

Care of the Second Patient

STARTS with full leadership support and involvement!

Creation of a hospital policy that addresses the care of the caregiver following an unintentional error or near miss should ideally incorporate:

1. Just Culture – Sydney Dekker
2. The concepts, principles and guidelines outlined in Dr. Charles Denham’s article, “T.R.U.S.T. The Five Rights of the Second Victim”, published in the Journal of patient Safety, June 2007.
3. ISMP’S October 5, 2006 newsletter article “Harmful errors: How will your hospital react?” (Which provides a set of guidelines for leaders to follow as they develop a preparedness plan and policy)
4. Full adoption and implementation of the national Quality Forums Disclosure Practice, and new 2009 practice “Care of the Caregiver”
5. Formation and training of a 24/7 peer support, Rapid Response Team, whose role and responsibilities are clearly defined. (see more on Rapid Response Teams below)
6. A communication component to all staff in which leadership’s commitment to provide a safe, secure and transparent just culture is shared.

This communication should include and provide the following:

1. An understanding of human factors and the nature and scope of human errors.
2. The reassurance of safety and security in the disclosure and sharing of error and near miss information, along with the importance and value of this information.
3. The absence of shaming.
4. Disclosure and care of the second patient policy clearly defined and interpreted.
5. Clearly defined expectations of what will happen following an unintentional error for all staff, including: the use of IHI’s unsafe acts algorithm, the organization’s commitment to transparency and open disclosure, the role of the rapid Response Team, available support resources.

6. Leadership will share their commitment to publicly communicate the organizations united stand, with both the family and the caregiver involved, along with the collective resolve of the entire organization to work together and transparently with these individuals, and pt and family involved, to make any needed changes and improvements to ensure this would not happen again.

Priority should be placed on staff education and preparedness training

PRIOR to an error occurring. (It will do no good to have a perfectly written, ideal policy that states we are going to care for and support the caregiver after an unintentional error or near miss if this policy lives in an organization that does not nurture a just culture and has an entire staff that does not understand the needs of this care giver.)

Ideally, curriculum should include:

1. How to create a just culture. (subject matter expert: Sydney Dekker)
2. Human factors
3. Nature and scope of human error.
4. Why humans err
5. The myth of human infallibility.
6. Attitudes, feelings, beliefs and biases all dictate our behaviors and in turn create our culture. In order to create a just culture of safety, we must first provide the education and training necessary to change the MIND SET, attitudes, feelings and beliefs that tend to believe that good and competent people are capable of never making a mistake, and that anyone who does is incompetent and should be ashamed of themselves and “weeded out” from the organization in order to make it safer.
7. How this type of “blame & shame “culture discourages disclosure and reporting of errors and near misses.
8. How difficult it is to make safety and process improvement changes without the valuable information from error and near miss reports.
9. Every employee should be encouraged to safely disclose their errors and near misses.
10. Possible emotional reactions and needs of the second patient – how do we meet those needs and provide support. (It is important to recognize that following an error or near miss, a caregiver immediately becomes a patient in need of at the very least, a quiet

moment away from the scene where a team member can make an assessment of the emotional condition and needs of the caregiver. Some caregivers may need very little support; others may have a delayed reaction of despair, guilt, fear or shame, and may need time off work, counseling services, or co workers who are willing to stay with them as time passes. Others may have an immediate and profound reaction of despair, including thoughts of suicide and a need for emergency intervention

11. Every employee should understand that they are never immune from being involved in an error.

12. Every employee should fully understand what it may be like to be involved, and the importance of knowing who and what your support systems are.

13. Every employee should fully understand what the hospitals policy's are regarding disclosure and the care of the second patient.

Creation of Rapid Response Teams:

Rapid Response teams should include individuals from several different disciplines (physician, nurse, pastoral care, psychiatry, social service etc.) who are specially trained, and available 24hrs a day, 7 days a week.

These individuals should be specially trained in:

1. Crisis intervention
2. Emotional needs assessment and supportive care
3. Disclosure practice
4. The hospitals policy for the just treatment and care of the second patient.
5. The understanding of the stages and process of grief. (Understanding that the immediate response of both the family and the caregiver involved may be that of shock and disbelief. It is difficult to display the full scope of motions felt at that time, know or express your needs, or to even hear what is being said. Understanding this will guide the Team member with ongoing assessment communication and support.)
6. The necessity of making the needs assessment, support and disclosure an ongoing, sequential process.

7. The importance of coordinating the care of the family with the care of the second patient, and providing as much transparency and opportunity for face to face communication, disclosure and apology if the family is agreeable.
8. The importance of including the caregiver in the Root Cause Analysis process. (No one knows why and how, or understands the dynamics and thoughts occurring during the error better than the one involved in the error. Why not really listen and study and hear what the one who made the error thinks may reduce the chance of this type error happening again?)

After any adverse event, members of the response team take prompt action: they keep the atmosphere in the unit calm, they do whatever is possible to mitigate harm to the patient and prevent further harm, they curtail any undue punitive action, they review what happened, and they support the family, staff and physicians. A trained response team for adverse events demonstrates commitment to a culture of support rather than a culture of blame.

Tips
<ul style="list-style-type: none"> • Conduct training and drills to develop an organized response for actual events. • Train enough staff members to have in-house response capability 24 hours a day, seven days a week. • Have a backup group of additional responders in case the people involved in the event are on the regular response team. • Meet with the response team and those involved in the adverse event to discuss ways to improve the response process. • Remember to have the response team support even medical staff who are not employees. Invite non-employed medical staff to join the response team.

Quick intervention with reversal agents can often help minimize the amount of harm to a patient when an adverse drug event (ADE) occurs. However, if the staff members involved do not have sufficient experience with these interventions, or if they are upset by the event, they may not respond appropriately or quickly enough. Consultants who have experience with the medication involved and the appropriate interventions provide a valuable level of support. When staff members can call upon expert consultants who can respond quickly to assist them, the amount of harm to the patient may be significantly reduced.

Tips
<ul style="list-style-type: none"> • Ensure that the consultants are available 24 hours a day, 7 days a week. • Identify personnel who are on-site to be consultants

whenever possible so they can report directly to the location of the ADE. Use nurses, pharmacists and physicians who work routinely with certain medications and are the best experts.

- Provide positive feedback to staff members when they call consultants — asking for help should never be counted against someone in a performance appraisal.
- Encourage staff members to consider their consultants as tools to help prevent ADEs and to call them with questions, not just to ask for mitigation help after things go wrong.
- Collect data on the frequency and reasons for calls to consultants, as they may identify education and training needs.
- Implement a training program to develop additional in-house consultants from within the staff.

Minimizing potential harm to the patient during an adverse drug event (ADE) requires staff to recognize quickly that an ADE has occurred and to respond rapidly with appropriate interventions. Because some very potent medications are administered only infrequently, staff may not be adept at recognizing an ADE when it occurs or remembering the appropriate interventions to take. ADE drills allow staff to test their skills and practice their response in a safe environment to help improve their reactions when a real ADE occurs. Drills are especially helpful for training those staff who work in areas of the health care organization where ADEs rarely occur.

Tips

- Schedule ADE drills regularly to emphasize their importance.
- Rotate the drills to include all areas of the hospital, shifts, and days of the week.
- Include other departments beyond inpatient care units in the drills, such as diagnostic testing areas.
- Discuss ADE drills afterwards with all staff that participate to identify the lessons learned and areas for improvement. Get feedback from staff about improvements that can be made to both the drills and, more importantly, to the response to ADEs.
- Videotape drills to use later as a tool for critique and learning.
- Emphasize that the purpose of the drills is to learn and improve staff members' response to ADEs; the drills are not used for performance review.
- Keep drills unannounced so that staff response is automatic or instinctive as it would be in a real event.
- Share the learning from ADE drills throughout the organization.

With staff members as actors, a simple skit or videotape of a reenacted adverse event or near-miss can raise safety awareness and teach both staff and management valuable safety lessons. You can tell one true story or patch together real or plausible events to create a fictional composite. A commentary from the [patient safety officer](#) senior leader, or the people involved in the real event can be a powerful ending that reinforces the management's non-punitive safety culture.

Tips

- Urge everyone involved in the event — including physicians — to contribute to telling the story.
- Allow people who are deeply uncomfortable to observe rather than participate.
- Encourage patients to participate; they can add tremendously to the message.
- Consider taking several real events and combining them into one fictional event with made-up names and dates.
- Videotape a skit version story, with staff volunteers as actors.

Many other industries, particularly aviation, use simulation to teach people to recognize problems and understand the effects of their responses in a safe environment. The technique is particularly helpful in preparing people for error-prone, high-risk, or unusual situations. Any organization can benefit from simulations, in whatever settings are available, even if they do not have dedicated patient safety labs to use as simulation theaters. Simulation has many applications in health care, and an organization's investment of staff time in simulation or in a patient safety laboratory demonstrates the leadership's commitment to a safety culture.

Tips

- Consider simulations excellent debriefing opportunities for people involved in adverse events or near misses.
- Use an empty patient room for simulations — it costs little and often already has the relevant equipment.

When an adverse drug event occurs, the amount of harm to the patient can sometimes be reduced through quick intervention. The staff must be able to quickly remember the steps to take, which may be difficult if they do not frequently access this information or if they are upset by the event. Compiling the steps in advance and having them available for immediate reference provides staff with a resource to guide them through the appropriate interventions.

Tips

- Make sure that response information is available 24 hours per day, 7 days per week to any staff member who might need it.
- Store response information in handheld electronic devices ([personal digital assistants](#)) so that staff can bring the information directly to the patient's bedside.
- Design responses as protocols that allow nursing staff to provide immediate interventions without having to locate a physician for an order. Make sure that physicians approve the protocol.