MATERNAL MORTALITY SENTINEL EVENT:

**Breaking Bad News**

“Though it be honest, it is never good to bring bad news”

William Shakespeare

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NO CONFLICT OF INTEREST

OBJECTIVES

- Define Sentinel Event and why reporting of a sentinel event is important
- Discuss Principles of breaking bad news (SPIKES)
- Define Critical Incident—Critical incident support—“the second victim”
- Discuss Reporting and Investigation of sentinel event and critical incident
- Key Points

ANESTHETIC DEATHS

- Deaths due to anesthesia are extremely uncommon
  - Estimated Incidence is 0.5-0.8 per 10,000 anesthetics
  - Maternal mortality due to anesthesia: 1 in million live births
- Majority of anesthesiologists during their career will either experience patient death on the operating table or will likely to be involved in a catastrophic event
- Whether a death is expected or unexpected may be irrelevant:
  - The Anesthesiologist/CRNA may be emotionally affected by an intraoperative death (especially unexpected) and may need support
  - Private Hospitals may not have the support systems compared to Academic Institutions
- Each hospital should have its own system of investigating a critical/catastrophic event
**SENTINEL EVENT**

- A **Sentinel event** is an **unexpected** occurrence involving death or serious physical or psychological injury, or the risk thereof …
  - Serious injury specifically includes loss of limb or function
  - "Or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of adverse outcome

- **A sentinel event: signals the need for immediate investigation and response**
  - Terms "sentinel event” and “error ” are not synonymous; not all sentinel events occur because of an error, & not all errors result in sentinel events
  - Joint Commission or DNV Sentinel Event Policy: Partner with Health Care Organizations that have experienced a serious patient safety event to protect the patient, improve systems, and prevent further future harm

**BREAKING BAD NEWS……..**

- **Bad News:**
  - Any information which adversely affects an individual’s or the family’s view of the future
    - Verbal Component
    - Ability to Recognize & Respond to Patients’ relative’s emotions; dealing with stress that the bad news creates; yet be able to involve the relatives in discussions of decisions to be made after the adverse event

**WHEN BAD THINGS HAPPEN……..**

- Breaking bad news to patients or relatives is never easy – it is a daunting task
  - Bad news delivered inadequately or insensitively can impair patients’ and relatives’ long-term adjustments to the consequences of that news
  - Good communication skills and honesty are of supreme importance

- The initial breaking bad news communication to the patient or the relatives about the series of events in a serious adverse outcome should be followed up:
  - An investigation into the contributing factors in such events (*Root Cause Analysis*)
  - Staff members involved in the incident must be supported (*Critical Incident Support*)
  - Departmental follow up (*Peer Review Process*)
**Delivering Bad News to Patients**

- Physicians/Practitioners lack proper training, breaking bad news can lead to negative consequences for patients, families, and physicians.
- Medical Education places emphasis on technical proficiency.
- A questionnaire was used in the Surgery Department to determine whether a didactic program on delivering bad news was needed.
- 91% of respondents perceived delivering bad news as a very important skill.
- Only 40% felt they had the training to effectively deliver such news.
- 85% felt they needed additional training to be effective when delivering bad news.
- Of the 85% of participants who felt they needed additional training, 59% were residents and 26% were attendings.

**Fine's Proposed Protocol: Five Phases**

- Phase 1: Preparation, involves establishing appropriate space, communicating time limitations, being sensitive to patient needs, being sensitive to cultural and religious values, and being specific about the goal.
- Phase 2: Information acquisition, includes asking what the family knows, how much the family wants to know, and what the family believes about his or her condition.
- Phase 3: Information sharing, entails reevaluating the agenda and teaching.
- Phase 4: Information reception, allows for assessing the information reception, clarifying any miscommunication, and handling disagreements courteously.
- Phase 5: Response, includes identifying and acknowledging the patient's response to the information and closing the interview.

**Rabow and McPhee Technique for Delivering Bad News**

- A~ Advance preparation
- B~ Build a therapeutic environment/relationship
- C~ Communicate well
- D~ Deal with patient and family reactions
- E~ Encourage and validate emotions
**PRINCIPLES OF BREAKING BAD NEWS**

**SPIKES**

- **S:** SETTING
- **P:** PERCEPTION: PATIENT/RELATIVES
- **I:** INVITE PATIENT/RELATIVES TO SHARE INFORMATION
- **K:** KNOWLEDGE TRANSMISSION
- **E:** EMOTIONS AND EMPATHY
- **S:** SUMMARIZE AND STRATEGY

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**S P I K E S:**

**SETTING**

- Plan the debrief interview: Anesthesia practitioner; key staff members; surgeon – should meet as soon as possible to plan the debrief interview with the patient and/or relatives

- First thing to plan is which faculty member is going to do the talking

- The team needs to agree on the details so that the patient or relatives hear a consistent account of what happened: the when, where, how and why the adverse event occurred

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**S P I K E S:**

**SETTING**

- Breaking Bad News Interview: Should take place at a time that is negotiated as close to the incident as possible

- Interview should take place in private (a conference room)
  - If it involves death, the relatives may wish to have a support person present, perhaps family doctor, religious representative or social worker
  - The physicians and support personnel

- Important that all staff members relay honest, consistent information of known events

- Individuals involved in the interview should ensure all mobile phones and beepers are turned off

- The anesthesia practitioner involved in the incident may be too upset to speak to the family, however at some point the practitioner must talk directly as he or she can provide the most accurate factual information

- The strategy will convey implicitly that an open process is occurring

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**SPIKES: Setting**
PRINCIPLES OF BREAKING BAD NEWS
What do patients & family members expect after a critical incident?

- The truth—what if anything went wrong?
- Why did it happen? To understand the ‘why’ results in patient or relative regaining some control in the situation, & gives some meaning to the event.
- What’s the diagnosis?
- Is the patient going to die?
- Will there be any pain or suffering?
- The consequences & social effects of the clinical diagnosis & treatment, e.g. being on a ventilator, tracheostomy, or colostomy.
- Will this happen again to anyone else?

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**SPIKES: Perception**

- The anesthetist should elicit how much the patient’s relatives know already.
  - Even if interview is arranged as close to the incident, it is often unclear how much information they may have acquired before breaking the bad news.
- The family members may have had discussion with nurses or other personnel to find out what had happened.
- Conversely, they may have no information, a little or incorrect information, or may have interpreted what others have said…
- Important information about the relative’s or patient’s emotional state can be gained at this stage.
- Uninterrupted listening is important.

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**SPIKES: Invite Patient's Relatives to Share Information**

- Checking what the person already knows or thinks will allow a better assessment of the situation.
  - Will gain some rapport & will gauge how much information the person may want to know.
- Some people will need every detail – others will need an outline, or very little information.
  - The anesthetist can ask:
    - ‘Can you tell me what you know?’
    - ‘What’s your understanding of what happened?’
    - ‘Did you think something serious was going on?’
Communication of bad news to patient/ or patient’s relatives is about giving the information in a caring, supportive and genuine way

Signaling bad news: Tactic start with a ‘a warning statement’

- ‘I’m afraid I have bad news’
- ‘I am sad to tell you that Mrs. … is seriously ill’
- ‘Unfortunately I am sad to tell you that something unexpected has happened in the operating room /operating room’
- ‘I am really sad to have to tell you some bad news’

What do patients & family members expect after a critical incident?

- Information is delivered or confirmed
- Aim is to build on what information is already known to the relatives; deliver the information in small bites, avoid jargon
- Important to emphasize that the facts as communicated are those known to the interviewer; restrict the discussion of what happened; avoid speculation as to the cause or blame directed towards the hospital & or colleagues
- In situations where there has been a critical incident resulting in an adverse event rather than death or adverse outcome, patients or relatives will want to know:
  - Whether changes in policies & procedures have been implemented that will reduce or abolish the chance of a similar incident happening again
  - If the ‘Why’ is unknown, patients & relatives can be informed that the hospital is investigating the incident
- Let them know that they will be informed of the results of an enquiry as soon as they become available
- Let them know that they will be informed of the results of an enquiry as soon as they become available
  - We will look at our processes to see if anything can be changed to ensure that this incident will never happen to another patient
  - Can you tell me if you understood what I am saying or would you like me to repeat something
- Important to allow time for the recipients to identify their feelings about the news, and allow time for them to frame questions

Vitally important to communicate bad news with empathy

- ‘I am really sorry to have to be the bearer of such tragic news’
- ‘I know how upsetting this news must be for you’

The recipient’s emotional response to the grief of bad news can range from disbelief, anger, sadness, desolation, & wailing, to resignation

- ‘I can see you are really angry about this incident’
- ‘I can see that this is very upsetting for you’
SPIKES: EMOTIONS and EMPATHY

- It is also helpful for the bearer of bad news to recognize the following:
  - Anger is a common response of the patient or relatives in these situations.
  - Where an adverse event has occurred, an apology should be made for any harm incurred without blaming anyone; reassurance that the incident is being investigated.
  - In response to the patient’s or relative’s hostility, the anesthesiologist might be tempted to show frustration, irritation, or defensiveness (need to be kept in check).
  - Natural tendency to plan what to say next, rather than listen to what the patient or relative is saying.
  - Anxious, uninterrupted listening is the most effective strategy to allow further discussion.
  - Even if emotions are running high, the anesthesiologist should avoid calling the hospital security to the first instance. However, need to be mindful of their safety especially if threatened.
  - Allow time for questions; avoid rushing the interview—this attitude can be interpreted as uncaring.

SPIKES: SUMMARIZE and STRATEGY

- Need to check that the patient or relatives have understood the information they have been provided.
- Follow up arrangements.
  - An appointment with a psychologist, or a minister of religion (chaplain) can be offered and arranged.
  - On-going support is appreciated by patients or relatives & it demonstrates genuine concern & care by the anesthesiologist.
    - "Perhaps we should meet again, to answer any further questions you might have."
    - "If you would like to come & talk to me at any time in the future, please contact me on this phone number.
    - We can arrange another appointment at a mutually convenient time.

DOCUMENTATION

- Vital to document immediately afterwards the information covered during the debriefing interview.
  - Document Facts only.
  - Salient details should be documented in patient’s records.
  - Retain a copy of the document and to submit a copy to the Chief Medical Officer (Patient Safety & Quality Improvement).
  - Any subsequent comments about the crisis should be documented in patient’s records, signed, dated and timed.
LITIGATION

- Patient and Relatives are more likely to proceed to litigation if they feel that:
  - breaking the bad news interview has gone badly & or the doctor was uncaring or insensitive
  - they were not given enough information
  - they were not being told the truth
  - concerns were not being heard & dealt with appropriately

<table>
<thead>
<tr>
<th>Reason for taking legal action</th>
<th>Percent of respondents who agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>So that it would never happen again</td>
<td>91.4</td>
</tr>
<tr>
<td>I wanted an explanation</td>
<td>90.7</td>
</tr>
<tr>
<td>I wanted the doctors to realize what they had done</td>
<td>90.4</td>
</tr>
<tr>
<td>To get an admission of negligence</td>
<td>86.7</td>
</tr>
<tr>
<td>So that the doctor would know how I felt</td>
<td>68.4</td>
</tr>
<tr>
<td>My feelings were ignored</td>
<td>66.8</td>
</tr>
<tr>
<td>I wanted financial compensation</td>
<td>65.6</td>
</tr>
<tr>
<td>Because I was angry</td>
<td>65.4</td>
</tr>
<tr>
<td>So that the doctor did not get away with it</td>
<td>54.7</td>
</tr>
<tr>
<td>So that the doctor would be disciplined</td>
<td>47.6</td>
</tr>
<tr>
<td>Because it was the only way I could cope with my feelings</td>
<td>45.8</td>
</tr>
<tr>
<td>Because of the attitude of the staff afterwards</td>
<td>42.5</td>
</tr>
<tr>
<td>To get back at the doctor involved</td>
<td>23.2</td>
</tr>
</tbody>
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CRITICAL INCIDENT

- Critical Incident: An incident in which a patient or staff member has experienced an adverse event a ‘near miss’
- An event that has occurred under anesthesia care which is a deviation from the expected course with a potential for an adverse outcome if left to progress
- An incident which has caused distress to patients or staff

- What constitutes an Adverse Event – Major event or Death
- Jehovah’s witness dies after MVA because she refuses blood Transfusion
- Paraplegia
- Young mother becomes paraplegic due to epidural abscess following labor analgesia
- Failed Intubation, Hypoxia resulting in ICU admission
- ‘Patient told never to have a GA after last surgery difficult intubation
- Staff suicide or Drug Overdose
- Colleague found on the floor of the operating room, blue & apneic with a needle attached to arm

CRITICAL INCIDENT

Current Practice of Open Disclosure

Open Disclosure:
- Despite wide acknowledgement of ethical duty to disclose: Evidence suggests open disclosure not common, Not always systematic, Substantial variation
- Barriers: At organizational level, Individual level
- Failure to disclose is a systematic problem at an organizational level which has a major impact on the practice of disclosure
  - Lack of open communication
  - Lack of support from colleagues and supervisors
  - Hospital atmosphere inhibited trainees to talk about mistakes
  - 20% reported that, “administration was judgmental”
GUIDELINES ON MANAGEMENT OF CRITICAL INCIDENTS

- Health care Organizations should share the responsibility for managing critical incidents
  - Establish guidelines including information about immediate measures and disclosure standards
- Crucial part of effective incident management at the Institutional level
  - Analyzing the event systematically from a systems perspective & learning from it to prevent future incidents
- Timelines for guidelines on the management of critical incidents: Recommendations specifically for anesthesia practice
- Adaptation at the departmental level: taking into consideration the nationwide organizational approach and the institutional/hospital policies
- Critical Incident support
  - Providing support for the anesthesiologist and others. Support for the 'Second Victim'

CRITICAL INCIDENT

Second Victim

- The second victim: Is the anesthesiologist or other anesthesia personnel involved in the adverse event
- Many doctors feel they are directly to blame for an adverse incident
- More than often it is a team responsibility & system errors are usually uncovered
- The perception of self-blame by the doctor involved leads to stress, mental illness, PTSD, occasionally resulting in suicide
- If litigation follows, the feelings are likely to worsen resulting in adjustment difficulties

- Appropriate to inform the anesthesiologist that a Root cause analysis and peer review process will be conducted
- Ask the anesthesiologist if he/she would like access to professional help-a psychologist, counselor or religious representative
  - It is often hard to persuade young physicians to seek outside help
  - The value of professional help may not be recognized initially
  - However the mentor can emphasize the value added effect of impartial and supportive advice
- On-going support can be provided
- If a resident/trainee is involved the program director would need to be notified and to ensure ongoing support
**FOLLOW UP**
Root Cause Analysis

- Root Cause Analysis: At the Institution/ Hospital Risk Management –
  - Examines the likely factors (root causes) which have contributed to a serious adverse event
  - Culminates in a report highlighting what can be avoided to mitigate future errors in similar circumstances
  - Implementation of the recommendations arising from root cause analysis will result in improvements in the health care process

**QUALITY VARIANCE CATEGORIES**

<table>
<thead>
<tr>
<th>CATEGORY 1</th>
<th>Predictable event within the standard of care</th>
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<tbody>
<tr>
<td></td>
<td>“Predictable” means these events are anticipated and manageable, but have been described in the literature; care is provided in accordance with contemporary standards of the specialty and departmental medical staff. The variance from the indicator is explainable and understandable (justified) after peer review.</td>
</tr>
<tr>
<td>Action:</td>
<td>Trend</td>
</tr>
<tr>
<td>NOTE:</td>
<td>Category 1 does not represent an escalation in seriousness; they are both within accepted standards of care.</td>
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<tr>
<th>CATEGORY 2</th>
<th>Unpredictable event within the standard of care</th>
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<tbody>
<tr>
<td></td>
<td>“Unpredictable” means that events in this category are infrequent and unanticipated, but have been described in the literature; care is provided in accordance with contemporary standards of the specialty and departmental medical staff. The variance is unusual, however, professional opinion and current practice does vary regarding this type of variance. The variance is unreasonable with the care provided.</td>
</tr>
<tr>
<td>Action:</td>
<td>Trend</td>
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<tr>
<th>CATEGORY 3</th>
<th>Marginal deviation from the standard of care</th>
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<tbody>
<tr>
<td></td>
<td>“Marginal” events in this category reflect care that is minimally outside of the contemporary standards of the specialty or the expected standards of departmental medical staff. The variance is questionable and unexpected. The reviewer is uncomfortable with the variance.</td>
</tr>
<tr>
<td>Action:</td>
<td>Trend, enter on Member’s profile, Service Chief or designee and Chief Medical Officer notified.</td>
</tr>
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<tr>
<th>CATEGORY 4</th>
<th>Significant deviation from the standard of care</th>
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<tr>
<td></td>
<td>These events represent gross departures from expected standards. Variance is unacceptable. Outcome of case may/may not have been impacted by the variance. The variance is unreasonable with little variance.</td>
</tr>
<tr>
<td>Action:</td>
<td>Trend, enter on Member’s profile, Service Chief or designee and CMO notified.</td>
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**SENTINEL EVENT/CRITICAL INCIDENT**
Summary / Key Points

- Critical Incident has serious psychological, performance & health-related impact on the Anesthesia Practitioner
- Patients & Families expect open disclosure after a critical incident
- A major motivation for taking legal action is the lack of reliable information; a perceived lack of respect & feeling of abandonment
- A systematic approach to the management of the aftermath of critical incidents should be an integral part of every patient safety strategy
- Hospital leadership plays a central role in the process by providing clear guidelines implementing effective support structures & actively promoting a culture that furthers communication
SUMMARY

Key Points

- Breaking Bad News & the Management of Sentinel Events & Critical Incidents requires:
  - Acceptance that "bad things happen" through disease processes, systems factors and the inevitability of human error
  - Anesthesiologists/CRNAs should communicate with the patients & relatives with empathy & care in a planned interview, including attentive uninterrupted listening
  - Open disclosure can benefit everyone involved in a sentinel event/critical incident: patients, family members, health care providers & HC organizations
  - Follow-up should be offered to patient & relatives
  - Support to those involved in the incident (critical incident support/second victim ongoing support)
  - Detailed documentation of the incident and the follow-up discussions in the EMR
  - Involvement in risk management processes: Root Cause Analysis, Sentinel event investigation and Peer Review Process

The END