DISCLOSURE TRAINING MANUAL

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Acknowledgements

The SPS Disclosure improvement work was a multi-disciplinary collaborative effort dedicated to improving the disclosure process. We would like to acknowledge and thank these contributors for their dedication and expertise.

Disclosure Core Planning Team

- Darlene Barkman (Parent Rep.), The Children's Hospital of Philadelphia
- Rebecca Cady (Legal), Children's National Medical Center
- Roberta Hales (Simulation), The Children's Hospital of Philadelphia
- Amanda Lerman (Physician), The Children's Hospital of Philadelphia
- Mary Rutherford (Physician), UCSF Benioff Children's Hospital Oakland
- Lisa Scafidi (Risk), Children's National Medical Center
- Jeanette Teets (Nurse), The Children's Hospital of Philadelphia
- Pam Trevino (Nurse), Arkansas Children's Hospital

Disclosure Core Planning Subject Matter Experts

- Vanessa Madrigal, (Simulation), Children's National Medical Center
- Susan Teman, (Simulation), Helen DeVos Children's Hospital
- Mary Kay Schwemmer (Legal), The Children's Hospital of Philadelphia

Disclosure Cohort Member Hospitals

- Arkansas Children's Hospital
- Children's Hospital & Medical Center (Omaha)
- Children's Mercy Hospital (Kansas City)
- Connecticut Children's Medical Center
- Cook Children's Medical Center
- Helen DeVos Children's Hospital
- Phoenix Children's Hospital
- UH Rainbow Babies & Children's Hospital
- The Children's Hospital of Philadelphia

SPS Support Staff

- Anne Lyren, SPS Network Clinical Director
- Jeanette Teets, SPS Culture Lead
- Aaron Dawson, SPS Quality Improvement Consultant
- Laurie Stevens, SPS Culture Project Specialist
- Laura Werts (CME), Cincinnati Children's Hospital Medical Center

Overview

This disclosure training is intended to prepare clinicians to disclose to patients and families. It should be used as a starting guide for your hospital and adjusted to meet your specific hospital policy and regulatory requirements.

The training focuses on a subset of the overall disclosure process including: disclosure huddle, disclosure conversation, post disclosure debriefing, medical record documentation as shown in green on the next slide. The training begins with teaching content and then engages learners in simulated practice.

Please provide feedback and enhancements to OCHSPS@cchmc.org with the subject "DISCLOSURE TRAINING FEEDBACK".

Individual Hospital Responsibility

This document is created to provide guidance to start disclosure work – and is not able to meet all local requirements. As such each individual hospital, must be responsible to do the following:

- Adjust this training to ensure alignment with your hospital policies
- Ensure this training is compliant with your governing bodies and all applicable regulations

Learning Objectives

1. Explain the steps to disclose safety event information when medicine and technology fail
2. Identify how to express empathy and be pro-active with a grieving family
3. Recognize what to say and how to say it when conversing with the patients and families about an event
4. Demonstrate how to maintain ongoing, open communication with patients and families after an event

Workshop Agenda

Topic	Facilitator	Length
Welcome and Introductions	TBD	10 mins
Background	TBD	15-30 mins
Teaching Slides 1. Disclosure HUDDLE 2. TIPS for a Respectful Disclosure 3. Disclosure CONVERSATION 4. Post Disclosure DEBRIEFING 5. Medical Record DOCUMENTATION	TBD	30 mins
Video Activity	TBD	10 mins
Simulation- Role Play	TBD	60-110 mins
Wrap-up	TBD	10-15 mins

Full Training Program

Duration: 4 hours Staff: Education & Simulation

- **CME offering & information**
- **AV equipped training room**
- **Disclosure worksheet**
- **Training slides**
- **Simulation examples**
- **Documentation Guide**

Partial Training Program

Duration: 60-90 minutes Staff: Education & Simulation

- **Adjusted CME offering & information**
- **AV equipped training room**
- **Adjusted training slides**
- **Simulation examples**
- **Documentation Guide**
- **Disclosure worksheet**

Just-in-Time Training Program

Duration: Minutes Staff: Review & Simulation

- **Disclosure worksheet**
- **Simulate the interaction**

Workshop materials

MATERIAL	PRINT
1. **Training slides** PPT file name: *Disclosure Training Slides.pptx* PPT file name: *Partial Disclosure Training Slides.pptx*	Print 1 copy per learner – as "Handout, 3 Slides"
2. ***Disclosure Worksheet** Note taking tool to guide the disclosure process	1 copy per learner
3. **Disclosure Learner Evaluation** **Example to measure training effectiveness**	1 copy per learner
4. CME Course Evaluation	1 copy per learner
5. Simulation Train the Trainer Guide	No
6. Simulation scenarios a. PSE 2: PIVIE b. PSE2: Retained Guidewire c. PSE3: Error Transposition of Weight d. PSE4: Wrong Patient Scheduled e. PSE4: GI Scope	1 copy per learner for selected scenario(s), **without** the "Good, Bad" scripts

***This is to be utilized for the Just-in-Time (JIT) training. JIT training should be utilized one the full or partial program has been completed by the clinician.**

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Disclosure Worksheet

Synthesize information into known facts

Identified Disclosure Spokesperson

Patient preferred name	
Patient Gender	
Patient MRN	
Age	
Event report number	
Language Interpreter Need	**NO** **YES,** contact at _____

Title / Salutation	Patient and family representative(s) present for the meeting	Relationship

Primary diagnosis/brief medical history

Clinical event facts

When did the clinical event happen?	Date/time:			
When was the clinical event recognized and by whom?	Date/time:		Recognized by:	
Where did the event occur? (Department, unit, etc.)				
When was the clinical event reported and to whom?	Date/time:		Reported to:	
Is the family aware of the clinical event? If so, what is their understanding of the clinical event?				
Was the family present during the event?				
Any family support needed? (social work, child life, chaplaincy)				

DO NOT SCAN INTO THE MEDICAL RECORD – NOT A PART OF PATIENT'S MEDICAL RECORD

MAY CONTAIN PHI, PLEASE DESTROY

What DON'T we know?

Determine the location, date and time for disclosure

Additional Planning Items:

1. Does risk/legal XXX-XXX-XXXX, hospital leadership XXX-XXX-XXXX, and/or quality & patient safety XXX-XXX-XXXX need to be consulted before the disclosure conversation?

☐ Yes. If yes, contact VIA number above
☐ No

2. Is Just-In-Time *disclosure* training needed?

☐ Yes. If yes, contact the trainer at XXX-XXX-XXXX
☐ No

3. Does Security need to be present for the disclosure conversation?

☐ Yes. If yes, contact security with date, time and location
☐ No

Clinical event treatment plan

Key clinical contacts for the family and date/time of next follow-up, if applicable

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Post Disclosure Debriefing

Confirm next steps and prepare documentation

Staff Members Present for the disclosure meeting

Patient and family representative(s) response to disclosure, including questions and answers provided, if applicable

Any type of assistance that was offered (i.e. social worker, child life, chaplaincy) **AND** family response

Identified team lessons learned about the disclosure PROCESS and corrective actions, if applicable

DO NOT SCAN INTO THE MEDICAL RECORD – NOT A PART OF PATIENT'S MEDICAL RECORD

MAY CONTAIN PHI, PLEASE DESTROY

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Medical Record Documentation

Clinical event FACTS and DECISIONS discussed with the family

Disclosure meeting documentation to include:	Documentation should **NOT** include:
– All of the bolded boxes above [redacted] (Edit bolded boxes to meet your institutions policies and governing regulations) – Destroy these *huddle worksheets* after notes are transferred to the EMR	– References that an incident report was completed – References of consulting legal or risk (still use these resources, just don't document) – Reveal attorney-client communications in the chart notes – The huddle sheet

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1. ***Adjust this training to ensure alignment with your hospital policies***
2. ***Ensure this training is compliant with your governing regulations***

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Disclosure Learner Evaluation

Demonstrating attributes of effective disclosure during simulated learning

Learner Name	
Role	
Department/Unit	
Evaluator	

1. The disclosure process was followed: Disclosure Huddle → Disclosure Conversation → Post Disclosure Debriefing → Medical Record Documentation?
   ☐ Yes *Considerations for improvement:* _____
2. The learner demonstrated empathy?
   ☐ Yes *Considerations for improvement:* _____
3. The learner appeared prepared for the conversation?
   ☐ Yes *Considerations for improvement:* _____
4. The learner appropriately offered to maintain an ongoing and open communication?
   ☐ Yes *Considerations for improvement:* _____
5. Only known facts were discussed and all speculative language was avoided?
   ☐ Yes *Considerations for improvement:* _____
6. The body language demonstrated was calm, humble and receptive?
   ☐ Yes *Considerations for improvement:* _____
7. The learner was an active listener and invited questions and feedback?
   ☐ Yes *Considerations for improvement:* _____
8. At the end of the disclosure, next steps were clear to the patient and family?
   ☐ Yes *Considerations for improvement:* _____
9. The patients and family's feelings were acknowledged?
   ☐ Yes *Considerations for improvement:* _____

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CME Course Evaluation

Demonstrating attributes of effective disclosure during simulated learning

Learner Name	
Role	
Department/Unit	

1. I was engaged with what was going on during the training. (Circle one)

Strongly Disagree	1	2	3	4	5	Strongly Agree

2. What I learned in this training will help me in my work. (Circle one)

Strongly Disagree	1	2	3	4	5	Strongly Agree

3. I feel confident about applying what I've just learned. (Circle one)

Strongly Disagree	1	2	3	4	5	Strongly Agree

4. I am clear about what is expected of me as a result of taking this class. (Circle one)

Strongly Disagree	1	2	3	4	5	Strongly Agree

5. The presentation style of the instructor contributed to my learning experience. (Circle one)

Strongly Disagree	1	2	3	4	5	Strongly Agree

6. Attending this session was a good use of my time away from my work. (Circle one)

Strongly Disagree	1	2	3	4	5	Strongly Agree

7. I am able to explain the steps to disclose safety event information when medicine and technology fail?

Strongly Disagree	1	2	3	4	5	Strongly Agree

8. I am able to identify how to express empathy and be pro-active with a grieving family?

Strongly Disagree	1	2	3	4	5	Strongly Agree

9. I know what to say and how to say it when conversing with the patients and families about an event?

Strongly Disagree	1	2	3	4	5	Strongly Agree

10. I am able to demonstrate how to maintain ongoing, open communication with patients and families after an event?

Strongly Disagree	1	2	3	4	5	Strongly Agree

11. How effective was the presenter?

12. What else do you suggest should be added to the program (what should be improved)?

13. What suggestions do you have that would have enhanced your involvement?

14. What positive impact do you expect to see because of applying what you learned?

15. What did you like about the training?

Simulation Train the Trainer Guide

The Disclosure Conversation

Workshop

About the Instructor Guide

The instructor guide is designed to be a comprehensive tool for facilitating this workshop. Thoroughly review this manual, as well as any related course materials and resources to prepare you to instruct this workshop.

The format for each page of the main instructional content is listed and described below. This information is provided so you can utilize these elements appropriately and effectively as you prepare to instruct.

Slides: The facilitation of the workshop is supported by a PPT presentation. Each slide in the presentation is displayed in the instructor guide with relevant facilitation information below it.

Key Message: the key message provides helpful guidance to make transitions between slides, activities or lessons. It also serves as a summary of the information to be discussed for each slide. The key message is not intended to be a script and should not be read to the class.

Facilitation Guidance: It is expected that, as a subject matter expert, you do not need guidance on what to say for each slide beyond that which is provided in the key message and background. However, often a slide contains animation, requires questions be asked, or includes an activity or video. In these instances, instructions are provided so you can facilitate the content.

These detailed instructions include information on timing, activity length, materials needed, directions to participants, and answers to questions.

Background – Whenever relevant, the background section is included to provide supplemental information to the slide content. Although you, as a subject matter expert, already possess this knowledge, it may serve as a reminder of any content that should be communicated to participants before advancing to the next topic or serve as a handy resource for detailed content, such as legal references, report titles, or dates.

Notes – This section lists specific references that support the content and may be of use to participants. It also includes considerations pertaining to facilitation.

Activity Time - This section indicates the overall length of the section or an activity. It may also be used to indicate recommended timing for breaks.

Preparation – This appears at the beginning of every section. It indicates all steps you need to take to prepare for facilitation of the section along with all materials that you should have on hand to teach the lesson and any ancillary resources used to develop the content.

Introduction

The importance of effective disclosure of adverse events must not be minimalized. It is regarded as a culture of safety, trust and respect for human rights and forgiveness enabled by ongoing and transparent communication (AHROM). The National Patient Safety Foundation's Lucian Leape Institute (2015) states disclosure and transparency between clinicians and patients can be defined as "extreme honesty with patients and their families from start to finish." The span of honesty includes shared decision making, fully informed consent before treatment, free and open communication during the process of care, and openness with patients and families when things go wrong. This domain of transparency is a key element of patient and family engagement and affords the following benefits to the patient, family and the clinician:

1. Improved care experience for patients and families
2. Ability to engage in effective shared decision making
3. Avoidance of adversarial situations between patients and clinicians
4. Consistency between messaging and behavior
5. Elimination of the disruptive consequences of litigation
6. Reduced legal fees

The disclosure of adverse events is an evolving process. With this in mind, the SPS Network already working to improve the pediatric Patient and Family Experience, recognized that standardization of the disclosure process is a missing need. The initial focus will be to equip our network hospitals' clinicians with the proper training and tools to have an effective and empathetic disclosure conversation for an adverse event.

The disclosure improvement work focused on the three areas:

- Huddle – A meeting that occurs to gather relevant facts, to plan for the patient and family conversation, and to quickly rehearse.
- Disclosure Conversation – The physical conversation where patients and families are informed of the facts that something has happened.
- Documentation in Medical Record – The process to document the disclosure conversation in the EMR.

This workshop is intended to help providers practice disclosure conversations of adverse events in the most effective manner. Simulation role-play will be a key component in training and coaching staff regarding disclosure conversations. The expectation is that our network clinicians will be better prepared to have effective and empathetic disclosure conversations with patients and families.

Workshop Overview

This is a 4-hour Disclosure Conversation Workshop to develop a thorough understanding of the adverse event disclosure process. The teaching will be through lecture, discussion, videos and role-play exercises. Most importantly, the workshop will allow the participants to practice using the huddle form and disclosure conversations.

Workshop Registration

Registration for the workshop will be defined by each organization.

Target Audience

This workshop is intended for health care providers primarily responsible for conveying disclosure conversations after an adverse safety event(s) to patients and families. This group would include, but not limited to clinical managers, medical directors and/or attending physicians.

Class Size

Maximum number of attendees is dependent on the trainer to trainee ratio.

Recommendation is 9 to 12 learners; smaller class size has less impact on finding numerous instructors for the workshop activities.

Trainer to Trainee Ratio: Simulation Exercises: 3 learners to 1 trainer for hands-on.

Workshop Overall Goal and Objectives

To prepare healthcare providers with the knowledge and tools to have an empathetic and effective disclosure conversation with patients and families.

After completing this workshop, healthcare providers should be able to:

1. Complete the huddle document for a disclosure conversation
2. Conduct a disclosure conversation with patients/families
3. Document the disclosure conversation in the EMR

Workshop Schedule

The 4-hour Disclosure Conversation Workshop is designed into three main sections.

- Section One: Background and tools for the disclosure conversation
- Section Two: Simulation role play of disclosure conversation
- Section Three: Conclusion/Wrap up

The workshop can be tailored to meet the needs of learners if needed.

Ideally learners should first complete the 4-hour workshop prior to advancing to the Just-in-Time Training in the real clinical environment (JITT):

- Initial Workshop: 4 hours training
- Successive sessions: JITT and Coaching for a simulated or real event

Sample Workshop Schedule

Time	**Activity**		**Notes for Instructor (not part of schedule)**
00:00-00:30	Set up/preparation for workshop		Set up tables, registration, rooms etc.
00:30-01:00	Registration participants		Registration table in or outside room
01:00-	Introduction		Opening and introductions of faculty and learner; Overall workshop goal and objectives
	Adverse Event slideshow	Lecture	Presentation of background and disclosure tools
	Videos	Large group activity	Examples of good and bad conversations Discussion
	Simulations		Role-play activities
	Case #1	Large and small group activity	Practice use of huddle checklist in small groups. Report out to large group for discussion Practice disclosure conversation using role play simulation in small groups Large group debrief
	Case #2	Small group activity	Practice use of huddle checklist for new case Practice disclosure conversation Debrief
	Conclusion/Wrap Up		Closing remarks, lessons learned, evaluations

Workshop Preparations

Space Requirements

The workshop will require one large conference room to accommodate workspace and chairs for up 9-12 participants; plus, role-play stations.

Instructors should be able to arrange the classroom as they deem most appropriate given the exact number of participants and role play stations.

The ideal arrangement allows participants to interact with the instructors and each other; e.g., a U- or V-shape arrangement, clusters of work areas, etc. Avoid "lecture hall" type of arrangements. All participants should be able to see the projector screen and instructors; however, participants and instructors should be able to move about the room without obstruction.

A preparation table and presentation table should be provided for the instructors. The room should be in a quiet area and have a lighting system that permits convenient dimming of the lights, especially where the screen is located.

Audiovisual and Other Equipment Requirements

Visual aids for this workshop consist of PowerPoint slides and video clips. The following audiovisual equipment is necessary for delivery of this workshop.

- LCD projector compatible with a notebook computer (Window 7 or greater) and cables for proper connection
- Projection screen
- Electronic remote device to advance slides in PowerPoint presentation, if available
- Contact information for technical assistance should be available in case needed
- Whiteboard with dry erase pens and eraser, if available
- Or flip chart with markers
- Large black markers for participant tent cards (at least one for every two participants should be placed at their workspace)

All equipment should be placed in the room for the instructors to check at least one hour prior to the first day of the workshop.

Final Preparations

Two weeks prior to the workshop:

- ☐ Reconfirm conference/training room(s)
- ☐ Prepare participant folder/workbook
- ☐ Prepare, confirm and copy final agenda for workshop
- ☐ Prepare and copy final evaluation form(s)
- ☐ Prepare roster for attendees and faculty to sign
- ☐ Discuss the seating arrangements and who will set-up the room.
- ☐ Discuss what time the room is unlocked/locked.
- ☐ Check to make sure a technician is available in case there are problems setting up the room or if something goes wrong during the workshop
- ☐ Reconfirm instructors for the workshop
- ☐ Order nametags if needed or use write-on nametags

One (1) week prior to the workshop

- ☐ Prepare directional signs to conference/training room(s) if needed.
- ☐ Email instructors the list of learners' names and departments
- ☐ Decide who will welcome the participants and introduce the instructors.
- ☐ Instructors should review the workshop agenda and content/plan for each of the sections
- ☐ If applicable: check hand-outs are copied and in the participant folder/workbook

One (1) day prior the workshop:

- ☐ Set-up the conference/training room if possible
- ☐ Organize and copy the participant materials and place in folder/workbook
- ☐Test all audio-visual equipment and presentations

One-hour prior to the workshop:

- ☐ Set up conference/training room if not done the day before
- ☐ Review objectives and content to remind yourself of end goal.
- ☐ Recheck audio-visual equipment, videos and presentation
- ☐ Review agenda and assignments with co-instructors for first and second sections

During the workshop:

- Deliver the content in a good-humored, motivational and participatory means
- Don't forget to end each section with summary and lesson learned
- Remember to give encouraging words
- Remember to spot check during the workshop to see how it is going

After the workshop:

- ☐ Complete the evaluation forms
- ☐ Complete any assessment tools
- ☐ Complete the workshop roster and submit to appropriate authorities
- ☐ Arrange a meeting to review evaluation/curriculum forms
- ☐ Post Instructor contact information if appropriate

Instructor: Presentation Requirements

Before the Workshop Preparation List

1. Confirm the training dates, location, and number of participants

2. Ensure you have the following materials:
    - Instructor Guide, one copy for each instructor
    - PowerPoint Presentation
    - Participant Folder/Workbook
    - Attendance Sign-in Sheets
    - Disclosure assessment checklist tool
    - Workshop Evaluation

3. Read and study the Instructor Guide, PowerPoint presentation, and simulation role play exercises.
    - Select the PSE cases to be used in the workshop per the audience. Familiarize yourself with the Participant Folder/Workbook

4. Check electronics (as stated above) and supplies
    - Whiteboard with dry erase pens and eraser
    - Flip charts (at least three)
    - Large markers, assorted colors for participant name tags

5. Prepare the agenda on a flip chart page or whiteboard or PowerPoint

For example:

A	Introductions
G	Section 1:
E	Section 2:
N	Section 3:
D	Wrap-up / Q & A/ evaluations
A	(Breaks as appropriate)

6. Prepare the following ground rules on a flipchart and post in the conference/training room so its visible during the workshop.

G R **R U** **O L** **U E** **N S** **D**	• Participate. • Be on time. • Stay on task. • Share responsibility for workshop. • Listen when others talk. • Respect the opinions and attitudes of others. • Turn off cell phones and pagers. • Use **flip chart parking lot**.

7. Ensure the room is set-up properly (i.e., tables and chairs are arranged to maximize interaction, projectors do not block participants' lines of sight, flip charts are convenient to you and visible to participants, etc.).

During the Workshop

1. Arrive early. Give yourself plenty of time to get organized.
2. Circulate the Attendance Sign-in Sheet. Be sure all participants sign-in.
3. Start on time and stay on track. Always start on time. Keep exercises within their time limits. End discussions when they cease to be productive. Lead participants away from digressions and tangents and back to the lesson.
4. Be available to discuss
5. Mentor participants during the activities. Walk among groups in class and on-site as they work on their activities, and answer questions and offer guidance as appropriate. Ensure participants are on track as they work. Give constructive feedback during the presentations and discussions.
6. Review Questions: Review the content of each section throughout the workshop to reinforce the learning outcomes. Make sure all questions directly relate to and support the learning outcomes.
7. Lesson Outcomes: At the beginning of each lesson, review that lesson's outcomes. Make sure participants are fully aware of the topics to be addressed in the lesson. At the end of each lesson, review the outcomes again.

Instructor ICON Key

Throughout the manual, several different icons will be used to help identify items in the manual. The ICONs will appear in the margins next to an item and at the beginning of lessons. The ICONs indicate:

Simulation Class Instructor Training Outline

Introduction

Time required

Approximately 30 mins

Instructions for Instructors

As the participants enter workshop:

- Welcome and shake their hands
- Distribute workshop materials and nametags
- Instruct them to wear nametag at all times during workshop

Welcome to the Disclosure workshop

1. Introduce the instructors (name and position)
2. Introduce the participants (name and position)
3. Ask Learners expectations for workshop:

    Question: What do you want to learn?

    Question: What do you hope not to happen?

Document Answers on whiteboard or flipchart:

- Ask each participant to answer questions or document on post it note and stick to the appropriate question board/paper.
- Review answers at end of workshop to see if achieved

- Review the Ground rules for the workshop
  - Basic Assumption:

    We believe all participants are intelligent, well-trained, and cares about doing their best to improve the disclosure conversation for patient and families.
  - Join in discussions-one person speaks at a time
  - Active listening of each other
  - Silence or turn off cellphones and/or pagers
  - Be respectful and courteous of other
  - Confidentiality
  - Start and end sessions on time
- Review the Overall Goal and Objectives for the workshop:
- Goal:
  - To prepare healthcare providers with the knowledge and tools to have an empathetic and effective disclosure conversation with patients and families.
- Learning Objectives:
- After completing this workshop, healthcare providers should be able to:
  - Review the background and rationale for the disclosure conversation
  - Formulate
  - Rehearse a disclosure conversation including huddle, disclosure and documentation in the EMR.
- Review the Workshop Agenda (Display on whiteboard/flipchart/PPT)
  - Section One: Background and tools for the disclosure conversation
  - Section Two: Simulation role play of disclosure conversation
  - Section Three: Conclusion/Wrap up
- Housekeeping Issues
  - Location of bathroom
  - Breaks
  - Location of beverages: coffee/water if needed applicable

Section one: Background and Disclosure Tool Kit

Time required

Part 1: Approximately 60 mins Lecture-PowerPoint presentation

Part 2: Approximately 30 mins Video and discussion

Instructions for Instructors

- Review learning objectives and topics for section one
- Present the PowerPoint presentation
- Show good and bad video examples followed by discussion

Learning Objectives

- Be versed in the steps to do when medicine and technology fail resulting in a safety event
- Be familiar with how to express empathy and be pro-active with an angry and grieving family
- Be conversant in what to say and how to say it after a safety event
- Be knowledgeable on precisely how to maintain ongoing, open communication with patients / families after a safety event

Learning Topics:

- Disclosure HUDDLE
- TIPS for a Respectful Disclosure
- Disclosure CONVERSATION
- Post Disclosure DEBRIEFING
- Medical Record DOCUMENTATION

Summary of educational activities

- Lecture-PowerPoint presentation
- Video and interactive discussion

Section One Content:

Part 1: Adverse Event Slideshow PPT. (See attached slide deck)
(Insert adverse event slide deck with notes in document at this point or add to the appendix)

Part 2: Video review: good and bad disclosure conversations (See attached videos)
Use Plus/Delta/Discuss debriefing methodology for review post each video

What went well? What needs to change?
Document on white board/large post it notes/paper

Section Two: Simulation Role Play Exercises

Time required

Approximately 110 mins (Each case includes simulations and debrief)

Instructions for Instructors

- Review the learning objectives for section two
- Choose the cases to be used for Case Exercise #1
- Choose the cases to be used for Case Exercise #2
- Review the instructions for the role play simulations

Learning Objectives:

- Complete the huddle document for a disclosure conversation
- Rehearse a huddle for a disclosure conversation with other team members
- Conduct a disclosure conversation with patients/families
- Document the disclosure conversation in the EMR

Learning Topics:

Huddle
Disclosure Conversation
EMR Documentation

Summary of educational activities:

- Interactive Discussion
- Role play simulations
- Debriefing (reflection)

Section Two Content: Simulation Role Play Exercises

Instructions for Instructor

Simulation Case Exercise #1: (see appendix)

Simulation Case Exercise #2: (see appendix)

Section Three: Conclusions and Questions

Time required:

Approximately 10 mins

Instructions for Instructors:

Review parking lot

Evaluation

Simulation Scenarios

Please consider variations of these scenarios to meet your needs, for instance:

1. Change the age to a minor-teenage patient that is present for the disclosure
2. Change the age of the patient to an adult, with or without a parent/legal guardian present
3. Include in your scenario a discussion with an 18-year-old teenager who sign their own consent forms

PSE 2: PIVIE

Goal	To practice the empathetic and apologetic medical disclosure process
Objectives	1. Employ the huddle tool in creating a disclosure plan 2. Practice the disclosure conversation with the simulated parents
Patient Information	Name: David Neville Age: 5 years
Reason for the Encounter	Summary: David is a 5-year-old with sickle cell crisis who is admitted to hospital with an IV for fluids and pain relief. Vital signs: Not given Weight: Not given Current status: Known sickle cell disease now with sickle cell pain crisis and IV for IVF's, ketorolac, morphine and diphenhydramine. Allergies: None. Possible adverse reaction to morphine (pruritis controlled with diphenhydramine) Medications: Ketorolac, Morphine PCA, Diphenhydramine History: 5-year-old with sickle cell pain crisis admitted to Hem/Onc floor for management requiring IV. Current Life situation: 5-year-old with sickle cell disease
Your Role	Physician and designated healthcare team members
Your Tasks	Develop a disclosure plan and communicate to the parents in an empathetic manner about what occurred …
Scene	Patient-Family Conference room on Hem/Onc floor. Both parents present.

Huddle Info: David is a 5-year-old with known sickle cell disease admitted in sickle cell pain crisis who requires IV for IVF's, IV ketorolac, morphine PCA and diphenhydramine. Today is day 3 of hospitalization. Peripheral IV infiltration right arm discovered requiring discontinuation of IV and elevation of arm for two hours.

Current status: Awake, alert, in room, right arm remains elevated but with normal pulses, decreased edema, resolved pain and good function without deficits. New IV has been started in left hand.

What Happened:

- David 5-year-old admitted for sickle cell pain crisis.
- 22 gauge IV catheter placed in right hand; all subsequent fluids and IV meds given through this IV
- IV maintenance fluids (D5 1/2 NS with KCl 20 mEq/L) started
- IV Ketoralac scheduled every 6 hours started
- IV Morphine PCA started
- David developed occasional itching; IV Diphenhydramine started
- On Day 3 complained of pain at IV site; noted by off-going nurse
- IV had been checked every hour, but multiple layers of tape covering site
- At shift change, IV site evaluated by off-going and on-coming nurse; on-coming nurse noted right arm to be larger, hard and cold. Right radial pulses also noted to be decreased.
- IV immediately removed, right arm elevated above head
- Re-evaluation right arm two hours later: decreased edema, normal radial pulse, no functional deficits.

Disclosure of the event needs to occur to the patient and family.

Scenario

Bad Scenario

The Encounter (SP)

Scene: Parents are asked to come to Patient-Family Conference room on Hem/Onc floor to discuss IV issues. Child Life worker left with David. Oncoming nurse and Hem/Onc physician knock and enter the room.

Hem/Onc physician: I am Dr. Smith, David's attending physician, and we are here to discuss a problem David had with his IV.

Mr. Neville: Yes, we know about the problem and are very upset that this happened. It seems no one pays attention to our son until something happens!

Hem/Onc physician: Look, that is not really what happened. We pay a lot of attention to our patients. Sometimes IV's don't last more than a couple of days. His right arm has almost returned to normal and his pain crisis has improved. This is not an unusual problem. The nurse caught it and took care of it. It is not a big deal.

Mr. Neville: This has never happened before and we think it is a big deal. We don't want it to happen again!

Ms. Neville: Don't you check the IV site? We would like to be at David's bedside more often, but we both work and it is hard for us to be here. We put our trust in you and your team.

Nurse: We check the IV site every hour. Someone put a lot of tape around the IV site and it was difficult to see if there was a problem. It flushed normally. When we found the problem, we took the IV out and elevated his arm. That is what we are supposed to do.

Hem/Onc physician: Look the nurses are the ones who make sure the IV's are working. Maybe this could have been caught earlier, but I don't think so. Everything is okay now. David is improving. We won't need the other IV for very long.

Ms. Neville: Look my boy was in pain and you made it worse. I'm glad you have taken care of it now, but I don't want this to happen again.

Hem/Onc physician: His arm is fine now. (Looking at nurse) This is not going to happen again. And if it does, someone will be in trouble. (Looking at David's parents) Now let's just get David better so you can go home. Mr. and Mrs. Smith if you have any more problems let the nurse supervisor know and they can call me. I will stop by later today to look in on David.

Scenario

The Encounter (SP)

Good Scenario

Scene: Parents are asked to come to Patient-Family Conference room on Hem/Onc floor to discuss IV issues. Child Life worker left with David. Oncoming nurse and Hem/Onc physician knock and enter the room.

Hem/Onc physician: Mr. and Ms. Neville, I am Dr. Smith, David's attending physician. I wanted to personally talk with you about the events of this morning. Before I get too far, can you tell me what you know?

Mr. Neville: David had a swollen arm from his IV. This has never happened before. My wife was here overnight and knows that the nurse checked on his IV several times. But she never said anything was wrong. Was something wrong? Could this have been prevented?

Hem/Onc physician: Yes, David did have a swollen arm from his IV and we had to take the IV out and elevate his arm for the swelling to decrease. Fortunately, David's right arm seems to be improving and he is starting to use it normally. We are very sorry that this happened to him. There was a lot of tape on David's IV that made it hard to evaluate. When he complained of pain, we should have better evaluated the IV site. We aren't sure yet why this did not happen and are looking into it. We don't want it to happen again.

Ms. Neville: What about the nurse who was taking care of him? Shouldn't she have done something?

Oncoming Nurse: She was upset at David's arm being swollen and really could not talk about it more. I know she is a good nurse that has several years of experience. We do plan to talk with her later today to understand more what happened.

Hem/Onc physician: We do have procedures we follow to prevent this from happening. We need to understand from everyone involved what was going on not only with David, but also on the floor. We need to talk with the person who started the IV. We have some unanswered questions and need to know more. I promise you that when we do know more we will come back and talk with you. As I said, we don't want this to happen again.

Ms. Neville: Is his arm going to be okay? It still looks a little swollen.

Hem/Onc physician: I think it is going to be okay. We are watching it closely and will continue to do so. We are also closely watching the IV in his other hand. I have checked it myself and it looks good and is functioning properly.

Mr. Neville: Doctor, I appreciate you talking with us and taking care of David. So, what is next?

Hem/Onc physician: I will be back later today to relook at David's right arm and his current IV site. I have asked the nurses to let me know if there are any concerns. I want you to feel free to do the same. If you have concerns, get hold of the nurse and if you still have concerns then have them call me. Thank you for your understanding. We will know more later and when we do I will talk with you again. I hope this will be in a couple of days. If we need to make changes in our procedures to make sure this does not happen again, we will do so. If there are other concerns, please have the nurses contact me. Again, I am sorry this happened. We will do our best to make sure it does not happen again. Thank you.

PSE2: Retained Guidewire

Goal	To practice the empathetic and apologetic medical disclosure process
Objectives	1. Employ the huddle tool in creating a disclosure plan 2. Practice the disclosure conversation with the simulated parents
Patient Information	Name: Jimmy Smith Age: 10 years
Reason for the Encounter	Current status: Admitted to PICU post trauma for severe intracranial injury. On day 3 the PICU attending receives a call from the radiologist that a retained guidewire is noted for the first time on CXR. Radiology does not have an explanation at this time as to why this was not seen earlier. PICU attending calls the anesthesiologist to inquire about the insertion. Anesthesiologist states that she did not have an assistant at the time (left the room due to another emergency surgery) and the patient had some increased bleeding due to dilutional coagulopathy and that this may have cause her to be distracted. She also felt there was a hurry to get the patient to the PICU. The patient will need to go to the cath lab for removal of the guidewire. Patient has not experienced any apparent harm from the retained guidewire except requiring an intervention for retrieval. Allergies: NKA Medications: N/A History: Admitted for intracranial injury post trauma. Current Life situation: Lives with mother and father
Your Role	Physician and designated healthcare team members
Your Tasks	Develop a disclosure plan and communicate to the parents in an empathetic manner about what occurred
Scene	Mother and father are moved to a small conference room in the PICU. PICU attending and PICU nurse manager enter the room and seat themselves at the table with the parents.

Dr. Jones: Hello Mr. and Mrs. Smith. I am Mike Jones, the PICU physician caring for Jimmy. I am sorry to have to take you away from his bedside but there is a concern that I would like to talk to you about. I received a call from one of the radiologists. He was reviewing one of Jimmy's chest x-rays. He noticed that when they put his central line in on Monday, there is a wire that was left in the catheter in error. While there does not seem to be any apparent harm from this wire currently we will need to take Jimmy to the cath lab to remove the wire. We are very sorry that this has happened.

Mr. Smith: I don't understand…..that was three days ago. Why has it taken so long to see that on an x-ray?

Dr. Jones: We don't really know at this time. When I spoke with the radiologist he did not have an answer to that question. He is going to be asking some questions of his partners in his department and get back to me tomorrow. Also, in speaking with the anesthesiologist that inserted the central line, she feels that she may have been distracted at the time. She states that there was some initial bleeding upon inserted the catheter due to the bleeding tendency that resulted from the massive transfusions, which were needed to replace all the blood loss from his injuries. That and the fact that there was some urgency to move Jimmy to the PICU quickly based on his condition at the time led her to assume that she had already removed the guidewire as she no longer saw it sticking out of the tubing. The anesthesiologist, Dr. Marks is going to come up and talk to you today after her OR cases are done.

Mrs. Smith: Are you blaming our son's critical condition for your mistake??

Dr. Jones: Not at all—when we have an error like this we like to be able to go back and look at all of the factors that led to it. We did not want this to happen and don't want it to happen again to Jimmy or anyone else's child. We just want you both to have an understanding of what led up to this, and I will get back to you when we have a plan for how this error will be prevented in the future in order to improve our care

Mr. Smith: When will he go get it out? How long is that going to take?

Dr. Jones: We are getting him prepped and ready right now. Since he is already sedated and intubated this should be less

than a ten-minute procedure to retrieve the wire in the cath lab. Again, I want to emphasize that there seems to be no apparent harm from this, but we are very sorry that this occurred.

Mrs. Smith: I feel like we need some more answers……..you just left a wire floating around in our son.

Dr. Jones: you are right—you do deserve more answers. I am the physician on until 7p today and again all day tomorrow. Dr. Kennedy will be your physician on from 7p-7a. Tomorrow I will circle back around with the radiologist to find out the issues that he finds in the reading of the x-rays. I will then come and talk to you about the findings. In the meantime, Dr. Marks from anesthesiology should have also visited you. When we meet tomorrow, I will have further answers for you. In the meantime, please feel free to ask Dr. Kennedy any questions you might have. Kelly here is our nurse manager. She has her phone number along with the charge nurse's phone number written down for you. They are also available if you need them at any time during your stay.

Mr. Smith: this is really upsetting but we appreciate your honesty and talking to us.

Dr. Jones: It is very upsetting, I am sure. And again we are very sorry, especially Dr. Marks, and we will be following Jimmy closely for any signs of complications.

PSE3: Error Transposition of Weight

Goal	To practice the empathetic and apologetic medical disclosure process
Objectives	1. Employ the huddle tool in creating a disclosure plan 2. Practice the disclosure conversation with the simulated parents
Patient Information	Name: Jenny Parsons Age: 3-year-old
Reason for the Encounter	Weight: 13.7 Current status: Admitted for neck abscess for antibiotics and I&D Allergies: NKA Medications: Clindamycin and IV fluids History: 3-year-old admitted for neck abscess to receive antibiotics and I&D of abscess. As the hospitalist, Dr. Kerns receives a call from anesthesia that the weight of the toddler in the in-patient record is 31.7kg but the outpatient weight in the clinic was actually 13.7kg. The clindamycin dose and the IV fluids dose were calculated for 31.7kg. The patient has received 2 doses of the Clindamycin. In discussion with the pharmacist it is agreed that the next dose will be held but he does not expect the patient to have problems as it is still within the dose limits for the child and the extra fluids she received will help the elimination of the drug. The pharmacist notes that most reactions to clindamycin are not dose related. The child does not have any detectable harm and is acting normally and required no analgesia overnight. Current Life situation: Lives with mother and grandmother
Your Role	Physician and designated healthcare team members
Your Tasks	Develop a disclosure plan and communicate to the parents in an empathetic manner about what occurred
Scene	Mother (Mrs. Parsons) and Grandmother (Mrs. Kelly) are seated in the conference room next to the unit. The physician (Dr.

Kerns) and the pharmacist (Bill) enter and seat themselves at the table with them.

Dr. Kerns: Hello Mrs. Parsons. I am Dr. Kerns and I am the hospitalist taking care of Jenny today. I have asked to speak with you because there was an error that occurred when Jenny's weight was entered into the computer on admission. Her weight is 13.7kg but it was entered into the computer as 31.7kg. As a result of that, her initial dose of her antibiotic, Clindamycin and her IV fluids were both given to her at higher levels. She does not seem to be experiencing any harm as a result of this currently. We are truly sorry this has occurred and we are looking into the cause.

Mrs. Parsons: How did this happen? I mean can't you see that she isn't that size? You said she isn't experiencing any harm currently…will she be hurt later from this?

Bill: I am Bill Peterson and I am the pharmacist for Jenny. We will be monitoring her throughout her stay but do not feel she will be having long term effects. When we administer antibiotics, we look at the total daily dose and she is still within the range of the normal daily dose. The fact that she received some extra IV fluids will actually help her infection but also in elimination of the drug from her system. I will be looking at our processes in the pharmacy though, as 31.7kg is very large for a 3-year-old and we will want to understand why the pharmacist checking her medications did not question that.

Mrs. Kelly: this just doesn't make any sense to me

Dr. Kerns: I know—it is difficult to understand and very concerning for you as her parents and for us as her care team. I don't have the answers right now. Bill and I are going to be looking into it today to try to get you some answers. In the meantime, we will be watching Jenny closely. Here is my number and also Bill's number. If you have any questions in the meantime, please feel free to call either of us. I will be back on rounds again tomorrow morning and hope to be able to have a better explanation. Again, we are very sorry that this happened.

PSE4: Wrong Patient Scheduled

Goal	To practice the empathetic and apologetic medical disclosure process
Objectives	1. Employ the huddle tool in creating a disclosure plan 2. Practice the disclosure conversation with the simulated parents
Patient Information	Name: Michaela Smith Age: 2 years
Reason for the Encounter	Summary: Michaela is a 2-year-old female with who now needs an outpatient swallow study. Vital signs: Not given Weight: Not given Current status: Dysphagia on honey thick liquids Allergies: Not given Medications: Not given History: At one year of age developed unilateral vocal cord paralysis and dysphagia after prolonged intubation due to complicated parainfluenza. She has been on honey consistency liquids since. Current Life situation: 2-year-old with unilateral vocal cord paralysis and dysphagia otherwise doing well.
Your Role	Physician and designated healthcare team members
Your Tasks	Develop a disclosure plan and communicate to the parents in an empathetic manner about what occurred …
Scene	Holding area for outpatient testing

Huddle Info: Michaela is a 2-year-old with unilateral vocal cord paralysis and dysphagia that developed after prolonged intubation one year ago, for complicated parainfluenza. She was to return today for an outpatient swallow study.

Current status: Pre-procedure, awake, alert in no distress

What Happened:

- Michaela Smith (DOB 7/11/2014) was mistaken for Michael Smith (DOB 8/11/2004) and scheduled for an outpatient EGD rather than a swallow study.
- This was not discovered at initial check-in to the outpatient testing area
- This was not discovered by the nurse verifying the procedure with mother
- The gastroenterologist, Dr. Murray, noted the error when she came to talk with Michaela's mother. Dr. Murray was expecting to find 10-year-old Michael Smith, not a two-year-old child.
- Dr. Murray then confirmed that Michael Smith was not scheduled and that Michaela Smith had been scheduled in error.
- Michaela Smith did not have an EGD done.

Disclosure of the event needs to occur to the patient and family.

Scenario

Bad Scenario

The Encounter (SP)

Scene: Michaela who is in hospital pajamas and her mother are in the holding area. Michaela is in mother's arms and is fussy since she has not eaten for the past 6 hours. Mother is waiting to talk with someone about the scheduled procedure. Dr. Murray and Nurse enter the room.

Nurse (a little embarrassed): Ms. Smith it seems we have had a little mix up this morning.

Dr. Murray (visibly upset): A little mix up and a lot of wasting of my time!

Ms. Smith (puzzled): What do you mean a mix up? You called me and told me to bring Michaela here for a procedure this morning. You told me it was an EGD to look at her swallowing. Michaela is

hungry and fussy (mother is now more upset) and I took off from work to be here. Is she not going to have the procedure done?

Dr. Murray: She is not going to have an EGD. That is not the right procedure for her.

(Physician Pager goes off): It looks like my next patient is ready. I'm sorry I can't stay here and discuss a hospital scheduling mistake!

Ms. Smith (starting to be angry): What do you mean not the right procedure? I did everything I was told. I took off work!

(Michaela starts crying for a bottle): Now look my daughter is crying. Is she not going to have the procedure she needs to look at her swallowing? This is a big mess!

Dr. Murray (heading out the door): I don't know what procedure your child needs. Maybe the nurse can help you. I have another procedure to do.

Nurse (a little panicked): Ms. Smith, everything is going to be okay. Let me go find the office manager and radiologist and see what we can do (hastily retreating out the door).

(Ms. Smith is left in the holding area angry with a crying Michaela).

Scenario

The Encounter (SP)

Good Scenario

Scene: Michaela who is in hospital pajamas and her mother are in the holding area. Michaela is in mother's arms and is fussy since she has not eaten for the past 6 hours. Mother is waiting to talk with someone about the scheduled procedure. Dr. Murray, nurse and office manager enter the room.

Dr. Murray: Ms. Smith, I am Dr. Murray and this is our office manager and Michaela's nurse. I wanted to speak with you directly about the procedure that Michaela needs and the one that she was scheduled for. It appears that when Michaela's procedure was scheduled, there was a mix up with another patient with a very similar name. Michaela was scheduled for that patient's procedure which is not the procedure she needs. Fortunately, we recognized this before the procedure was done. We are sorry that this happened to you and your daughter.

Ms. Smith: How did this happen? Don't you have procedures in place to keep this from happening? Michaela hasn't eaten for 6 hours and I took off work.

Dr. Murray: Our office manager and staff will be looking into how this happened. We do have procedures in place to prevent this, but for some reason they did not work this time. We will look into what happened and fix it. We certainly don't want this to happen again. And all of us are sorry that Michaela has not eaten for 6 hours and you took off work. We are very aware of the importance of your time and the difficulties procedures may cause our patients. We may still be able to do the procedure that Michaela needs, a video swallow study. As soon as our conversation is completed, our office manager will check with the radiologist and speech therapist to see if we can do the procedure today.

Ms. Smith: This really has been an inconvenience and it is difficult not to feed a two-year-old her breakfast! How much longer do you think it will be before we know whether or not the right procedure can be done? I still don't understand how this happened.

Office Manager: I placed a call to our speech therapy department just before we came to talk with you. I hope to have an answer from them very soon, within 15-30 minutes. Our radiologist has already said he can be available for the video swallow study this morning. Of course, we understand if you

want to reschedule. As far as how this happened, I really don't know yet. I need to speak with the person who does the scheduling and the person who checks the procedure that is scheduled against the procedure that the doctor requested. I hope to have answers in a few days.

Ms. Smith: I am willing to wait until you hear from the speech therapist, but if it is more than 30 minutes then we should reschedule. I just hate to take off another day from work. What can we do to help Michaela from being more upset? And I want to know what happened and that you have fixed the problem. No one else should have to go through this.

Office manager: I understand and agree that this scheduling error should not have happened. Once I know more I will personally contact you.

Nurse: I will find a toy for Michaela to play with. Perhaps that will take her mind off the fact she is hungry. I will also get back with you within the next 30 minutes to let you know if we can proceed with the video swallow study.

Dr. Murray: I will also check on you in the next 30 minutes and be happy then to answer any additional questions.

Office manager: If the procedure can't be done, if you want, we can reschedule it before you leave. Also, we may be able to provide you a parking voucher today and also gasoline and food cards. If you have to reschedule, we will make sure that you receive a parking voucher and gasoline and food cards for when you return.

Ms. Smith: Thank you. Please let me know as soon as possible if the video swallow study can be rescheduled this morning.

Disclosure Medical Error Case

Goal:

Objectives

To practice the empathetic and apologetic medical disclosure process

1. Employ the huddle tool in creating a disclosure plan
2. Practice the disclosure conversation with the simulated parents

Patient Information

Name: Katie Templeton

Age: 8

Reason for the Encounter

Katie Templeton is female with Crohn's disease who came to the Gastroenterology suite for routine colonoscopy.

Pre-op Vital signs: HR 90, RR 18, B/P 92/66, T 37.

Weight: 25 kg

Current status: remission, Last flare-up 6 months, controlled by diet and Remicade.

Allergies: None

Medications: Remicade, Corticosteroids when needed.

History: Diagnosed at 6 years of age. Family history of autoimmune disease.

Current Life situation: Attend elementary school –entering 3rd grade

Physician and designated healthcare team members

Your role

Your tasks

Develop a disclosure plan and communicate to the parents in an empathetic manner about what occurred in the GI suite

Scene

Post recovery room

Disclosure Medical Error Case

Scenario

Katie is an eight-year-old female with Crohn's Disease who was appropriately screened and prepped for the colonoscopy procedure. She is now post-procedure in the GI suite recovery room with her parents. She is awake, alert and interactive, tolerating sips of clear fluids.

- Procedure: RN and the GI technologist had gathered, opened and prepared the supplies and equipment for the procedure. She received deep conscious sedation for the procedure. The colonoscopy was uneventful and the biopsies that were obtained were properly labeled and sent to the laboratory.
- Procedure clean up: In the procedure room the RN and the GI tech were cleaning up the room when the RN discovered that the sterilization date on the scope was labeled with the wrong date. The scope was out of date by one day.
- The attending physician was notified and ID was consulted. After review of the case with the attending and ID they recommended that no treatment was needed.
- Disclosure of the event needs to occur to the patient and family.

The Encounter (SP) Role

Bad Scenario

Mom is Mrs. Templeton, Aunt is Margaret (or Ms.) Jones

Scene: Child is dressed and ready for discharge, looking through a sticker book given by Child Life. Parents are sitting in chairs next to bed awaiting physician to arrive, holding onto prescriptions and discharge instructions. Physician and Nurse Manager enter the room. They stand by where the parents are sitting.

Nurse Manager (nervously looking around the room): Well, Mom and Dad, we need to have a little chat before you go.

Dr. Johnston: (snorts): LITTLE chat is right. This is SERIOUSLY not a big deal.

(Physician's phone rings and he/she answers it. "Uh, huh. Well what are you calling me for? Of course, just go ahead)

Dr. Johnston: Now, as I was saying. We had an issue today that comes from some not so smart technicians not doing their job. In any case, it's all FINE, just FINE.

Mrs. Templeton: What's the matter? Is Katie alright? She seems to be doing well.

Dr. Johnston: Yes, yes, Mom she's fine. The procedure went perfectly. (Smiles at Katie). But the scope that we used goes through a process for sterilization. SOMEONE wasn't paying attention and they gave me a scope that had expired.

Margaret: What does that mean 'expired'? How does that happen? Don't you have procedures for that? How is it kept clean?

Dr. Johnston: Those processes are really not for you to worry about at all. Just know that it is not a big deal.

Mrs. Templeton: Do we need to worry about her getting an infection? Will she need to be watched for anything? Does she need to stay? I can't believe this happened! (Voice gets a little louder) WE bring her here for a test and you could have made her sicker!

Margaret: Calm down. I am sure there is an explanation. (Puts arm around sister to comfort her). Dr. what should we be looking for?

(Physician's pager goes off) Physician: Oh, good Lord. Just a minute. (Physician dials phone, "Yes darling. Yes, the striped ones are fine for the guest room. No, no, I am OK with that)

Dr. Johnston: as I was saying. Let's see. So, one of our staff mucked things up. No, she does not need antibiotics. No, she won't need anything different in follow up than her nurse instructed you.

Mrs. Templeton: Will she have to have the procedure done again?

Dr. Johnston: (slightly exasperated) Of course not.

Margaret: I would really like to know that this will not happen again to another child

Nurse Manager: Oh believe me I will be talking to Steve….ooops…..I mean the technician who was not doing his job.

Dr. Johnston: So, see, Katie will be fine. There are no worries. Just call my office with any problems.

Disclosure Medical Error Case

Good Scenario

Mom is Mrs. Templeton, Aunt is Margaret (or Ms.) Jones

Hello, Mrs. Templeton and Ms. Jones (Margaret),

I asked to speak with you again because I need to explain something about Katie's colonoscopy procedure. What I told you initially still stands; she was stable throughout the procedure and sleeping comfortably from the sedation, and as I said after her procedure, it went very well without any complications in the operating room and she seems to be completely recovered now, which is great.

However, since we last spoke, I have learned from our OR team that the endoscope we used to perform the colonoscopy was **out of date by one day** over the recommended time period from the last cleaning and sterilization process. Unfortunately, this was not detected by our team or by me until after the procedure. I am extremely sorry for this oversight on our part, and I want to apologize and give you all the information I have at this time. I want to let you know that it should not affect her health, and she should not experience any complications from the miscalculation of one day. But, first let me say again, that I am very sorry to have to explain something like this when it should not have happened. I am disappointed that I have to tell you this and I imagine that you are even more disappointed to hear it. We will be doing a prompt review of our checking processes before each procedure and a thorough analysis of how we will prevent this from happening in the future to your daughter and all our endoscopy patients.

Mother (annoyed voice): How did this happen? She has had a previous colonoscopy and endoscopy, could this have happened then, too? It seems like someone was sleeping on the job and not paying attention to what they should have been.

Dr. Johnston: Our team miscalculated the date by one day, and did not realize that it was overdue for what is a recommended re-sterilization every 7 days following initial sterilization. I have already spoken to our Pediatric Infectious Disease specialist that wrote our policy for re-sterilization. She explained to me that while we need to strengthen and mistake-proof our process of checking the correct expiration date daily, they as the experts in infection control, intentionally chose the 7-day period to be very protective of our patients. The actual medical safety studies done on this equipment describe a 10 – 14-day expiration time period and many other hospitals use that whole-time period. So, they feel confident that she will be fine and should not experience any infection as the instrument was still sterile, wrapped and stored inside a clean case, and at 8 days it was still well below the outside safety limits that are referenced by many experts including the Centers for Disease Control.

Margaret, the sister: How is this equipment sterilized? The newspapers have had a lot of articles recently about these scopes and a lot of new, weird infections caused by them, haven't they? We didn't totally understand it all, but it sounded like some people were getting really serious or deadly infections.

Dr. Johnston: I'll do my best to answer this myself, but I have already asked our Infection Control department to meet with you today to answer all the other questions that you still may have. Even before the problems in the newspaper began, we have had a specific infection prevention plan for endoscopic procedures written by our Infectious Disease Experts. They will be able to describe the large number of cleaning steps better than I can, but the CDC calls it **"high-level disinfection"** and it starts immediately after each procedure with soaking the endoscopic instrument in a solution that immediately begins to kill the surface germs, then the equipment goes to our central processing department where all the parts and joints are taken apart for initial strong chemical cleaning that is selected to kill all the germs. Then after that cleaning and soaking and inspection for any debris, the instruments are packaged for steam sterilization, which is the "gold standard" as our best method of sterilizing against bacteria and viruses and it reaches well over 370 degrees. We use chemical indicators placed in the packs of every load that indicate by a change of color when it is hot enough to make sure that the pack of instruments has been fully sterilized. Routine checks are also done weekly of all the sterilization equipment itself using other kind of indicators.

We know from the information on the pack where and what sterilizer was used, the date and the expiration date. They are dried thoroughly prior to reuse and after high-level disinfection, our devices are stored in a way that protects them from contamination. We also keep a log for each procedure that includes the patient's name and medical record number, procedure, date, the doctor doing the procedure, system used to clean or reprocess the endoscope and the serial number and other identifiers of the scope that we use.

Margaret: So, if you do all that, how did you miss this wrong date?

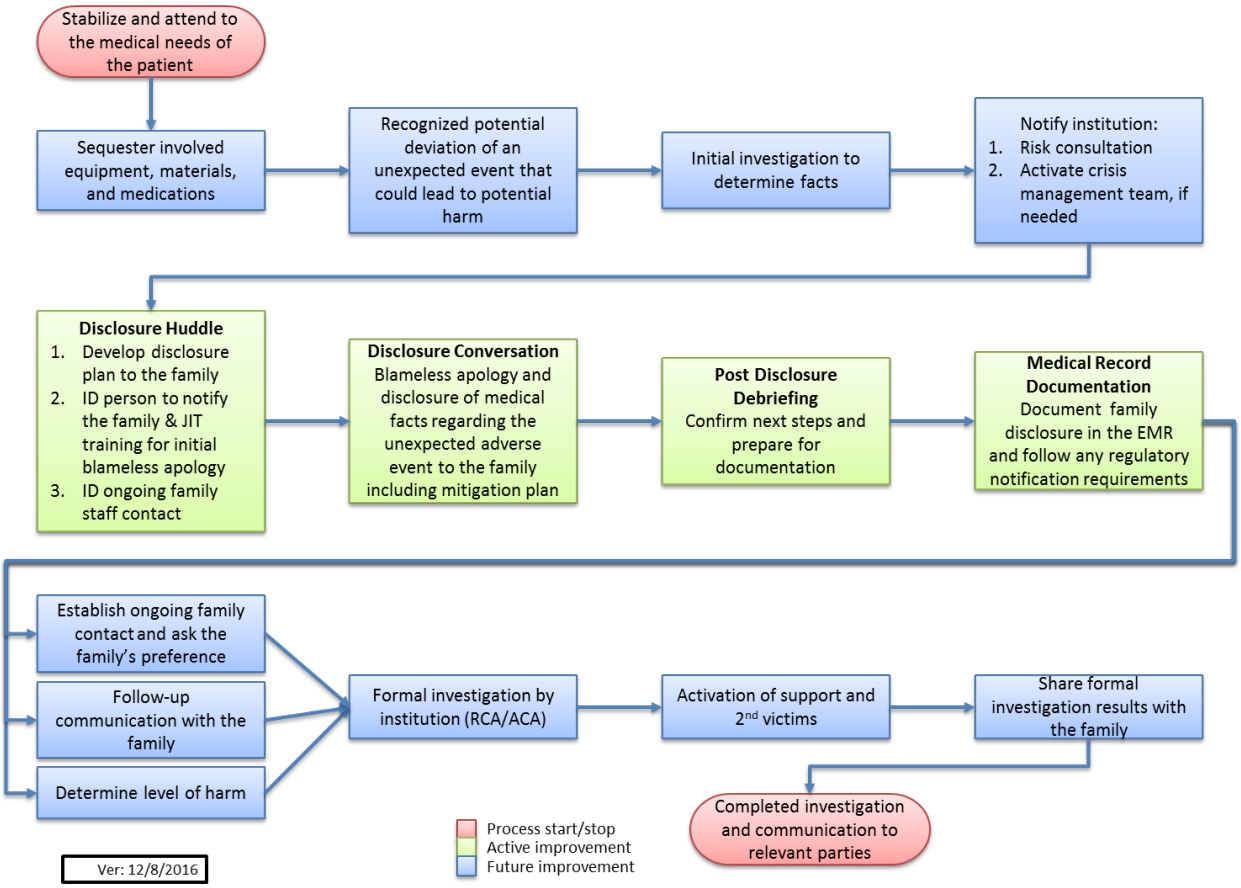
Dr. Johnston: Well that is the question that we are going to investigate and fix. We look at these events that might have caused an even bigger problem for our patients as an opportunity to find and fix the holes in our system. Some of these holes include better communication, checking equipment with a checklist many hours before the procedure and a final check again before the procedure, and possibly making the expiration date of something like this VERY CLEAR and UNAMBIGUOUS, and not something we need to calculate or miscalculate.

So, I will be glad to contact you when we have thoroughly reviewed this situation and tell you how we are going to fix it from happening again. I should hopefully know those answers before her follow up visit and other tests come back and I will let you know what additional safety steps we have added to our plan.

I am comfortable with her going home today if you are, but I or the nurse practitioner, Jaimie Adams with whom you regularly talk will contact you daily for a few days so we can all be reassured that she is doing absolutely fine after this procedure. The discharge instructions will also tell you what to watch for, but call my office if anything unusual is bothering her or you. Again, our whole OR team as well as our infectious disease experts take this event extremely seriously as it makes it clear that we need to mistake-proof the expiration date information as soon as possible. Thank you for your time and patience with us and for your very good and understandable questions of concern for her health. We all share that concern and agree that this could have been prevented. How we will do that for Katie and all the others is what we will discuss the next time I see you, if not before. Call us if you have other questions once you get her home.

Appendices

Appendix 1: Disclosure Process Map



Appendix 2: CME Resource Document

Children's Hospital Solutions for Patient Safety (SPS)
Disclosure Training
CME Application Template

Basic Information

Activity Description:
Disclosure Training

Activity Leadership and Administrative Staff Support:
Please place your hospital's information here

Planning Committee:
Please place your hospital's information here

Presenters/Panel Members:
Please indicate who from your hospital will be facilitating Disclosure Training as selected by your lead physician and/or nurse educators

Target Audience:
All front-line ordering clinicians at your hospital

Competency Designed to Address:
Indicate competency designed to address based on options provided by CME office

Financial Disclosure Information:
Each hospital uses their own disclosure process

Time Frame:
- *Full Training: 4 hours*
- *Partial Training: 2 hours*
- *Just in Time Training: 5-10 minutes (No CME provided)*

Practice Gap

What is the activity designed to accomplish?
While receiving care at children's hospitals, there is the possibility that something unplanned can go wrong with treatment, resulting in harm and/or a hospital acquired condition (HAC). Clinicians are not prepared or trained to provide an effective and productive disclosure conversation, if this need arises. This disclosure Training provides an approach to preparing clinicians to have this disclosure conversation that builds the physician-patient-family relationship and provided the information needed for required documentation of said disclosure.

How do you know (Documentation)?

Parents want disclosure if harm occurred and for nonharmful events, most parents wanted disclosure for themselves but few for their child(ren)/patient (Coffey, Espin, Hahmann, Clairman, Lo, Friedman, Matlow, 2017). It is important that clinicians understand this delicate dynamic and understand how to navigate an effective and successful disclosure.

Surgeons with more negative attitudes about disclosure reported more anxiety about patients' surgical outcomes or events following disclosure and less likely to apologize to the patient (Elwy, Itani, Bokhour, Mueller, Glickman, Zhao, Rosen, Lynge, Perkal, Brotschi, Sanchez, Gallagher, 2016). Completing a Disclosure Training Program could change the attitudes of surgeons and emphasize why an apology is a necessary component in disclosure, by equipping them with tools to have an effective and successful disclosure.

The essential point is that when errors occur, patients and families should be told about the error, and an apology provided (Levinson, Yeung, Ginsburg, 2016). Our network clinicians need to be trained appropriately to provide patients and families with what is needed to maintain a productive physician-patient-family relationship. Additionally, our clinicians will have a different disclosure outcome if the disclosure was done properly.

References:

M. Coffey, S. Espin, T. Hahmann, H. Clairman, L. Lo, J. Friedman, A. Matlow (2017). Parent Preferences for Medical Error Disclosure: A Qualitative Study. *Hospital Pediatrics, April 2017, Volume 7 Issue 4. doi: 10.1542/hpeds.2016-0048*

A.R. Elwy, K.M.F. Itani, B.G. Bokhour, N.M. Mueller, M.E. Glickman, S. Zhao, A.K. Rosen, D. Lynge, M. Perkal, E.A. Brotschi, V.M. Sanchez, T.H. Gallagher (2016). Surgeon's Disclosures of Clinical Adverse Events. *JAMA Surgery, November 2016, 151(11):1015-1021. doi:10.1001/jamasurg.2016.1787*

W. Levinson, J. Yeung, S. Ginsburg (2016). Disclosure of Medical Error. *JAMA Professionalism, August 2016, 316(7):764-765. doi: 10.1001/jama.2016.9136*

How will this activity help change practice?

This activity will provide recommended approaches to hospitals looking to improve their Disclosure training and process or create a Disclosure training within their existing clinician education program. Clinicians will be given strategies and have an opportunity to practice having these conversations.

What might prevent them from changing (Barriers)?

- *Priorities and organizational culture - i.e. lack of resources (people's time) or lack of buy-in from leadership.*
- *State-to-state requirements/laws could influence what can be discussed during this conversation*
- *Personal reluctance to having this kind of conversation*

Presentation-Specific Objectives:

- *Explain the steps to disclose safety event information when medicine and technology fail*
- *Identify how to express empathy and be pro-active with a grieving family*
- *Recognize what to say and how to say it when conversing with the patients and families about an event*
- *Demonstrate how to maintain ongoing, open communication with patients and families after an event*

How will this information be presented and why?

Lecture, Discussion, Small Group Discussion, Case Based Discussion, Role-play and/or simulation

Why are these methods appropriate?

- *Didactic portion allows for dissemination of information*
- *Case studies and small group discussions related to case studies provide specific examples from the institution and the opportunity to discuss application of concepts learned.*
- *Role-play and/or simulation provides the platform to practice and receive real-time learning via self and peer evaluation feedback*

Is this a gap in knowledge, competence, or performance?

There will be variabilities depending on the experience of the clinician. Some clinicians will not know the best way to have these conversations (i.e. use of verbal and non-verbal empathetic language). Some clinicians need strategies to employ the knowledge they already possess. Some clinicians need practice in a safe environment.

How will effectiveness be measured?

The effectiveness of Disclosure Training will be measured:

1) *Standard learner evaluation measuring satisfaction and intent to change behaviors*

This activity is designed to address:

- *Knowledge*
- *Competence*
- *Performance*

Below are some ways approval of this activity could add to you CME program's ability to meeting Accreditation with Commendation criteria.

Additional Benefits to meet Accreditation with Commendation Criteria

Criteria 23: Members of interprofessional teams are engaged in the planning and delivery of interprofessional continuing education (IPCE)

All work of the Solutions for Patient Safety is designed by and anticipated to be delivered by interprofessional teams. Individual institutions are encouraged to attend all trainings as a team.

Criteria 27: The provider addresses factors beyond clinical care that affect the health of populations.

Trust between patient/family and provider are a critical factor in health. Learning to disclose with empathy and in a way to build trust has the potential to be a positive factor in patient health.

Criteria 28: The provider collaborates with other organizations to more effectively address population health issues.

Solutions for Patient Safety is a collaborative of 130+ pediatric hospitals and health systems that work together to address Hospital Acquired Conditions and building a reliable safety culture. This training is a result of the collaborative effort.

Criteria 29: The provider designs CME to optimize communication skills of learners.

This training is focused on communication skills related to the disclosure conversation with an emphasis on empathetic communication

Disclaimer: This document is meant to be a guide and will require each individual institution to review and add or delete any information accordingly.

Appendix 3: Just-in-Time Training

Utilizing the Disclosure Worksheet, the clinician can collaborate with a disclosure lead/simulation staff or another clinician and role play the upcoming disclosure conversation. Real-time feedback can be presented to the clinician and the necessary changes/suggestions can be made. This is intended for those who are well versed in disclosure but may need a quick refresher or the opportunity to rehearse their plans and obtain feedback. All the provided job aids can be utilized as support.

Appendix 4: Disclosure FAQ Sheet

Disclosure FAQ Sheet

Where can I access the slide deck and other guidance documents?
Everything you need is located on the SPS SharePoint site in the '**Disclosure**' workspace, under 'Culture Domains'. The link is: https://portal.cchmc.org/sites/ochsps/Disclosure/default.aspx

Who should attend the training?
This training was developed with the clinician in mind. It is recommended that all physicians, advanced practice nurses and nursing leaders attended. This training is focused on engaging in an event disclosure conversation with a patient and their family. Anyone who needs to disclose to a family should be encouraged to attend.

Can our parent representatives/family faculty in my hospital be invited to participate?
Yes, we encourage their participation as training personnel.

How long is the training?
The full training takes approximately 4 hours. However, we also have put together a partial training outline (abbreviated slide deck) as well as just in time training, which is only recommended after the full training has been completed.

Can the clinicians earn CME credits?
Yes, we have provided guidance for the CME application in the appendix of the training manual.

Can I change the slide deck?
Yes, all the documents created are to provide guidance to start the disclosure work – and is not able to meet all local requirements. As such, each individual hospital must be responsible to do the following:

- Adjust this training to ensure alignment with your hospital policies and ensure the training is compliant with your governing bodies and all applicable state and local regulations

Can I copy the job aids?
Yes, just be sure to make the adjustments to meet your hospital's specific policies and procedures.

Who should become trainers?
It is recommended to collaborate with your simulation or educational staff in your hospital to deliver the material. Other staff are always welcome to become trainers.

Does our risk/legal department need to approve the training?
If you have any concerns, we recommend that you share this content with your risk/legal leaders and/or colleagues. In the development of the training, SPS had input from our risk/legal experts.

Are the worksheets a part of the patient's medical record?
No, the worksheets are NOT a part of the permanent medical record. These were developed for fact gathering purposes to be used as a checklist/job aid. We recommend that they be destroyed (shredded) due to the probability that PHI and other sensitive information is documented on the worksheets.

If you have other clarifying questions that were not addressed above, please send an email to SPS at ochsps@cchmc.org and someone from the SPS Culture Management Team will follow-up with you.

Appendix 5: 2nd Victim Support

PURPOSE:

To create awareness that staff may need some additional support

To support the rights of the 2nd Victim:

- Just treatment
- Respect
- Understanding and compassion
- Supportive care
- Transparency and the opportunity to contribute

Determine need for **2nd Victim** support:

- Ask: "*How can I help you right now?"*
- Be empathetic and pro-active; stay connected and follow through
- Make effort to remove 2nd victims from immediate patient care *(temporarily "off duty")*
- Ensure respectful and non-blaming interactions with 2nd victims
- Identify immediate and long-term support resources for 2nd victims
- When the time is right . . .
  - Give 2nd victims the opportunity to talk with the patient and family
  - Get 2nd victims involved in the fix
  - Allow 2nd victims to tell their story with colleagues and friends

Appendix 6: References

1. Amori, G.: *Risk Management: Pearls on Disclosure of events*; 2006.
2. Amori, G.: *Risk Management: Disclosure of Unanticipated Events in 2013 (Prologue to the Re-Release of the Three ASHRM Disclosure Monographs);* 2013.
3. ASHRM. *Disclosure of Unanticipated Events: The Next Step in Better Communication.* Chicago: ASHRM whitepaper / Monograph 1; 2003.
4. ASHRM. *Disclosure of Unanticipated Events: Creating an Effective Patient Communication Policy.* Chicago: ASHRM whitepaper / Monograph 2: 2003.
5. ASHRM. *Disclosure: What Works Now & What Can Work Even Better.* Chicago: ASHRM whitepaper / Monograph 3: 2003.
6. Honfeldt, R.: *Disclosure of Medical Errors (Training and Workshop);* October, 2014
7. Wojcieszak, D.: *Sorry Works! Tool Kit Book*.