UT Southwestern Medical Center

SAGE NEXT STEPS

UNIVERSITY OF TEXAS ARLINGTON

ERROR DISCLOSURE: AN INTERPROFESSIONAL CLINICAL SKILLS SESSION

REYNOLDS MARKETPLACE PRODUCT 2015

OVERVIEW

Disclosure of medical errors is something all health professionals may have to do over the course of their careers. In this clinical skills session, students from various health professions practice disclosing a medical error to a standardized patient using a team-based approach.

DESCRIPTION

This session was developed to assist students in multiple health professions demonstrate effective team communication behaviors when: 1) discussing a medical error; 2) planning for the disclosure of the error; and 3) conducting this disclosure.

Figure 1: Screen shot of video module

Prior to the session, the students view an online module ("Interprofessional web-GEM on Values & Ethics"). This module features a video of a geriatric patient who is brought to the hospital by her daughter after falling at home. Over the course of her hospital stay, numerous members of the healthcare team participate in her care. Each team member makes a mistake that ultimately leads to the patient falling in the hospital and fracturing her hip.

After viewing the online module, the students meet to disclose the error in a team to a standardized patient (SP) portraying the patient's family member. The session is videotaped. The SP provides feedback and the students debrief with faculty.

In addition to the video, a mentor's manual is provided. There is content that outlines the errors made and describes basic principles of team-based error disclosure. There are pre- and post- tests over the module's content.

METHODS

A team of faculty from our medical and health professions schools joined by faculty from a nursing school at a sister institution developed the materials for this session. In our medical and health professions schools the session was a part of our preclinical learning community course (Colleges). The students were instructed to review the online module in the two to three weeks prior to the SP session, which took place over two Saturdays and involved over 500 students (240 medical, 120 health professions, and 200 nursing).

The students met in groups of three (medical, health professions, and nursing) for 20 minutes to plan for the error disclosure to the SP portraying the family member. They then interacted with the trained SP for 8 minutes and received feedback based on a defined rubric from the SP for 3-5 minutes. The SP session was videotaped and the medical and health professions students were subsequently debriefed in a learning community session with their faculty mentors.

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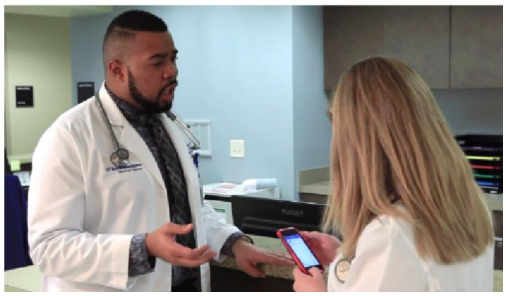

Figure 2: Screen shot of video

TEACHING OPPORTUNITIES

We were able to use standardized patients for this clinical skills session. However the materials could be used to promote the acquisition of these communication skills in many formats including:

· Group discussion
· Reflective exercise
· Role playing

SESSION MATERIALS

Materials for the session include a video titled "Interprofessional web-GEM on Values & Ethics" and a mentor's guide/handout. The handout contains the student's syllabus, mentor's guide, SP patient script, and SP checklist. These resources can be found at the following links:

- Video module (web-GEM)
  - via POGOe ID#31836 (pogoe.org/webgem/31836)
    or
  - via geriSAGE.com→ Educational Modules link→ "Interprofessional web-GEM on Values & Ethics"
- Handout
  - via POGOe ID# 21868 (pogoe.org/productid/21868)
    or
  - via geriSAGE.com→ Resources link→ "IP Error Disclosure Guide"

OUTCOMES AND FUTURE DIRECTION

Students from all three schools demonstrated improvement in knowledge and attitudes about team-based medical error disclosure between the pre- and post-tests. Feedback from the students was generally positive but outlined several logistics issues which are being addressed.

This module will be repeated in February, 2016. Social Work students from the same institution as the nursing school will be added to the team. We will also add to the pre– and post– tests a validated instrument to assess attitudes about interprofessional collaboration. The students will be asked to write a brief reflection of the experience to discuss at the debrief with their faculty mentors.

CONCLUSIONS

Interprofessional education for an important and challenging communication skill, error disclosure, is feasible and effective. The materials developed for this module can be adapted for a wide variety of educational settings and health care professions students.

MENTOR'S GUIDE/HANDOUT

STUDENT SYLLABUS & MENTOR'S GUIDE

Medical School Mentor Version

The goal of Skills Clinic 7 is for students to gain skills in working in teams during a particularly difficult situation: the team disclosure of medical errors. There will be an encounter with a standardized patient (SP) acting as a family member, followed by feedback from the SP and for some students, a review of the recorded interview in a meeting with their mentors and mentor group.

Health professionals are human, and medical care is often administered in unwieldy systems; errors in health care are inevitable. Errors are also usually multi-factorial, with many people and systems contributing to the error. Studies have shown that disclosure of errors, besides being the ethically correct thing to do, yields positive outcomes: patient satisfaction is higher, and health professionals are less likely to be sued. It has been shown that practicing these skills as a student reduces the anxiety and increases effectiveness for health professionals doing this during their career, which is unfortunately inevitable. It is for these reasons that we will devote this session to this uncomfortable process.

Learning Objectives

At completion of this case, the student will demonstrate effective team communication behaviors when:

1. Discussing a medical error (by demonstrating four important principles),
2. Planning for the disclosure (by demonstrating three important principles), and
3. Conducting the disclosure (by demonstrating eight important principles).

The principles mentioned above are described below and in the online module.

TEACHING FORMAT(S)

Skills Clinic 7 will use small-group teaching formats, as well as digitally recorded clinical interview sessions with standardized patients (SPs) that are reviewed with their mentors.

PREPARATION FOR COLLEGES SESSION - STUDENTS

1. Before your scheduled SP session
    a. Place on your calendar the scheduled time to interview your SP. This date will be sent to medical students several weeks in advance of this event. Nursing and Health Professions students will receive an email and link to sign up for the SP session.
    b. Watch an online module (https://pogoe.org/webgem/31836) that sets the stage for your encounter and reviews error disclosure skills. At the SP session, you and your interprofessional team members will meet with a family member of the patient (who may be different than the daughter in the video) that suffered harm due to medical error to discuss what happened to his/her mother. If you are a medical, nursing, nurse practitioner, physician assistant, or physical therapy student, you are the member of the team caring for Mrs. Cooper who made a mistake and will need to explain your actions.

       In the video, the physical therapist leaves the patient in the chair; this could be done by any visiting health professional. If you are a student of another health profession, you will take the role of the health professional who left the patient up in the chair before she fell.

       Please explain to the patient's family member that a risk management team will be meeting to discuss plans to address the additional costs to the patient's hospitalization related to the broken hip.

2. During your scheduled time,
    a. Meet with and get to know your interprofessionalteam. If necessary, review the video to refresh the team's understanding of the task at hand. Discuss with your team the error disclosure task, and plan very specifically for the disclosure (20 minutes):
        i. what will you communicate?
        ii. who will say what and when?
        iii. how will you respond to questions the SP asks?
        iv. how will you conclude the discussion?
    b. Disclose the error(s) to the SP and address any questions (10 minutes).
    c. Receive direct feedback from the SP (5 minutes for review of the feedback checklist).
    d. Document the encounter (the medical student has 2 minutes for the note).
3. After the SP session,
    a. Complete an online survey, which will be emailed to students immediately after the session.
    b. The feedback checklist and documentation will be provided to the medical student mentor (checklists to be provided to nursing and HP mentors).
    c. For medical and HP students, during scheduled college time, review with your mentor (and psychiatry faculty) your digital recording of your interview as well as your written comments.

PREPARATION FOR COLLEGES SESSION – MENTORS

1. Prior to the Colleges session, each mentor will receive their students' digital recordings for review.
2. A mentor faculty development session will be available on the Colleges website, which will provide guidance to mentors in their review of these recordings.

Supplemental materials for Students

Online modules to be completed prior to patient interview (see above)

You will be asked to sign a participant authorization, which is provided as an appendix to this document. Please let the coordinator at your school know well in advance of your session if you are uncomfortable signing it.

SUPPLEMENTAL MATERIALS FOR FACULTY

Streaming video (on colleges website) of preparatory material given to students.

SUPPLEMENTAL FACULTY

Psychiatry faculty

NOTES

Teaching Points to Emphasize

- ✓ Health professionals are human, and medical care is often administered in unwieldy systems; **errors in health care are inevitable**.
- ✓ **Errors are also usually multi-factorial**, with many people and systems contributing to the error.
- ✓ **Disclosure of errors is the ethically correct** thing to do.
- ✓ Studies have shown that**disclosure of errors yields positive outcomes:** patient satisfaction is higher, and physicians are less likely to be sued.

DISCLOSING UNANTICIPATED ADVERSE OUTCOMES

Because medicine is quite complex, patient outcomes may be different than expected. The two main types of unanticipated outcomes are medical errors and adverse events. An adverse event is any negative occurrence that is not directly caused by the patient's disease. The Institute of Medicine's "To Err is Human" report states that adverse events or medical errors occur in 2.9 to 3.7 percent of hospitalizations[1].

Our profession is finally recognizing that disclosure of these events to patients is an important component of being a doctor. Many, if not most, medical systems now have policies on disclosure. In addition, the agency that accredits hospitals mandates the disclosure of certain unanticipated outcomes.

Physicians are human, and medical care is often administered in unwieldy systems; errors in health care are inevitable. Disclosing a medical error to patients, their families, and/or their representatives can be quite challenging. There are several important components to disclosing an error:

1. Acknowledging to the patient that an error has occurred
2. Expressing remorse for the error (which does NOT mean taking or assigning blame for the error)
3. Explaining
    a. How the error occurred and
    b. The outcome resulting from the error
4. Describing how the cause of the error has been/will be investigated to prevent recurrence and improve future care
5. Arranging follow-up with the patient
6. Documenting the disclosure
    a. The date and time of the disclosure
    b. Descriptions of all persons present
    c. What was stated
    d. Description of the patient's/family's expressed understanding and questions and the answers to those questions.
    e. The plans for follow-up
    f. Avoid
        i. Documenting information unrelated to patient care (e.g. "risk management notified")
        ii. Alteration of any part of the medical record

The importance of most of these components is self-evident. The assignment of blame is less obvious. No matter how clear the person responsible for the error seems at the time of the incident, the issue of culpability should be left for later, when all the facts can be evaluated in a non-emotional manner.

Studies have shown that disclosure, besides being the ethically correct thing to do, yields positive outcomes: patient satisfaction is higher, and physicians are less likely to be sued. It is for these reasons that we will devote part of this session to this uncomfortable process.

Finally, it is also important to recognize WHO should lead these difficult encounters, regardless of whether one is delivering bad news, disclosing an unanticipated outcome, or any other uncomfortable situation. Often there are many people involved in the care of patients. Disclosure should ALWAYS involve the patient's primary caregiver (called the "attending physician" in the hospital setting), and other members of the health care team. Ideally, the team will do the disclosure.

[1] http://www.nap.edu/catalog.php?record_id=9728#toc

GUIDANCE FOR THE TEAM DISCLOSURE OF AN ERROR

Disclosing a medical error to patients, their families, and/or their representatives can be quite challenging. To prepare for this disclosure, keep in mind there are three stages of team disclosure:

1) Team discussion of a medical error
2) Planning for team disclosure to a patient and/or family member
3) Conducting a team disclosure to a patient and/or family member

TEAM DISCUSSION OF A MEDICAL ERROR

There are several important principles leading to the successful discussion of an error as a team in the first stage of error disclosure preparation:

7. There must be acknowledgement the error has occurred, including acknowledgement of each contributing component.
8. The discussion must be conducted free of blame
9. Team-oriented communication must be practiced – Examples of team-oriented communication include soliciting and respecting other team members' viewpoints about what happened, focusing on patient-centered goals, responding empathetically to each other's distress about event, and willingness to speak against authority gradient.
10. Differences of opinion must be negotiated collaboratively, which means the team member listens, paraphrases, yield floor/doesn't interrupt, summarize to check for mutual understanding)

Planning for Team Disclosure to a Patient and/or Family Member

Once the team has discussed the error and come to a consensus as much as possible, the team must plan for the disclosure. The factors leading to successful planning include:

1. Advocating for full disclosure by listing reasons why full disclosure is desirable. Again, team members must responds respectfully and effectively to arguments presented to the contrary.
2. Planning roles for disclosure includes collaborating on a plan for who will lead and what role each team member will play. At a minimum, each team member should directly disclose how he/she contributed to the error.
3. Planning for responses to a family member questions by anticipates likely questions from family member and formulating reasonable responses.

Conducting a Team Disclosure to a Patient and/or Family Member

The actual disclosure of the error must be well orchestrated. The factors leading to successful conducting of a team disclosure to a patient and/or family member include:

1. Conducting explicit disclosure of error to a family member of the patient by describing the nature and source of the error and the consequences of the error to the patient. For example, the team should explain how the error occurred and the outcome resulting from the error.
2. Responding forthrightly to family member questions about event by responding truthfully to the family member's questions.
3. Apologizing upfront and early in conversation – This means the team apologizes to the family member at the beginning of the disclosure conversation. Apology involves expressing remorse for the error (which does NOT mean taking or assigning blame for the error).
4. Exhibiting general communication skills with family members of patients by displaying verbal and nonverbal empathy and support of family member emotion.
5. Conducting blame-free disclosure, acknowledge personal role avoids blaming of other team members, resists family member's attempt to affix blame.

6. Offering plans to prevent future errors by explaining to family member what specifically will be done to prevent such errors from occurring in the future. This involves describing how the cause of the error has been/will be investigated to prevent recurrence and improve future care.
7. Planning a follow up with family member by offering to follow up with the family member for other potential questions the patient may have.
8. Documenting the disclosure with the date and time of the disclosure; descriptions of all persons present; what was stated; the patient's/family's expressed understanding, questions, and the answers to those questions; and the plans for follow-up. It is important to avoid documenting information unrelated to patient care (e.g. "risk management notified") and any alteration of any part of the medical record.

The importance of most of these factors is self-evident. The assignment of blame is less obvious. No matter how clear the person responsible for the error seems at the time of the incident, the issue of culpability should be left for later, when all the facts can be evaluated in a non-emotional manner.

NOTES (MENTORS ONLY)

The following is a synopsis of what happens during the video scenario the students will watch:

First Environment: Emergency Department (ED) of a large metropolitan hospital. Sunday evening 9:00 pm. Attending care provider: Physician Assistant (PA) or Nurse Practitioner (NP)
Setting specifics: PA or NP extending his or her shift until 11 pm. ED understaffed, and constantly busy. Supervising MD specializes in trauma patients, currently involved with 3 critical patients from large MVA

The following information is in the EMR
Presentation: Lois Cooper is an 84-year-old white female with a history of mild Alzheimer's disease, hypertension, osteoporosis and osteoarthritis. On Sunday evening, she presented at the emergency department with her daughter and 90-year-old husband, after rising quickly from a chair in the living room, complaining of dizziness and falling. The husband reports she might have hit her head and now seems more confused than at baseline.

Social History: Mrs. Cooper and her husband moved a year ago into Lakeside Living, an assisted living facility. The daughter lives with her family in a single family home in the adjacent neighborhood. The Coopers receive assistance for medication management and bathing. They are independent in mobility, personal self-care, and finances. This is the first time Mrs. Cooper has fallen at home.

Past Medical History: Hypertension (current medication for the past 10 years). Osteoporosis-last DEXA (bone scan) in 2010 with T score of -2.8 at the hip. Osteoarthritis bilateral knees. Alzheimer's disease-had mild cognitive impairment for about eight years prior to current diagnosis. Folstein Mini-Mental status exam: 6 months ago was 21/30.

Medications: Lisinopril 20 mg. once a day for hypertension
Alendronate 70 mg once a week for osteoporosis
Acetaminophen 350 mg., one-two every 6-8 hours as needed for joint pain.
Calcium citrate 600+D twice a day dietary supplement

Allergies: no known allergies.

Vital Signs: BP 128/72 sitting/102/62 standing | Pulse 78 sitting/102 standing | Temp (Src) 37 °C (98.6 °F) (Tympanic) | Resp 12 | Ht 5' 2" | Wt 182 lb | BMI 33.3 kg/m2 | SpO2 97%

Physical Exam: Constitutional: Elderly woman mildly confused, daughter is the spokesperson

Head: bilateral peri-orbital ecchymoses
Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.
Cardiovascular: Normal rate, regular rhythm. S4 present. No murmurs heard.
Pulmonary: lungs clear to auscultation.
Abdomen: soft, nontender without organomegaly. Active bowel sounds.

Extremities: crepitus in the knees bilaterally. All joints with full range of motion, obvious muscle atrophy in upper and lower extremities. No edema. 2+ pulses bilaterally, superficial scape on R knee and R forearm
Cognition: normal affect, but easily distracted. Oriented to name and place, but thought it was1998
Mobility: Steadying assistance needed to assume standing; stands with broad base of support; did not attempt walking this evening
Plan: Patient will be admitted to the hospital for observation and assessment by hospitalist health care team.

1) Order head CT scan
2) Decrease Lisinopril to 10mg daily
3) Order PT evaluation for mobility needs
4) Order Neurological consult

The PA/NP reviews the patient with the MD on staff; charts the information in the electronic medical record (EMR) assumes the MD will sign the note and moves on to their last patient of the evening.

The Hospital Medicine team (MD and NP/PA) comes to the ED to admit the patient, Confirming and recording the history and physical noted above by the ED staff.

The PA/NP writes the following admission orders which the MD co-signs:

1. Admit patient to ACE unit. Diagnoses: orthostatic hypertension, confusion.
2. Activity: up at bedside or to chair with assistance only.
3. Diet: low sodium as tolerated
4. Medications (cut and pasted home meds):
    a. Lisinopril 20 mg p.o. q day (Hold for SBP<100).
    b. Fosamax 70 mg once a week orally
    c. Tylenol 350 mg., one-two p.o. every 6-8 hours as needed for joint pain.
    d. Calcitrate 600+D p.o. bid
5. PT consult.
6. Neurology consult.
7. Head CT without contrast.

Second Environment: Acute Hospital in the large metropolitan hospital
Setting Specifics: Patient is the geriatric acute care (ACE)medical floor (6th). 32 beds per floor; 4 RN's, 3 Patient Care Technicians (PCT) 1 Physical Therapist (PT)

Patient Management Activities on Monday Morning
7:00: Nursing finds the patient sleeping in the hospital bed with the rails up. Patient is not restrained. Wakes easily with gentle voice and nurse elevates the head of the bed and the side rail down. Takes BP: 90/60mmHg; Administers medications: Lisinopril 20 mg; acetaminophen 350 mg and calcium citrate 600+ 500 IU vitamin D. Nurse puts the bed rails up and lowers the head of the bed slightly, checks to make certain the call button is within the patient's reach and leaves the room.

7:30: PCT comes in with breakfast tray. PCT sits patient up on side of bed; patient's feet touch the floor; positions bedside table; opens breakfast items; leaves Mrs. Cooper to go on to her next patient. 7:45 RN walks by patient room; sees patient sitting bedside; assists patient back to the upright bed, puts bed rail up and repositions the bedside table so patient can finish breakfast.
8:30: PT sees patient in room. PT leaves the patient at 9:15 am up in chair, takes the gait belt and the walker to her next patient's room. PT walks barefoot patient. PT writes an assessment in the EMR: "This is an overweight elderly female with obvious balance limitations. Balance issues present upon standing when patient complains of dizziness, but patient also presents with bilateral lower extremity weakness and sensory loss that could also be contributing factors. Patient needs to be supervised when sitting bedside; basic transfers require close supervision and gait training with a walker is indicated."

10:00: PCT comes to check on the patient and finds her sprawled on the floor between the chair and the bed, complaining of right hip pain. PCT calls for assistance. Patient assessed by the nurse, PA/NP, and MD and X-rays are ordered.

Patient Follow Up: X-Ray of pelvis and both lower extremities revealed an intertrochanteric fracture of the R hip. Patient placed on narcotics to control pain, family notified and surgery scheduled for 2 o'clock that afternoon.

12:00: The patient relations office of the hospital receives a call from Ms. Cooper's daughter. Her family is very upset that Ms. Cooper sustained a fall with a hip fracture while in the hospital. They would like to speak to the people in charge about how this could have happened. She or her brother will be here at 2 PM today.

Summary of errors:
Error #1 by Hospital Med PA/NP and MD in ordering home dose of lisinopril.
Error #2: Nurse administers ordered dose of lisinopril despite SBP<100.
Error #3 (near miss): leaves patient up at bedside without supervision/assistance.
Error #4: Walks patient barefoot and leaves patient up in chair without supervision.
Error #5: doesn't report symptoms to nurse or hospital med team so they can evaluate further.

STANDARDIZED PATIENT SCRIPT/ CHECKLIST

STANDARDIZED PATIENT CASE SCRIPT

PHYSICIAN SCENARIO

An elderly female patient arrives in the emergency room with her husband and daughter after quickly arising from a chair and falling at home. The husband reports that she may have hit her head and appears confused. There is a history of mild Alzheimer's, hypertension, osteoporosis and osteoarthritis. The patient was admitted and was found by hospital staff on the floor. The family was notified and a family meeting has been set for today.

PERSONAL HISTORY

NAME OF SP:	Linda Everett	***GENDER:***	Male or Female
NAME OF SON/DAUGHTER:	Avery Myerson	***RACE:***	White
AGE:	***50-55-YEAR-OLD***	***PHYSICAL CHARACTERISTICS:***	Any
RESPONSE TO NEWS ABOUT YOUR MOTHER:	You are very upset to find out that your mother has fallen.		

OPENING STATEMENT

Say the following statement word for word.

"Someone please tell me how in the world can something like this happen? Aren't you considered to be one of the best hospitals?"

HISTORY OF PRESENT PROBLEM

KEY ATTRIBUTES

- Yesterday, you brought your mom to the Emergency Room after she fell at home where she was with your father. After getting up from her chair, she had felt dizzy and then fell possibly hitting her head. She appeared more confused than her baseline, so your father called you and you brought her into the emergency department (ED) and she was hospitalized.
- Your mom knew her name, where she was but not the date.
- On exam in the hospital, her blood pressure fell and her pulse increased when she stood up. She was admitted for further evaluation.
- The next morning, she was found on the floor. Further examination found that her hip was broken.
- The hospital called you about the incident and you became upset. They set up a meeting with you at 2:00 pm today to speak with the team who is caring for your mother in the hospital.
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FAMILY HISTORY

DAD:	He is 90 years old and has some health problems.
MOM:	Your mom is 84 years old. She has mild dementia, hypertension, osteoporosis and osteoarthritis.

SOCIAL HISTORY

- Your parents live together in an assisted living apartment. You and your family live close to them.

PREVENTABLE ERRORS

Listed below are the errors that the team should discuss with you. In the discussion, please interject questions to the team.

1. The admitting provider wrote for the higher BP medicine dose despite knowing that your mother had orthostatic hypotension and was at risk for falls.
   "The guy who called to set up this appointment said my mom fell because of orthostatic hypotension; please explain to me what orthostatic hypotension is?"

2. The nurse administered this dose to your mother without asking whether she should receive this much medicine given that her blood pressure was low and the symptoms she was admitted for.
   "Why didn't the nurse check with the doctor or PA before she gave the medicine, since she knew the blood pressure was low and my mother had fallen?"

3. The patient care technician left your mother sitting on the side of the bed and at risk for a fall. This was a "near miss" in that the nurse found her and put her in bed with the bed rails up.
   "How could someone leave an older patient alone sitting on the side of the bed when they knew she had recently fallen?"

4. The physical therapist did not report your mother's symptoms of dizziness upon standing and left her sitting in a chair, where she was at risk for falling.
   "Why didn't the physical therapist let the nurse or doctor know my mother was dizzy and how could she leave her where she could get up and fall?

OTHER QUESTIONS: HERE IS A LIST OF QUESTIONS TO ASK IN RESPONSE TO THE ANSWERS YOU MAY GET.

"Who dropped the ball here? My mother does not deserve to suffer because you did not do your job."

"She was brought to the hospital because she fell? She has a wristband on her wrist that makes you aware she may fall and there are signs in her room. How could you let this happen?"

"What have you done to help my mother since she fell?"

Only if surgery is mentioned - "I'm scared for her to have surgery here; what else could go wrong? How can I be assured nothing else will happen to my mother?"

"Are we going to have to pay for all this extra care?"

"How will you make sure this doesn't happen to another patient in this hospital?"

STANDARDIZED PATIENT CHECKLIST

RUBRIC TO ACCESS TEAM COMMUNICATION OF ERROR DISCLOSURE BEHAVIORS

MS2 - SC VII - SP EVALUATION

	EXAM ROOM			TIME	
SP NAME				STATION	A

Key Section	Behaviors	Positive Instance (2 pts)	Neutral Instance (1 pt)	Negative Instance (0 pts)	POINTS
Team disclosing an error with a family member of a patient	1. Conducts explicit disclosure of error to a family member of the patient	Describes the nature and source of the error and the consequences of the error to the patient.	Partially describes the nature and source of the error and the consequences of the error to the patient.	Does not explicitly explain that an error took place and the patient had suffered as a result.	
	2. Responds forthrightly to family member questions about event.	Responds truthfully to the family member's questions.	Responds directly to the family members questions, but only partially truthful.	Avoids direct responses to the family member's questions.	
	3. Apologizes upfront and early in conversation	Apologizes to the family member at the beginning of the disclosure conversation.	Apologizes to the family member after the beginning of the disclosure conversation.	Does not apologize.	
	4. Exhibits general communication skills with family members of patient	Displays verbal and nonverbal empathy and support of family member emotion.	Displays only verbal or nonverbal empathy and support of family member emotion.	Remains aloof and distant to patient's or family member's emotional distress.	
	5. Conducts blame-free disclosure, acknowledges personal role	Avoids blaming of other team members, resists family member's attempt to affix blame.	Does not avoid blaming of other team members or does not resist family member's attempt to affix problem.	Blames a team member in front of the patient.	
	6. Offers plans to prevent future errors	Explains to family member what specifically will be done to prevent such errors from occurring in the future.	Partially explains to the family member what will be done to prevent such errors from occurring in the future.	Does not address specific plans for preventing errors.	
	7. Plans a follow up with family member	Offers to follow up with the family member for other potential questions the patient may have.	Ambiguous on follow up with family member.	Does not offer to follow up with the family member.	

DEBRIEF/SUMMARY

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DEBRIEF SESSION

The goal of this clinical skills session is for students to gain skills in working in teams during a particularly difficult situation: the team disclosure of medical errors.

- Health professionals are human, and medical care is often administered in unwieldy systems; **errors in health care are inevitable.**
- **Errors are also usually multi-factorial**, with many people and systems contributing to the error.
- **Disclosure of errors is the ethically correct** thing to do.
- Studies have shown that **disclosure of errors yields positive outcomes**: patient satisfaction is higher, and physicians are less likely to be sued.

Today's Objectives for the Group Debrief
Discuss reactions to the clinical skills team exercise
Analyze the team interactions during the exercise - List phases in team-based disclosure of medical error - Identify gaps in team performance
Summarize reflections into take–aways with respect to future performance

Brief Overview

- Lois Cooper is an 84-year-old white female with a history of mild Alzheimer's disease, hypertension, osteoporosis and osteoarthritis. On Sunday evening, she presented at the emergency department with her daughter and 90-year-old husband, after rising quickly from a chair in the living room, complaining of dizziness and falling. The husband reports she might have hit her head and now seems more confused than at baseline.
- Patient falls in hospital room due to errors.
- The patient relations office of the hospital receives a call from Ms. Cooper's daughter. Her family is very upset that Ms. Cooper sustained a fall with a hip fracture while in the hospital. They would like to speak to the people in charge about how this could have happened.

Reactions to the clinical skills team exercise
How did you feel about working with students from other programs?
What did you think about the clinical skills simulation using a standardized patient as a family member?
How did acknowledging and disclosing medical error make you feel?

Analyze the team interactions during the exercise
Phases
I. Team discussion of error
II. Team planning of error
III. Team Disclosure of error to a family member of a patient

Analyze the team interactions during the exercise **I. Team discussion of error** 1. Acknowledges error 2. Conducts blame-free communication during team conversation 3. Practices team-oriented communication 4. Negotiates differences of opinion collaboratively	**Analyze the team interactions during the exercise** **II. Team planning of disclosure** 1. Advocates for full disclosure 2. Plans roles for disclosure 3. Plans responses to a family member
Analyze the team interactions during the exercise **III. Team disclosure of error to a family member of a patient** **The team:** 1. Conducts explicit disclosure of error to the family member 2. Responds forthrightly to the family member's questions about the event 3. Apologizes up front and early 4. Exhibits general communication skills with the family member 5. Conducts blame-free disclosure, and acknowledged their personal roles 6. Offers a plan to prevent future errors 7. Plans a follow-up with the family member	**Watch video:** https://mediasite.utsouthwestern.edu/Mediasite/Play/b8db10519f7b475a8865f2b0012c67cb1d ***How did this team perform?***
Analyze the team interactions during the exercise **Identify gaps in team performance** - How did your team perform? - How was feedback from the standardized patient? - Did the feedback match your perceptions? Any surprises?	**Summarize reflections** **What take-away points did you get from this clinical skills exercise?** **How will this affect your future performance?** **Additional reflections?** DISC behavioral styles, teamwork, interprofessional roles and responsibilities, patient communication, etc. **Other?**

SUMMARY

Several hundred students participated in our pilot session, and the feedback was mostly positive. There was an increase in scores in the pre- and post- tests. A major obstacle was organizing several hundred students to gather together for the session.

PRE- AND POST- TESTS

PRE/POST-TEST

1) Several mistakes are made by multiple members of the healthcare team caring for a patient. Because of these errors, the patient has a bad outcome. Which errors should be disclosed?
   - ✓ None of the errors should be disclosed.
   - ✓ Only the errors that the lead physician made should be disclosed.
   - ✓ Only the error that the patient or his/her family inquire about should be disclosed.
   - ✓ *All errors impacting the patient should be disclosed.

2) If the error(s) should be disclosed, what is the best approach to disclosure?
   - ✓ The team member that made the biggest contribution to the error(s) should disclose the error.
   - ✓ Each member of the team should meet individually with the patient to disclose the error.
   - ✓ The team should let the department chairman know so the hospital leadership can disclose the error.
   - ✓ *The team should disclose the error(s) together.
   - ✓ The risk management office should disclose the error.

3) Should there be an apology for the bad outcome?
   - ✓ Yes, if we have chosen to disclose the error.
   - ✓ Yes, if the patient and/or his her/family are upset.
   - ✓ Yes, the person most to blame should apologize.
   - ✓ *Yes, all errors impacting the patient should be accompanied by an apology.
   - ✓ No, apology will lead to a law suit.
   - ✓ No, apology will erode patient trust in our team.

4) Which of the following is not a component of an apology?
   - ✓ Explicit disclosure of all errors
   - ✓ *Assigning blame for the bad outcome
   - ✓ Stating you are sorry
   - ✓ Expressing remorse
   - ✓ Offering plans to prevent future errors
   - ✓ Planning a follow up with the family or patient

5) Which of the following statement is most true?
   - ✓ When disclosing an error, the risk management department or hospital lawyer should be present to prevent a lawsuit.
   - ✓ Before disclosing an error, the team should meet to determine who will take the most blame for the error.
   - ✓ An apology should be delivered toward the end of the meeting after the errors have been disclosed.
   - ✓ *An apology should be delivered upfront and early on in the meeting.
   - ✓ The team should meet before disclosing any errors, so there is a plan about which particular errors to disclose.

* INDICATES CORRECT ANSWER