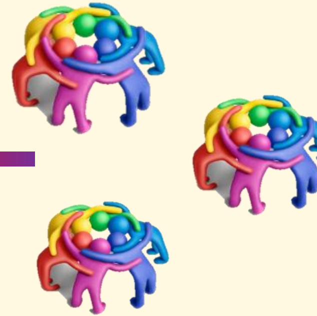
Recognizing & Acknowledging Medical Error

A Modified Team-Based Learning Session

Coral L. Steffey



Teachers of Quality Academy
Medical Education Day
April 22, 2015

Background

- AAMC's Entrustable Professional Activities
  - EPA 9: "Collaborate as a member of an interprofessional team,"
    - "establish and maintain a climate of … integrity and trust"
    - "communicate with respect for and appreciation of team members and include them in all relevant information exchange."
  - EPA 13: "Identify system failures and contribute to a culture of safety and improvement."
    - "understand systems and their vulnerabilities"
    - "identify actual and potential errors in care"
    - "use system mechanisms for reporting errors"
    - "admit one's own errors and reflect on one's contribution"

AAMC. (2014, May 28). *Core Entrustable Professional Activities for Entering Residency (UPDATED)*. Retrieved from MedEd Portal: www.mededportal.org/icollaborative/resource887

Background

- Vidant Interns (self evaluation)
  - 91% were confident in their ability to “collaborate as a member of an interprofessional team.”
  - 77% were confident that they could “Identify system failures and contribute to a culture of safety and improvement.” Garrison, H., & colleagues, V. (2014). *EPA Intern Survey Data.*
- Brody Grads (residency program evaluation)
  - Below Average for “Knowledge of patient safety and care quality issues.”
  - Below Average for “Knowledge of health care systems.” Outcomes of Medical Education Project. (2014). *Residency Program Directors Survey.*

Modi

Individual students complete IHI modules

End of lesson quizzes (I-RAT)

Welcome, Gue

Institute *for* Healthcare Improvement

Open School

HOME | ONLINE LEARNING | MY LEARNING

Course Catalog | Search Catalog

Patient

Institute *for* Healthcare Improvement

Open School

HOME | ONLINE LEARNING | MY LEARNING

Course Catalog | Search Catalog

Lesson 4: Error versus Harm

Course: PS 101: Fundamentals of Patient Safety

Page 8 of 8

Post-Lesson Assessment

1) Which of the following statements is true?

- a) Errors always result in harm.
- b) Harm is always caused by identifiable error.
- c) Organizations should always consider situations in which harm occurs as opportunities to learn.
- d) None of the above

2) What is the Swiss cheese model?

Institute for Health Care Improvement. (2015). *Open School*. Retrieved from Institute for Healthcare Improvement: http://app.ihi.org/lms/onlinelearning.aspx

Modified Team-Based Learning Session

Student groups answer select questions together (G-RAT, 9 items)

Individual students complete IHI modules

End of lesson quizzes (I-RAT)

Instructor feedback

Within your small group, consider the following questions and select the best answer.

1. Approximately what percent of medical harm is caused by incompetent or poorly
   a. <10%
   b. 25%
   c. 50%
   d. >75%

Use the following scenario to answer questions 2-3:
Two women – one named Camilla Tyler, the other named Camilla Taylor – arrive at a par
emergency department at about the same time. Ms. Tyler needs a sedative, and Ms. Tay
antibiotic. The doctor orders the medications, but mixes up the patients when filling out
The pharmacist dispenses the medications as ordered, and the nurse administers an anti
and a sedative to Ms. Taylor.

2. What is the active error in this scenario?
   ...he forms are completed by hand at the same time for different patients
   ...he nurse administers an antibiotic to Ms. Tyler and a sedative to Ms. Tay
   ...he emergency department is particularly busy

Institute for Health Care Improvement. (2015). *Open School*. Retrieved from Institute for Healthcare Improvement: http://app.ihi.org/lms/onlinelearning.aspx

Modified Team-Based Learning Session

Student groups answer select questions together (G-RAT, 9 items)

Individual students complete IHI modules

Student groups review case and answer application questions together

End of lesson quizzes (I-RAT)

Instructor feedback

Institute for Health Care Improvement. (2015). *Open School*. Retrieved from Institute for Healthcare Improvement: http://app.ihi.org/lms/onlinelearning.aspx

A true patient story:

Jonah is a 6 month old with a history of Severe Combined Immunodeficiency. He develops a fever, and is admitted to the hospital for evaluation and empiric treatment.

Blood, urine, and cerebrospinal fluid specimens are obtained, and Jonah is started on ceftriaxone and vancomycin.

On day 2, the lab calls to report that Jonah's CSF cultures are growing four different pathogens. IV access is difficult, and a central venous line has to be placed.

Jonah develops a severe fungal diaper rash while on antibiotics, and he develops a venous blood clot in his right internal jugular from his central line.

On day 4, the lab calls to report that there has been an error. Another patient's culture of eye discharge was confused with Jonah's spinal fluid culture. Jonah's CSF specimen actually had no bacterial growth.

Modified Team-Based Learning Session

If you are responsible for the initial communication with the parents about the error, which of the following should you say?

a) I am sorry that Jonah's fever was mistakenly diagnosed as meningitis. The microbiology lab gave our team another patient's information, and that caused us to think Jonah had meningitis. We will find out who is responsible, and address the problem immediately.

b) I am sorry that Jonah's fever was mistakenly diagnosed as meningitis. This should not have happened, and we will take steps to make sure it does not happen again. We will discontinue the unnecessary antibiotics immediately.

c) Although Jonah's fever was mistakenly diagnosed as meningitis, there is no cause to worry because Jonah is going to be fine. Rest assured that you are good hands; this type of error is extremely rare in our hospital.

d) I am sorry that Jonah's fever was mistakenly diagnosed as meningitis. I assure you that our team has provided Jonah with excellent care, however I understand if you would like to transfer to another hospital to continue his evaluation and treatment.

This question can be used to facilitate discussion about the structure and content of an effective apology. Apologies should include some of the following aspects: an acknowledgement; an explanation; an expression of shame, remorse, and humility; and reparation. Part of the reparation aspect can be a systems-based analysis to prevent the same error from occurring in the future.

will take steps to make sure it does not happen again. We will discontinue the unnecessary antibiotics

Modified Team-Based Learning Session

Indiv
stude
comp
IHI n

Er
le
qu
(I

Student groups answer select questions together (G-RAT, 9 items)

Student groups review

eview

questions

Role play of sample cases with peer feedback in groups of 3-4

Completion of peer evaluations and session evaluation

Evaluation Plan

- After the session, learners will complete an evaluation that
  - Rates their comfort with disclosing a medical error to a patient both before and after the session
  - Offers an opportunity to state two things learned from the exercise
  - Offers an opportunity to provide suggestions for the exercise

Next Steps

- Pilot with Pediatric Residents this summer to gather qualitative feedback and evaluate efficacy
- Currently making plans to incorporate this into the M1 curriculum for the incoming class.

Acknowledgements

- This poster was prepared with financial support from the American Medical Association (AMA) as part of the Accelerating Change in Medical Education Initiative. The content reflects the views of the authors and does not necessarily represent the views of the AMA or other participants in this initiative.
- Other acknowledgements:
  Dr. Steve Schmidt & Dr. Luan Lawson

Questions?