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**

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<th>Cost to Implement</th>
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<tr>
<td></td>
<td>The monetary resources required to implement this process</td>
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<td><strong>Minimal:</strong> Just the cost of the improvement effort itself</td>
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<th>Time to Implement</th>
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<td>The amount of time, from months to years, it will take on average to establish this process</td>
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<td><strong>1 to 2 years</strong></td>
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<th>Difficulty to Implement</th>
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<td>The challenges of implementing this process</td>
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<td><strong>Most Challenging:</strong> Involves multiple units or disciplines AND requires a substantial shift in culture and/or operations</td>
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<th>Level of Evidence</th>
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<td>The degree to which the actions in this process are supported by research and experience; based on the Cochrane scale</td>
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<td><strong>Opinion:</strong> Level IV — Experience in a few organizations, case studies</td>
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**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.”
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
  Patient Safety Toolkit: Disclosure Chapter

- The Commonwealth Fund
  Why Not the Best?
  Comparative performance data on patient experiences

- Johns Hopkins University Bloomberg School of Public Health
  Removing Insult from Injury: Disclosing Adverse Events
  • 25-minute training video

- Agncy for Healthcare Research and Quality (AHRQ)
  Developing a Community-Based Patient Safety Advisory Council
  Toolkit and Resource Descriptions

- The Joint Commission (TJC)
  The Sorry Works! Coalition: Making the Case for Full Disclosure

- American Society for Healthcare Risk Management

- The Joint Commission (TJC)
  Journal on Quality and Patient Safety:
  The Sorry Works! Coalition: Making the Case for Full Disclosure

- Department of Veterans Affairs (VA)
  Disclosure of Adverse Events to Patients

- Massachusetts Coalition for the Prevention of Medical Errors
  When Things Go Wrong: Responding to Adverse Events

- COPIC Insurance Company
  COPIC’s 3Rs Program: Recognize, Respond, Resolve

- Institute for Safe Medication Practices (ISMP)
  ISMP Medication Safety Alert. Full and timely disclosure of errors to patients: honesty is the best policy

- Robert Wood Johnson Foundation (RWJS)
  Speaking Together Toolkit

- New England Journal of Medicine

Information Compiled By

IHI