Patient perspectives of being informed about iAEs

Prof. Tanja Krones, MD MS

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You are the treating neuro-surgeon of a 28 year old patient, working as a model and is suffering from meningeoma, which could be resected in toto. For fixing the sterile covering of the patient you had used a sharp clamp. When the cover was removed, the surgical nurse assistant discovers that the clamp went through the root of the nose and has injured the patient, now having two wounds at the right and left side of the nose

A 58 year old patient on ECMO is referred to the operation theatre for a lung surgery intervention. After anaesthesia (the patient was awake during ECMO since 1 week) the perfusionist has to change an adapter within the system due to a leak. Yet the new one does not fit into the system resulting in a heavy blood loss, need of mass transfusion and a short mechanical resuscitation of the patient. The operation goes well and the patient has seemingly and luckily not incured serious consequences.

Prospective validation of classification of intraoperative adverse events (ClassIntra): international, multicentre cohort study

Salome Dell-Kuster,[1,2,3] Nuno V Gomes,[1,3] Larsa Gawria,[2,4] Soheila Aghlmandi,[2] Maame Aduse-Poku,[5] Ian Bissett,[6] Catherine Blanc,[7] Christian Brandt,[8] Richard B ten Broek,[4] Heinz R Bruppacher,[9] Cillian Clancy,[10] Paolo Delrio,[11] Eloy Espin,[12] Konstantinos Galanos-Demiris,[13] I Ethem Gecim,[14] Shahbaz Ghaffari,[15] Olivier Gié,[16] Barbara Goebel,[17] Dieter Hahnloser,[16] Friedrich Herbst,[15] Ioannidis Orestis,[13] Sonja Joller,[18] Soojin Kang,[5] Rocio Martín,[12] Johannes Mayr,[17] Sonja Meier,[5] Jothi Murugesan,[19] Deirdre Nally,[10] Manoksa Ozsolik,[20] Ugo Pace,[11] Michael Passeri,[21] Simone Pehanser[22]

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Table 1 | ClassIntra version 1.0 classification of intraoperative adverse events. The classification defines intraoperative adverse events as any deviation from the ideal intraoperative course occurring between skin incision and skin closure. Any event related to surgery and anaesthesia during the index surgery must be considered and should be rated directly after surgery.* A requirement is that the indication for surgery and the interventions conform to current guidelines

Grade	Definition	Examples
Grade 0	No deviation from the ideal intraoperative course	—
Grade I	Any deviation from the ideal intraoperative course: • Without the need for any additional treatment or intervention • Patient with no or mild symptoms	• Bleeding: bleeding above average from small calibre vessel, self-limiting or definitively manageable without additional treatment than routine coagulation • Injury: minimal serosal intestinal lesion, not requiring any additional treatment • Cautery: small burn of the skin, no treatment necessary • Arrhythmia: arrhythmia (eg, extrasystoles) without relevance
Grade II	Any deviation from the ideal intraoperative course: • With the need for any additional minor treatment or intervention • Patient with moderate symptoms, not life threatening, and not leading to permanent disability	• Bleeding: bleeding from medium calibre artery or vein, ligation; use of tranexamic acid • Injury: non-transmural intestinal lesion requiring suture(s) • Cautery: moderate burn requiring non-invasive wound care • Arrhythmia: arrhythmia requiring administration of antiarrhythmic drug, no haemodynamic effect
Grade III	Any deviation from the ideal intraoperative course: • With the need for any additional moderate treatment or intervention • Patient with severe symptoms, potentially life threatening or potentially leading to permanent disability	• Bleeding: bleeding from large calibre artery or vein with transient haemodynamic instability, ligation or suture; blood transfusion • Injury: transmural intestinal lesion requiring segmental resection • Cautery: severe burn requiring surgical debridement • Arrhythmia: arrhythmia requiring administration of antiarrhythmic drug, transient haemodynamic effect
Grade IV	Any deviation from the ideal intraoperative course: • With the need for any additional major and urgent treatment or intervention • Patient with life threatening symptoms or leading to permanent disability	• Bleeding: life threatening bleeding with splenectomy; massive blood transfusion; stay at intensive care unit • Injury: injury of central artery or vein requiring extended intestinal resection • Cautery: life threatening burn injury by cautery leading to fire requiring intensive care treatment • Arrhythmia: arrhythmia requiring electroconversion, defibrillation, or admission to intensive care
Grade V	Any deviation from the ideal intraoperative course with intraoperative death of the patient	—

*These events were not defined as intraoperative adverse events: sequelae, failures of cure, events related to the underlying disease, incorrect site or incorrect patient surgery, or errors in indication.

1. Would you tell the patient what happened?

- ◯ Yes
- ◯ No

2. Would most of your colleagues tell the patient what happened?

- ◯ Yes
- ◯ No

3. Would your institution clearly recommend to tell the patient what happened?

- ◯ Yes
- ◯ No

Transparency, Compassion, and Truth in Medical Errors: Leilani Schweitzer at TEDxUniversityofNevada

155,058 views • Feb 12, 2013

Physician-Patient Communication

A Key to Malpractice Prevention

From the Departments of Medi
Sciences University, Portland, Or
Corresponding author: Wendy
22nd Ave, Portland, OR 97210.

JA

Joint Commission™ Journal on Quality and Patient Safety

Patient and Family Involvement

Disclosing A dverse Events to Patients

The Journal of Emergency Medicine, Vol. 51, No. 5, pp. 605–609, 2016

0736-4679/$ - see front matter

ELSEVIER

http://dx.doi.org/10.1016/j.jemermed.2016.06.048

Ethics

CrossMark

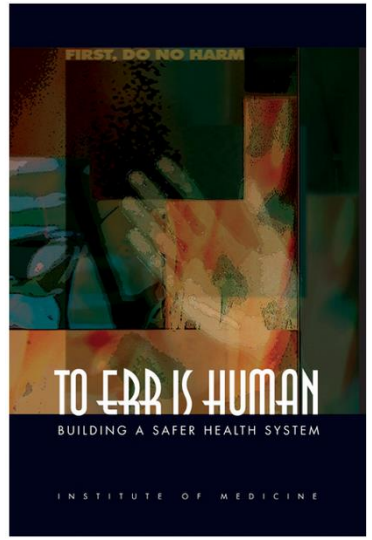
IN SUPPORT OF THE MEDICAL APOLOGY: THE NONLEGAL ARGUMENTS

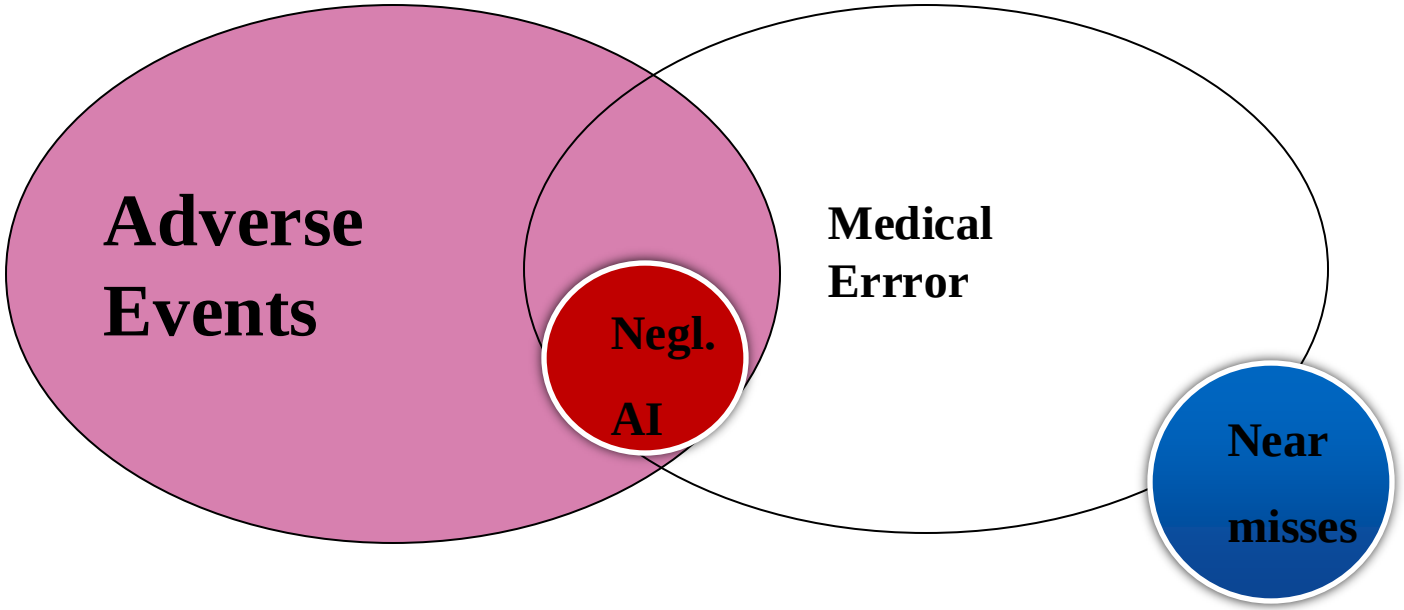
Heather A. Heaton, MD,* Ronna L. Campbell, MD, PHD,* Kristine M. Thompson, MD,† and Annie T. Sadosty, MD*

*Department of Emergency Medicine, Mayo Clinic, Rochester, Minnesota and †Department of Emergency Medicine, Mayo Clinic, Jacksonville, Florida

Corresponding Address: Heather A. Heaton, MD, Department of Emergency Medicine, Mayo Clinic, 200 First Street Southwest, Rochester, MN 55905

Medical Error, Adverse Events, Near Misses





Medical Error in grey zones

«A medical error is «an act or an omission with potentially negative consequences for the patient that would have been judged wrong by skilled and knowledgable peers at the time it ocurred»

Wu, et al. To tell the truth: ethical and practical issues in disclosing medical mistakes to patients. J Gen Intern Med 1997; 12:770-775.

Principal Relevant
Objectives and Framework
for Integrated Learning
and Education in Switzerland

Bern, March 15th 2017

9. Contribute to a culture of safety and improvement

(linked roles: EXP / COM / COL / ADV / SCH / PRO)

EPA 9.1	Identify actual and potential ("near miss") errors in care; speak up in case of real or potential errors, and use error reporting systems if available
EPA 9.2	Empower team members to "stop the line" if they discover a significant safety breach
EPA 9.3	Admit and disclose one's own errors, reflect on one's contribution and develop an improvement strategy
EPA 9.4	Address situations in which a patient could have been the victim of a medical error
EPA 9.5	Understand existing safety/quality procedures, their vulnerabilities and the concept of accountability

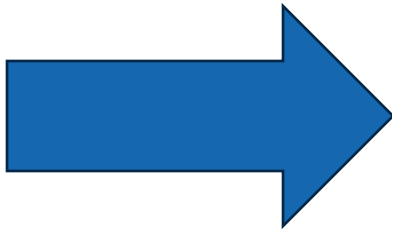
errors or misconduct of a co-worker or other healthcare professional

Principal Relevant Objectives and Framework for Integrated Learning and Education in Switzerland

Bern, March 15th 2017

A new era for the practice of medicine and a challenge for medical faculties

Over the last decades, the sectors of health and medicine have changed dramatically and will continue to do so. This evolution is on one hand linked to the transformation of medical practice, and on the other hand to demographic changes that are occurring in the population itself and within the medical profession. Both should influence the way in which medical students and doctors must be trained (3-8). Indeed, physicians nowadays find themselves in an environment that is becoming increasingly technical and which involves imaging techniques or genetic and biological tests, which are becoming more and more sophisticated and available even to lay people. In high income countries in particular, patients are increasingly literate in the area of health (9), and this is radically transforming the nature of the patient-doctor relationship; the concept of shared decision-making is a good example (10, 11). Moreover, many countries increasingly emphasize the issue of professionalism, including issues such as patient safety, adequate reactions to potential errors (12) and attention to cost-ef-



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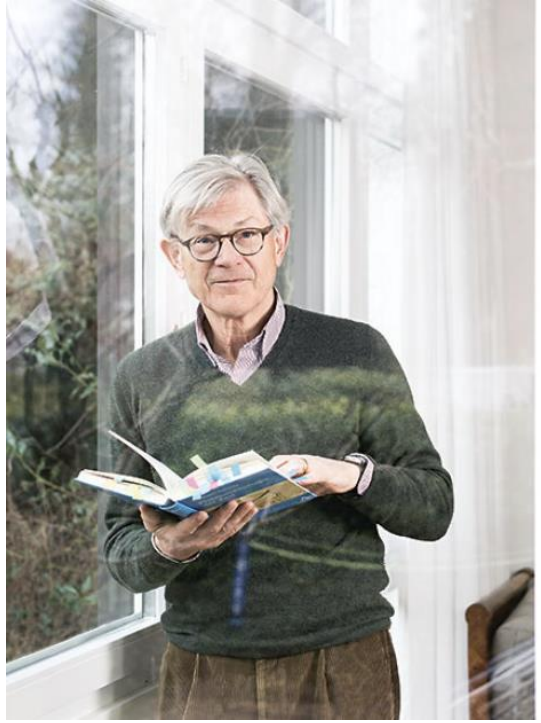

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Improving communication skills--a randomized controlled behaviorally oriented intervention study for residents in internal medicine.

Psychosomatic Medicine. 60(3):268-76, MAY 1998

W A Langewitz; P Eich; A Kiss; B Wössmer show less

Interventions to Improve the Breaking of Bad or Difficult News by Physicians, Medical Students, and Interns/Residents: A Systematic Review and Meta-Analysis

Judith Johnson, PhD, ClinPsyD, and Maria Panagioti, PhD

Abstract

Purpose
To assess the effectiveness of news delivery interventions to improve observer-rated skills, physician confidence, and patient-reported depression/anxiety.

Method
MEDLINE, EMBASE, CINAHL, PsycINFO, and Cochrane Register of Controlled Trials databases were searched from inception to September 5, 2016 (updated February 2017). Eligible studies included randomized controlled trials (RCTs), non-RCTs, and controlled before–after studies of interventions to improve the communication of bad or difficult news by physicians, medical students, and residents/interns. The EPOC risk of bias tool was used to conduct a risk of bias assessment. Main and secondary meta-analyses examined the effectiveness of the identified interventions for improving observer-rated news delivery skills and improving physician confidence in delivering news and patient-reported depression/anxiety, respectively.

Results
Seventeen studies were included in the systematic review and meta-analysis, including 19 independent comparisons on 1,322 participants and 9 independent comparisons on 985 participants for the main and secondary (physician confidence) analyses (mean [SD] age = 35 [7] years; 46% male), respectively. Interventions were associated with large, significant improvements in observer-rated news delivery skills (19 comparisons: standardized mean difference [SMD] = 0.74; 95% CI = 0.47–1.01) and moderate, significant improvements in physician confidence (9 comparisons: SMD = 0.60; 95% CI = 0.26–0.95). One study reported intervention effects on patient-reported depression/anxiety. The risk of bias findings did not influence the significance of the results.

Conclusions
Interventions are effective for improving news delivery and physician confidence. Further research is needed to test the impact of interventions on patient outcomes and determine optimal components and length.

Physicians frequently break bad or difficult news to patients. Research into the delivery of bad or difficult news originated in oncology services, where it was found that news communication practices can have a strong and lasting impact on patients' subsequent symptoms of depression, anxiety, and posttraumatic stress disorder and can influence their treatment choices.[1–5] Studies have since investigated the delivery of bad and difficult news in a range of health care settings, including pediatrics,[6] emergency medicine,[7,8] and obstetrics services.[9,10] Together, this body of research has identified several challenges that physicians may face in scenarios where they have to deliver bad or difficult news, such as when the news occurs suddenly and without warning (e.g., in emergency settings), when there is limited time for physicians to prepare to deliver the news (e.g., in obstetric ultrasound settings), or when the news itself is uncertain because the diagnosis or prognosis is unclear. It has also highlighted the negative impact that these events can have on the physicians involved, including increased stress and burnout.[8,11]

A range of interventions that aim to improve the communication skills and confidence of physicians in delivering bad or difficult news have been described. These interventions vary in length and format but share some similar components; for example, most include elements of didactic teaching, role-playing or simulation,[9] group discussions,[12] or the viewing of instructional videos.[13] The interventions are often designed to enhance fidelity to existing guiding frameworks for bad or difficult news delivery. SPIKES[14] is the most widely used of these frameworks; it proposes six steps, from which the acronym is derived, to improve news delivery events. These steps are (1) setting up the interview, (2) assessing the patient's perception of the situation, (3) obtaining the patient's invitation to deliver the news, (4) giving knowledge and information to the patient, (5) addressing the patient's emotions empathically, and (6) providing a summary and discussing prognosis and treatment options.[14] Similarly, the more recently proposed SHARE[15] protocol suggests that health care staff should follow four steps, which taken together form the acronym. These steps are (1) create a supportive environment, (2) consider how to deliver the news, (3) discuss additional information that patients would like to know, and (4) provide reassurance and emotional support.[15]

J. Johnson is joint lecturer, School of Psychology, University of Leeds, Leeds, United Kingdom, and Bradford Institute for Health Research, Bradford, United Kingdom; ORCID: https://orcid.org/0000-0003-0431-013X.

M. Panagioti is senior research fellow, National Institute for Health Research School for Primary Care Research, Manchester Academic Health Science Centre, University of Manchester, Manchester, United Kingdom; ORCID: https://orcid.org/0000-0002-7153-5745.

Correspondence should be addressed to Judith Johnson, School of Psychology, University of Leeds, Lifton Place, Leeds LS29JT, UK; telephone: +44 (0) 1133435719; e-mail: j.johnson@leeds.ac.uk; Twitter: @DrJTJohnson.

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Rapid Learning of Adverse Medical Event Disclosure and Apology

Daniel B. Raemer, PhD, Steven Locke, MD, Toni Beth Walzer, MD, Roxane Gardner, MD, MPH, DSc, Lee Baer, PhD, and Robert Simon, EdD

Introduction: Despite published recommended best practices for full disclosure and apology to patients and families after adverse medical events, actual practice can be inadequate. The use of "cognitive aids" to help practitioners manage complex critical events has been successful in a variety of fields and healthcare. We wished to extend this concept to disclosure and apology events. The aim of this study was to test if a brief opportunity to review a best practice guideline for disclosure and apology would improve communication performance.
Methods: Thirty pairs of experienced obstetricians and labor nurses participated in a 3-part exercise with mixed-realism simulation. The first part used a standardized actor patient to meet the obstetrical team. The second part used a high-fidelity simulation leading to an adverse medical event (retained sponge), and the third part used standardized actors, patient, and husband, who systematically move through stages of grief response. The participants were randomized into 2 groups, one was provided with a cognitive aid in the form of a best practice guideline for disclosure and apology and the other was only given time to plan. Four blinded raters working in pairs scored subjects on a 7-point scale using a previously developed assessment instrument modified for this study.
Results: Pooled ratings of the disclosure and apology discussion for the intervention group (n = 167, mean = 4.9, SD = 0.92) were higher than those from the control group (n = 167, mean = 4.3, SD = 1.21) ($P < 0.0001$). One specific element was rated higher for the intervention group than the control group; posture toward the patient (n = 27, mean = 5.1, SD = 0.82 versus n = 28, mean = 4.3, SD = 1.33) ($P = 0.020$). The elements of dealing with anger, dealing with depression, dealing with denial, bargaining, and acceptance were not different.
Conclusions: Experienced practitioners performed better in a simulated disclosure and apology conversation after reviewing a cognitive aid in the form of a best practice guideline than a control group that was only given time to prepare.

Key Words: apology and disclosure, patient safety, medical error, simulation

(*J Patient Saf* 2016;12: 140–147)

Adverse medical events are an unfortunate part of healthcare.[1,2] A number of guidelines from health-care organizations and specialty societies, including obstetrics and gynecology, promote appropriate and prompt disclosure of medical errors and adverse events to patients and families.[3–5] Despite available guidelines for the process,[6–8] studies of disclosure have shown gaps between the recommended and actual practice.[9–14] A variety of reasons have been identified for these gaps, including fear of litigation, professional repercussions, and concern that disclosure and apology will not benefit the patient and, clinicians being uncomfortable with difficult conversations or with the emotional expressions of patients' feelings.[15–17] Patients and families report experiencing a variety of negative emotions upon learning of an adverse event, including feeling sad, anxious, depressed, or traumatized.[18] They are sometimes angry and frustrated as well as guilty for not avoiding the incident themselves.[19] Uncertainty about current policies and best practices may also affect the willingness to provide full and open disclosure and apology.[20]

To close the performance gap, it has been suggested that educating clinicians on best practices and encouraging effective disclosure and apology should be part of successful patient safety programs.[21,22] A variety of educational programs, curricula, and methods have been used to provide all or parts of this learning.[23–31] Most studies of educational practice for this topic are descriptive, involve only trainees, and there is little guidance as to the most effective approach for experienced practitioners.[10,32,33] The use of cognitive aids (A cognitive aid is a checklist, manual, or guideline that is immediately available in printed or electronic form to assist a clinician in performing a procedure, follow an algorithm, or help diagnose or treat a condition.) has been successful for improving management of medical crises.[34–36] We wondered if this would apply to difficult conversations for disclosing and discussing adverse medical events.

Simulation has been used successfully for the past 10 years at our institution with Labor and Delivery clinicians for learning crisis resource management as well as teamwork skills.[37] Similar courses have been developed at other institutions with the aim of improving teamwork and crisis response for Labor and Delivery teams. Studies have shown that simulation training for obstetrical teams can be effective to develop and refresh skills, even among experienced teams, and improve patient outcomes.[38–40]

We used a mixed-realism combination of an encounter with a standardized actor patient, then a high-fidelity simulation case using a mannequin, followed by an encounter with standardized actor patients.[26] High-fidelity simulation using mannequins has been used most recently to raise the engagement of the participants in the adverse outcome itself.[27,41,42] The use of standardized patients for studying disclosure practice has long been used in a number of settings.[24,29,43–45] Because of its repeatable presentation of situations and the requirement that subjects declare actual rather than espoused actions, simulation is an important patient safety research technique.

To depict a wide spectrum of plausible emotional responses of patients and their families, to elicit a broad range of the clinician's disclosure skills, and to standardize the issues raised during the disclosure discussion, a structured process for the disclosure and apology discussion was chosen, wherein the standardized patients would enact all five stages of the grief response described by Kübler-Ross.[42]

We wanted to observe how experienced obstetricians and labor nurses would handle informing a patient and family about an avoidable surgical mishap. Furthermore, we sought to assess whether reviewing a cognitive aid in the form of a brief

From the Center for Medical Stimulation, Charlestown, Massachusetts.
Correspondence: Daniel B. Raemer, PhD, Center for Medical Simulation, 100 First Avenue, Charlestown, MA 02129 (e-mail: draemer@partners.org).
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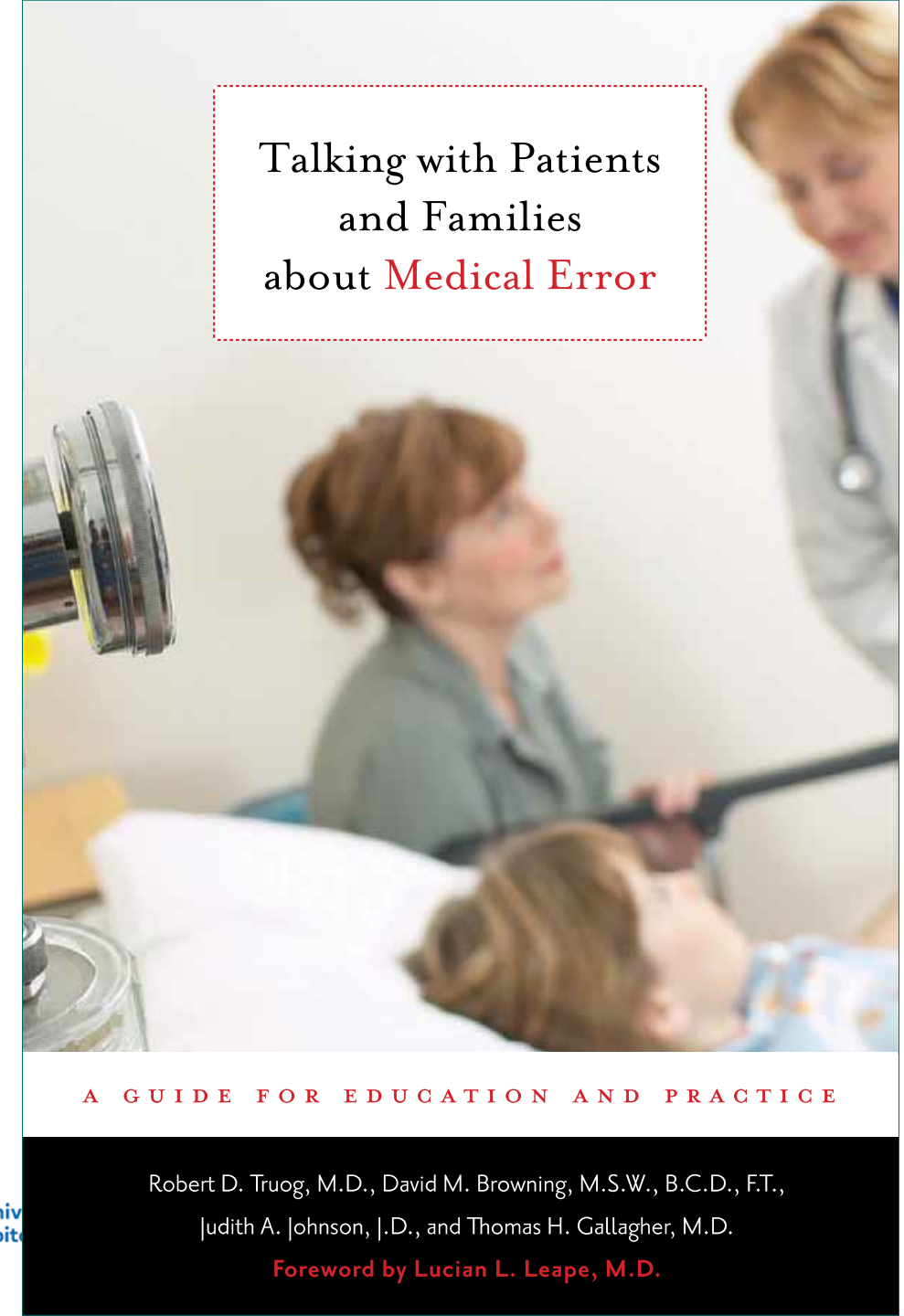
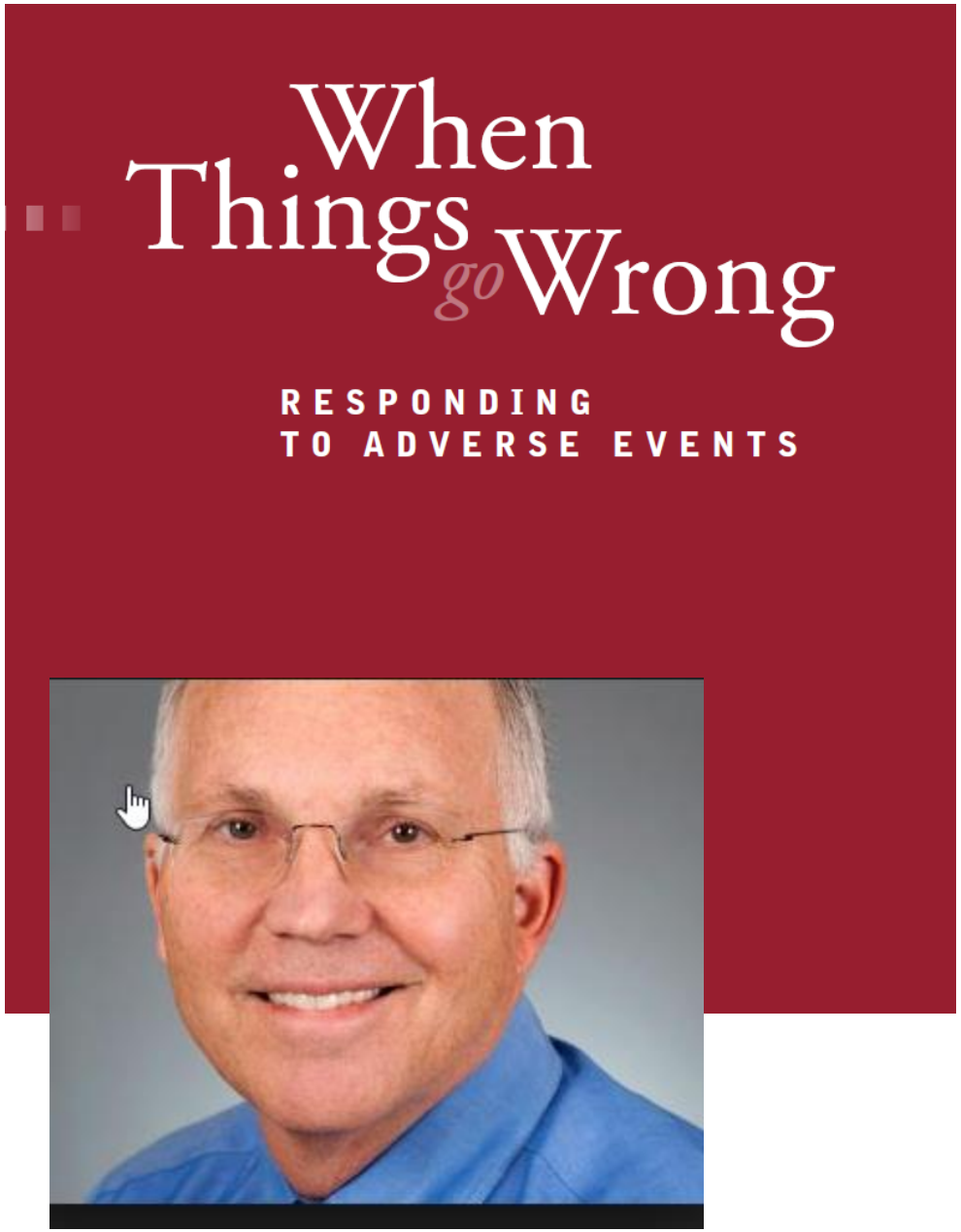

Talking with Patients
and Families
about Medical Error
A GUIDE FOR EDUCATION AND PRACTICE
Robert D. Truog, M.D., David M. Browning, M.S.W., B.C.D., F.T.,
Judith A. Johnson, J.D., and Thomas H. Gallagher, M.D.
Foreword by Lucian L. Leape, M.D.


When
Things go Wrong
RESPONDING
TO ADVERSE EVENTS

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What is the "red line" for communicating an (preventable) adverse event?

Unexpected adverse events must be communicated if:

- You would yourself want to know about the incident, if you yourself or a family would have been in the same situation ("Application of the Golden Rule")

or

- The problem results or could result immediately or later in a change of the treatment or care plan

What should be told?

Facts should always be told and – generally the sooner the better …

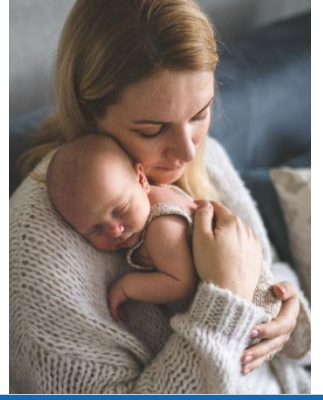
…But

The initial story is in most cases incomplete and sometimes totally wrong

Avoid the natural wish to draw a «complete picture», summarizing the initially few known facts

For these questions, a skillfull experienced coach can be extremely helpful

TRACK



Central communication skill and attitude	Definition	What should reach the patient
Transparency	Attitude of being open and honest	I get timely access to the information I need
Respect	Honoring the intrinsic dignity and values of the patient	I was perceived and treated as an individual person
Accountabilty	The art of being available and responsive	The right persons have taken responsibility for their actions
Continuity	The commitment of continuous relatedness and caring, shared time span	The treatment I receive is comprehensible, without interruptions (I do not feel surrendered and abandoned) and makes sense to me
Kindness	The skill to act attentively, kindly and cordially	I was treated with respect, empathy and full attention

A possible “sequence” of the conversation


AUSSEN WALD - NACHT

Hänsel und Gretel essen vom Hexenhäuschen.

HEXE (OFF)
Wer knuspert an meinem Häuschen?

HÄNSEL
(schüchtern)
Der Wind, der Wind, das himmlische Kind.

- ✓Recapitulation of facts
- ✓Clear , authentic, honest expression of apology
- ✓Steps to adequately take care for the patient
- ✓Steps being planned to investigate the incident and prevent another occurrence of the same situation
- ✓Offer of multifaceted individualized support for patient/family
- ✓Who is talking next to patient/family and when
- ✓Close with an honest, serious expression of support, sympathy and deep interest in the situation of the affected/injured person

When and how to apologize

Two meanings of «I'm sorry"-

- Expression of compassion and solidarity– "I am so sorry that this has happened" (German "Es tut mir leid")
- Expression of responsibiliy and accountability "We know that what has happened was a preventable adverse event and I want to truly apologize" (German "ich möchte mich dafür aufrichtig entschuldigen")

The first "sorry" is always adequate

The second form of apology is only adequate, when a preventable medical error has occurred

How apologogies fail…

"I apologize for ***everything*** that has happened…"

"***If*** a mistake has happened…"

"There was a mistake, ***but*** …"

"This happens to the **best** physicians…"

"The mistake has **for sure not changed the outcome** of your treatment …"

Quote of a (very experienced) surgeon: "I know, I know , for you it is uncomfortable, terrible, but believe me, for me it is devastating»

Lazare JAMA 2006; 296:1401, Berlinger After Harm. Johns Hopkins, 2005

First/Second/Third Victim

SBB CFF FFS

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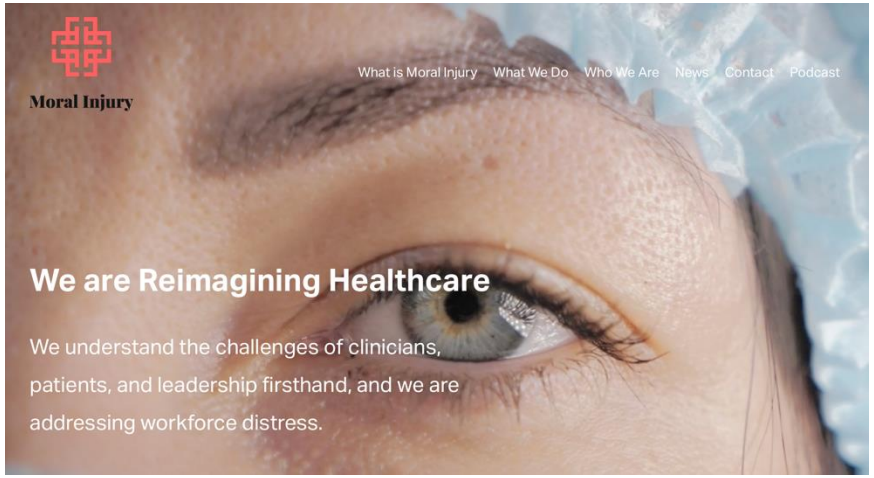
FIRST OPINION

Physicians aren't 'burning out.' They're suffering from moral injury

By Simon G. Talbot and Wendy Dean July 26, 2018 Reprints

Supporting troops of the 1st Australian Division form a silhouette as they pass towards the front line in Belgium during the first World War.



Moral injury occurs when clinicians are repeatedly expected, in the course of providing care, to make choices that transgress their long standing, deeply held commitment to healing.

It reframes the challenge of distress from "burnout", which suggests a lack of resilience on the part of clinicians, to one that more accurately locates the source of distress in a conflict ridden healthcare system.

SIWF awarded communication instructor/ Coaching course

Simulationstrainings von Sicherheitskulturkompetenzen (hier **EPA 9.3**)

Simulationstrainings von Sicherheitskulturkompetenzen (hier **EPA 9.3**)

Simulationstrainings von Sicherheitskulturkompetenzen (hier **EPA 9.3**)

Train-The-Trainer

(Faculty Development)

Competencies to implement a simulation training for safety culture and communication of adverse events and errors

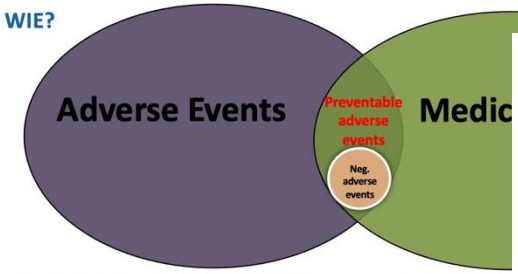
	Day 1	Day 2
08:30 – 09:00	Introduction & Relevance	SimSession for Disclosure & Apology after a preventable adverse event according to TRACK & Observation & Feedback
09:00 – 09:30		
09:30 – 10:00		
10:00 – 10:30		
10:30 – 11:00	Disclosure & Apology after a preventable adverse event according to TRACK	
11:00 – 11:30		SimSession for Disclosure & Apology after a preventable adverse event according to TRACK & Observation & Feedback
11:30 – 12:00		
12:00 – 12:30	Break	
12:30 – 13:00		
13:00 – 13:30	Disclosure & Apology after a preventable adverse event according to TRACK & observation - With simulated persons-	Breack
13:30 – 14:00		
14:00 – 14:30		SimSession for Disclosure & Apology after a preventable adverse event according to TRACK & Observation & Feedback
14:30 – 15:00		
15:00 – 15:30	Disclosure & Apology after a preventable adverse event according to TRACK & observation - With simulated persons-	
15:30 – 16:00		
16:00 – 16:30		Take Aways, next Steps & Evaluation
16:30 – 17:00		

"Fehler"- Definitionen

WAS? Unterscheidungen, Überschneidungen von verschiedenen, die Patient:innensicherheit gefährdenden Ereignissen[1]

WOZU?
- ✓ Je nach Sachverhalt sind unterschiedliche Herangehensweisen adäquat[2]
- ✓ Es ist wichtig, überschiessende Reaktionen («jede Abweichung muss kommuniziert werden») ebenso zu vermeiden, wie das Übersehen relevanter Abweichungen («es ist ja nichts passiert») [2]
- ✓ Reflexion über Definitionen und Grenzfälle erhöht die Sensibilität und fördert eine aktive, hilfreiche Fehlerkultur [1, 2]

WIE?



Unerwünschtes Ereignis	Medizinischer Fehler	Beinahe-Schaden/CIRS
Engl.: Adverse Event Ein Ereignis, das eher auf der Behandlung als auf der Erkrankung beruht. Es kann vermeidbar ("preventable") oder unvermeidbar (mögliche Nebenwirkung/ Komplikation) sein	*Engl.: Error* Eine Handlung oder ein Unterlassen, bei dem a) eine Abweichung vom Plan, b) ein falscher Plan oder c) kein Plan vorliegt. Ob daraus ein Schaden entsteht, ist für die Definition des Fehlers irrelevant.	*Engl. Near Miss/Critical Incident* Eine Situation, Ereignis oder Fehler ohne Schaden, der zu einem Schaden hätte führen können.
Beispiel: Ein Patient erhält Penicillin und entwickelt eine allergische Hautreaktion	**Beispiel:** Bestellung des falschen Patienten in den OPS	**Beispiel:** Aufgrund eines Lieferketten-engpasses wird Temesta knapp (Situation/Ereignis)

[1] Reason J. *Human Error*. New York: Cambridge University Press, 1990
[2] Leape LL. Error in medicine. *JAMA* 1994;272(23):1851-7;

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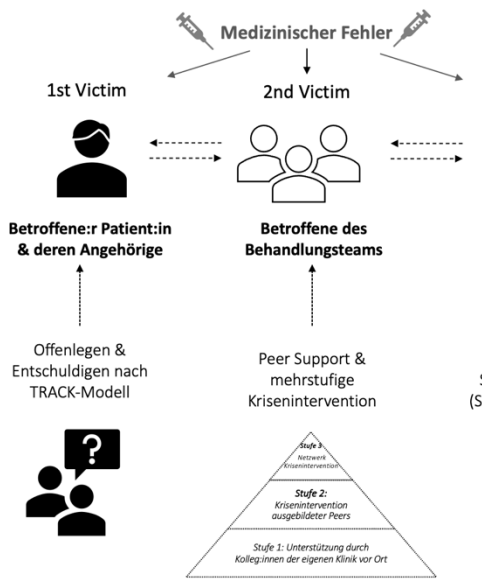
First, Second & Third Victim

WAS? Unterscheidung drei verschiedener «Opfer» von medizinischen Fehl

WOZU?
- ✓ Ermöglicht unterschiedliche Unterstützungsformen
- ✓ Offenlegen & Entschuldigen gegenüber »Erstem Opfer» ermöglic Würde und Kontrolle[1-5]
- ✓ Offene, an die Sachlage angepasste Fehlerkommunikation und b Unterstützungsformen senken das Risiko einer schweren, anhalt des «zweiten Opfers» und führen für das «zweite» und «dritte C haftungsrechtlichen Fällen[1-5]

WIE?



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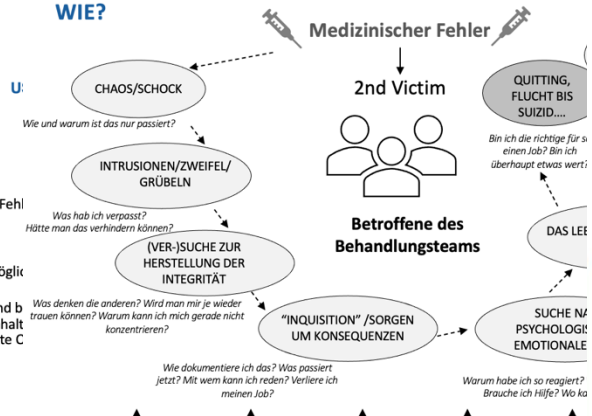
Second Victim und Coaching

WAS? Beschreibung der Reaktionen und Bedürfnisse der «Second Victims», d.h. der Betroffenen des Behandlungsteams, und angemessene Unterstützungsstratgien[1]

WOZU?
- ✓ Offene, angemessene Fehlerkommunikation und bedarfsgerec können das Risiko einer schweren und anhaltenden Traumatisi Opfers» senken
- ✓ Weniger haftungsrechtliche Fällen für das «zweite» und «dritte

WIE?



- Kurze **Auszeit** von der klinischen Tätigkeit anbieten bzw. sicherstellen, auch bei Personalknappheit
- Aktives kollegiales **Gesprächsangebot**, nicht nur bei vermuteten Fehlern, sondern in regelmäßigen Abständen
- Routinehafte kurze, aber effektive **Debriefings** in belastenden Situationen/ Schichten
- Einfühlsame, aber eindeutige und klare Sprache
- Grundsätzliche **Bestätigung** der fachlichen Kompetenz und Bestärkung des Selbstwertgefühls des/der Mitarbeitenden
- Emotionen und Ängste **zulassen**, **validieren** und **normalisieren**
- **Fachliche Unterstützung** und Rückversicherung im klinischen Arbeiten anbieten
- Bei Fehlern in der Behandlung: Beteiligten **eine Rolle bei der Fehleranalyse** geben und über Ergebnisse informieren
- Aufmerksame **Beobachtung**, um Isolierung und Rückzug frühzeitig zu erkennen
- Vorbeugung und Management von Lästereien, Mobbing, Schuldzuweisungen und Herabwürdigungen der Beteiligten

Psycho über F Unsich und O Verant gegenü Um Hil Selbstt Niema

Sicherheit, Lernen, (Simulations-)Training

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Ethische Grundlagen

WAS? Ethische Grundlagen für die Kommunikation medizinischer Fehler

WOZU?
- ✓ Ermöglicht tieferes Verständnis der «äusseren» und «inneren Gründe» für eine offene und empathische Mitteilung [1-5]
- ✓ Ordnet die Kommunikation medizinischer Fehler als wichtigen Teil einer aktiven Sicherheits- und Fehlerkultur (Entrustable Professional Activity EPA 9) ein [4,6]

WIE?
- ✓ Selbstreflexives, vertieftes Lernen, Stärkung der «Advocacy»[5]

2020: Interprofessionelle gemeinsame ethische Grundlagen

2010: Verinnerlichte Prinzipien der Fürsorge und Beziehung

2000: Grundprinzip "Do not harm"

1990: Weniger Haftpflichtfälle

Gründe der offenen Mitteilung: Historische Entwicklung

Bsp.: Wer fühlt sich im Alltag verantwortlich für Patientensicherheit?

Bsp: Wo suchen Führungskräfte die Ursachen für Fehler?

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