

**DOMAIN 6 CASE DISCUSSION
DISCLOSURE OF AN ADVERSE EVENT
FACILITATOR'S GUIDE**

Most adverse events that occur in pediatrics do not lead to death of a patient. This is an unusual and very sad situation for everyone involved. Discuss with the group, the following aspects of the case:

- 1. Discuss the difference between harm, adverse event and close call. Did this patient suffer harm as the result of an adverse event, or is this simply natural progression of disease?**
- 2. An event such as this will bring out emotional responses in team members. The attending physician was the team leader. What do you think of the attending physician's initial response of "fury"? How do you think he/she handled this initial response? What are things that he/she did or did not do to support the team?**
- 3. Break into small groups, and role-play disclosing this event to the parents.**
 - *State an AE has occurred*
 - *Factual account of the event without speculation*
 - *Provide an expression of regret "we are sorry that this happened"*
 - *Apologize – typically once an investigation has determined organization is responsible "I apologize that the care we provided has been less than reasonable")*
 - *Offer emotional support*
 - *Outline next steps*
 - *Allow time for questions*
 - *Identify contact person from the team questions can be asked of*
- 4. Does your facility have a policy and procedure regarding disclosure of adverse events? If so, share this with the learners. If not, see CMPA or other resources for examples.**
- 5. What are other important items to address as a result of this event?**
 - *Administration must be made aware that a severe/fatal AE has occurred*
 - *Physicians should contact CMPA*
 - *Family care:*
 - *Support as much as possible (bereavement team, clergy, funeral arrangements)*
 - *Discuss completion of post-mortem exam*
 - *Arrange follow-up with the family to discuss post-mortem exam/answer other questions*

Safety Competencies Curriculum

Domain 6: Recognize, Respond and Disclose Adverse Events

- *Staff care:*
 - *Critical incident debriefing*
 - *Counseling may be needed for those involved*
- *Quality Improvement*
 - *Critical incident review process around event.*
 - *Team identified RN answering phone as a factor that may be modifiable in future events.*
 - *Quality improvement system should initiate changes as appropriate to prevent future events*

ALL KEY COMPETENCIES OF DOMAIN 6 CAN BE ADDRESSED BY DISCUSSING THIS CASE