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

CACCN Dynamics Conference

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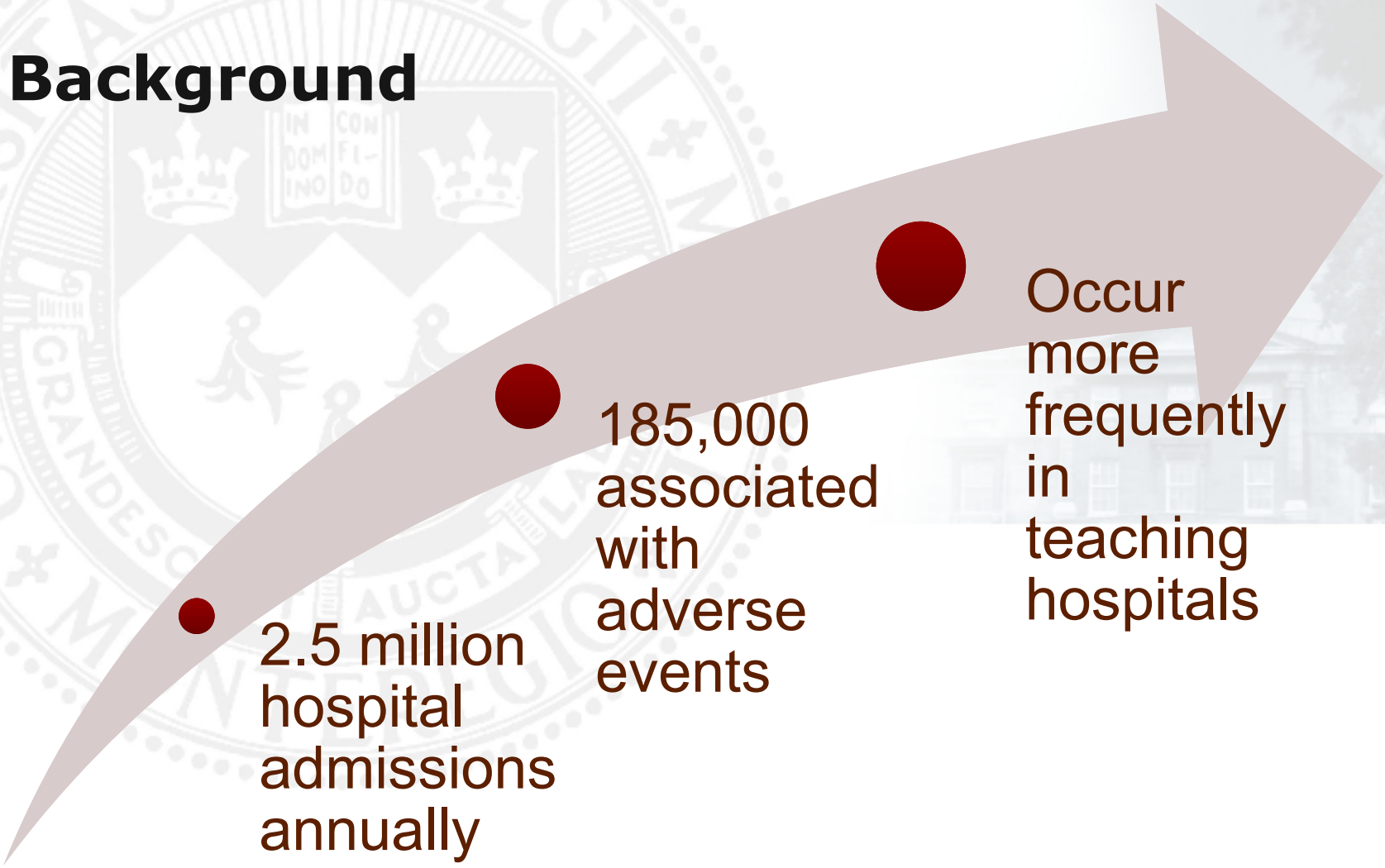
Background



(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

(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

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

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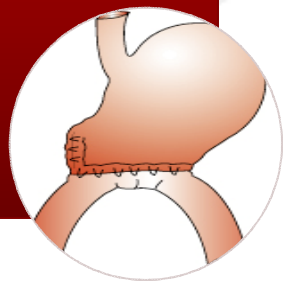
Case Presentation

- **Medical**
  - Coronary Artery Disease
  - Ovarian Cancer
  - GERD
- **Surgical**
  - Billroth 2 gastrectomy

Past Medical History



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

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**

ICU Admission

- **Intubated with mechanical ventilation**
- **Insertion of central & arterial lines**
- **Medication**
  - Levophed
  - Propofol
  - Antibiotics
- **Insertion of NG tube**

Interventions

Case Presentation

ICU Day 2

Chest and abdominal CT Scan to r/o perforation

NG Tube seen in patient's left lower lung lobe

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).

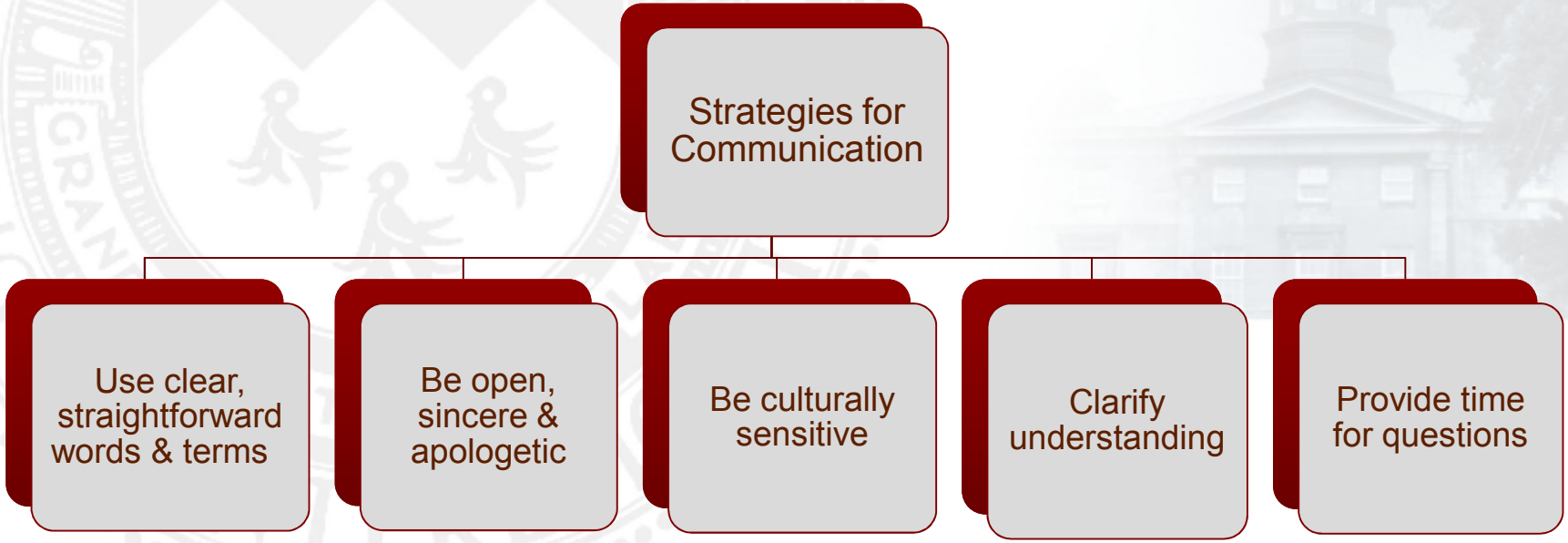
"Promotes a culture of safety" (Daly, 2006).

Policy & Procedures

Immediate Steps	Within a few hours	Following Day	Within a few weeks
• 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



(CPSI, 2008)

The MUHC Policy in Practice

Immediate Steps	Following Day	Within a few weeks	Long Term Care
• Family informed right away of Mrs. McGill's current condition • Patient returned to OR	• Family meeting held with interdisciplinary team	• Follow up meeting with family member physician	• Ongoing communication • Follow up 'disclosure meetings' • Patient admitted to rehabilitation

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

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

Implications for Practice

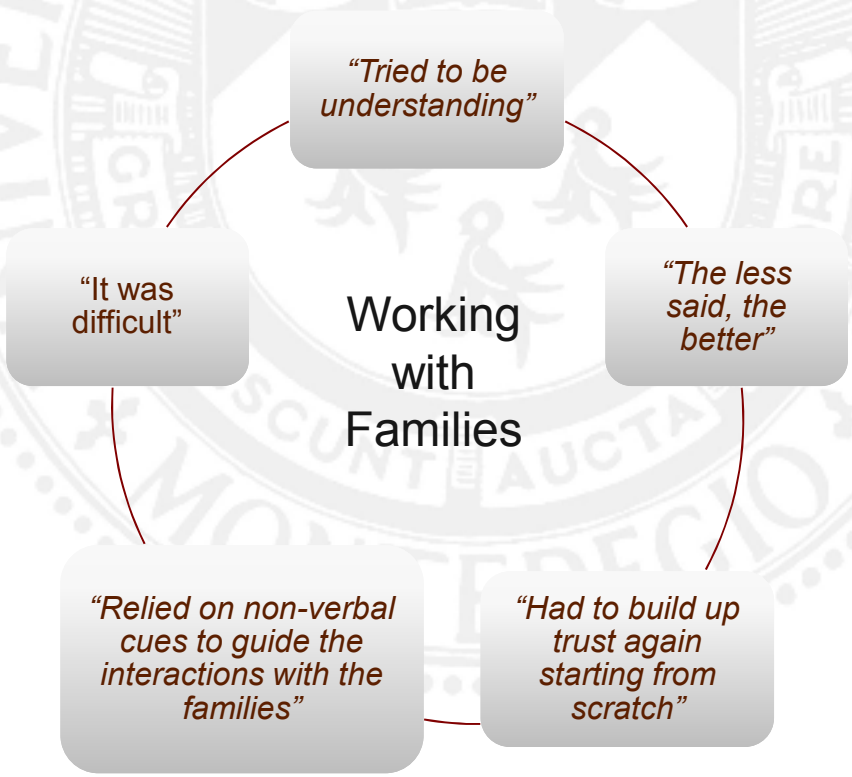
In any environment it is important to have a nursing model of care to guide us in nursing patients and families.

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



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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)

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