Taking Care of our Providers and Staff After an Adverse Event

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Why We Provide Post Adverse Outcome Support to Our Patient Care Providers

- Ensures that we're taking care of our most valuable resource – our employees
- It's the right thing to do (can this be argued?)
- Costs are minimal, benefits are endless
  (Med errors are reduced, quality of care is improved, affected providers are retained, pt. care teams can rebound more quickly.)
- Fosters goodwill, trust and appreciation:
  "the organization cares about the well-being of its providers."

Disaster Response and Critical Incident Stress Management: How Adverse Outcome Support fits into Kaiser Permanente's Planning/Response Model

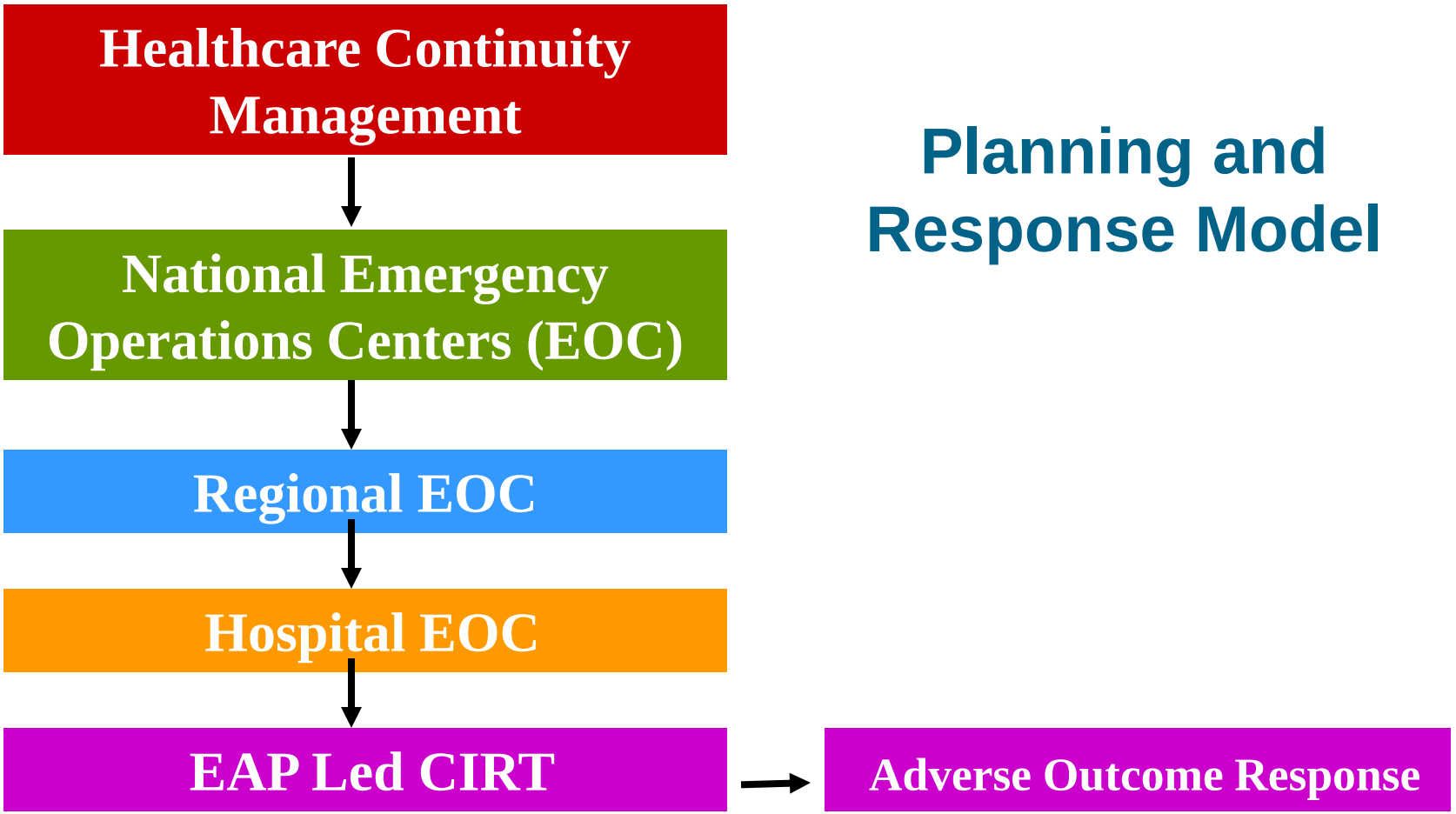
1. **National** - *Healthcare Continuity Management Team* is the organizational point of contact for insuring the continuity of healthcare and business operations in response to natural or man-made disasters

2. **Regional & Local** - *Emergency Operations Centers (EOC)* are regional and facility based teams - support continuation of essential functions and critical processes during and after a disaster. Prepare staff and facilities via biannual disaster drills

3. **Local** *Multidisciplinary Facility Based Critical Incident Response Teams (CIRT)* led by EAP to respond to disasters and critical incidents at each medical facility

4. **Local Healthcare Operations** - EAP led Critical Incident Response for adverse clinical outcomes. Part of organizational Patient Safety Initiative with services to:
   - ♦ Kaiser Emergency Room Staff
   - ♦ Intensive Care Units
   - ♦ Operating Rooms
   - ♦ Perinatal Units
   - ♦ Pediatric Units

Healthcare Continuity Management Org Chart



Planning and Response Model

When is Support Needed and Who Needs It

- After the Event
- After Regulatory Scrutiny
- After Media Exposure
- After the Demand for Arbitration

Any healthcare staff affected by the event, including, but not limited to:

- *Physicians*
- *Nurses/CRNAs*
- *Midwifes*
- *Pharmacists*
- *Residents*
- *Lab Technicians*
- *Managers/Leaders*
- *Support staff*

“Don’t Talk To Anyone”

- Traditional medical legal and risk management advice has stressed not talking to anyone
- This prohibition on talking denies need and stopped those effected from getting help
- We needed to change the advice to something more supportive

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- Residents discussed only 54% of mistakes with supervising physician
- In only 24% of cases were mistakes discussed with patients or patients’ families
- Emotional reactions included remorse (81%), anger (79%), guilt (72%), inadequacy (60%)
- Wu et al., 1991

What Have Staff Done After An Event/Claim?

- Increased Absenteeism
- Increased Presenteeism
- Lost trust in organization
- Resisted cooperation with litigation
- Left the organization
- Left the profession

Creating Organizational Accountability
Kaiser Policy: Responsible Reporting for Adverse Outcomes

Six Step Process

#1 Immediate care of the Patient

#2 Communicating adverse outcome

#3 Report to internally and externally

#4 Document in the Medical Record

#5 Follow up with Patient and Closure

#6 Support to Patient Care Team

Safe Places and Individuals for the FACTS of the Event

- Persons employed in the Risk Management or Quality Depts.
- Medical Legal Chief, APIC for Risk, Quality Chief
- Ombudsman
- Professional Liability Staff
- Defense Counsel
- Spouse
- Domestic Partner, (CA)

Goals of Adverse Outcome/Critical Incident Response Services For Emotional Needs

1. Provide education and consultation to management and staff prior to and following an adverse outcome re: emotional needs
2. Allow staff to discuss and share thoughts, feelings and reactions to adverse outcomes
3. Help stabilize the workplace post-event
4. Mitigate the effects of critical incident stress
5. Promote a return to normal productivity
6. Provide identification of individuals who will need additional follow-up

Potential Effects of a Critical Incident or Adverse Outcome on Org/Dept/Team Function

1. Increased absenteeism
2. Increased Presenteeism
3. Staff turnover and resulting costs
4. Increased workers' compensation stress claims and stress-related physical illness claims
5. Decreased productivity
6. Feeling unsupported by Management
7. Exacerbation of existing problems and tensions
8. Lowered morale
9. Fractured Team, Splitting of staff
10. Rumors
11. Grievances
12. Feelings of anger, devaluation, frustration, helplessness
13. Increased tensions
14. Work unit viewed as unsafe
15. Litigation against the organization

Organizational Support Needed

- Leadership buy-in: Medical group, administration and labor
- Key stakeholders must participate in, and support implementation of services
- Support from department leadership and department culture will strongly influence success or failure of process

Operational Sequence Post Adverse Outcome

- Situation Management Team contacted after an event
- Manager of Patient Care Team member contacts EAP/CISM team
- Consultation with manager and/or Situation Management Team for assessment of situation and team to include:
  - All shifts
  - All staff
- Time and place for groups are determined

Operational Sequence Post Adverse Outcome (contd.)

- Time available for support intervention (debriefing)?
  - Should groups include managers?
  - Should groups include physicians?
- Determination of appropriate intervention
  - Crisis management briefing / defusing / debriefing / 1x1 / organizational consultation
- Provide intervention
- Follow-up with situation management team/manager/staff/other resources

Employee & Physician Assistance Program (EAP) Services for Adverse Outcomes

Why Call EAP?
- Good process + bad outcome
- Bad process + good outcome
- Bad process + bad outcome

Pre-Incident Education

When, why, how, and what purposes might EAP be considered for after an adverse outcome (Simulated/mock adverse outcomes are used as basis for pre-event education.)

Who Calls EAP?

Any physician/staff, individual or group. (Most calls are initiated by dept. chief, nurse mgr, ombudsman)

What Will EAP Need to Know in the initial consultation:

If an individual issue:
- Circumstance, effect of the experience, any relevant hx, primary concern.

If group issue:
Identification of impacted staff
Operational debriefing (yes/no?)
Discussion of case; relevant facts and emotional impact on staff and providers and family
Clarification regarding patient and family support
Medical legal aspects (yes/no?)

Should EAP provide intervention?

No → Consider other resources as appropriate

YES

Planning decisions will include:
- Type of intervention
- Timing of intervention
- Who will provide services

Types of support services available:
- Crisis Management Briefing
- Defusing
- Critical Incident Stress Debriefing (CISD)
- Individual Services
- All services to include follow up

Intervention(s)/ Support provided.

Follow up plan determined - short term and long term

Evaluation of support services

For managers, staff and potential users of services

Pre-Event Training

- Secure administrative and management/ union partner support of the critical incident response process
- Provide pre-incident training to all appropriate individuals/groups
- Include in training:
  - the potential cognitive, emotional and behavioral impact
  - of adverse events
  - description of process to be utilized by EAP staff

Pre-Event Education Audiences

- All of Your Key Stakeholders:
- Staff of high risk departments-ED, Perinatal, OR, Pediatrics, and Oncology
- Local Administration
- Risk Manager
- Med-Legal Chief and Physician Risk Leaders
- Quality Chief and Manager
- Chief/Manager of high risk departments
- Ombudsman

Educational Flyer For Use Before/After An Event

- Endorsed by executive leadership
- States clearly that reactions are normal and that employees need support
- Gives permission to use services
- Describes the safe individuals and forums for discussion of:
  - Facts of events
  - Emotional reactions

We Care About You…

Emotional Support for the Patient Care Team for Adverse Outcomes

An adverse outcome can generate emotional stress for all involved. Health care professionals are not immune from the psychological turmoil associated with a disappointing outcome. Feelings of isolation, anger, shame, guilt and frustration sometimes occur. The emotional reactions may be triggered by the event and /or exacerbated by regulatory scrutiny or an allegation of medical malpractice. **It is normal to want to talk about this event and its effect on you.**

The leadership of Kaiser Permanente is committed to supporting our physicians and employees through this trying time. We encourage you to discuss how this event has affected your professional and /or personal life if you wish.

Here are some general guidelines and resources available to support you in that discussion:

You may speak candidly about the facts of the event under the protection of the quality/peer review or attorney client privileges. This includes: anyone working within the Quality or Risk Management Departments or Committees, Medical Legal Chief, Ombudsman, professional liability staff and/or defense counsel. You may discuss the facts with your spouse. You may also discuss the facts with your registered domestic partner (California AB205, effective date: Jan 1, 2005).

You may speak candidly about the emotional impact of the event on you to your spouse, domestic partner, clergy, mental health provider, personal physician or Employee Assistance Program (EAP). Physicians may also speak with your facility's Professional Staff Well Being Committee.

Brochures describing EAP and Professional Staff Well Being programs are available. Local contact information for EAP may be obtained through your facility's Human Resource Department or on the EAP website at http://xnet.kp.org/hr/ca/north/docs/hrpeople/eap/index.htm.

Contact the Physicians Health Department at (510) 625-4101/8-428-4101 for information on your facility's Professional Staff Well Being Committee.

We encourage you to take advantage of these resources as needed.

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After an Event - Initial Management Consultation

- Review of facts of the event
- Consider med-legal aspects and potential impact on RCA
- Clarify status of operational debriefing
- Identify primary staff members involved and secondary staff implications
- Clarify support for the patient and family: chaplain, and social services

Support and Intervention Planning

Mitchell Model (CISM) - used as foundation for response/support

- Flexibility within the model is essential for success
- Consider organization, timing and activation of interventions:
- Crisis management briefing: large group intervention, educational
- Defusing: within 24 hrs. after event, short duration
- Debriefing for groups: 1-10 days after event, structured intervention
- Individual crisis intervention: one-on-one counseling

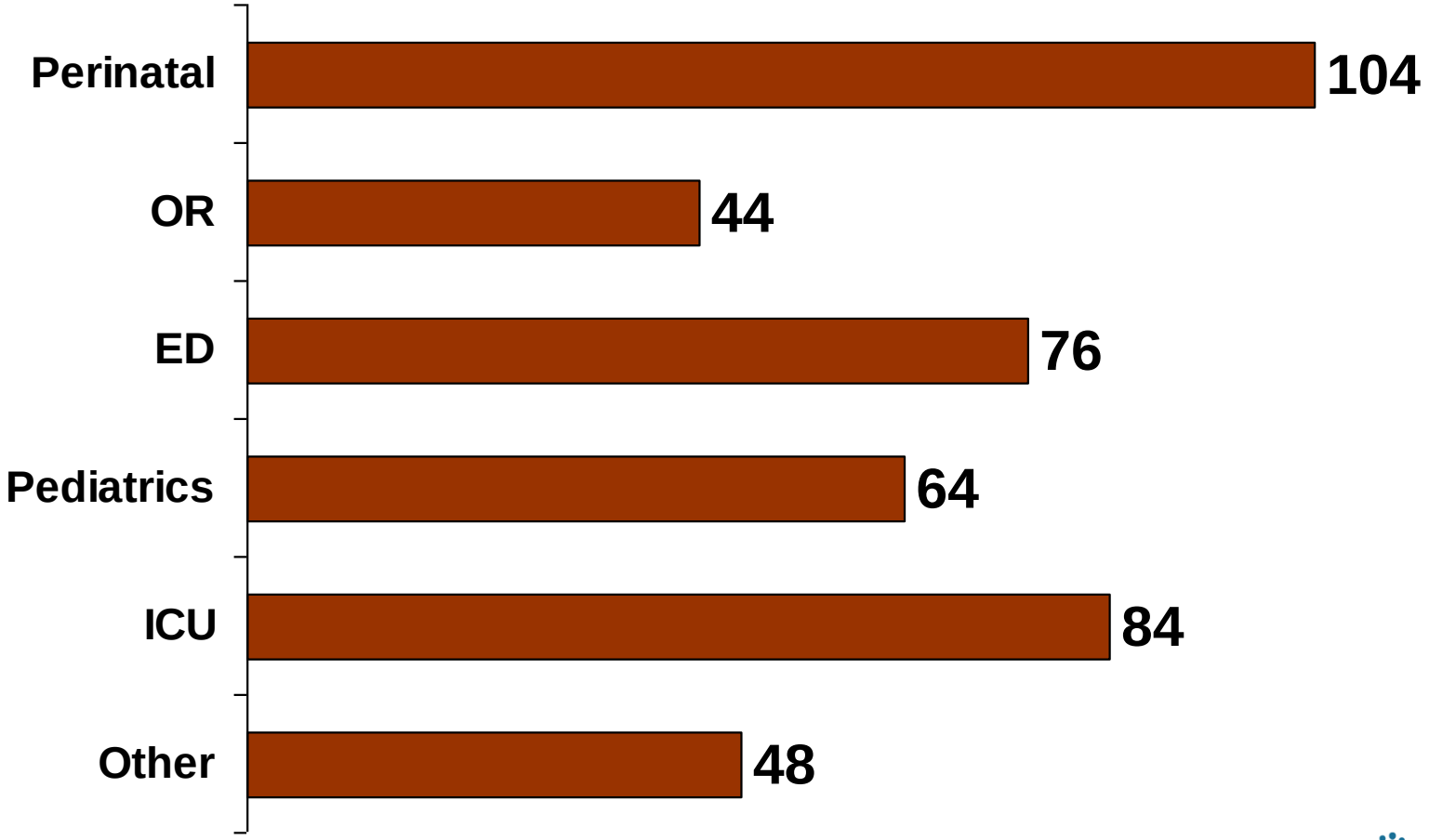
Follow Up - Short Term/Long Term

- Short-term follow-up with referral source and staff

- Long-term follow-up particularly re:
  - Anniversary dates, or
  - Legal action to include depositions, which may re-activate stressful reactions

Initial Response After Roll Out of Program

EAP Response to Adverse Events in 2004 to Present



Making It Work - Lessons Learned

- "One Chance To Make A First Impression"- Need to obtain support at all levels and clarify roles of responders prior to rolling out program
- Flexibility within the model is essential for success
- EAP, Risk, Quality and Management need to partner closely
- Out-reach to providers and staff regardless of whether they initiate contact is OK
- Only after careful consideration of the benefits/risks, stipulation of confidentiality, creating a safe environment and ensuring participants are in agreement, should you proceed
- Follow up with each other periodically after an event considered closed is important

In Closing . . .

**“It is now expected that
we will take care of providers and staff
when adverse events occur.”**