LCC Session 6

CanMEDS Competency: Professional: Error Disclosure

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What will happen in this session?

Suggested Time 60 minutes.

30 Minutes: Discuss cases

30 Minutes: Review Slides with Facilitators

Objectives:

1. Define adverse events, disclosure & near miss
2. Discuss ethical implications of disclosure of near missed/mistakes
3. Learn key points of successful disclosures.

CASE 1

You have admitted a 10 yo newly diagnosed diabetic to the ward. You handwrite an order for the patient to receive a 10U of insulin. The U looks like a zero. The patient receives 100U of insulin, ten times the patient's normal dose, and is later found unresponsive with a B.S. of 1.5. The patient is resuscitated and transferred to the PICU. You expect the patient to make a full recovery.

CASE 2

You start a patient with a new medicine with a common side effect of increasing the potassium level in your continuity clinic. The patient's baseline K+ is normal. You order a repeat K+ test to be drawn the next week, but are away on conference. Two weeks after the patient begins this new medicine she feels palpitations and goes to the ER. In the ER the patient has VT requiring cardioversion. The patient's K+ at this time is 7.5. She's hospitalized and makes a full recovery. The patient returns to your clinic for a follow up visit. On reviewing the patient's chart you see the overlooked labs which showed the patient's K+ has risen from 4-5.6.

CASE 3

A 5 yo boy was admitted with recurrent seizures of unclear etiology. He was loaded with Dilantin and then switched to daily dose. You write the transfer orders and mistakenly write the loading dose. The medication error wasn't noticed by the nurse or pharmacist. The patient falls and hits his head while ambulating to the washroom. Their Dilantin level was elevated. Head CT was normal. The family is worried that another seizure caused her fall.

Questions:

How likely would you be to disclose the error to the patient?

What would you most likely say, how much detail would you provide?

Think of a case from your own experience – have you witness an error during training? Have you made a mistake during training? Were these reported? Were these disclosed? How about near-misses?

What is the rationale for disclosure?

Readings:

Please find resources below for reference only. The only mandatory reading is Communicating with your patient about harm. CMPA. 2008.**,

http://www.cmpa-acpm.ca/cmpapd04/docs/resource_files/ml_guides/disclosure/pdf/com_disclosure_toolkit-e.pdf

Disclosing Near/Missed Mistakes Resources Guide.

Reading list (all journal articles available via Mac Health Sciences in full text):

Bell et al., Improving the patient, family, and clinician experience after harmful events: the "when things go wrong" curriculum. Acad Med. 2010 Jun; 85(6):1010-7.

Gallagher et al., US and Canadian physicians' attitudes and experiences regarding disclosing errors to patients. Arch Intern Med. 2006 Aug 14-28; 166(15):1605-11.

Gallagher et al., A 62 year old woman who experienced wrong-site surgery: review of medical error. JAMA, 2009 Aug 12; 302(6):669-77. Epub 2009 Jul 7.

Gallagher et al., Disclosing harmful medical errors to patients: tackling three tough cases. Chest. 2009 Sep; 136(3):897-903.

Kachalia et al., Liability claims and costs before and after implementation of a medical error disclosure program. Ann Intern Med. 2010 Aug 17; 153(4):213-21.

Stroud et al., Skills of internal medicine residents in disclosing medical errors: a study using standardized patients. Acad Med. 2009 Dec; 84(12):1803-8.

West et al., Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. JAMA. 2006 Sep 6; 296(9):1071-8.

Woods MS, Healing Words: the power of apology in medicine. 2007.

Wu et al., Do house officers learn from their mistakes? JAMA. 1991 Apr 24; 265(16):2089-94.

Websites:

http://www.cmpa-acpm.ca/cmpapd04/docs/resource_files/ml_guides/disclosure/pdf/com_disclosure_toolkit-e.pdf

Communicating with your patient about harm. CMPA. 2008.**

http://www.patientsafetyinstitute.ca/english/toolsresources/disclosure/pages/default.aspx

Canadian Patient Safety Institute. Canadian Disclosure Guidelines.**

www.josieking.org

Video:

http://www.institute.nhs.uk/safer_care/safer_care/SBAR_escalation_films.html