Helsedirektoratet
Norwegian Directorate of Health

Adverse Events

Seminar for health care workers - Preparing for mastery

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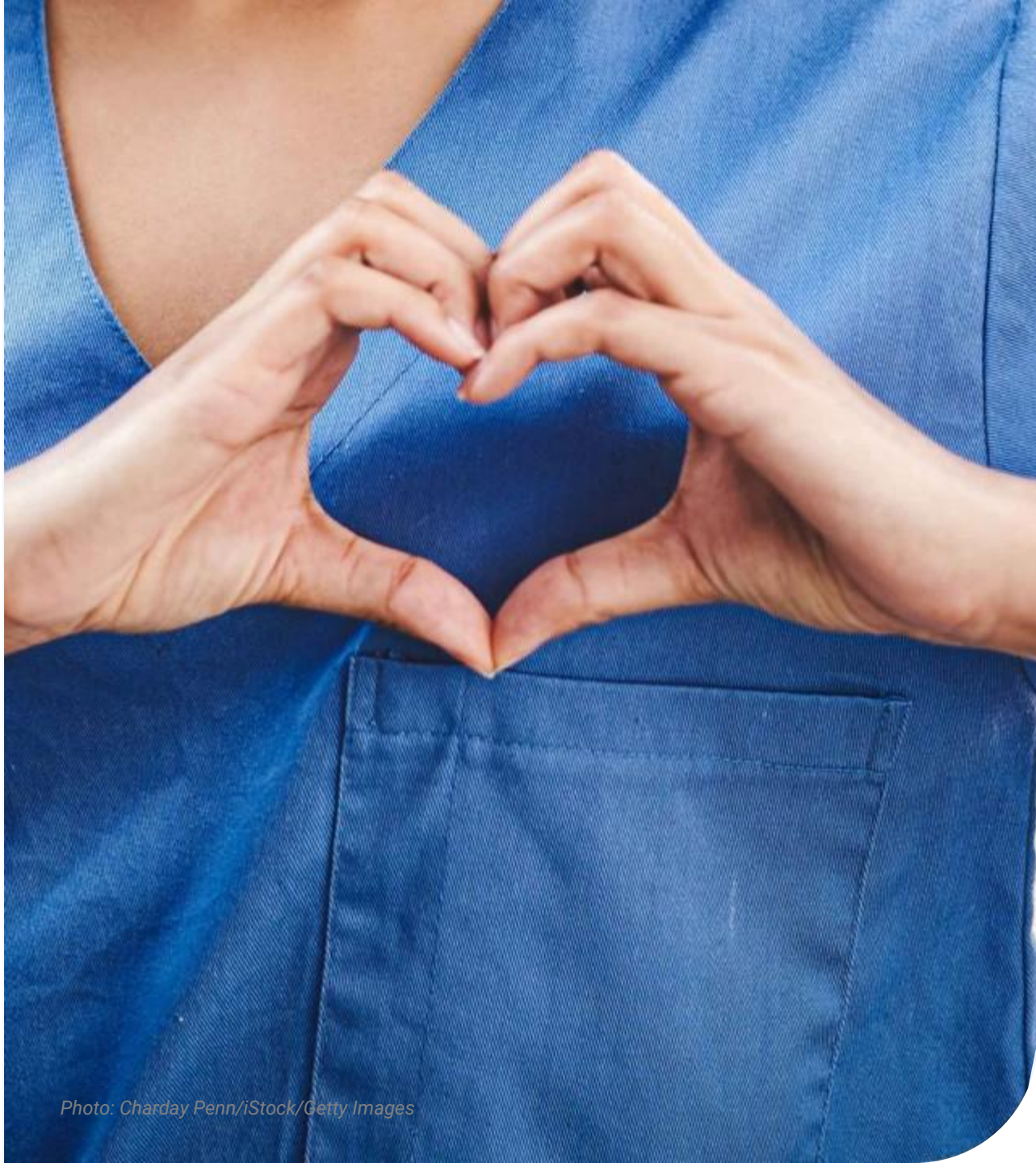

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See the facilitation guide for more information on holding such seminars.

Please credit the use of the presentation slides and other materials.

QR-code for selected supporting materials

10%

of hospital stays result in patient harm

12-15%

of health budgets can be tied to consequences of patient harm

?

the human costs

Global patient safety action plan WHO 2021
The Economics of Patient Safety OECD 2021

Patients, users, family

Employees

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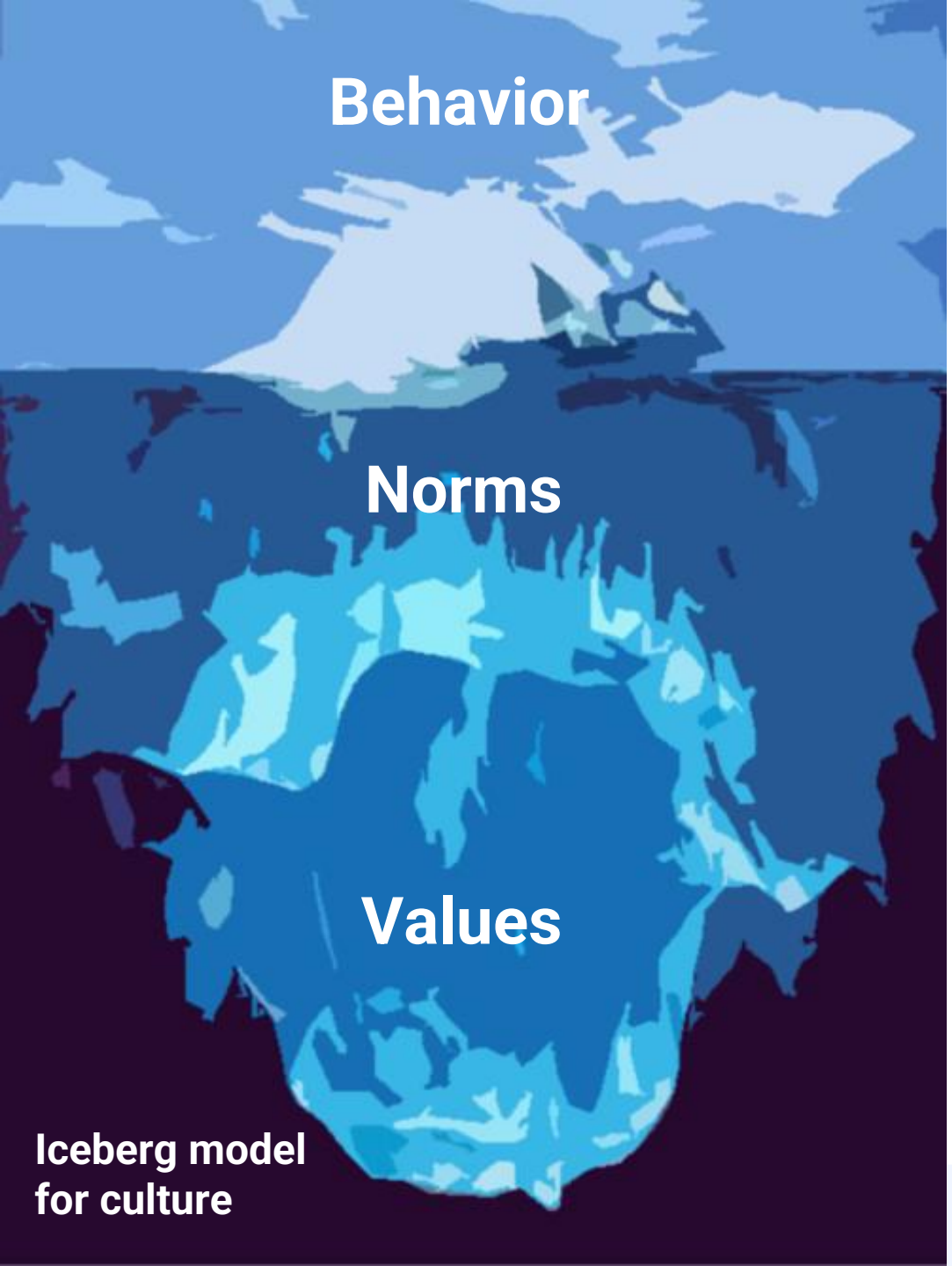


Iceberg model for culture

«Values and norms expecting doctors to be infallible…»[1]

«[Norm] 'Make no mistake, and if it does happen, you are the one responsible' is still very much alive….» [2]

«We have to dismiss the illusion of perfection.» [2]

[1] *The professional culture among physicians in Sweden: potential implications for patient safety. Danielsson et al 2018 BMC Health Services Research*

[2] *Rikshospitalet i Københavns podcast «Svært at tale om på Riget», episode «Ufejlbarlig pr definition» 2021*

Consequences

- **Fear of making mistakes**
- **Heavy burden**

The culture of infallibility «is experienced as a burden, and doctors describe the silence that occurs, as the consequence of the aversion to discussing errors» [1]

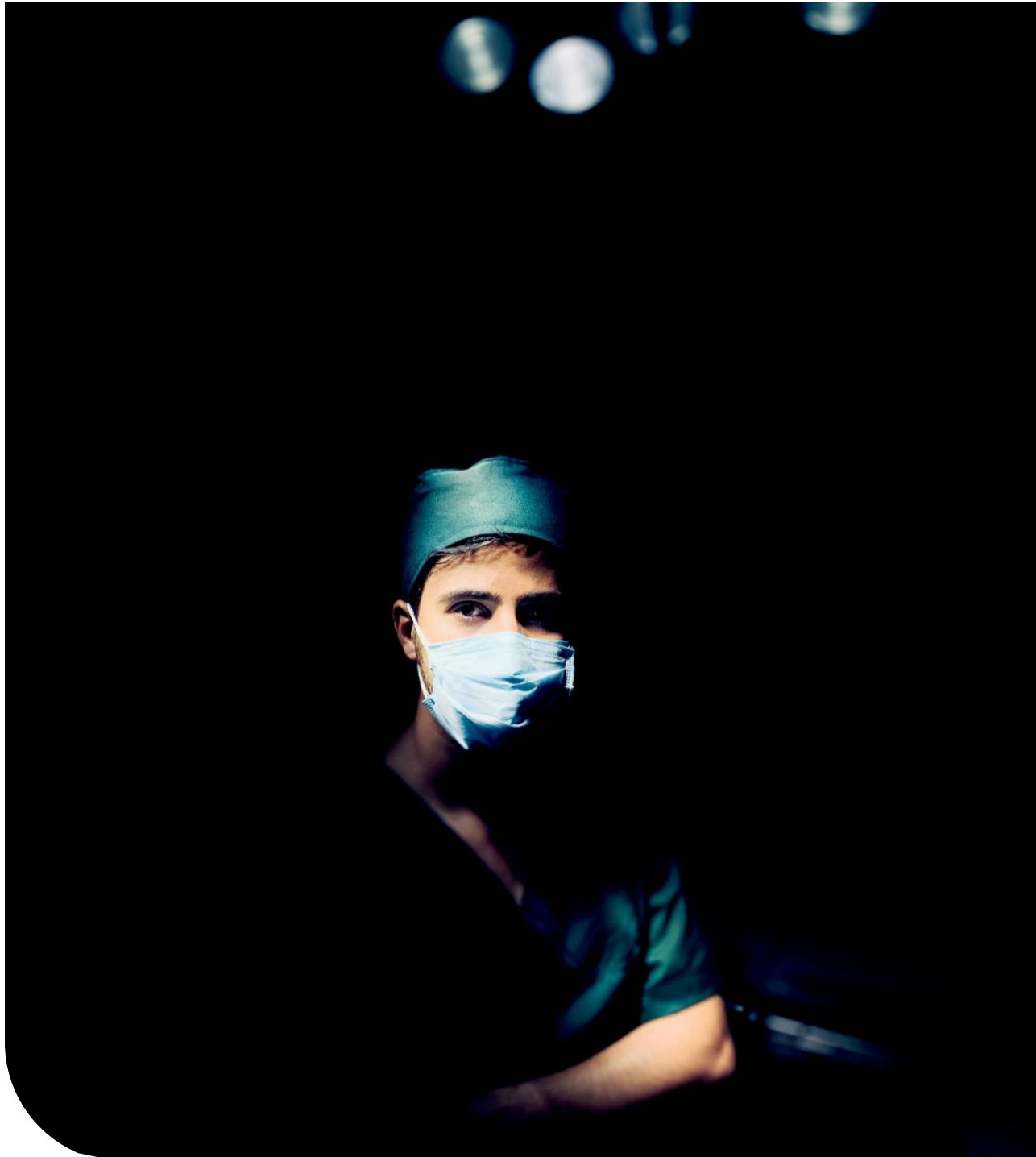


Foto amirreza jamshidbeigi, Unsplash

- **Silence**
- **Pain is kept hidden**

Expected to be stoic when an adverse event occurs. “We hold the grief hidden and suffer in silence. The pain can almost destroy you.”[3]

[3] *Bohnen et al (2019) When Things Go Wrong -The Surgeon as Second Victim. Annals of Surgery*

Photo: Yuri Arcurs Mostphotos

Culture of infallibility

Swedish and Danish research show that 71-92% of midwives and obstreticians have experienced serious adverse events

yet have **low acceptance for fallibility.**

Schrøder, et al. 2021

→ Hindrance for psychological safety

Photo: Pixel/iStock/Getty Images

Consequences can be

- change in sense of identity
- shame
- isolation

- anxiety, depression, burnout
- defensive practice
- leaving the profession

Schrøder et al. 2021, Van Gerven et al 2016, Øyri et al. 2023, Busch et al. 2020 and others

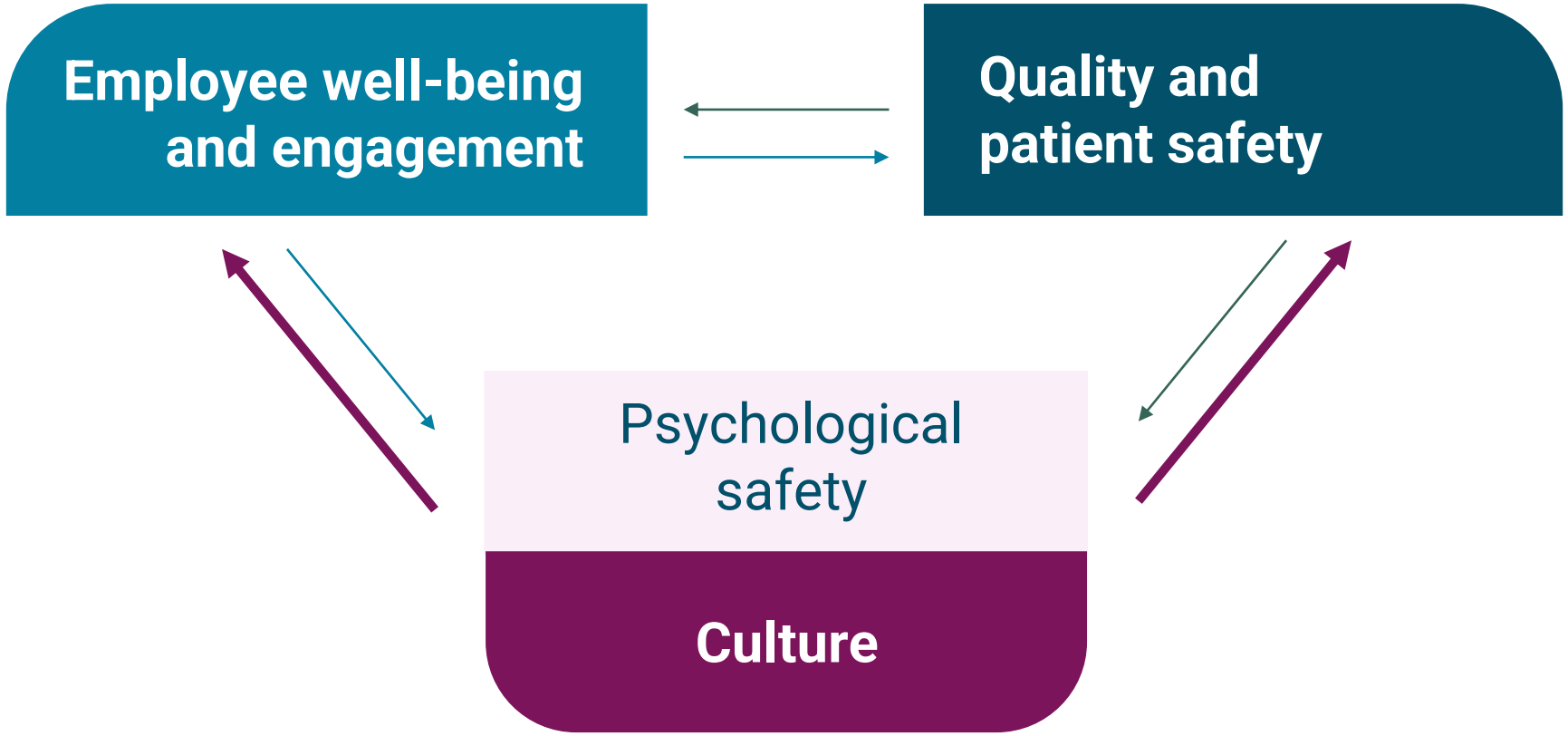

Employee well-being and engagement
Quality and patient safety
Psychological safety
Culture


Foto: Stockbilder

Preparation for mastery

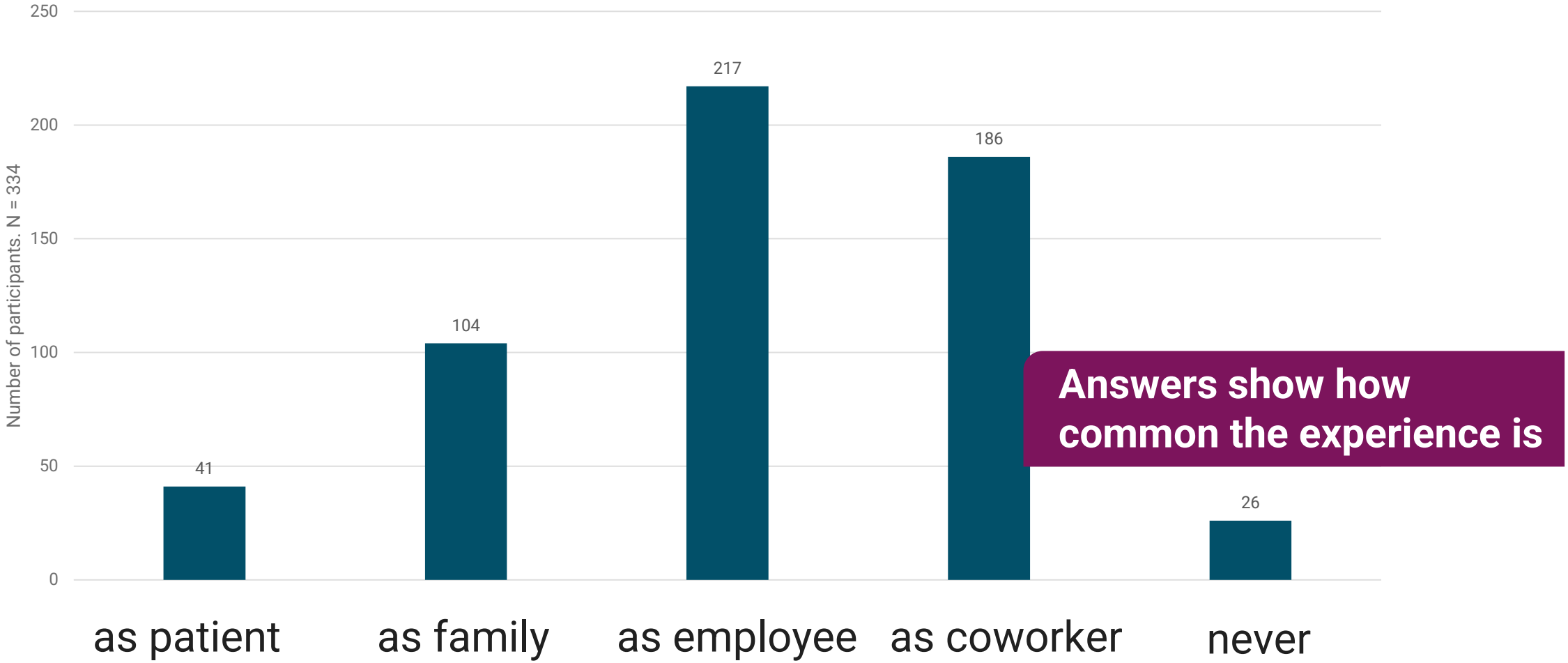
- adverse events: prevalence, type
- normal reactions
- how would you like to be treated?
- peer support

- training for conversations with patients and relatives

→ Build resilience
→ Avoid stigmatization

1 Have you ever been involved in an adverse event?

patient harm, potential harm, complication, medication error, misdiagnosis, missed care…



1

Think of an adverse event or a traumatic experience you have been involved in – which emotions or themes do you connect with this experience?

Skam	Shame
Skam	Shame
Maktesløshet	Powerlessness
Skam	Shame
Redsel	Fear
Utilstrekkelighet	Inadequacy
Alene	Loneliness
Skam	Shame
Sorg	Grief
Maktesløshet	Powerlessness

The first of 214 answers in this session.

Answers demonstrate common reactions and normalize them

2

Think of the same situation again. How would you have liked to be met, what were your needs?

Forståelse, mulighet til å snakke	Understanding, opportunity to talk
Forståelse	Understanding
Forståelse	Understanding
Forståelse	Understanding
Støtte	Support
Støtte, forståelse	Support, understanding
Forståelse, støtte	Understanding, support
Omsorg	Caring
Openhet	Openness
Tid til å sette seg ned og prate gjennom	

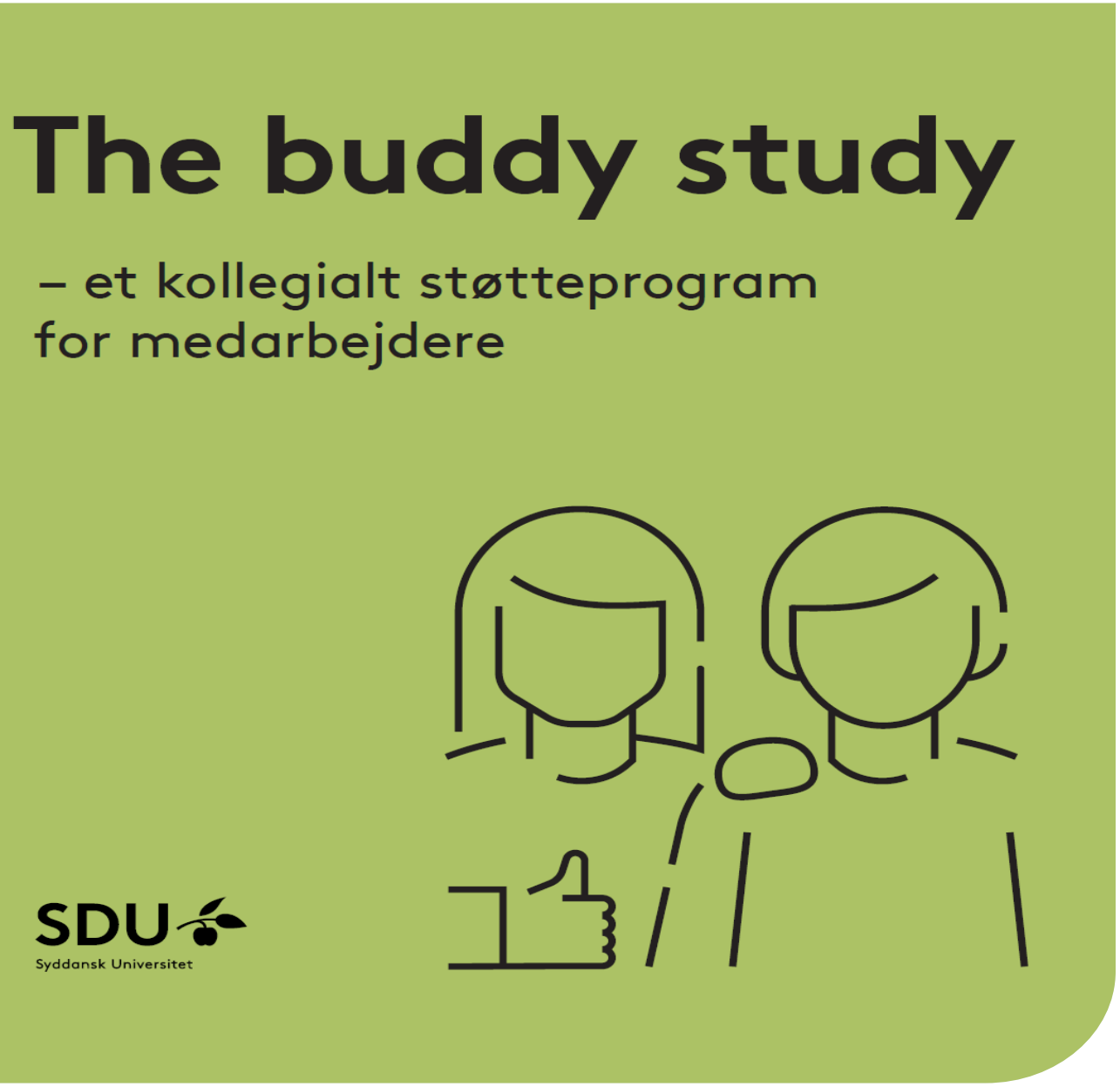
Answers demonstrate that needs are such that colleagues can support one another

Types of peer support

- Informal peer support
- Buddy system
- Local team
- Central resource group
- Professional associations' peer support systems

Formalizing peer support

- shows that the organization cares
- influences the culture positively
- can be implemented with low-threshold, low-cost interventions



Buddy system

- All HCPs must attend a seminar about second victim, listening skills and 'buddy talk' (2 hours).
- After this, all must choose two buddies from their group of peers (interprofessional).
- The buddy is notified if there has been an adverse event.
- Buddy-talks are confidential.
- Two hours are allocated for the buddy-talks – distributed as you see fit. Must not extend beyond four weeks.

The buddy role

- Contact the colleague involved within 24 (or 48) hours. If this is not possible, the alternate buddy is activated.
- Provide psychological first aid:
  Be present and able to contain and support the other person.
- ”Walk with the person” – be a companion on the journey.

Photo: Priscilla du Preez/Unsplash

Results

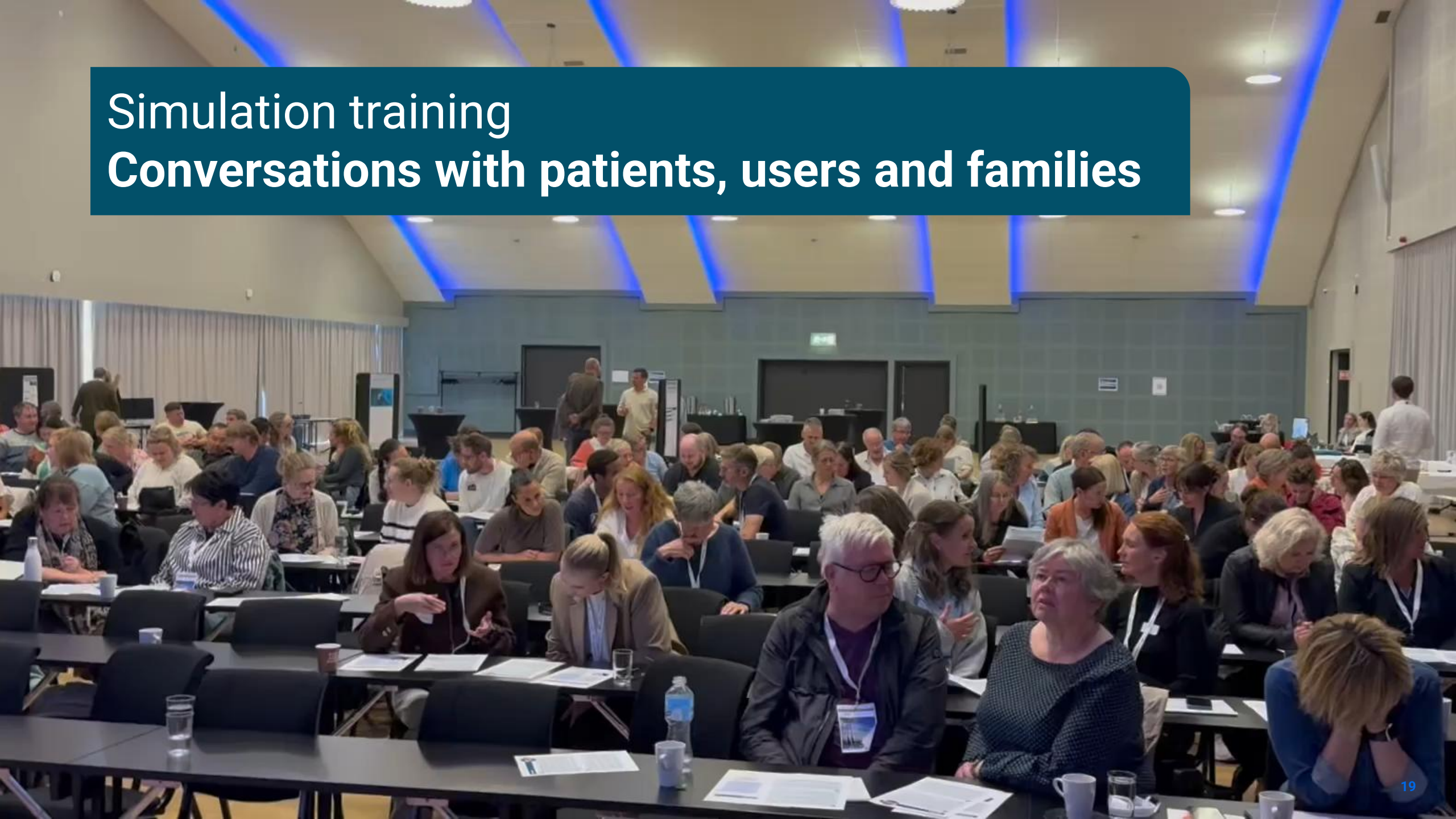
Seminar

- I have gained knowledge about the second victim phenomenon 98%
- I feel prepared to become a buddy for my colleagues 87%
- I am satisfied with the overall content of the seminar 92%

Buddy-talks

- After 18 months, 26 HCPs had activated their buddy (out of 29 registered buddy calls)
- Other support programs report that smaller numbers use the programs than anticipated

Self-selected relations were considered to add a greater sense of safety and to encourage a general sense of responsibility toward each other.
Talking to a peer with the same background and training was considered to provide more qualified professional assessment of clinical decision-making.



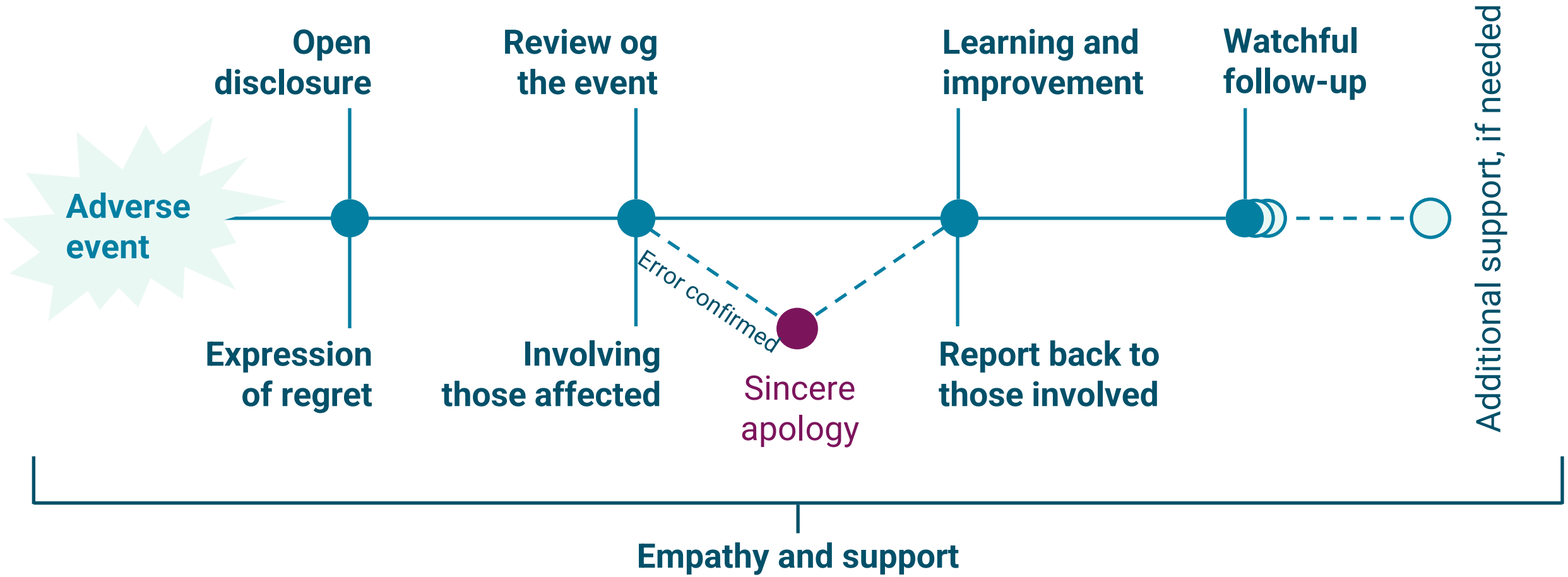
Simulation training
Conversations with patients, users and families

Foto: SDI Productions/iStock/Getty Images

1

What is the difference between expressing regret and apologizing?

Ivaretakelse av pasienter, brukere og pårørende



Distinction between expressing regret and apologizing.

Until the circumstances have been clarified, an apology should not be made.

Acknowledging, and expressing regret that an unfortunate event **has occurred,** and well as showing empathy, should be done as soon as possible.

If an error or flaw is confirmed, if something **has been done** (or not done, that should have been), it is essential that those affected receive a sincere apology.

Foto: Pixel/iStock/Getty Images

2

What is the difference between sincere and pseudo-apologies?

Pseudo-apologies

1

to regret the pasient's, user's or relative's **experience** of, or reaction to, the event, not the event itself

2

to give an **explanation** of why treatment was carried out the way it was, without regretting or apologizing for it

3

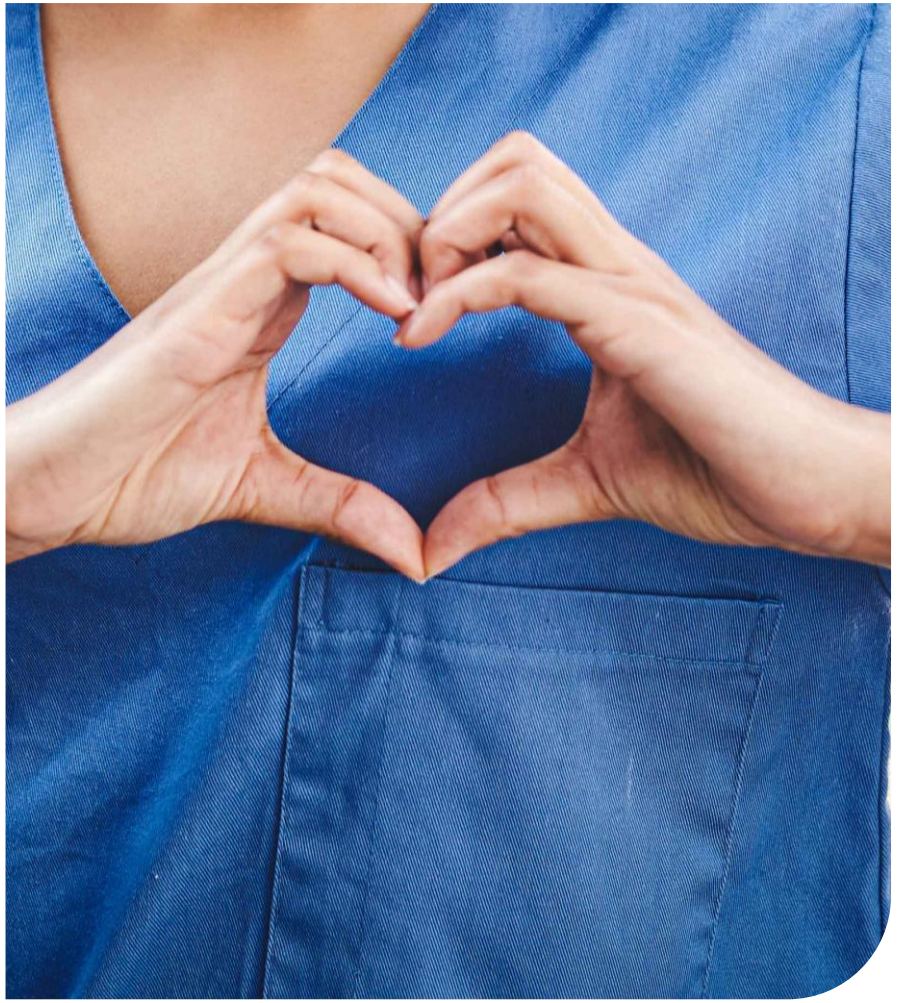
when it seems the person is being **forced** or apologizing without meaning it, because s/he has been asked to do it

4

when it's carried out as a **formality**

Elements in a sincere apology

1. Acknowledgement of error(s)
2. Description of what happened
3. Clear statement on taking responsibility
4. Expression of remorse
5. Change in behavior/practice



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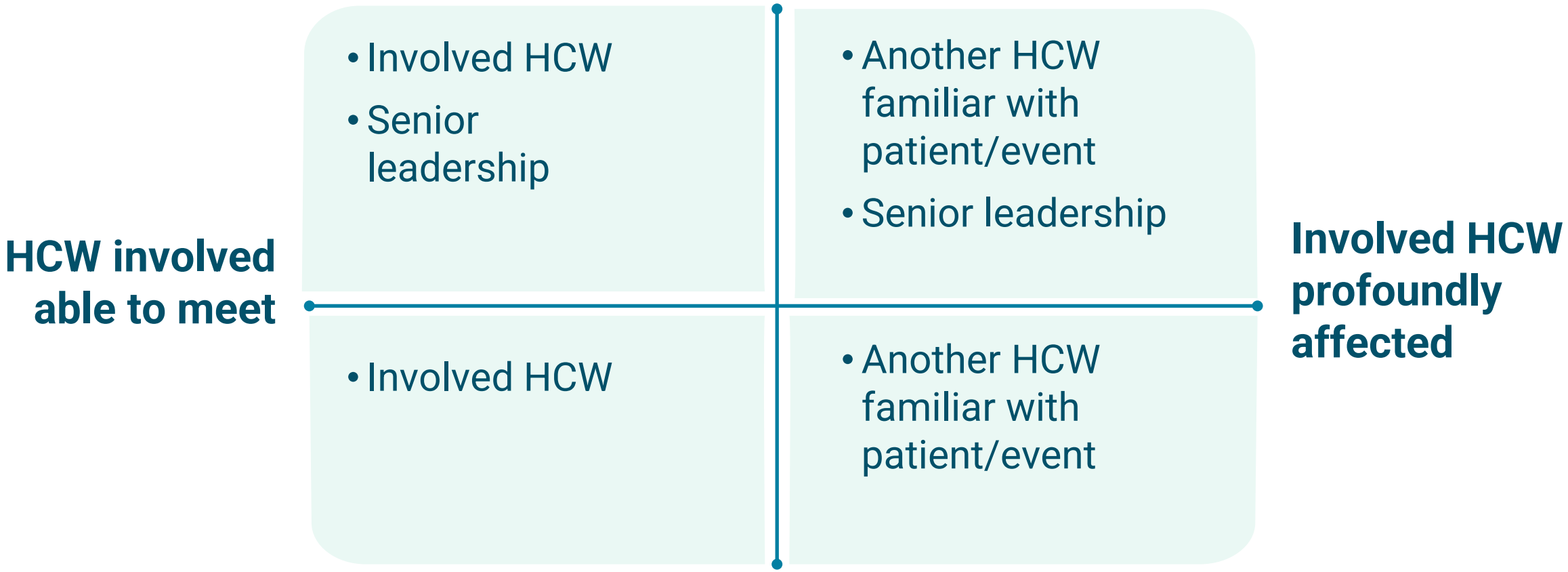
Serious event



Adapted from Mira, 2015

Practicing conversations in pairs

In a real situation there are often more participants. Here it is you and your partner who have the conversation – one in the role as patient/user/family member, and the other as a health care worker (HCW).

Photo: Andrea de Martin/Mostphotos

"Imagine the event involved your wife, children, mother, father, or yourself.... Imagine the conversation you would like to have with the doctor and the team, and if necessary, management."

Jannicke Mellin-Olsen (1957-2025)
anesthesiologist and board member
Patient Safety Movement

Learning objectives – practice conversations

1. Acknowledge that an unfortunate event has occurred.
2. Determine whether the case calls for an expression of regret and/or apology.
3. Show empathy and acknowledge (validate) reactions.
4. Express regret and/or apologize in a way that feels genuine and sincere.
5. Give the patient/family time to process what is said.
6. Invite them to give feedback (then and there, or later), so that services can be improved.

Check the memory card "Caring for patients, users, and families" for the distinction between expressing regret and conveying a sincere apology.

Procedure – steps in the simulation training

1. Choose a case and determine roles. Use your imagination and fill in the case so it is meaningful for you.
2. The patient/family member/HCW specified says the opening line.
3. HCW leads a conversation in line with the learning objectives.
4. The HCW shares their reflections on the conversation.
5. The patient reports back with the learning objectives in mind
   - what worked well
   - what they would like more of.
6. If time permits, have another round of the conversation.
7. Switch roles and go through the case again, or choose a new one.

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Four cases

1 Medication error. Wrong dose

Edel was an active 78-year-old widow who lived at home without assistance from the health services. She had the misfortune to fall and break her hip, and is staying in the orthopedic ward for a few extra days due to severe pain.The doctor prescribed 5 mg morphine at a strength of 10 mg/ml intravenously every 3-6 hours as needed.

During the night Edel asked for morphine for the pain. There was a lot to do that shift, and the nurse on duty did not get any help to double-check the medication. She was stressed by all the patients who needed help and supervision. The nurse administered the morphine dose, but miscalculated it. Instead of 0.5 ml of morphine, Edel received 5 ml of morphine intravenously.

When the nurse checked on Edel half an hour later to see if the morphine had effect, Edel was unresponsive, her skin pale and clammy, and her breathing rate low. The nurse called the doctor and said she suspected that Edel has been given too much morphine. The doctor prescribed Naloxone repeatedly throughout the night until Edel is stable.

The next day, Edel received information about what had happened and called her daughter. Her daughter asked to meet with the nurse and doctor.

Opening remark from daughter:
"How could something like this happen? It was just luck that this turned out well. Don't you have procedures for double-checking?"

2 Suicide. Man with cognitive impairment

Kjell was 60 years old and had a senior management position. He had been in mental health care for the past three weeks, examined and diagnosed with frontal lobe dementia.This was a great loss and sorrow for Kjell. According to his spouse, he had recently been restless, irritable, slept little and eaten little.

He was discharged at his own request. He wanted to go home, explaining he had things to do in order to finish his job properly. He also wanted nothing more to do with mental health care.

Kjell took his own life two days after being discharged.

You invite the family members to follow-up conversations, in order to express regret/apologize for the patient being discharged without further action.

You and head of the mental health center meet with the son (27) from a previous marriage. He is angry and wants an explanation as to why there was no follow-up after discharge.

Opening remark from son:
"How could you discharge Dad without offering any follow-up? The guidelines state that families should be involved in the discharge process, but I heard nothing."

QR-code for selected supporting materials

Example **Implementation**

- Case and simultation training is **integrated in a new competance program** for suicide prevention and follow-up, 13 000 users
- To better care for families og promote more openness to their ideas for improvement
- To better prepare health care workers and build resilience

Photo: Nikki Meel/Mostphotos

Simulation training for hospital leaders

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