PReP 14 — Adverse Events, Disclosure, and Apology

Lesson 2 — Adverse Events

Pam:
We have all kinds of terms for the things that go wrong, adverse events is one of those terms.

Kim:
An adverse event is an incident of harm which occurs during the course of care, which is not related to the patient's underlying medical condition. We typically refer to adverse events as preventable or unpreventable.

Prevalence of Adverse Events in Canada

Pam:
There's been a lot of research done. The Baker Norton report certainly in Canada, and they also looked at some of the other reports. There's the Institute of Medicine report, there's the British report, there's Australia . . . a number of countries have done these kinds of reports. From the Baker Norton numbers it's something like 7.5 per cent of every hundred admissions there's some kind of an adverse event that happens.

Kim:
Put to real numbers, The Canadian Adverse Events Study acknowledged that of over 2.5 million hospital admissions in the year 2000 that would be equivalent to 185,000 adverse events, 70,000 of those being preventable.

Pam:
And even those numbers are probably low because they didn't look at obstetrical care, they didn't look at mental health care, they didn't look at outpatient care where, clearly, I'm sure, errors are happening there too.

Kim:
So that is the magnitude of the issue with adverse events.

Why Adverse Events Happen

Pam:
When you look at the actuality of the way things happen, there's a lot of things that happen that are no one person's fault. They're the result of a system that has so many moving parts in it that things can go wrong.

Kim:
I think there's no question, sometimes public perception is that adverse events occur at the hands of individual providers. In fact, that's very rare, less than one per cent. It's the majority that happen because of a multitude of system factors within the practice environment.

Pam:
Well the notion that you're going from A to B in healthcare is not true. You're going from A to Z and you're stopping at every point along the way.

Kim:
Transfer of care is a time when all patients and their family members are very vulnerable from a patient safety perspective. The risk of adverse events occurring is heightened.

Pam:
James Reason uses this model called the Swiss cheese model where all the holes in the Swiss cheese have to line up for the mistake, or the situation, or the event to hit the patient. So medication error—pharmacist, pharmacy technician, manufacturer of the drug, the storage of the drug, the delivery of the drug, the way that it's injected into the patient by the nurse, maybe the route is wrong, maybe the time is wrong, maybe the dose is wrong, the order might have been written wrong. So there could have been fifteen things that led to what we call "the sharp end," which is what hits the patient.

Impact on Patients

Pam:
I think patients are devastated when a mistake happens, family members as well. People are expecting good care, safe care, timely care, things to go right. And when they don't, it sort of shatters their faith and their trust in us. It's a human reaction to go, "I thought you

were looking after me. How could you have done this to me?" And they take it very personally, which of course they should.

So if it happens to that person, and they're still luckily able to talk about it, then all of those issues will come up in terms of trust, and anger, and anxiety, and "What are you going to do to fix this, and how's this going to affect me going forward?" If sadly, unfortunately the patient's died and you now have the family members to deal with, you now have on top of that all the anger and emotion as well as the guilt that they may feel that they didn't do something, or that they might have been able to stop what we did or prevent what happened.

So I think there's a lot of mixed up emotions when these things happen. I think they're very hurt and anxiety-ridden and just devastated from the point of view, "I thought here to help me and now look what you've done to me." So on top of the trying to fix the mistake or do the right treatment, we also have to deal with this loss of trust and faith in us.

Impact on Healthcare Providers

Kim:
The impact that providers feel is beginning to be very well documented. Providers quietly struggle with being involved.

Pam:
For wrong site surgery or for failed treatment or error that caused the demise of a patient, serious errors like that, healthcare professionals are, again, totally devastated. They lose faith in themselves. They worry that their colleagues are going to think that they're incompetent or unsafe. They can't believe that they've made such a mistake. So they go through the gamut of those emotions too. They go through grief, and anxiety, and stress. So there's all kinds of psychological effects, and then it turns into physiological effects where people can't sleep, where they feel sick, where they lose weight. We have employment assistance programs for physicians and for nurses and other healthcare professionals who can access those if that happens. And many people still don't.

Kim:
It can drive them to drop out of their profession; it can drive them to have a lot of social, financial, emotional consequences. And it is a

great loss to the clinical community at large if we don't support individuals involved in preventable harm. The system does suffer consequences from that as well.

Pam:
The public is slowly, I think, coming around to this idea of system thinking. And that when bad things happen they want to know about it, and we absolutely need to tell them about it. And they need to be helped to understand why nobody's getting fired or why punishment's not happening.

To treat them as blame, and fault, and culpable would be to, a) stop the learning about how to fix them, and also not really be fair. It wouldn't be fair to blame the nurse who happens to give the wrong medication because six other things happened to allow it to happen.