Safety Action Series

Patient, Family, and Staff Support: Managing Medical Trauma
Speakers

Michelle E. Flaum Hall, Ed.D., LPCC-s
Associate Professor
Department of Counseling
Xavier University –Cincinnati OH

Patrice M. Weiss MD
Chief Medical Officer
Executive Vice President
Carilion Clinic
Professor of OB/Gyn
Virginia Tech Carilion School of Medicine
Roanoke VA, 24014
Disclosures

➢ Michelle E. Flaum Hall, Ed.D., LPCC-s has no real or perceived conflicts of interest.

➢ Patrice M. Weiss, MD has no real or perceived conflicts of interest.
Objectives

• Share examples of successful protocols and practices used to support patients, their families, and staff after a severe maternal event.

• Discuss the significance of creating a culture and system that recognize the importance of supporting providers and staff during stressful cases and after adverse events.

• Explain the impact that clinical care systems like this may have on patient safety.
Severe Maternal Morbidity: My Experience of Medical Trauma

- Michelle Flaum Hall. First pregnancy, induction, placental abruption, emergency C-section, severe postpartum hemorrhage, uterine atony, hysterectomy after 6 hours of intervention (uterine massage and clot extraction). **Total Blood Loss: 10 liters.**
- 5 days in ICU: Developed Acute Stress Reaction; pneumonia; discharged from maternity unit after 2 days.
- No mental health assessment or intervention while in hospital or post-discharge by OB-GYN; debrief focused on medical interventions.
- Developed PTSD despite no pre-existing mental health diagnoses.
My Experience of Medical Trauma: A Tale of Silent Suffering

PREOPERATIVE DIAGNOSIS: Postpartum hemorrhage.
POSTOPERATIVE DIAGNOSIS: Severe uterine atony
PROCEDURE PERFORMED: Exploratory laparotomy followed by total abdominal hysterectomy and

LARGE AMOUNT OF CLOTS

PAIN ASSESSMENT
Level of Pain
Pain Frequency
IncPain
Constant

04/09 17:07
12:58

Recovery
151
18
135/64

1. HR remains tachycardic, BP

Pt., verbalizes fear.

If the patient meets any of the following

- Use "Ordering N" (DR001111) as "ordered by" when entering a Nurse Order in LastWord.
- Items highlighted in yellow require physician’s order.
- Initiate Referral to SOCIAL SERVICES DISCHARGE PLANNING if:
  ONE OF THE FOLLOWING APPLIES:
  - Suspected abuse/neglect – domestic violence, child or elder abuse/ neglect.
  - Admitted from another institution.
  - ECF Name: ____________________
  - Assisted Living Name: ____________________
  - Other Name: ____________________
  - Was being served by a home health agency or another referring community agency prior to admission. Name:
  - Patient or caregiver expressing concerns about discharge.
  - Nursing and/or Physician expressing concerns about patient’s discharge

COUNCIL ON PATIENT SAFETY IN WOMEN’S HEALTH CARE

safe health care for every woman
Implications of Undetected Medical Trauma

- **Patient:** Multiple crises, including physical, emotional, psychological, spiritual, existential, relational, health (medical avoidance)
- **Family:** Context of near-loss
- **Staff:** Implications of no clear protocols; powerlessness; emotional toll; fear of legal repercussions; miscommunication

**All:** No support, no closure
What is Medical Trauma?

“Medical trauma is a trauma that occurs from direct contact with the medical setting, and develops through a complex interaction between the patient, medical staff, medical environment, and the diagnostic and/or procedural experience that can have powerful psychological impacts due to the patient’s unique interpretation of the event” (Hall & Hall, 2016)
Characteristics of Medical Trauma

- Is based on the subjective experience of the patient
- Exists on a continuum
- Is bio-psycho-social-spiritual
- Is contextual
- Exists at all levels of care
- Is relational
  - Double-bind of the patient-healer relationship
- Is complex
  - Disenfranchisement of medical trauma
Medical Errors: Emotional Impact on Health Care Providers

- Medical errors occur in approximately 5-10% of hospitalized patients
  - Up to 50%
- Reporting of Medical Errors and Follow-up has been Patient Focused
  - “The First Victim”
- Effect on Resident and Attending Physicians
Medical Errors-Trainees

• 34% of internal medicine residents reported at least one major medical error during training
• 18% of multi-disciplinary residents reported an adverse event related to his/her care in the previous week
• No good data about the frequency of medical errors among attending physicians

www.webmm.ahrq.gov  Jan 2008
Providers - the “Second Victim” of Medical Errors

- 3-fold increase in depression
- Increase in burnout
- Decrease in overall quality of life
- Feelings of distress, guilt, shame may be lasting
- Feelings appear to occur regardless of stage of training

West CP et al. JAMA. 2006;296:1071-1078.
Emotional Impact of Medical Errors on Physicians

Predictors of Impact of Medical Error

• Patient outcome
  – The more severe the morbidity the greater the impact

• Degree of personal responsibility
  – The more responsible, the more damaging the error

Medical Error Processing for Patients

• Disclosure
  (Explanation, Apology, Prevention of recurrence)
• Family, Friends
• Hospital Support
• Legal Action

www.webmm.ahrq.gov
Personal Reaction to Medical Error

• “It will never happen again”
• Singled-out
• Exposed
• Replay over and over and over
• Confess, admit, tell

Acad Med. 2006; 81:86-93
Medical Error Processing for Residents/ Attendings

• Morning Report
• Morbidity / Mortality
• QA / PI
• Root Cause Analysis

• NAME BLAME SHAME GAME

Support for Providers Involved in Medical Errors

• Traditional Morbidity and Mortality conference
  – Errors regarded as lapses resulting from unacceptable personal fallibility
  – Risk for public humiliation and shame
  – Changing emphasis of such conferences could provide powerful opportunity for professional role-modeling of error acknowledgment and open discussion

See Notes for References.
Whack-a-Mole

The Price We Pay For Expecting Perfection

David Marx
“Whack a Mole”
The Price We Pay For Expecting Perfection

- Human Error
  - Console

- At-risk Behavior
  - Coach

- Reckless Behavior
  - Punish

David Marx  2009
Event Investigation I

- What happened?
- What normally happens?
- What did policy/procedures require?
- Why did it happen?
- How was the organization managing the risk before the event?

Carilion Clinic Joint Quality Committee
Processing of Medical Errors – a New Approach

Morbidity and Mortality Review

• Framed differently
• Role modeling
• Error acknowledgment
  – System
  – Individual
• Attention to personal impact not just clinical

www.webmm.ahrq.gov
Medical Error Processing for Providers

- Focus on Prevention is First KEY
- Accepting responsibility
- Understanding of error event
- Need for Support – “not sign of weakness”
- Discussions with family and colleagues
- Professional and Social networks
- Disclosure

www.webmm.ahrq.gov
Emotional Impact of Medical Errors on Physicians (cont.)

- Felt that Hospitals/Health Care Orgs Offered Inadequate Support for Coping with Stress: 90%
- Expressed Interest in Counseling: 82%
- Anxiety about Future Errors: 61%

Processing of Medical Errors – a New Approach

- Institutional support
  - Educational curriculum
  - Employee assistance program
  - One-on-one peer support
  - “Confessor” figures

- Program Director, Chair, Teaching Faculty

forYou Team Principles

• Peers with listening and supportive skills
  – Not counselors
• Strictly confidential
• Focus: “second victim’s” emotional response
  – Not event details
• Safe zone of supportive intervention

www.muhealth.org
We’re here for you and your family.
Organization: The Johns Hopkins Hospital
Solution Title: Implementation of the “Second Victim” Support Program: RISE

Program/Project Description: What was the problem to be solved? How was it identified?
What baseline data existed? What were the goals—how would you know if you were successful?
The healthcare environment is a vulnerable place for any care provider to work. Many patients suffer from unexpected outcomes, errors, and other events that cause distress to the care providers. These care providers are more recently known as "Second Victims." Recent nationwide news events have demonstrated the lack of support systems in healthcare settings. It has been validated via survey that a support program is needed at the Johns Hopkins Hospital.
Second Victim Conceptual Intervention Model

- Unanticipated Clinical Event
- Second Victim Reaction: Psychosocial & Physical
- Institutional Response
- Clinician Recovery
  - Surviving
  - Thriving
  - Dropping Out
- Supportive Interventions

Credit: University of Missouri ForYOU Team
The TRUST Team

- Developed by a multidisciplinary advisory committee. The TRUST team was initially founded to support Second Victims but is now being considered to support other front line staff who are facing work related stressors.

- Treatment that is fair and just
- Respect
- Understanding and compassion
- Supportive care
- Transparency and opportunity to contribute
To Err is Human

Institute of Medicine-2001
Preventing “Second Victim” Casualties is Humane
TO SAVE A LIFE!

- Pick up life ring
- Grab the rope
- Keep hold of end of line
- Throw ring to casualty
- Pull casualty to shore

If possible send somebody else for assistance - Dial 999 for emergency services

Do not interfere with this equipment

Under the Criminal Damage Act 1971, any person found tampering with this equipment may receive up to a £5,000 fine and/or imprisonment.
Identification, Assessment, Intervention: A Key to Helping Patients and Staff

- If we recognize and assess for medical trauma, we give patients the best chance at regaining psychological health following a medical event.

- By adopting new protocols and tools, we may be able to prevent severe psychological consequences of medical trauma.
Use Tools that Specifically Address Medical Trauma

- Many screening tools that assess for a traumatic stress reaction focus on PTSD and don’t address the unique context of medical trauma.
Take-Home Points

• Medical errors are an inevitable part of medical practice resulting in significant distress for providers

• Coping strategies are necessary and range from personal approaches to formal organized forums for discussion of errors

• Institutional efforts should focus on implementing curriculum in medical errors at all levels of medical training

• Culture shift will be necessary to create a productive process for the provider sharing the medical error
Q&A Session
Press *1 to ask a question

You will enter the question queue
Your line will be unmuted by the operator for your turn

A recording of this presentation will be made available on our website:
www.safehealthcareforeverywoman.org
Next Safety Action Series

Maternal Mortality: What Do Numbers Mean?

April 3, 2017
1:30 p.m. ET

Marian F. MacDorman, Ph.D
Research Professor
Maryland Population Research Center
University of Maryland, College Park

Donna L. Hoyert, Ph.D
Center for Disease Control (CDC)

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