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

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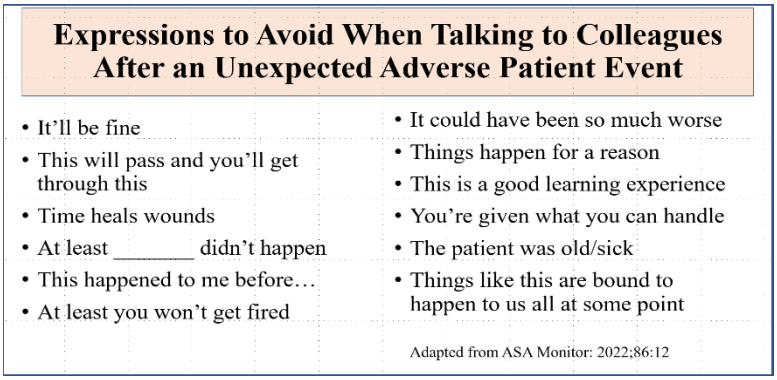
- Adverse events can have medical, legal, and emotional implications for patients, families, and medical professionals. A protocol can facilitate appropriate actions even in a chaotic environment. Institution-specific guidelines should be followed.
- Along with patient care implications (first victim), 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. 8. Document events objectively for medical record and incident report. Consider personal notes for future reference.
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.



References:

1. Organized response to major anesthesia accident will help limit damage. Anesthesia Patient Safety Foundation. Published March 10, 2006. Accessed May 11, 2023. Link
2. Enhancing a culture of safety through disclosure of adverse events. Anesthesia Patient Safety Foundation. Published February 1, 2021. Accessed May 11, 2023. Link
3. Providing care for a colleague involved in an unexpected adverse event. ASA Monitor. 2022;86:12.Link
4. Tanabe K, Janosy N, et al. Caring for the caregiver following an adverse event. Paediatr Anaesth. 2021;31(1):61-7. PubMed
5. Liukka M, Steven A, et al. Action after adverse events in healthcare: An integrative literature review. Int J Environ Res Public Health. 2020. 17(3): 4717. PubMed