities Partnership (NPP) Patient and Family Engagement
- National Quality Forum (NQF)
  Safe Practice for Better Healthcare—2009 Update
  Safe Practice 7: Disclosure
  Safe Practice 8: Care of the Caregiver
  Safe Practice 11: Intensive Care Unit Care
- The Joint Commission (TJC)
  Standard RI.2.90: "Patients and, when appropriate, their families are informed about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes."

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Financial Implications

- Expense reduction due to possible reduction in medical malpractice claims.
- Expense increase due to providing compensation and early intervention funds.

Prerequisites

- Board and senior leadership engagement and approval
- Training for staff, including physician engagement and training
- Collaboration with liability insurance company

Resources

Additional Resources

- [University of Michigan Health System](http://www.med.umich.edu/ps/Docs/PS-Policy-Contact.pdf)
  Patient Safety Toolkit: Disclosure Chapter

  Why Not the Best?
  Comparative performance data on patient experiences

- [Johns Hopkins University Bloomberg School of Public Health](http://www.jhu.edu)
  Removing Insult from Injury: Disclosing Adverse Events
  - 25-minute training video

- [Agency for Healthcare Research and Quality (AHRQ)](http://www.ahrq.gov)
  Developing a Community-Based Patient Safety Advisory Council Toolkit and Resource Descriptions

- [The Joint Commission (TJC)](http://www.jointcommission.org)
  The Sorry Works! Coalition: Making the Case for Full Disclosure

- [American Society for Healthcare Risk Management](http://www.ashrm.org)

- [The Joint Commission (TJC)](http://www.jointcommission.org)
  Journal on Quality and Patient Safety:
  The Sorry Works! Coalition: Making the Case for Full Disclosure

- [Department of Veterans Affairs (VA)](http://www.va.gov)
  Disclosure of Adverse Events to Patients

- [Massachusetts Coalition for the Prevention of Medical Errors](http://www.masscoalition.org)
  When Things Go Wrong: Responding to Adverse Events

- [COPIC Insurance Company](http://www.copic.com)
  COPIC's 3Rs Program: Recognize, Respond, Resolve

- [Institute for Safe Medication Practices (ISMP)](http://www.ismp.org)
  ISMP Medication Safety Alert. Full and timely disclosure of errors to patients: honesty is the best policy

- [Robert Wood Johnson Foundation (RWJS)](http://www.rwjf.org)
  Speaking Together Toolkit

- [New England Journal of Medicine](http://www.nejm.org)

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