Dealing with a Bad Event

Problem

Bad events happen in healthcare facilities. Mistakes and errors occur in the most efficient and safety conscious areas. Healthcare providers do not come to work with the intention of harming their patients. As a result, adverse events are devastating experiences not only for the patient and the family, but also for nurses and the healthcare team.

Consequence

Dealing with bad events in a positive and supportive manner offers an opportunity to learn and grow, and decreases the chance of the event occurring again. However, if mistakes are treated in a negative way, this greatly increases the risk of staff avoidance in reporting and thus affecting patient safety.

Solution

Here are some considerations related to managing bad events.

- Significant commitment is required from healthcare organizations and leaders to develop a framework for open disclosure, to ensure its quality and to support healthcare providers in the process.

- Organizations also need to address the emotional needs of healthcare professionals in the aftermath of an adverse event.

- Adequate systems need to be in place for debriefing and incident analysis to learn from the adverse events and to implement strategies / actions to prevent their recurrence.

- Adverse events must be addressed with total transparency and honesty to both the patient and the institution.

- Research has found that open disclosure remains uncommon although the ethical duty to disclose is widely acknowledged.

- Barriers to open disclosure include a discomfort and lack of training on how to disclose, fear of litigation, and a culture of infallibility among healthcare professionals.
- Patients expect open disclosure that includes an explanation of what happened, an apology for harm done, an assurance that appropriate action will be taken, and an explanation of what will be done to learn from the event to prevent it from happening again.

- Most institutions have clear processes in place for reporting adverse events; know and follow them.

- The entire incident should be thoroughly investigated within a short time frame to determine if this was a process issue (the process was not clear, appropriate, or up to date), or a practice issue (failure to follow appropriate process).

- The investigation should include the individuals directly involved, the nurse leader within the environment, and any staff who are specially trained to facilitate the process.

- Once the investigation is completed, the next steps should be determined; these can be root cause analysis, peer review, further education, or disciplinary action.

- In reviewing these adverse events, it is important to create an environment of opportunity as opposed to one of punishment or remediation.

- If management approaches bad events in a negative way, this greatly increases the risk of staff avoidance in reporting bad events in the future; this in turn significantly affects patient safety as the opportunity to learn and make adjustments / corrections is lost.

References

*Avoiding Common Nursing Errors*, Lisa Marcucci, MD, Editor, Lippincott Williams and Wilkins, 2010