Rancho Los Amigos National Rehabilitation Center

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT:	**DISCLOSURE OF UNANTICIPATED OUTCOMES**	**Policy No.:**	**B518**
		Supersedes:	**April 19, 2017**
		Revision Date:	**September 1, 2021**
		Page:	**1 of 3**

PURPOSE:

To define the role of the healthcare provider in communicating unanticipated outcome of any treatment, procedure, or diagnostic test to the patient or patient's surrogate decision-maker.

POLICY:

Patients or legally authorized representatives have the right to be fully informed of all relevant outcomes in their care, treatment, and services including outcomes that are unanticipated. An unanticipated outcome of care, treatment or services may include the following:

- Result in minor or significant change in the patient's condition
- Require additional test, monitoring, and or hospitalization
- Require unforeseen medical or surgical intervention
- Result in minor, major, or permanent harm to the patient
- Adverse event
- Unusual Occurrence
- Sentinel Event

Definition:

- Unanticipated Outcome: A result that differs from what was intended to be the result of a treatment or procedure. This may or may not result from an error. A known complication or side effect is not an unanticipated outcome, but information about such outcomes should also be disclosed to patients as a routine course of their treatment and care.

- Error: Defined as the failure of a planned action to achieve its intended outcome. It may also be a deviation between what was actually done and what should have been done.

- Adverse Event: Any event which is not consistent with routine patient care or the routine operation of the facility or which is not caused by the patient's underlying disease and which adversely affects or has the potential to affect the health, life or comfort of the patient.

- Unusual Occurrence: Events including epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety, or health of patients, personnel, or visitors.

- Sentinel Event: An adverse event or unexpected occurrence involving death or serious physical or psychological injury or the risk thereof.

- Disclosure: Communication of information regarding the results of a diagnostic test, procedure, medical treatment, or surgical intervention

Procedure:

1. Identify the unanticipated outcomes as soon as possible.

2. Ensure the person affected is receiving optimal care.

3. Notify the patient' physician immediately. Additional staff to be notified as indicated may include—immediate supervisor, attending physician, medical officer of the day, etc.

4. Disclose the event to the patient or surrogate as applicable. A disclosure of an unanticipated outcome does not necessarily constitute an admission of guilt or liability.

   a) **Disclosure is the responsibility of the primary physician or designee**. The designee must have the appropriate medical knowledge and familiar with the patient's care to answer questions regarding the patient's care. Nursing and other services may notify the patient or patient's surrogate of incidents including but not limited to fall, pressure injuries, medication errors, etc. and refer medical care related questions to the physician. If more than one clinical service is involved, collaboration should occur when appropriate.

   b) It is advisable to request another staff member to participate or witness the patient discussion.

   c) When a non-physician is involved in an adverse or sentinel event, the attending physician shall be responsible for the disclosure of the event to the patient or the patient's representative. Risk Management is available for consultation.

   d) Disclosure shall be made in a timely manner.

   e) Healthcare personnel with concerns about disclosure may discuss their concerns with their supervisors, Risk Management, Ethics Committee, Employee Assistance Program (EAP), or Rancho's Helping Healers Heal (H3).

5. The elements of disclosure include the following:

   a) Acknowledge the occurrence and nature of the unanticipated outcome. Express concern, sympathy, empathy, and compassion. Do not assume fault, or error, or blame, or designate blame to other personnel or department.

   b) Discuss the facts only and verified information. Include the time, place, circumstances of the occurrence, and proximal cause if known.

c) Provide the necessary medical information including how the unanticipated outcome will affect the patient, and actions to treat the patient. Provide information on who will manage the ongoing care of the patient.

d) State that the case is being reviewed if the information is incomplete at the time of the disclosure. **DO NOT** discuss Root Cause Analysis, Peer Review process, Mortality and Morbidity conference or entry of event report.

e) Focus on immediate needs for service recovery. For example, assistance with phone calls transportation, referral to social work, clergy, or other departments.
Do Not discuss financial compensation, or waiver of medical cost, etc. Notify Risk Management if the patient or family wishes to discuss compensation.

6. Documentation of disclosure includes:

a) The disclosing provider shall document that the discussion occurred with patient or patient's surrogate, including the contents of the discussion.

b) The documentation shall include the time and date of disclosure and the list of names and relationship to the patient present during the disclosure process.

c) The documentation shall include a brief, factually based description of the unanticipated outcome.

d) **DO NOT** document assumption of blame or fault by other providers.

e) **DO NOT** document Root Cause Analysis, Peer Review process, Mortality and Morbidity conference or entry of event reports in the patient's medical records.

7. Enter an online Safety Intelligence event report before the shift ends.

References:
California Code of Regulations, Title 22, Section 70707, Patient Rights
DHS Policy 311.201 Communication of Unanticipated Outcome
Joint Commission Patient Safety Standards

CM 8/27/14, 4/19/17, 9/1/21