Improving Adverse Event Communication in Nursing Homes

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Research Funding

- American Nurses Foundation Virginia Stone Award in Gerontological Nursing Research
- UCSF Hellman Family Faculty Fellows Program

Overview

- Nursing home (NH) residents have complicated medical concerns
- Even with excellent care, errors and adverse events happen
- Nurses usually are the ones to tell families and residents about adverse events
- Talking to residents and families about adverse events conversations can be hard
- Most nurses are not trained in adverse event communication

Current Evidence: Adverse Event Research

- Successful communication includes:
  - Open, empathetic, and apologetic approach
  - follow up for learning opportunities
  - support systems for family and staff
- There is very little research on adverse event communication in NHs
  - Most research is about hospitals and physicians

Results

- ½ Nurses (n=1180) reported that errors are one of the most serious problems in NHs
- Who discloses error depends on severity
- RNs and those with experience in error disclosure more likely to disclose
- Information disclosed depends on Severity level
- High fear in being punished.

Adverse Event Disclosure

"Mrs. Smith is a new diabetic resident admitted to your facility. You handwrite an order for the resident to receive '10U Regular Insulin' The "U" looks like a 0 and the resident receives 100U the next morning. The resident is later found non-responsive with a BS of 35. The resident is resuscitated and transferred to the hospital. The resident will make a full recovery."

Definitely Disclose: 65%

Very likely to be punished: 87.3%

Disclosure of a Clinical Scenario

	Full Disclosure	Partial Disclosure	No Disclosure
1. What would you say?	30.6%	47.8%	20.2%
2. How much detail would you provide?	20.4%	35.7%	43.1%
3. Say about the cause?	25.3%	37.4%	37.3%
4. Apology	32.3%	61.6%	6.1%
5. Preventability	45%	46%	7.0%

Current Research: Adverse Event Communication

- NH Nurses' views on events:
  - Event reporting is a serious problem
  - Serious events should be communicated by management
  - More likely to share if they have experience in sharing adverse events with residents/families
- Most residents and families want to know if an event happened, even if minor

Wagner, Laura M., et al. "Nurses' Perceptions of Error Reporting and Disclosure in Nursing Homes." Journal of nursing care quality 27.1 (2012): 63-69.

Current Research: Adverse Event Communication

- NH Nurses' views on errors:
  - Being involved in an event is upsetting
  - Worried about reputation and punishment
  - More likely to report serious errors though less likely to share details or fully apologize
  - More likely to fully apologize for less serious errors
  - *Majority want training on communicating with residents and families about errors*

Wagner, Laura M., et al. "Nurses' disclosure of error scenarios in nursing homes." Nursing Outlook (2012).

Current Research: Adverse Event Communication

- Nurse reported barriers:
  - Unclear definition of adverse events
  - Heavy workload, not enough time
  - Unclear role accountability and responsibility
  - Need for culture supportive of open communication
  - Individual accountability and fear of punishment
  - Need for professional standards

Wagner, Laura M., et al. "Barriers and Facilitators to Communicating Nursing Errors in Long-term Care Settings." Journal of patient safety 9.1 (2013): 1-7.

Study Aims:

- To see if communication training in NHs helps nurses talk to residents and families about adverse events, unanticipated outcomes, and errors
- To see if communication training improves conversations between nurses and families

Disclosing and Resolving Adverse Outcomes

And Medical Errors

Institute for Healthcare Communication

Learning Objectives

- Understand why openness is important
- Appreciate others' perspectives and needs
- Review what makes a disclosure effective
- Understand how different causes of an adverse outcome require different steps for resolution
- Identify skills for having effective adverse event communication conversations with patients and families
- Practice the skills in a range of situations

Qualities of an Effective Resolution

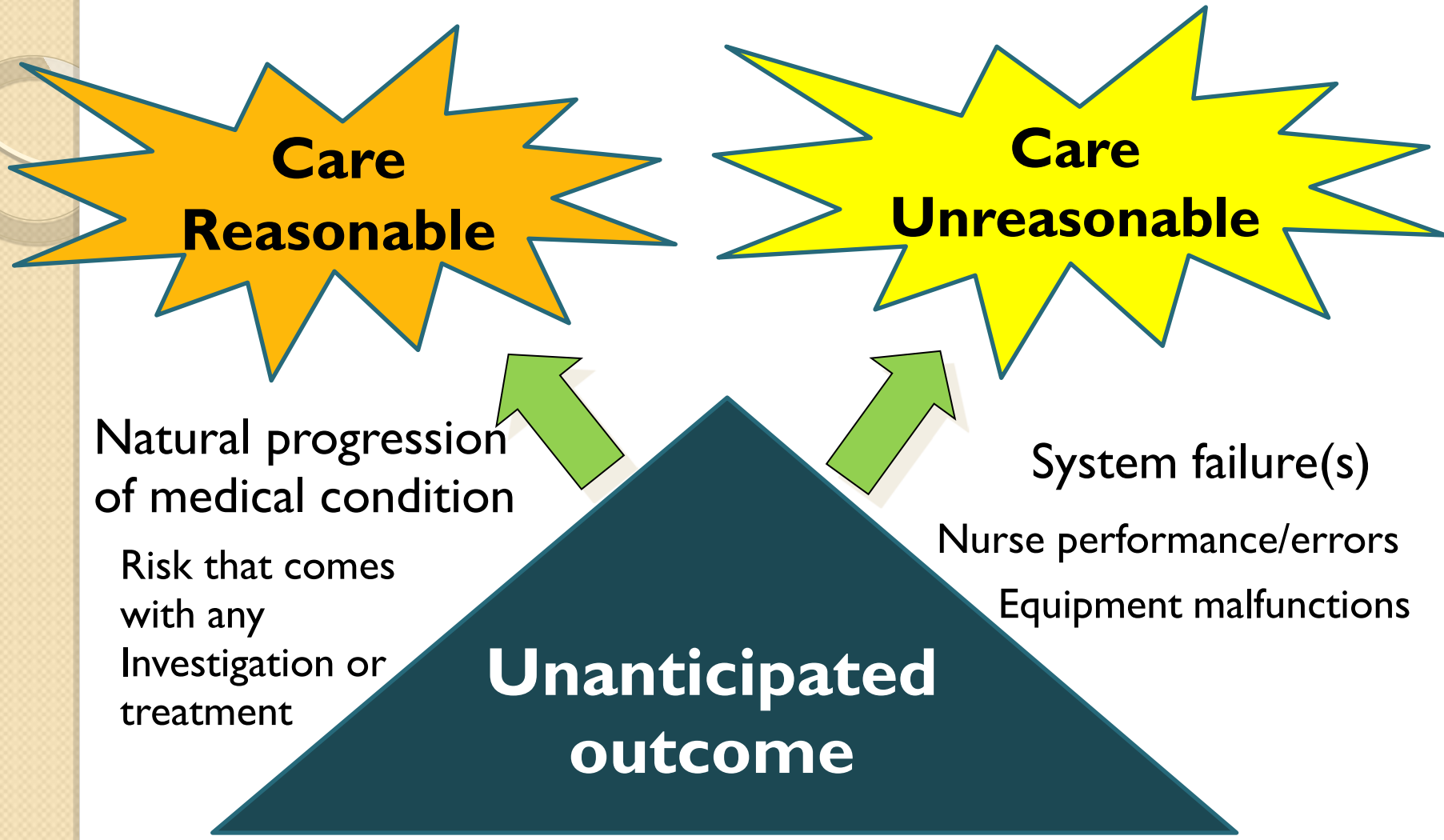
Causes of "Unanticipated Outcomes"

- Unaddressed "unreasonable" expectations by patients & families
- Natural differences between people
- Individual, team or systems errors and equipment failures

After the Event/Outcome: 4 Tasks

1) Attend to care of the resident
   - Chart the facts
   - Preserve material for investigation
2) Address staff member's own emotions
3) Piece together what happened
4) Prepare for discussions with resident and family

Which Track?


Care Reasonable
Care Unreasonable
Natural progression of medical condition
Risk that comes with any Investigation or treatment
System failure(s)
Nurse performance/errors
Equipment malfunctions
Unanticipated outcome
Harm not preventable
Harm preventable

Care Reasonable

A L E E

- A**NTICIPATE** and A**DJUST**
- L**ISTEN** for concerns and questions
- E**MPATHIZE** and normalize reactions
- Offer to E**XPLAIN** what you believe happened

Empathy or Apology?

– Express **empathy** for their experience

"I'm very sorry you and your family have had to endure so much pain this last week."

– **Apologize** for causing harm

"I'm so sorry that our actions have caused you harm."

Practice 1:
Case Video Analysis

Notice how the Nurse.	What I observed

• **A**nticipates and adjusts
• **L**istens to patient's perspective
• **E**mpathizes via
  • Voice tone and pace
  • Body language
  • Words
• **E**xplains and answers questions	

Resident Fall

Practice 1:
Case Video Analysis

Notice how the Nurse.	What I observed

• **A**nticipates and adjusts
• **L**istens to patient's perspective
• **E**mpathizes via
  • Voice tone and pace
  • Body language
  • Words
• **E**xplains and answers questions	

Insulin Overdose

Mr. Smith is a new diabetic resident admitted to your facility. He is cognitively intact and able to make her own care decisions. The nurse handwrites a telephone order from the physician for the resident to receive “10U” of insulin. The “U” in her order looks like a zero. The following morning the resident is given 100 units of insulin, ten times the resident’s normal dose, and is later found unresponsive with a very low blood sugar level. The resident is resuscitated and transferred to the hospital. At this point, Mr. Smith has made a full recovery and has returned to the facility. What you are about to see is the nurse who made the error meeting with Mr. Smith the next day to begin the process of communication and resolution.

Study Sites

- 3 Nursing Homes in Northern California
- 3 month study period
- Main outcomes: Nurse and Resident/Family Satisfaction with the Quality of the Communication

Nurse Satisfaction

IMPROVING ADVERSE EVENT COMMUNICATION IN NURSING HOMES

NURSE SURVEY

This survey is intended to learn more about the way you communicated with the resident or family about an event that recently occurred. You may have had more than one conversation with the resident or family about the event. Please consider all of these conversations together as you complete the survey. These conversations include those you had with the family in cases where the resident was unable to participate.

1. **Did you complete the special training on Adverse Event Communication at your facility? Y N**

2. **On a scale from 0 to 10, where 0 is extremely dissatisfied and 10 is extremely satisfied, how satisfied were you with the conversation(s) you had with the resident and/or family about the event that occurred? (*Circle one number.*)**

Extremely dissatisfied 0 1 2 3 4 5 6 7 8 9 10 *Extremely satisfied*

3. **Please indicate how much you agree or disagree with the following statements about the communication you had during the conversation(s) with the resident and/or family: (*Circle the corresponding number.*)**

	Don't Know ←	Strongly Disagree ←	Disagree Somewhat ←	Neither Agree nor Disagree ←	Agree Somewhat →	Strongly Agree →
a. I explained the event using terms the resident/family could understand	-1	0	1	2	3	4
b. I exhibited good listening skills	-1	0	1	2	3	4
c. I provided compassion to the resident/family for this event and was "there for them"	-1	0	1	2	3	4
d. I was truthful when explaining the event to the resident/family	-1	0	1	2	3	4
e. I told the resident/family as much information as they wanted to know about the event	-1	0	1	2	3	4
f. I told the resident/family why the event happened	-1	0	1	2	3	4
g. I told the resident/family whether or not the event was preventable	-1	0	1	2	3	4
h. I assured the family that steps would be taken to prevent similar events from happening again	-1	0	1	2	3	4
i. I felt like I did a good job in preparing for our conversation about the event	-1	0	1	2	3	4

ID: ☐☐☐☐

Turn the Page

Resident/Family Satisfaction

IMPROVING ADVERSE EVENT COMMUNICATION IN NURSING HOMES)

RESIDENT/FAMILY SURVEY

This survey is intended to learn more about the way in which your nurse communicated to you an event that recently occurred. The nurse may have had more than one conversation with you. Please consider all of these conversations together as you complete the survey.

1. **On a scale from 0 to 10, where 0 is extremely dissatisfied and 10 is extremely satisfied, how satisfied were you with the conversation(s) you had with the nurse about the event that occurred? (*Circle one number.*)**

Extremely dissatisfied 0 1 2 3 4 5 6 7 8 9 10 ***Extremely satisfied***

2. **Please indicate how much you agree or disagree with the following statements about the communication you had during the conversation(s) with the nurse: (*Circle the corresponding number.*)**

	Don't Know ←	Strongly Disagree ←	Disagree Somewhat ←	Neither Agree nor Disagree	Agree Somewhat →	Strongly Agree →
1. The nurse explained the event using terms I could understand.....	-1	0	1	2	3	4
2. **The nurse had good listening skills**	-1	0	1	2	3	4
3. The nurse provided compassion to me for this event and was "there for me"	-1	0	1	2	3	4
4. **The nurse was truthful when explaining the event to me**	-1	0	1	2	3	4
5. The nurse told me as much information as I wanted to know about the event.....	-1	0	1	2	3	4
6. **The nurse told me why the event happened**.....	-1	0	1	2	3	4
7. The nurse told me whether or not the event was preventable	-1	0	1	2	3	4
8. **The nurse assured me that steps would be taken to prevent similar events from happening again**	-1	0	1	2	3	4
9. I felt like the nurse did a good job in preparing for our conversation about the event.....	-1	0	1	2	3	4

Future Directions:

1. R21 Application
2. Extension of research:

-Expanding out to include all uncomfortable conversations

-Communication w/underserved populations