Recommendations

for providing an appropriate response

when patients experience an adverse event

with support for healthcare's second and third victims

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This document aims to be support tool for responding appropriately to an adverse event. The recommendations, which are not binding, are based on a review of the scientific literature and the experience of numerous professionals.

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Second and Third Victim Research Group
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Recommendations for providing an appropriate response when patients experience an adverse event with support for healthcare's second and third victims

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INTRODUCTION

In the field of patient safety, most studies undertaken to date have focused on the frequency, causes, and consequences of and how to avoid adverse events (AEs) experienced by patients. Despite many plans and initiatives to improve patient safety, AEs still occur, in some cases arising from clinical errors with significant consequences for patients.

However, although it is clear that patients, their families and friends are those who suffer most (first victims), they are not the only ones affected or who suffer. The health professionals involved directly or indirectly in AEs and who suffer emotionally as a consequence, though less visible, are also victims. The term second victim was introduced by Wu in 2000 referring to professionals who are involved in an unavoidable AE and who are traumatised by the experience or unable to cope emotionally with the situation. Some years later, Scott et al. (2009) broadened this definition to all health care providers who are involved in an unexpected adverse patient event, medical error or patient-related injury, and become victims in the sense that they are traumatized by it. These two authors (Albert Wu from Johns Hopkins University and Susan Scott from the University of Missouri Health Care) are currently the most widely cited internationally in relation to second victim research.

According to the available research, the most common emotional reactions of second victims include: anxiety, obnubilation, confusion, difficulty concentrating on tasks, depersonalisation, frustration, guilt, sadness, mood changes, insomnia, constant replaying of the incident, lack of professional confidence, and fear of legal action and loss of reputation.

In terms of the frequency of such events, a study carried out in the USA and Canada with the largest sample of doctors to date (Waterman et al., 2007) indicates that only 5% of clinicians are not closely or directly involved with AEs during their entire professional careers. In Spain, the Spanish National Study of Adverse Events (ENEAS; Aranaz et al., 2008) and the Adverse Events in Primary Care Study (APEAS; Aranaz et al., 2012) suggest that every year, 15% of clinicians are involved in AEs with relatively serious consequences for patients. In the first phase of the research project under which this guide has been developed, 1087 health professionals were interviewed, and among this sample, 62.5% of those working in primary care and 72.5% of those working in hospitals reported having gone through the second victim experience in the previous 5 years, either directly or indirectly through a colleague.

As well as the impact AEs may have on patients and clinicians involved, they may damage the reputation of and reduce trust in healthcare organizations (third victims). This view of healthcare organizations as third victims was advanced by Charles Denham in 2007. There has been little research on the consequences for third victims and how to address them, but it has been suggested that healthcare organizations should develop a crisis plan and take other measures to minimise potential loss in reputation.

In this context, we have produced this guide, providing a list of actions recommended for supporting second and third victims and providing an appropriate response to patients after an AE. The recommendations are based on information collected from a review of the literature on this topic and sharing the experience of the research team.

DEFINITIONS

Adverse event (AE)

An unintended injury or complication resulting in prolonged hospital stay or hospital admission, change or introduction of a new drug, disability at the time of discharge or death and caused by healthcare management rather than by the patient's underlying disease process. This incident may or may not have been related to a medical error (based on WHO definition, 2009).

Sentinel event

An unexpected occurrence involving death or serious physical or psychological injury to patients, or the risk thereof. All sentinel events are AEs but due to their consequences, sentinel events additionally meet criteria for undertaking a comprehensive review of what has occurred to prevent happening again in addition to providing clinician support and guidance. (UNE-EN-ISO179003:2013).

First victim

A patient who experiences an AE, and also their close relatives (Mira et al., 2015).

Second victim

Healthcare providers involved in an unexpected AE, medical error or injury affecting a patient, who become victims in the sense they are traumatised by it (Scott et al., 2009)

In these recommendations, we have considered as second victims not only the clinicians most directly affected by the AE experienced by a patient[1], but also other members of their healthcare team, since AEs often have a systemic cause, and hence other members of the team may be involved.

Further, throughout this document we refer to the most common situation in which the second victim phenomenon occurs, namely, after the occurrence of an adverse event with serious or very serious consequences for one or several patients. However, it should be underlined that there may be second victims after any patient safety incident (PSI) which include AEs but also after other harmless incidents.

Third victim

Healthcare organizations that may experience a potential loss of reputation as the result of a PSI (Denham, 2007).

In these recommendations, we advise using the terms proposed in the WHO International Classification for Patient Safety to refer to PSIs in documents and protocols as well as in interactions between health professionals and patients.

[1] *Throughout this document, the term patient also refers to cases in which a single adverse event involves several patients. The same applies when referring to the health professional involved in the incident.*

Set of recommendations

SAFETY AND ORGANIZATIONAL POLICIES

PATIENT CARE

PROACTIVE APPROACH TO PREVENTING REOCCURRENCE OF AN AE

SUPPORTING THE CLINICIAN AND THE HEALTHCARE TEAM

ACTIVATION OF RESOURCES TO PROVIDE AN APPROPRIATE AND TIMELY RESPONSE

INFORMING PATIENTS AND/OR FAMILY MEMBERS

DETAILED ANALYSIS OF THE INCIDENT

PROTECTING THE REPUTATION OF HEALTH PROFESSIONALS AND THE ORGANIZATION

Color reference to order actions according to aims

FOR INSTITUTIONAL CARE | FOR PATIENT CARE | TO REDUCE THE RISK OF AE IN THE FUTURE | TO SUPPORT THE PROFESSIONAL

Set of recommendations

SAFETY AND ORGANIZATIONAL POLICIES

Objective: to establish a positive attitude towards safety and organizational policies covering support for second and third victims as well as for the patient after an AE.

1. Create a safe patient-centred healthcare environment, which safeguards patient rights, including honest communication with and an apology to the patient after an AE.
2. Establish action plans for meeting the varied needs of the second and third victims in the organization's safety policies.
3. Establish an agreed approach to making an apology to the patient without implying an admission of guilt.
4. Establish recommendations on what information it is appropriate to provide to both ensure transparency and safeguard the legal position of health professionals (indicating what to report and how, as well as guidelines concerning what to do immediately after the AE for the health professional most directly involved and the team conducting the root cause analysis (RCA)).
5. Include workshops in staff training programmes on the provision of information to a patient who has experienced an AE, and on the actions to be taken by the organization after an AE.
6. Develop an action plan for AEs that includes learning from experience, action items to address any identified deficiencies in care, and establishing measures to prevent similar AEs occurring in the future.
7. Establish and raise awareness among health professionals of the steps to be taken when a serious AE (or sentinel event) occurs. These must include a plan for substituting for staff who, for a period following their involvement in the AE, may not be able to provide care to patients.
8. Regularly assess the effectiveness of the AE procedures.
9. Develop and organize a team of professionals able to immediately and effectively take on the management of a crisis that can be called on when necessary, in particular, when colleagues of second victims feel overwhelmed. These personnel require special training on how to provide support to colleagues involved in Aes. See the recommended personal and professional profile of key health professionals providing support to second victims.
10. Establish a crisis communication plan during the crisis to protect the reputation of the organization and its professionals.
11. Proactively, make staff aware of the agreed action plans and the way they can potentially benefit from them.
12. Establish a procedure for assessing the effectiveness of the measures taken and procedures introduced to support second and third victims.

Set of recommendations

PATIENT CARE

Objective: to minimize the consequences of an AE and meet the clinical, emotional and information needs of the patient and his/her family.

1. Provide the patient with the care required with no delay and following protocols of the centre.
2. Contact the clinician in charge of the patient's case as soon as possible to inform them and request their involvement. If they are not available, inform the doctor caring for the patient at that point in time.
3. Offer psychological support to the patient and family members.
4. Contact the health professional supervising nursing services in the care unit (nursing supervisor) to inform them and request their involvement.
5. Assess whether there is an imminent risk to the patient who has experienced the AE or other patients (including those in other centres) to rapidly take appropriate action to prevent a new AE.
6. Ensure direct and personal line of communication with the patient, continuing through the 3 months after the incident if the case needs follow-up. Designate a consistent contact person for this communication.
7. Inform the patient's primary care doctor.

Set of recommendations

PROACTIVE APPROACH TO PREVENTING REOCCURRENCE OF AN AE

Objective: to learn from one's own experience in order to offer a safer environment.

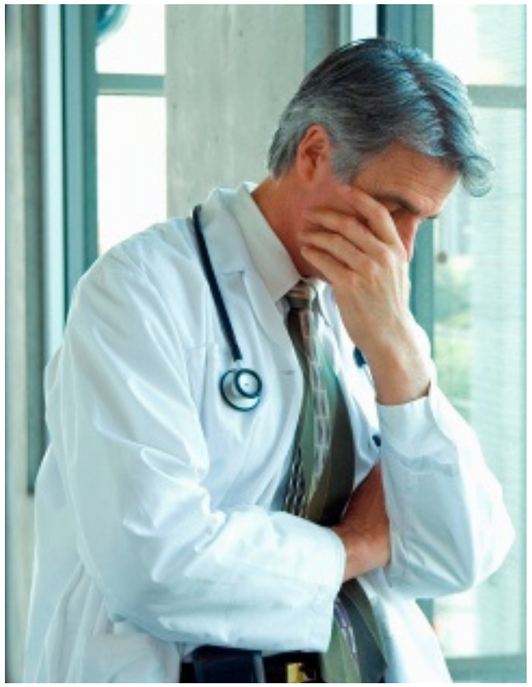
1. Collect and store evidence that may help to determine what happened in relation to the AE, how and why, for example, the use of materials that were inappropriate, broken, dangerous, etc. Take photographs if possible. Do not add, amend or delete notes in any related documents including the patient's medical record.
2. Record information on what happened as soon as possible while the memories of staff involved are fresh (that is, before they are influenced by other experiences).
3. Make a note of who was present at the time of the incident, in order that they can be called on subsequently to provide information and proposals during the RCA, with the goal of developing measures to make improvements and prevent recurrence of the same type of AE.
4. Construct a detailed timeline of what transpired during the care of the patient.
5. Draft a report of the most important information for subsequent analysis of the AE.

Set of recommendations

SUPPORTING THE CLINICIAN AND THE HEALTHCARE TEAM OF WHICH HE/SHE IS A MEMBER

Objective: to mitigate the emotional burden on the clinician following a patient-related AE.

1. Adopt a positive attitude, not attributing blame, recalling that AEs often have systemic causes.
2. Identify who may be second victims of the AE (health professionals and healthcare students most directly involved in the patient's care, the team, etc.)
3. First of all, allow a colleague (from the immediate environment with a similar professional profile) to talk with the second victim in a quiet place. This colleague should be capable of helping, listening and providing emotional support to the second victim in coping with the situation. Avoid attributing blame. The focus should be on clinician support and not investigative details of the care rendered. and . See the algorithm for providing support to second victims and the recommended personal and professional profile of key professionals providing support
4. Designate a volunteer or team of volunteers in all units, departments and services trained provide peer support to second victims. Health professionals should immediately know who they can turn to. This should also be available for involvement in an incident despite it not causing any harm to the patient.



5. Place importance on ensuring that the second victim does not at any time feel rejected by their colleagues or the centre. Avoid making second victims feel that they have been branded with a “scarlet letter”.

6. Encourage the second victim to increase (or at least maintain) their level of physical activity (gym, walking, running, dancing) and daily leisure activities, including activities with friends and family. Help them to plan the next day or week, including positive activities in their life. Further, it may be important to alert their closest social contacts (family, closest friends) to ensure that they receive support outside the health care setting as well.

7. Avoid the following in interactions with second victims: asking probing questions about the incident attempting to find out whether they made a mistake, trivializing the situation, telling them how they should feel or underestimating the strength of their emotions, telling them what they should do now, and asking them how they feel.

8. Seek to do the following in interactions with second victims: listen to them, ask only open questions in order that they can talk freely, allow them to express their feelings and help them think about what to do next and where they can find help.

9. Inform the Occupational Health and Safety Service, according national rules, if the physical or psychological health of the second victim is affected, and if they need work leave, support them with the necessary paperwork through the aforementioned service.

10. Arrange for the clinical duties of the second victim to be covered by others, if necessary and desired, taking pressure off them in the hours or days following the incident.

11. Be alert to symptoms suggesting the second victim needs more support: anxiety/restlessness, at work or at home; changes in mood, including symptoms of depression; doubts about whether they can continue their professional career and/or about their clinical decisions; or feelings of guilt.

12. Assess whether the second victim needs personalised care. See algorithm for providing support.

13. Assess whether the second victim needs legal advice and offer guidance on how to act and where to find help.

14. Inform the second victim about the professional liability coverage under the centre's policy.

15. Inform the second victim about the specific types of support available within and outside the organization, and facilitate their provision if necessary. Coordinate such emotional and legal support.

16. Monitor the second victim during the days following the AE to ensure they are coping with the aftermath of the AE. Watch for symptoms of post-traumatic stress disorder and act accordingly.

17. Keep the second victim informed about the patient information process and the analysis of what happened underway. Assess whether it is appropriate for him/her to participate in the meeting to inform the patient (this being advisable only when completely sure the professional involved in the AE is the best person to explain what has happened to the patient and always ensuring that he/she is accompanied by a colleague).

18. Invite the second victim to participate in the RCA, if they are emotionally able to do so.

19. Organize the second victim's return to clinical practice following the AE, establishing a progressive increase in their duties, without him/her feeling that there is a lack of trust in their professional capacity, but rather recognising this as contributing to his/her emotional stability and wellbeing.

20. Plan regular monitoring in the 3 months following the AE to ensure that the second victim is coping with the professional and emotional burden associated with the incident. Be aware of avoidance behaviours, doubts about his/her clinical skills, changes in mood, anger, flashbacks or other symptoms of post-traumatic stress disorder.

Set of recommendations

ACTIVATION OF RESOURCES TO PROVIDE AN APPROPRIATE AND TIMELY RESPONSE

Objective: to ensure an appropriate and proportional response to an AE.

1. Inform the managers of the clinical units, departments, services, or the centre of what has happened. Inform the legal and management, as well as the press office.
2. Inform all involved members of the healthcare team involved in the care of the patient of what has happened as soon as possible.
3. Ensure that those in direct contact with the patient understands what has happened in order that communication with the patient is consistent and coordinated.
4. Activate the crisis communication team, if required.
5. Define the roles the head of the medical service and the nursing supervisor. The medical and nursing directors should play a significant role in communicating with the patient.
6. Produce an information pack on this type of incident and what has happened as information becomes available.
7. Designate a spokesperson (if this has not already been done).
8. Provide information within the first 24 hours after the incident and be proactive about sharing information about this type of incident and the AE that has occurred.
9. Strengthen internal communication in the case of a serious AE to avoid rumours, ensuring that members of staff have reliable and timely information about what has happened and how to avoid it in the future.

Set of recommendations

INFORMING PATIENTS AND/OR FAMILY MEMBERS

Objective: to provide appropriate and timely information to patients who have experienced an AE (and/or their families).

1. Ensure that there is a suitable place to talk with the patient and/or his/her family members without interruptions.
2. With the available information well organized, arrange for a senior medical practitioner (it is not always a good idea that the health professional involved in the incident informs the patient)[2], together with another health professional known to the patient (or his/her family) to provide honest information to the patient, and show empathy with their suffering, including making an apology. If various patients are involved, the information should be provided privately to each one. In some cases, the health professional involved, if willing and capable of doing so, may participate in this meeting to inform the patient (though never on their own). Algorithm for deciding who should communicate with the patient, according to the seriousness of the event and its impact on the professional involved.
3. Consider setting up an information team depending on the characteristics and magnitude of the AE.

[2] *Some studies published in the USA and Canada, as well as recommendations drawn up by North American institutions, suggest that the information to patients is provided directly by the health professional involved in the incident, showing details of what has happened, causes and consequences, showing empathy with the patient, expressing frustration and pain about what has happened and saying sorry. However, in the places where these studies have been carried out, Apology Laws have been introduced (Mira & Lorenzo, 2015), providing a framework of legal protection to the health professional different from that in Spain and other countries with a different legal frame.*

4. Ensure that the communication does not intimidate the patient. The amount of information given, the frequency and the number of professionals who inform should be carefully controlled.

5. Place importance on supplying information fast, even though it may initially be incomplete, making patients aware of this limitation.

6. Assess whether there are intrinsic patient-related factors (personality, emotional situation, etc.) that weigh against informing the patient directly. This will occur in isolated cases. Assess what the patient(s) and family members know and what they want to know.

7. Decide, by consensus between a team of professionals, what information is to be given, in what order, and how to apologise with empathy. Confine the discussion strictly to facts and objective data.

8. Do not make judgements about causality or responsibility, confining the conversation to what is known about the incident and objective clinical data. Avoid speculation. Do not use jargon or words that the patient does not understand. As a general rule, avoid terms that could be confusing or have legal implications that go beyond the goal of providing honest information to the patient. In relation to this, it is not recommended to use terms such as error or mistake; rather explain that the outcome has been unexpected. The way this process is carried out should reflect the fact that most AEs have systemic causes, which are not directly attributable to a specific health professional.

9. Strive to reduce uncertainty without entering into detailed analysis. Pay attention to nonverbal communication, ensuring that the patient and family members feel that the concern and respect shown by the health professional are genuine. Health professionals should talk to each other about the AE before informing the patient in order to reduce the emotional stress and create a climate of trust among healthcare team members.

10. Meet any special needs of the patient in terms of communication, taking into account their age, family situation, and language in which they are most comfortable, among other factors.

11. Record the meeting for informing the patient and/or family members, provided that they give their consent. In such cases, a copy must be made available to the patient on request.

12. Check whether the patient will or would like to be accompanied by a family member, in particular in the case of patients under 18 years of age.

13. Request written consent from the patient to share information with specialists in other centres or health services, as appropriate. In such cases, do not supply the name of the patient or other personal details, sharing only the minimum necessary information with third parties.

14. Have and make available information an legal advice about when and how to proceed with an asset of financial compensation[3].

15. Inform the patient and/or family not only about the incident but also about the steps being taken to determine what happened and how to prevent similar events in the future. See the algorithm for providing honest information to the patient.

16. Make sure that the patient and/or family members understand the information given and that they do not have any outstanding queries.

17. Keep a line of communication open between the patient and the contact health professional. Update the information regarding the incident as more details become available.

18. Make a note in the patient's medical record specifying the information given to the patient/family with details of their questions and level of understanding of the information.

19. Plan follow-up to support the patient through the course of their illness and with paperwork, in such cases.

20. When needed, offer to the patient the option of changing his/her healthcare team.

[3] *Mira JJ, Romeo-Casabona CM, Astier-Peña MP, et al. Si ocurrió un evento adverso piense en decir "lo siento". An Sist Sanit Navar. 2017; 40: 279-90.*

Set of recommendations

DETAILED ANALYSIS OF THE INCIDENT

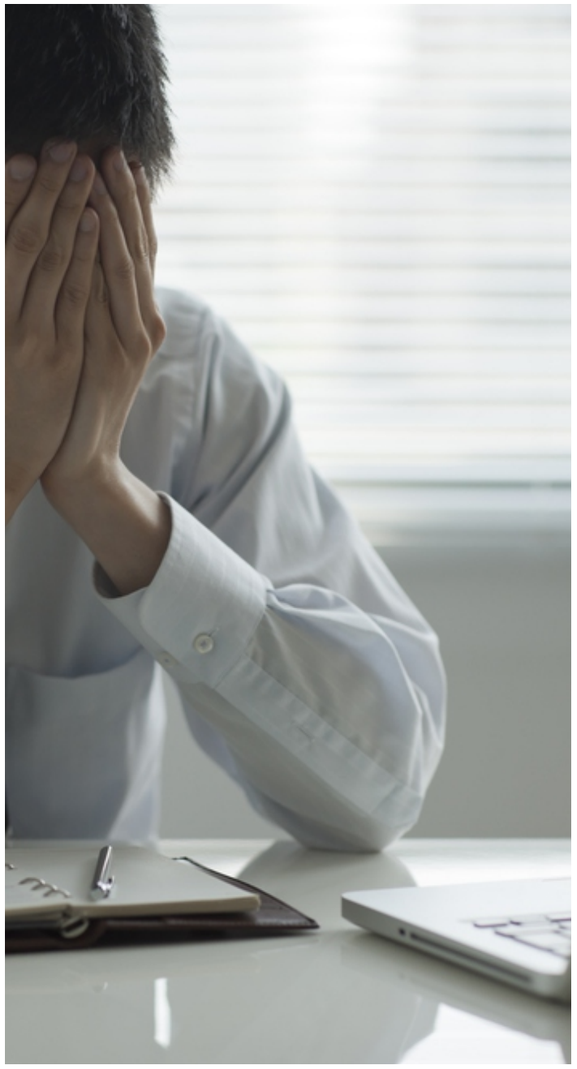
Objective: to learn from experience to provide an increasingly safer environment.

1. Ensure that information is reported in an appropriate context and through an appropriate medium addressing all questions as openly and honestly as possible as they arise.
2. Activate the team responsible for conducting the RCA (as appropriate).
3. Arrange a meeting of the Safety Committee to analyse the results of the case analysis or RCA (as appropriate) and propose measures to increase patient safety.
4. Establish the information required and a deadline for reporting it, minimising delays.
5. Decide whether it is appropriate to invite representatives of registered patient associations to participate in the case analysis or RCA (as appropriate)
6. When needed, inform the patient who has experienced the AE (or his/her family) of the results of the analysis. This could be useful in some cases.
7. Introduce measures to increase patient safety and assess their effectiveness.
8. With the appropriate confidentiality, hold clinical sessions to discuss medical errors and how to decrease the risk of them occurring in the future.
9. Reflecting on the experience of an AE, review procedures for ensuring that personal information disclosed about patients and health professionals after an AE with media impact respect their rights to confidentiality and personal privacy. Consider that once agreement has been reached on measures to improve procedures and avoid AEs due to a similar cause in the future, it is not relevant or necessary to provide further information, remembering also that relevant information has been noted in the patient's medical record.

Set of recommendations

PROTECTING THE REPUTATION OF HEALTH PROFESSIONALS AND THE ORGANIZATION

Objective: to sustain the reputation of the centre and its staff even in the event of a serious or very serious AE.



1. Review the communication plan in the light of experience, to ensure that in the months following the incident positive news about the care work are disseminated, to help to generate trust in the centre and its staff among the public.
2. Regularly update information on new interventions in the field of clinical safety underway in the centre.
3. Disseminate news on the therapeutic achievements and training activities carried out, to help strengthen confidence of patients, and the public in general, in the organization and its staff.

Checklist of actions

Checklist of actions recommended regarding safety culture and policies

Date: _____

Centre/Hospital: _____ **Unit/Service:** _____

SAFETY CULTURE AND POLICIES

Starting premise: For a healthcare environment to be safe, it needs to be patient-centred

	Action	Date	Comments
☐	Establish an agreed approach to making an apology to the patient without implying an admission of guilt		
☐	Establish guidelines to ensure transparency and safeguard the legal position of health professionals		
☐	Include workshops in staff training programmes on the provision of information to a patient who has experienced an AE, and on the actions to be taken by the organization after an AE		
☐	Develop an action plan for when an AE occurs		
☐	Assign key leaders to ensure that action items are completed within a timely manner		
☐	Establish and raise awareness among health professionals of the steps to be taken when a serious or very serious AE occurs		
☐	Regularly assess the effectiveness of the procedures agreed for AEs		
☐	Train, in each healthcare unit/service, health professionals able to provide first-line support to a colleague who has become a second victim		
☐	Form a team for the management of crisis situations, composed of health professionals trained to provide support to colleagues potentially involved in an AE		
☐	Train health professionals who have themselves been second victims to provide support to colleagues in this situation		
☐	Develop a crisis communication plan		
☐	Make staff aware of the agreed action plans and the way they can potentially benefit from them		
☐	Establish a procedure for assessing the effectiveness of the actions taken and measures introduced to support second and third victims		

Checklist of actions recommended regarding care of patients who experience an adverse event

Date: _____

Centre/Hospital: _____ **Unit/Service:** _____

PATIENT CARE

	Action	Completed		Comments
		Date	Time	
☐	Inform the clinician in charge of the patient's case of the incident and request their involvement			
☐	Inform the nursing supervisor of the hospital ward/unit of the incident and request their involvement			
☐	Provide the patient with the care he/she requires without delay.			
☐	When needed, offer to the patient the option of changing his/her healthcare team.			
☐	Assess whether there is an imminent risk to the patient who has experienced the AE or other patients			
☐	Act rapidly and appropriately to prevent the risk of a new AE			
☐	Ensure a direct and personal line of communication with the patient (3-month follow-up)			
☐	Designate a health professional as the contact person for the patient			
☐	Inform the patient's primary care doctor			
☐	Offer psychological support to the patient and family			

Checklist of actions recommended to prevent recurrence of the same type of adverse event

Date: _____

Centre/Hospital: _____ **Unit/Service:** _____

PROACTIVE APPROACH TO PREVENTING REOCCURRENCE OF AN ADVERSE EVENT			
Action	**Completed**		**Comments**
	Date	**Time**	
☐ Collect and store evidence that may help to determine what happened			
☐ Record information on what happened as soon as possible (testimonials of involved healthcare professionals)			
☐ Make a note of the people present at the time of the incident (including healthcare students)			
☐ Construct a detailed timeline of what happened			
☐ Write a brief report of the most important information for subsequent analysis of the AE			
☐ Submit this brief report containing the key information to trigger the launch of the process of reviewing what happened and learning from the experience			

Checklist of actions recommended regarding the provision of support to the second victim

Date: _____

Centre/Hospital: _____ **Unit/Service:** _____

SUPPORTING THE CLINICIAN AND THE HEALTHCARE TEAM OF WHICH HE/SHE IS A MEMBER		
Action	**Date**	**Comments**
☐ Adopt a positive attitude, recalling that AEs often have systemic causes.		
☐ Identify who may be second victims related to the AE		
☐ Speak to the potential second victim(s) – *this being done by a close colleague with a similar professional profile and skills to provide support*		
☐ Arrange for the clinical duties of the second victim to be covered by others (only if the clinician desires)		
☐ Encourage the second victim to increase/maintain their level of daily leisure activities including activities with friends and family		
☐ Help the second victim with the paperwork related to work leave (if appropriate) in coordination with the centre´s Occupational Health and Safety Service (according national rules)		
☐ Be alert to symptoms suggesting the second victim needs additional support		
☐ Assess whether the second victim needs personalized care with a professional counsellor		
☐ Assess whether the second victim needs legal advice		
☐ Inform the second victim about the professional liability coverage under the centre's policy		
☐ Inform the Occupational Health and Safety Service only if the physical or psychological health of the second victim is affected		
☐ Inform the second victim about the specific support within and outside the institution		
☐ Coordinate emotional and legal support		
☐ Monitor the second victim the days following the incident to ensure effective recovery from event		
☐ Keep the second victim informed about the patient information process and analysis of what has happened		
☐ Invite the second victim to participate in the root cause analysis of the incident if the clinician is able and it is adequate		
☐ Organize the second victim's return to clinical practice following the AE (with a progressive increase in their duties)		
☐ Plan monitoring of the second victim during the 3 months following the AE		

Checklist of actions recommended to ensure an appropriate and timely response to an adverse event

Date: _____

Centre/Hospital: _____ **Unit/Service:** _____

ACTIVATION OF RESOURCES TO PROVIDE AN APPROPRIATE AND TIMELY RESPONSE

Action	End		Comments
	Date	Time	
☐ Inform the managers of the clinical units, departments, services or centre of what has happened			
☐ Inform all members of the healthcare team involved in care of the patient			
☐ Activate the crisis communication team, if required.			
☐ Define the roles the head of the medical service, the nursing supervisor and the medical and nursing directors should play in dealing and communicating with the patient.			
☐ Produce an information pack on this type of incident and what has happened			
☐ Designate a spokesperson and keep that person consistent			
☐ Be proactive about sharing information (providing information in the first 24 hours)			
☐ Strengthen internal communication			

Checklist of actions recommended regarding the provision of honest information to patients and their families

Date: _____

Centre/Hospital: _____ **Unit/Service:** _____

INFORMING THE PATIENT AND/OR FAMILY MEMBERS

Action	Completed		Comments
	Date	Time	
☐ Provide honest information to the patient, together with an apology – *this being done by a senior clinical specialist and another health professional with an established relationship with the patient*			
☐ Give the health professional involved in the incident the option of participating in the meeting to inform the patient, accompanied by another health professional (if they would like and are able to do so)			
☐ Set up an information team depending on the characteristics and magnitude of the AE			
☐ Assess whether there are intrinsic patient□related factors that weigh against informing the patient directly			
☐ Decide, by consensus among a team of professionals, what information is to be given (facts and objective data)			
☐ Meet any special needs of the patient in terms of communication			
☐ Provide a suitable place to talk with the patient and/or family members without interruptions			
☐ Record the meeting for informing the patient (with patient consent)			
☐ Check whether the patient will or would like to be accompanied by a family member			
☐ Request written consent from the patient to share information with specialists in other centres or health services			
☐ Have available information about potential financial compensation			
☐ Inform the patient about the steps being taken to determine what happened and how to prevent similar events in the future			
☐ Make sure that the patient and/or family members understand the information given			
☐ Make a note in the patient's medical record of the information given in this meeting			
☐ Plan patient follow□up			

Checklist of actions recommended regarding detailed analysis of the incident

Date: _____

Centre/Hospital: _____ **Unit/Service:** _____

DETAILED ANALYSIS OF THE INCIDENT			
Action	**Completed**		**Comments**
	Date	**Time**	
☐ Report the incident in an appropriate context and through an appropriate medium			
☐ Activate the team for conducting root cause analysis (RCA)			
☐ Arrange a meeting of the safety committee to analyse the results of the RCA and suggest preventive measures			
☐ Establish the information required and a deadline for reporting it			
☐ Decide whether it is appropriate to invite representatives of registered patient associations to participate in the case analysis or RCA (as appropriate)			
☐ Inform the patient who has experienced the AE of the results of the analysis within 15 days			
☐ Introduce measures to increase patient safety			
☐ Hold clinical sessions on medical errors			

Checklist of actions recommended to protect the reputation of the health professionals and the organization

Date: _____

Centre/Hospital: _____ **Unit/Service:** _____

PROTECT THE REPUTATION OF PROFESSIONALS AND THE INSTITUTION			
Action	**Completed**		**Comments**
	Date	**Time**	
☐ Review the communication plan in the light of experience gained			
☐ Regularly update information on new interventions in the field of clinical safety underway in the centre			
☐ Regularly disseminate news on the therapeutic achievements and training activities carried out, in accordance with the communication plan			

Personal and professional profile

Personal and professional profile of candidates for the team providing first-line support to second victims

The following is a list of skills, types of knowledge and other characteristics that professionals who are going to form the team providing first-line support to second victims should possess and develop. Ideally, in each ward, unit, department, service or team, there should be a person who possesses these characteristics to offer support to second victims:

Personal qualities

- Empathy.
- Reflexive, non-impulsive personality.

Basic knowledge

- of the second victim experience (stages of recovery, needs, etc.).

Experience in the centre

Knowledge

- of the patient safety plan and associated interventions.
- of the referral process for cases in which a need for more specialised care is identified.

Skills

- to adopt a supportive attitude based on active listening and avoiding at all times a judgemental attitude.
- to adopt a respectful attitude, avoiding being judgemental.
- of verbal and nonverbal communication.
- to identify symptoms of depression, anxiety and post-traumatic stress disorder.
- to identify specific needs at personal, family and professional levels.
- to share, in a respectful way, similar personal experiences, if this may be reassuring for the second victim.

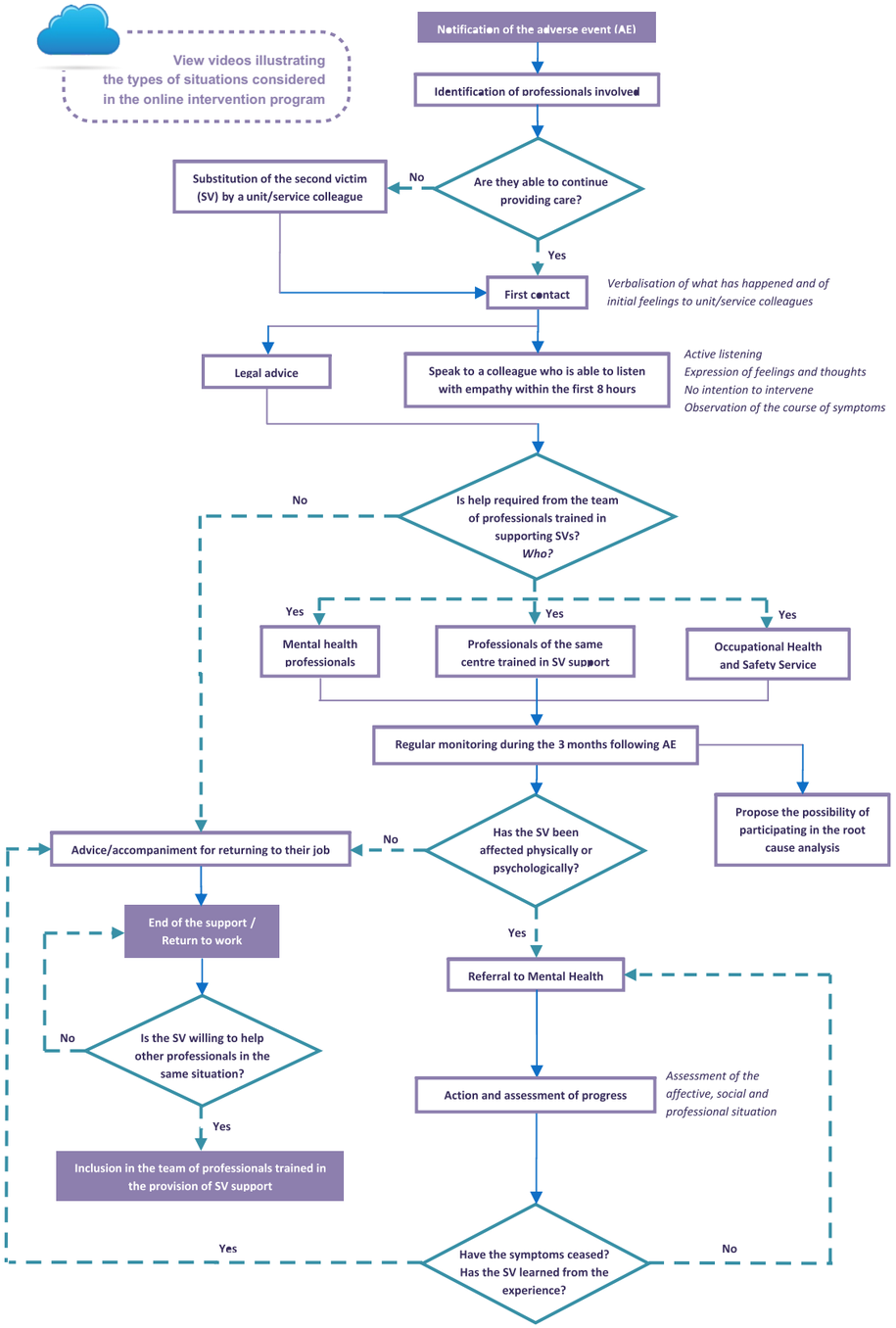
Appropriate management

- of key words and actions (what to say/do and what not to say/do).
- of physical contact in response to the emotional needs of the health professional involved.
- of silences in order that they are reassuring for the person involved.

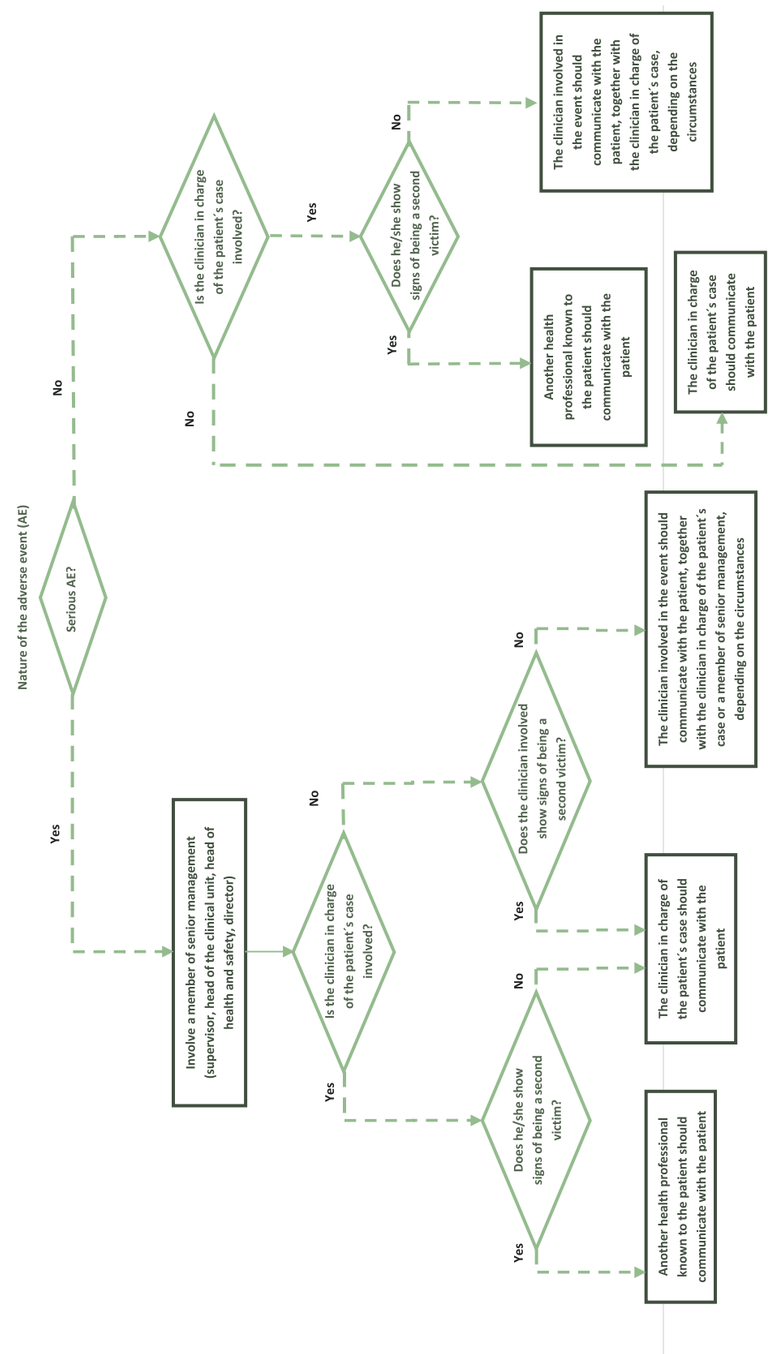
According to methodology of Scott and her team, asking healthcare staff who they would look to for help if they became a second victim is a strategy that could be used to identify individuals in each area with the desired characteristics to offer support.

Link to online intervention program related to second victims

Algorithm for providing support to second victims (SVs)



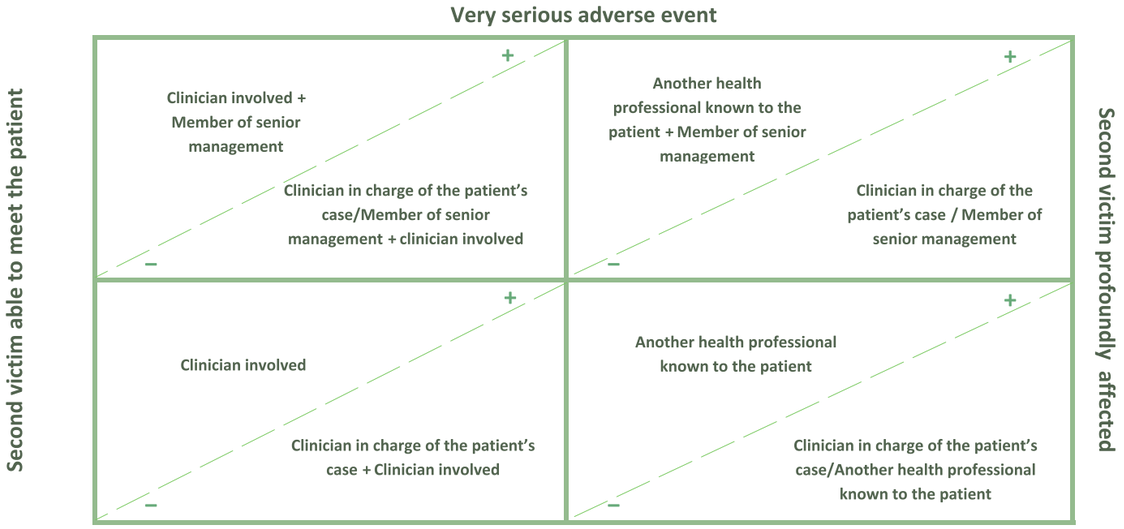
Algorithm for deciding who should communicate with the patient



The following are considered serious AEs: death and other sentinel events, surgical intervention or reintervention, hospital admission, permanent injury or damage, or similar

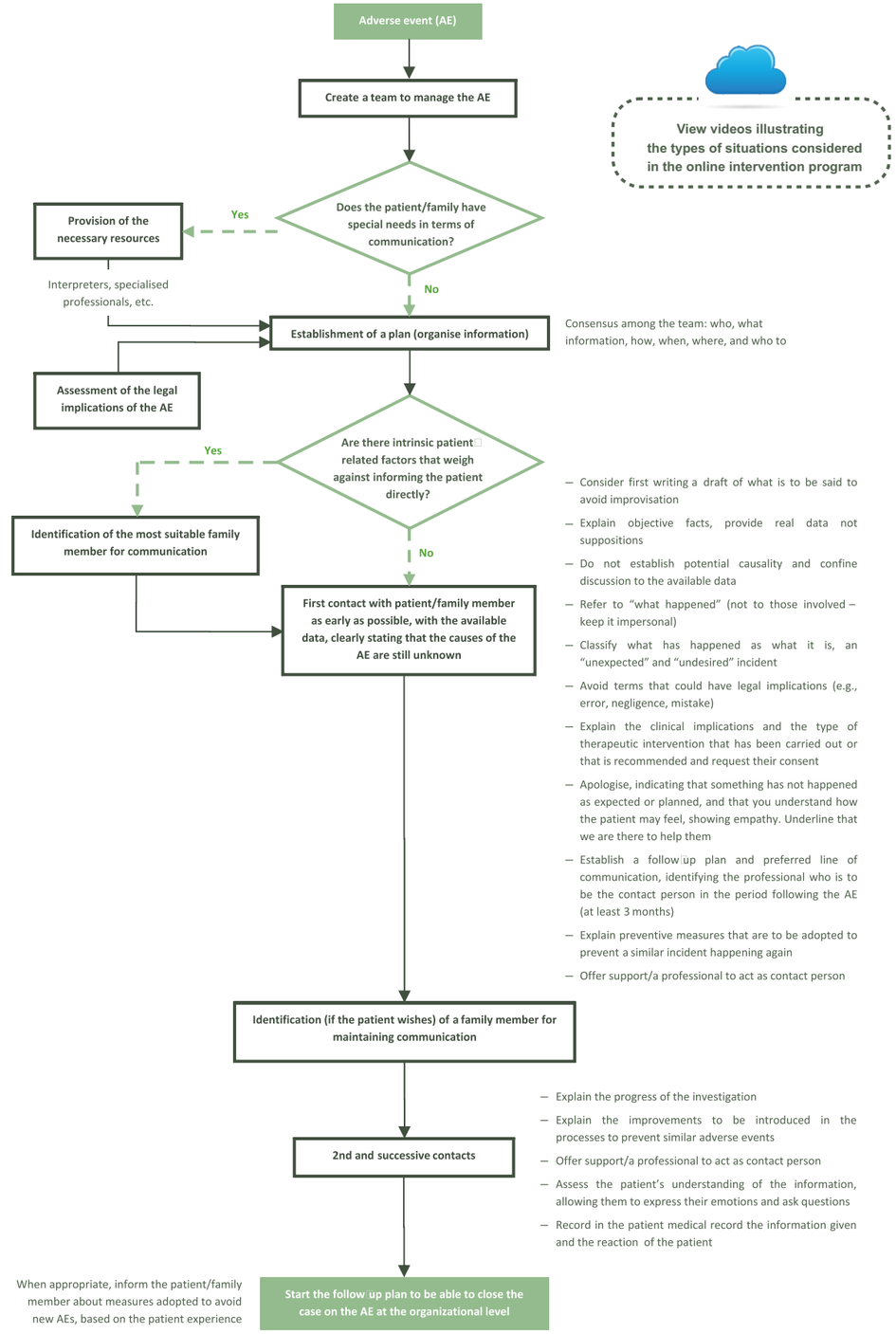
Algorithm for deciding who should communicate with the patient

Criteria for identifying the person who should communicate with the patient



Clinician in charge of the patient's case YES (+) vs NO (–)

Algorithm for providing honest information to patients in case of serious adverse events



TYPES OF SENTINEL EVENTS

In 2011, the USA's National Quality Forum (NQF) published the second edition of a list of a 29 serious reportable events that meet the criteria for sentinel events. The aim of the NQF in developing this list was to facilitate comparable public reporting that enables systematic learning between healthcare organizations and systems and thereby leads to improvements in patient safety at the national level based on what has been learnt (concerning adverse events and how to prevent their recurrence).

I. Surgical or invasive procedure events

1. Surgery or other invasive procedure performed on the wrong site
2. Surgery or other invasive procedure performed on the wrong patient
3. Wrong surgical or other invasive procedure performed on a patient
4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
5. Intraoperative or immediately postoperative/post-procedure death in an ASA Class 1 patient

II. Product or device events

6. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
7. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
8. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

III. Patient protection events

9. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorised person.
10. Patient death or serious injury associated with patient elopement (disappearance)
11. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting

IV. Care management events

12. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
13. Patient death or serious injury associated with unsafe administration of blood products (haemolytic reaction)
14. Maternal death or serious injury associated with labour or delivery in a low-risk pregnancy while being cared for in a healthcare setting
15. Death or serious injury of a neonate associated with labour or delivery in a low-risk pregnancy
16. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
17. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
18. Artificial insemination with the wrong donor sperm or wrong egg
19. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
20. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

V. Environmental events

21. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
22. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
23. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
24. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

VI. Radiologic events

25. Death or serious injury of a patient or staff associated with introduction of a metallic object into the MRI area

VII. Potential criminal events

26. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
27. Abduction of a patient/resident of any age
28. Sexual abuse/assault on a patient within or on the grounds of a health care setting
29. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting

The events included on the list are classified into seven categories: (I) surgical or invasive procedure events, (II) product or device events, (III) patient protection events, (IV) care management events, (V) environmental events, (VI) radiologic events and (VII) potential criminal events.

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Design of guides and tools to reduce the impact of adverse events on health professionals (second victims) and hospitals (coordinated project) - PI13/0473 and PI13/01220