Uncharted territories: Navigating the aftermath of adverse events

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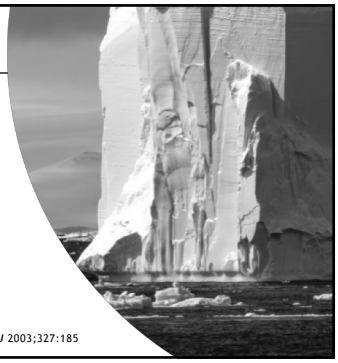
Disclaimer

We have no actual or potential conflict of interest in relation to this presentation

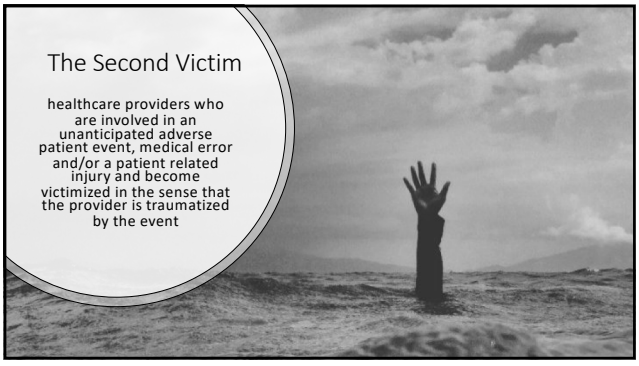
Our Anesthetic Plans

Adverse Events

Studies indicate that you will experience the intraoperative death of 1 patient in the course of your career

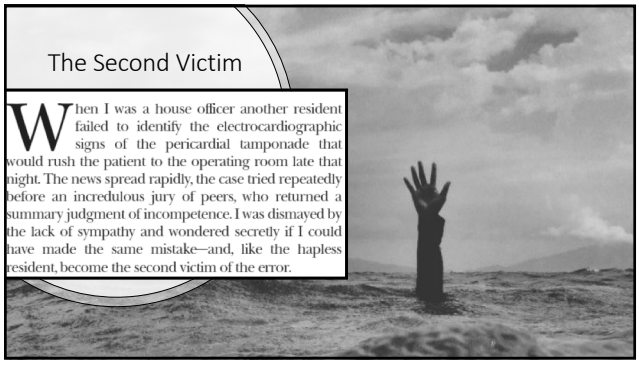


Redinbaugh EM, Sullivan Am, Block SD et al. ***BMJ*** 2003;327:185



The Second Victim

healthcare providers who are involved in an unanticipated adverse patient event, medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event



The Second Victim

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error.

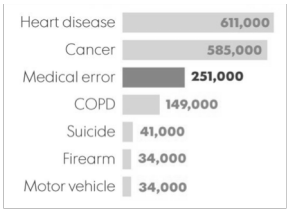
To Err is Human

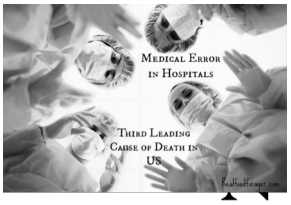
- **Institute (National Academy) of Medicine:** Serves as an advisor to the US nation to improve healthcare
- On November 1, 1999, the IOM "**broke the silence**" that has surrounded medical errors & their consequences:

  "Health care in the United States is not as safe as it should be—and can be."

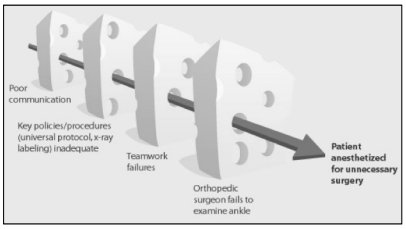
  "At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of preventable medical errors …"

Medical Errors





To Error is Human



Kohn, L.T., Corrigan, J.M., Donaldson, M.S., To Err is Human: Building a Safer Health Care System. 2000.

Risks

Signs and Symptoms

Resources

Navigating the Aftermath: Plot out a course

The Anesthetic Plan

I. Anesthetic Plan
II. Adverse Event
III. Aftermath

The Adverse Event

I. Anesthetic Plan
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Second Victim Recovery Trajectory

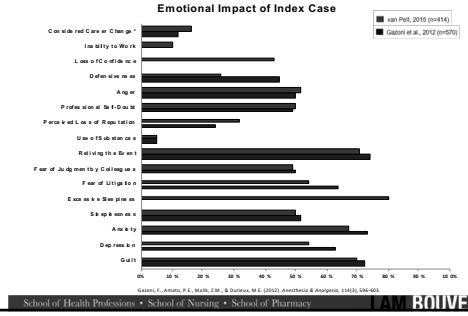
Stages 1-3 Impact Realization			Stage 4 Enduring the Inquisition	Stage 5 Obtaining Emotional First Aid	Stage 6 Moving On		
Chaos & Accident Response	Intrusive Reflections	Restoring Personal Integrity			Drop Out	Survive	Thrive

Individual may experience one or more of these stages simultaneously

The Aftermath

I. Anesthetic Plan
II. Adverse Event
III. Aftermath

Emotional Impact is Similar Across (Anesthesia/Healthcare) Professionals



Gazoni, F., Amato, P.E., Malik, Z.M., & Duncuss, M.E. (2012). *Anesthesia & Analgesia, 114*(3), 596-603.

Support

- Clinician may become a patient
- Majority do not receive any formal professional support
- This is **not** just about being nice

Ways of Coping

- Addiction is a disease/maladaptive coping mechanism
- Accessibility (Easy Diversion)
- Personality Type/Addiction
- Profession (95/5)
- "Memorable event"
  - ***"People are disturbed not by things but by the views they take of them"***
- Recipe for…DISASTER

Ways of Coping

Resources	Percentage who felt resource would be helpful in the future		Percentage who felt resource should be standard operating procedure	
	van Pelt 2015	Gazoni et al. 2012	van Pelt 2015	Gazoni et al. 2012
Talking with other anesthesia personnel	87%	98%	88%	87.5%
Debriefing with the entire OR team	85%	89%	78%	87.8%
Talking with the patient	73%	NA	NA	NA
Talking with the patient's family	71%	87%	37%	63.2%
Talking with own spouse /family members/friends	78%	88%	NA	NA
Talking with a professional counselor	74%	64%	36%	24.3%
Departmental Morbidity and Mortality Conference	83%	81%	63%	56%
Interdepartmental Morbidity and Mortality Conference	81%	77%	NA	NA
Confidential hospital quality assurance	77%	75%	50%	50.4%
Other	NA	NA	5%	NA

AANA Resources

Health and Wellness

- www.AANA.com/Stress
- www.AANA.com/MentalWellBeing
- www.AANA.com/WorkplaceWellness

Peer Assistance Program

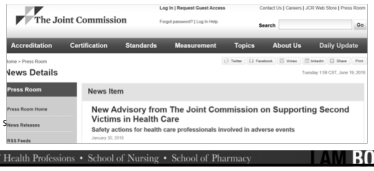
- www.AANA.com/SPA

Where are the policies related to the second victim?

There are no policies!

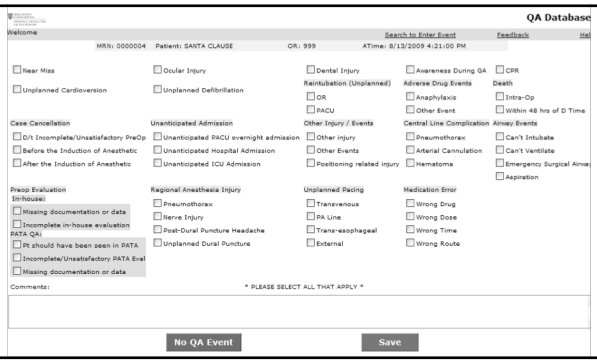
The Need For Support

- Many medical societies have put forth statements **acknowledging** the impact of patient death/adverse events



How? Organizational Background

	CORE ELEMENTS
INTERNAL CULTURE OF SAFETY	The organization is grounded in the core values of compassion and respect and the ethical responsibility to always tell the truth to the patient and family.
	There is an expectation for ongoing communication, honesty, and transparency that is set from the board and leadership and closely monitored.
	Error is seen as the failure of systems and not people.
ORGANIZATIONAL AWARENESS	It is generally accepted throughout the organization that adverse events can cause significant emotional distress to clinician(s) involved.
	There is an expectation that clinicians at the sharp end of unanticipated outcomes and near misses will be supported.
	There are policies in place to support clinicians and staff.
FORMATION OF A MULTI-DISCIPLINARY ADVISORY GROUP	An environmental scan has been done to determine what supports (formal and informal) are available both inside and outside the institution.
	Key stakeholders from various departments have been identified to determine how support will be provided in the institution.
	A survey conducted of staff needs after an adverse event occurs has been done.
	The type of support that might work in your particular institution has been determined.
LEADERSHIP BUY-IN	An executive leadership member is on board to champion this effort.
	If not, the case to influence leadership buy-in has been prepared.



The Second Victim Support Tool

Table 5
Desirability, means, and standard deviations (SD) for the support options chosen by participants

Support Option	% Desired	% Not Desired	Mean	SD
1. A respected peer to discuss the details of what happened	80.5	4	3.59	1.15
2. A discussion with my manager or supervisor about the incident	73.8	9	3.75	0.98
3. A specified peaceful location that is available to recover and recompose after one of these types of events	67.1	10.5	4.06	0.91
4. The ability to immediately take time away from my unit for a little while	64	15.9	3.68	1.06
5. An employee assistance program that can provide free counseling to employees outside of work	62.4	12.4	3.88	0.98
6. The opportunity to schedule a time with a counselor at my hospital to discuss the event	48	20.7	3.32	1.10
7. A confidential way to get in touch with someone 24 hours a day to discuss how my experience may be affecting me	47.5	20.5	3.34	1.09

Debriefing/Support May Intensify Feelings…

- Responsible
- Blame
- Depression
- Anxiety
- Fear of judgment
- Reliving of the event
- Anger

Peer Supporter Role Description

What a Peer Supporter Does	What a Peer Supporter Does NOT Do
Normalizes feelings of peer	Participate in Quality Assurance, RCAs
Validates competence of peer	Offer disclosure coaching (there are other resources for this: page 3-HELP)
Assesses peer's need for professional resources	Deal with job performance issues
Directs peer to other resources as appropriate	Handle substance abuse coaching or violence prevention
Follows up with peer in the short term and long term to "check-in"	Offer malpractice suit support (there are other resources for this)

Think about a time that you received support from friends or family for some kind of problem

- To whom did you speak and why?
- How did they communicate and interact with you?
- How did they support you?
- What was helpful?
- What was not helpful?

Basic Peer Communication Techniques

- Peers should be mainly listening
- Use "I" statements
- Maintain eye contact
- *Relate personal experiences to their situation
- Pay attention to your non-verbal cues. Sit, Sit, Sit
- Don't assume your experience is the same
- Don't judge/don't fix

Some Dont's

"That's not so bad."	• Don't downplay their feelings
"Wow. That sounds like a bad mistake. You must feel awful."	• Don't undermine their competency/confidence
"What happened to me was much worse!"	• It's not about you. Don't take over the conversation with your own experience, but do briefly share your own experience to reduce the peers feelings of isolation/shame

The power of "words":
Something said only *one time*
can make the difference in one
person's *lifetime*...

Thank You

Northeastern University