What to Do After an Adverse Event: An Overview and Suggested Algorithm

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- Adverse events can have medical, legal, and emotional implications for patients, families, and medical professionals. A protocol can facilitate appropriate actions even in a chaotic environment. Institution-specific guidelines should be followed.
- Along with patient care implications (first victim), second victim syndrome is the distress healthcare professionals experience after caring for a patient who suffered an adverse event.
- Supporting the care team involved will help to prevent a third victim (the next patient cared for, or the healthcare organization as a whole). Additional medical errors may occur as a result of the trauma experienced by the second victims.

**Adverse Event Algorithm**

| Immediately after event | 1. Mobilize a multidisciplinary support team ([How to Approach Medical Errors](#))
| | 2. Continue to provide patient care to its conclusion, if able.
| | 3. Delegate an Incident Supervisor to assign tasks and speak with perioperative teams and family.
| | 4. Close the involved operating room to investigate potential equipment or medical error. Do not discard, clean, disassemble, or alter anything (medical equipment). If applicable, allow family viewing of deceased.
| | 5. Debrief event with perioperative team.
| | 6. Contact hospital administrator and risk management.
| | 7. Disclose event to patient/families and provide support ([How to Break Bad News to Families](#)). Plan discussion with the family, select a suitable space, involve support teams (interpreters, clergy, etc.), explain events, verify understanding, consider apology, and offer follow-up with families. Full disclosure and apology is beyond the scope of this one-pager due to administrative, risk management, and potential state-dependent medical-legal implications.

| Within days-weeks after event | 1. Designate a Follow-up Supervisor (may be Incident Supervisor). Consider follow-up debrief with support services. Continue communication and investigation, and report to authorities if needed.
| | 2. Review formal reports submitted to authorities for accuracy.
| | 3. Communicate with hospital staff involved and consider process improvement interventions. Consider third party presentation at quality improvement and/or morbidity and mortality conferences.

**Caring for Colleagues** ([see also How to Set Up a Peer Support Program & Be a Good Peer-Supporter](#))

- Involve formally trained peer supporters, if available.
- Allow ample time, provide uninterrupted attention.
- Listen without judgement, avoid asking for specifics.
- Offer reassurance and validate colleague’s feelings and experience.
- Avoid shifting the focus to your own experiences.

**Expressions to Avoid When Talking to Colleagues After an Unexpected Adverse Patient Event**

<table>
<thead>
<tr>
<th>It'll be fine</th>
<th>It could have been so much worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>This will pass and you’ll get through this</td>
<td>Things happen for a reason</td>
</tr>
<tr>
<td>Time heals wounds</td>
<td>This is a good learning experience</td>
</tr>
<tr>
<td>At least _____ didn’t happen</td>
<td>You’re given what you can handle</td>
</tr>
<tr>
<td>This happened to me before…</td>
<td>The patient was old/sick</td>
</tr>
<tr>
<td>At least you won’t get fired</td>
<td>Things like this are bound to happen to us all at some point</td>
</tr>
</tbody>
</table>

Adapted from ASA Monitor: 2022;86:12

**References:**

3. Providing care for a colleague involved in an unexpected adverse event. ASA Monitor. 2022;86:12. [Link](#)