# The media and social impact of the adverse events. The hospital as third victim. Some ideas for an effective Crisis Communication

José Joaquín Mira
Health Department of Sant Joan and Alacant – Consellería Sanitat. Generalitat Valenciana. Spain

Clinical practice is not without risk. Adverse events are more common than we thought[1,2,3,4,5].

According the ENEAS study the frequency of AE in Spanish hospitals oscillates around 10%[6]. In primary care the frequency of AE ranges around the 1,8‰[7]. A conservative estimation shows that around 15% of Spanish health care providers are involved in some AE for one or more patients every year.

Apart from the clinical and emotional consequences for patients (first victims) and the professionals involved (second victims), the AE are also cause for a media impact with negative consequences for the reputation of health institutions (third victims). The study of the consequences for health institutions has practically unnoticed.

The Institute for Healthcare Improvement (IHI) in the United States has developed a series of recommendations and tools to help health care institutions to deal with this difficult situation[8]. This and other references were useful for us. In our hospital we have designed a procedure to prepare a possible future crisis related to an AE expecting that it should be a useless work because never use it.

In our case we seek two goals:

1. Consolidate the procedure for an effective crisis communication in case of AE with severe consequences.

2. Strengthen and consolidate a culture of safety in the whole of the Health Department (in our case primary care and hospital belongs to the same managerial structure).

<u>Actions to be implemented to achieve these objectives</u>:

1. To keep a **proactive attitude** that favors a safety framework (strengthen positive arguments).
    1.1. To conduct periodically the study to determine the frequency of AE and the effectiveness of the barriers to prevent them.
    1.2. To promote reporting to our reporting system of incidents and AE, collecting useful information to avoid risks to patients.
    1.3. To assure that all AE detected with moderate or severe consequences are analyzed to know their causes and how to avoid them in the future (we are able to learn of our own experience).
    1.4. To offer training opportunities to the medical residents of all the specialties so that they know how to act in case of AE.
    1.5. To conduct with the necessary confidentiality clinical sessions on the occurrence of clinical errors to analyze and prevent risks in the future.

2. To promote a **positive image** of the institution and its professionals to address successfully a possible future crisis situation.

2.1. Takes advantage of our communication plan that carries out the information initiative and provides details of the activities performed by hospital and its professionals to reinforce the image of the Department as active and leading in quality assurance.

3. To **learn** how to act in a responsible and orderly manner in case of crisis

3.1. To define a procedure that ensures that personal information of patients and professionals that is provided to journalists when occurs an AE keeps confidentiality and respect.

3.2. To define a plan of crisis that includes what to do and what not to do when an AE with severe consequences occurs.

3.3. To prepare a Crisis Report Instructions detailing procedures to be applied and responsibilities among the members of the management team and the rest of the staff.

3.4. To constitute a Crisis Committee including managers, clinicians and other personnel.

3.5. To identify a spokesman to take action in crisis.

3.6. To design a training program for the Crisis Committee participants so that they can respond effectively and learn about their role in the event of a crisis.

3.7. To define the role that different profiles which must be played in the relationship and communication with the patient when an AE occurs.

3.8. To define a procedure to report responsibly to the patient(s) who suffered an AE with severe consequences and to assure that we apply all appropriate measures of care that may be required.

3.9. To identify the actions that must be performed to protect the second victims.

3.10. To assure that our training plan includes specific training on how to communicate a patient (or their families) that he/she has suffered an AE.

3.11. To establish a procedure to enhance internal communication to prevent rumors and in which staff should have timely and reliable information of what has happened and how to avoid it in the future.

4. To restore a **positive image** of our institution after a crisis.

4.1. To define who must interact with the patient(s) (or their families) who has suffered an AE.

4.2. To develop a procedure to provide the patient(s) a channel to contact professionals to guide them and answer their questions in the days following the AE.

4.3. To elaborate a procedure for the follow-up of the patient(s) who has suffered an AE. This procedure is for a few months to ensure that the consequences of the AE have been controlled.

4.4. To assure that in the months following an AE our communication plan offers positive information of our care approaches and results that contributes to building trust in our institution.

Some ideas for a global approach to share the same culture safety and protect the institutional image.

The following questions could help us to review and share alternatives to coping with a crisis related to AE. Any of them are enough useful by itself, but combining some of them we could be able to cope with a crisis successfully.

First assess the utility assigned to each according you criteria. Second, if you have experience in your hospital assess the actual utility of each.

| **OUR SAFETY CULTURE** | | | | | | | |
|---|---|---|---|---|---|---|---|
| In our hospital…. | Utility assigned to this activity | | | Assessing its utility in our experience | | | |
| 1. The frequency of AE and the effectiveness of the barriers to prevent them are periodically assessed. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 2. We carried out periodically studies to assess aspect of our safety culture. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 3. We have a reporting system of incidents and AE. This system is collecting useful information to prevent risks. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 4. Our patient safety policy includes find an honest relationship with the patient who has suffered an AE. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 5. We share a proactive culture to avoid risks to patients. When an AE is detected we analyzed their causes and how to avoid it in the future (we are able to learn from own experience). | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 6. We celebrate clinical sessions on the occurrence of clinical errors to analyze and prevent risks in the future. Confidential measures are applied if required. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |

| **CRISIS PLAN** | | | | | | | |
|---|---|---|---|---|---|---|---|
| In our hospital…. | Utility assigned to this activity | | | Assessing its utility in our experience | | | |
| 7. We have defined a crisis plan that includes what to do when occurs an AE with severe consequences on one or more patients. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 8. We have a Crisis Committee involving managerial leaders, supervisors, clinician and other personnel. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 9. Our training plan includes specific training on how to communicate a patient (or their families) that he/she has suffered an AE. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 10. The medical residents receive training to know how to act in case of AE. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 11. When an EA with serious consequences for any patient occurs, we assure internal communication to avoid rumors. Our procedure assures that staff should have timely and reliable information of what has happened and how to avoid it in the future. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 12. In the case of an AE with severe consequences for a patient, always carry out an internal analysis to determine what, when, where, how it happened and what were its causes in order to prevent it. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |

| **COMUNICATION AND TRANSPARENCY WITH PATIENTS AND RELATIVES** | | | | | | | |
|---|---|---|---|---|---|---|---|
| In our hospital… | Utility assigned to this activity | | | Assessing its utility in our experience | | | |
| 13. We agreed who should interact and inform the patient (or their relatives) that has suffered an AE. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 14. We have established the role that must be played in the relationship and communication with the patient who suffers an AE, the direction of the medical service, the nursing supervisor, medical management and nursing. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 15. We have a protocol on what, how, when and who to inform a patient (or their relatives) that has suffered an AE. Open disclosure approach. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 16. The protocol information to the patient who has suffered an AE specifies the importance and need to ask for an apology to the patient. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 17. We respect that the patient (or their relatives) that has suffered an AE with severe consequences can access to his/her medical record. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 18. The patient (or their relatives) that has suffered an AE with severe | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| consequences can, if desired, receive psychological assistance offered by the hospital. | | | | | | | |
| 19. Whenever it happens we try to provide the patient (or their relatives) agile, clear, honest and complete information. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 20. The patient (or their relatives) that has suffered an AE with severe consequences has a channel to contact professional to guide him/her in the days following the incident. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 21. We put up the necessary mechanisms to compensate properly the patient (or their relatives) that has suffered an AE. | | | | | | | |
| 22. The patient or a family member may participate, in some point of the investigation into the incident, to clarify what has occurred and identify what to do to avoid that happened again. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 23. We have the caution to follow up the patient who has suffered an AE for a few months to make sure that the consequences have been controlled. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |

| **SECOND VICTIM CARE (professionals)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| In our hospital… | Utility assigned to this activity | | | Assessing its utility in our experience | | | |
| 24. The professionals have an insurance policy that covers the possible compensation and provides legal cover in the event that happens an AE. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 25. Professionals involve in an AE have legal advice from the first moment, offered by the hospital. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 26. Professionals who are involved in an AE have access to psychological support offered by the hospital to cope with feelings of guilt, stress, loss of confidence in their professional decisions and reduce the impact as a second victim. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 27. It has developed a protocol on how to act with the second victims to discuss | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| what and how it happened. | | | | | | | |
| 28. We offer and recommend systematically to the professionals involved in an AE that they can talk with their peers to analyze what has happened. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 29. We offer professionals who have been involved in an AE a specialized care and a contact person with whom to share the experience and obtain support. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 30. The directive staff is always available to assist practitioners who suffer as second victim, respecting the rights and the personal circumstances of these professionals. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 31. We are looking for involving second victim in the search of solutions so that the AE never occurs again. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 32. We have a comprehensive program of orientation, advice, support and assistance to the second victims. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |

| **COMMUNICATION AND INSTITUTIONAL IMAGE** | | | | | | | |
|---|---|---|---|---|---|---|---|
| In our hospital… | Utility assigned to this activity | | | Assessing its utility in our experience | | | |
| 33. We are very careful and zealous with the personal information of patients and professionals that is provided when occurs an AE with media impact. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 34. We do not offer any information to the media about an AE without having made first an analysis of what happened and have spoken with the professionals involved. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 35. When an AE has media impact our Communication Office reports details in the first 24 hours. They avoid communication gaps. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 36. The Communication Office seeks to maintain contact with health journalists to correctly report what has happened in the case of an AE with media impact. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 37. A spokesperson who is responsible for communication and relations with the media has been named. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 38. When happened an AE with severe consequences for a patient with an inevitable media component, we report what has happened to the rest of the hospital to give them real information and avoid guesses. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |
| 39. We have a communication plan to offer positive information of our work that contributes to rebuilding the trust in our hospital in the following months about clinical error. | POOR | FAIR | GOOD | NOT YET | POOR | FAIR | EXCELENT |

References

[1] Brennan TA, Leape LL, Laird NM, Hebert L, Localio AR, Lawthers AG, et al. Incidence of adverse events and negligence in hospitalized patients. Results of the Harvard Medical Practice Study I. N Engl J Med 1991;324:370-6.
[2] Leape LL, Brennan TA, Laird N, Lawthers AG, Localio AR, Barnes BA, et al. The nature of adverse events in hospitalized patients: Results of the Harvard Medical Practice Study II. N Engl J Med 1991;324:377-84.
[3] Gandhi TK, Weingart SN, Borus J, Seger AC, Peterson J, Burdick E, et al. Adverse drugs events in Ambulatory Care. N Eng J Med. 2003; 348:1556-64.
[4] Wilson T, Sheikh A. Enhancing public safety in primary care. BMJ. 2002;321:581-7.
[5] Kuzel AJ, Woolf SH, Gilchrist WJ, Engel JD, La Veist TA, Vincent C, et al. Patient reports of preventable problems and harms in primary health-care. Ann Fam Med. 2004;2:333-40.
[6] Aranaz-Andrés JM, Limón R, Mira JJ, Aibar C, Gea MT, Agra Y, and the ENEAS Working Group. What makes hospitalized patients more vulnerable and increases their risk of experiencing an adverse event? International Journal for Quality in Health Care 2011; 23:705-11.
[7] Aranaz J, Aibar C, Limon, Mira JJ, Vitaller J, Agra Y, Terol E. A study of the prevalence of adverse events in primary healthcare in Spain. The European Journal of Public Health 2012; 22: 921-925.
[8] Conway J, Federico F, Stewart K, Campbell M. *Respectful Management of Serious Clinical Adverse Events*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2010. (Available on www.IHI.org).