Full Disclosure of Adverse Events to Patients and Families in the ICU: Wouldn’t You Want to Know?

CACCN Dynamics Conference

Fredericton
September
2009

McGill
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Background

- 2.5 million hospital admissions annually
- 185,000 associated with adverse events
- Occur more frequently in teaching hospitals

(CMA, 2004)
Definitions

Adverse Event

• “An event which results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient’s underlying medical condition” (CPSI, 2008).

Sentinel Event

• “An unexpected occurrence involving death or serious physical or psychological injury, or risk there of. Such events are called ‘sentinel’ because they signal the need for immediate investigation and response from all levels of the health care team” (Joint Commission, 2006).
Critical Care Settings

“In a critical care setting, the complexity of illness and trauma exponentially increases the risk of error and subsequent adverse events.”

(Healthcare Purchasing News, 2006)
Importance of Full Disclosure
Different Perspectives

- Patient & Family
- Ethical & Professional
- Healthcare Organization

(CPSI, 2008)
Goal of the Presentation

To describe and share our learning experiences and our reflections, as nurses/students within a multidisciplinary team in an intensive care unit, when guidelines are needed to communicate a harmful incident to patients and families.
Statements on Full Disclosure
Support Across North America

Joint Commission for Accreditation of Healthcare Organizations
Require licensed practitioners in hospitals to tell patients and families whenever outcomes are different from anticipated (CPSI, 2008).

Canadian Council on Health Services Accreditation (CCHSA)
“Organizations must implement a formal and transparent policy and process of disclosure of adverse events to patients” (CCHSA, 2007).

Canadian Patient Safety Institute – Guidelines Disclosure (CPSI)
Intended to encourage and support development and implementation of “disclosure policies, practices and training methods” (Boyle, O’Connell, Platt & Albert, 2006).
Statements on Full Disclosure
Support Across Canada

• Canadian Nurses Association – Code of Ethics 2008
  • “Nurses admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event (...) they work to ensure that health information is given to individuals, families (...) in an open, accurate and transparent manner.”
• 7 Primary Values

Providing safe, compassionate, competent & ethical care
Promoting health & well being
Promoting & respecting informed decision making
Preserving dignity
Maintaining privacy & confidentiality
Promoting justice
Being accountable
**Statements on Full Disclosure**

**Provincial Support**

**British Columbia**
- Apology Law – “Makes an apology for an adverse event inadmissible in court for the purposes of proving liability” (Levinson & Gallagher, 2007).

**Manitoba**
- 2005 Amendment – Regional Health Authorities Act & Manitoba Evidence Act – full disclosure & protection of health care workers

**Quebec**
- Bill 113 – “Any person working in an institution will be under obligation to report any incident or accident” (National Assembly, 2002).
Case Presentation
Mrs. McGill – 81 years old
Case Presentation

• Medical
  • Coronary Artery Disease
  • Ovarian Cancer
  • GERD

• Surgical
  • Billroth 2 gastrectomy

• Choledocholithiasis

• Endoscopic Retrograde Cholangiopancreatography (ERCP)
  • Via balloon dilatation method
  • In Lab – respiratory distress, agitation, vomiting & possible aspiration

Past Medical History

Current Hospitalization
Case Presentation

- Presented with respiratory distress post ERCP
  - O2 Saturation at 90% on 10L O2
  - Tachypneic & Tachycardic @ 120 with chest pain
  - Febrile at 39°C
  - Hypotensive

Intubated with mechanical ventilation
- Insertion of central & arterial lines

Medication
- Levophed
- Propofol
- Antibiotics

Insertion of NG tube

ICU Admission

Interventions
Case Presentation

ICU Day 2

NG Tube seen in patient’s left lower lung lobe

Chest and abdominal CT Scan to r/o perforation

Perforated Viscous
The McGill University Health Centre Policy on Sentinel Events

**Definition**

“An unexpected occurrence involving death or serious physical or psychological injury, or risk thereof…”

“Signals the need for immediate investigation and response” (Daly, 2006).

**Creation**

MUHC becomes one of the first Canadian healthcare centers to adopt a disclosure policy.

Implemented the Policy for Sentinel Events in 2005 (Daly, 2006).

**Purpose**

“Takes proactive steps to reduce and prevent errors” (MUHC Quality Management Department, 2005).

“Promotes a culture of safety” (Daly, 2006).
## Policy & Procedures

<table>
<thead>
<tr>
<th>Immediate Steps</th>
<th>Within a few hours</th>
<th>Following Day</th>
<th>Within a few weeks</th>
</tr>
</thead>
</table>
| • Stabilize & treat patient  
• Provide information & appropriate support  
• Address family & loved ones as soon as possible  
• Collect all relevant information  
• Decision is made whether the event is deemed “sentinel”  
• Contact appropriate personnel  
• Devise long term care plans  
• Family meeting held with interdisciplinary team  
• Provide information  
• Answer questions  
• Address concerns  
• Further cause analysis  
• Recommendations are made to improve safety & practice  
• Follow up support for patient & family |

(MUHC Quality Management Department, 2005)
Throughout the Disclosure Process

Strategies for Communication

- Use clear, straightforward words & terms
- Be open, sincere & apologetic
- Be culturally sensitive
- Clarify understanding
- Provide time for questions

(CPSI, 2008)
### The MUHC Policy in Practice

<table>
<thead>
<tr>
<th>Immediate Steps</th>
<th>Following Day</th>
<th>Within a few weeks</th>
<th>Long Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family informed right away of Mrs. McGill’s current condition</td>
<td>• Family meeting held with interdisciplinary team</td>
<td>• Follow up meeting with family member physician</td>
<td>• Ongoing communication</td>
</tr>
<tr>
<td>• Patient returned to OR</td>
<td></td>
<td></td>
<td>• Follow up ‘disclosure meetings’</td>
</tr>
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<td></td>
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<td>• Patient admitted to rehabilitation</td>
</tr>
</tbody>
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**Best Practice Guidelines Implemented**
Our Role as Health Care Professionals

“Promoting a culture of safety within organizations includes translating the lessons learned from sentinel events into concrete changes that will improve patient safety.”

(Daly, 2006)
### The McGill Model of Nursing

#### The Concept of Nursing

<table>
<thead>
<tr>
<th>Situation responsive / collaborative approach</th>
<th>Nurses take a health vs. illness perspective</th>
<th>Views nurse as a learner</th>
<th>Adopts a long term perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tailors interventions to “fit” clinical situation</td>
<td>Involvement is multidimensional, holistic &amp; broad based</td>
<td>Exploratory approach – a “continuous inquiry”</td>
<td>Over time, across situations and settings</td>
</tr>
<tr>
<td>Understanding and working from client’s perceptions</td>
<td>Assessment &amp; development of strengths &amp; potentials</td>
<td>Nurse learns from the client or family</td>
<td>Assessing and promoting client’s readiness</td>
</tr>
</tbody>
</table>

**Exploratory approach** – a “continuous inquiry”
Implications for Practice

In any environment it is important to have a nursing model of care to guide us in nursing patients and families.

Specifically, in a critical care unit it becomes paramount, as families are often in crisis.

In disclosing an adverse event where nurses are confronted with a range of emotions from family and relatives, a nursing model provides a foundation for effective communication and collaboration.
Reflections from the Unit

Nursing Perspective

Working with Families

“Tried to be understanding”

“It was difficult”

“The less said, the better”

“Relied on non-verbal cues to guide the interactions with the families”

“Had to build up trust again starting from scratch”

General Comments

“It is a very good thing”

“There must be diplomacy, not blame”

“The team must stay together, work as one”

“It must be done in a non-judgmental, matter-of-fact way”

“Families have a right to know if something has gone wrong”
Our Reflection

“Patients often opened up a lot to us as students in the ICU. We had more time to offer, and therefore made excellent listeners. As with any family experiencing a crisis or uncertainty, often the best thing we can do is listen.”
Conclusion

“The process of disclosing errors requires courage, composure, communication skills and a belief that the patient is entitled to know the truth.”

(Boyle, O’Connell, Platt & Albert, 2006)
References


References (cont’d)


http://www.jointcommission.org/SentinelEvents/se_glossary.html
References (cont’d)


National Assembly of Quebec. (2002). An Act to amend the Act respecting health services and social services as regards the safe provision of health services and social services. *Bill 113 (2002, Chapter 71)*. Quebec, QC: National Assembly.