Los Angeles County Department of Health Services

Policy & Procedure Title:	Communications of Unanticipated Outcomes		
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Distribution: DHS-wide ☒	**If not DHS-wide, other distribution:**		

PURPOSE:

The purpose of this policy is to define the role of the healthcare provider in communicating the outcome of any treatment, procedure, or diagnostic test, to the patient, and/or to the family/legally authorized representative, whenever the outcome differs significantly from that which was anticipated.

DEFINITION(S):

Primary Healthcare Provider: Individual responsible for the overall care of the patient at the time of the unanticipated outcome, or at the time the unanticipated outcome is discovered.

Primary Service: The service predominately involved in the unanticipated outcome.

Unanticipated Outcome: An unanticipated outcome is one that differs significantly from that which was anticipated. The outcomes do not necessarily occur as the result of substandard practice, error, or negligence. Unanticipated outcomes may occur when treatment is excellent. The unanticipated outcome may be either a negative or positive outcome.

POLICY:

It is the policy of the Department of Health Services (DHS) that all patients are involved in their care and treatment through frequent effective communication. This communication may take the form of discussion related to an unanticipated outcome in the patient's planned medical treatment.

Despite the cause of an unanticipated outcome or its subsequent results, healthcare providers have an ethical duty to communicate information about outcome to a patient. This ethical duty requires healthcare providers to ensure that the patient receives all facts necessary to make informed decisions regarding current and future medical care related to the unanticipated outcome. This obligation holds even though the patient's medical treatment may not be altered by the new information received. Communication should not be limited to those cases in which the outcome is obvious or severe. Concern about the ramifications which might result following truthful communication should not affect the healthcare provider's honesty with the patient. The therapeutic relationship relies on trust and is compromised when deception or concealment of information occurs. Communication of unanticipated outcomes offers the following benefits: improving upon a patient centered care philosophy through openness and transparency, learning from and not repeating mistakes, and fostering the healing of physical and psychosocial traumas.

This policy applies to all caregivers who provide patient care.

PROCEDURE:

COMMUNICATION OF UNANTICIPATED OUTCOMES

1. When to Communicate

   The first priority after an unanticipated outcome is to provide for the immediate clinical needs of the patient. Once these needs are addressed, arrangements should be made to plan and coordinate the communication process with the patient, family, or legally authorized representative.

2. Who Should Communicate

   It is recommended that the appropriate representative from the primary service area most involved with the unanticipated outcomes communicate the event with the patient (i.e., nursing, radiology, orthopedics, etc.). The lead communicator in this discussion will have participated in DHS approved education on the disclosure process. Should the primary service representative involved be different from that of the patient's primary health care provider, communication of the unanticipated outcome may be deferred with mutual agreement of both parties to the primary health care provider. The primary service representative shall be present for the communication to answer any questions.

   This communication should take place under the supervision and guidance of the attending physician/nurse manager/supervisor where indicated. Care should be taken to ensure that any special needs of the patient/family/legally authorized representative, such as hearing, speech or language barriers, or met.

3. Deciding to whom to Disclose

The primary communication about the unanticipated outcomes will take place with the patient when the patient is a competent adult or mature minor receiving confidential care. Communication with the family/legally authorized representative is generally appropriate when the patient is

a. a minor (other than a mature minor who is receiving confidential care such as treatment for sexually transmitted diseases, substance abuse, or pregnancy).
b. Lacks decision-making capacity, or
c. a competent adult who request that certain family members be told.

4. How to Communicate the Information

Participants involved in the communication process will provide accurate and factual information about the unanticipated outcome and not rely on assumptions or predictions about the contributing factors. Communication should focus on communicating empathy, offering emotional assistance, and providing factual information about the circumstances of the event.

Explanation of the event will include the likely consequences of unanticipated outcome, actions taken to prevent its recurrence, the patient's current condition, and plan for continued treatment.

Facility policy or guidelines may further describe the communication process, detailing the timeframe for communication of unanticipated outcomes, the team members present for the discussion, and how the investigation into the unanticipated outcome should be conducted.

5. Use of interpreters

Qualified medical interpreters will be used when there is a need to discuss an unanticipated outcome with a limited English proficient patient, family member(s), or legally authorized representative.

6. Documentation

If the situation meets criteria for a critical clinical event, or sentinel event, appropriate reporting and documentation will be completed.

Documentation of the discussion of the unanticipated outcome will be present in the patient's medical record. Components of the documentation will include the following:

a. Time, date and place of the discussion
b. The names and relationships of those present
c. A summary of the discussion
d. Any subsequent information provided to the patient/family/legally authorized representative

GUIDELINES:

The following guidelines for communication of the unanticipated outcome are intended as a reference for facility process and are not part of DHS policy and procedure. These communication guidelines were developed to assist the health care provider in communicating unanticipated outcomes that may have negative results.

1. Communication should not be significantly delayed pending improvement in the patient's condition. If there is concern that the patient's condition may interfere with the understanding of the unanticipated outcome, communication should be repeated again after the patient status improves.
2. Risk Management personnel may also provide assistance with the communication process, however, the involvement of Risk Management personnel may be interpreted by the patient/family/legally authorized representative as a defensive act by the facility.
3. When meeting with the patient/family/legally authorized representative, the communication should take place in a quiet, private location. Enough time should be set aside, without interruptions, to provide communication about the event, and address all questions. In serious cases, social workers, chaplains, or other staff may be present to help the patient/family/legally authorized representative, cope with the news and to offer ongoing support if needed.
4. The communication team should offer a sincere expression of sorrow and regret for the harm the patient experience. An apology should not be worded as an attribution or acceptance of blame, or as an admission of liability. The communication team should accept responsibility for the follow-up of the event, but should not criticize the care or response of other healthcare providers. The patient/family/legally authorized representative should be reassured that an investigation of the event is underway, and that the facility is actively working to prevent a reoccurrence. The discussion should end with an offer to be available for any future questions, and the identification of a "liaison" that can assist with answering these questions. The liaison is expected to regularly communicate with the patient/family/legally authorized representative regarding the progress of the investigation into the event.
5. Summary documentation in the medical records should include questions posed by the patient/family/legally authorized representative and responses that were provided by the health care provider.

REFERENCE(S)/AUTHORITY:

DHS Policy 311.2, Critical Clinical Event (Including Sentinel Event) Reporting and Follow-up

DHS Policy 311.202, Adverse Event Reporting to the State Department of Health Services

American College of Emergency Physicians (ACEP). ACEP Policy Statement: Disclosure of Medical Errors. September, 2003

American College of Physicians. Ethics Manual. 1998

American Nurses Association. Code of Ethics for Nurses with Interpretive Guidelines. 2001

American Society for Healthcare Risk Management. Perspectives on Disclosure of Unanticipated Outcome Information, April, 2001

American Society for Healthcare Risk Management of the American Hospital Association Disclosure: What Works Now & What Can Work Better, February, 2004

Cantor, M.D., Barach, P., Derse, A, Makian, C.W., Wloody, G.S., & Fox, E. Disclosing Adverse Events to Patients. Joint Commission Journal on Quality and Patient Safety 2005, 31; 4-12

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