Communication with Disclosure and Its Importance in Safety

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Kristin Cummins, Katherine A. Feley, Michele Saysana, and Brian Wagers

Chapter Objectives

- To demonstrate the critical role of communication in contributing to and preventing medical errors
- To demonstrate the structure and processes needed to support effective communication
- To demonstrate how effective bidirectional communication drives a culture of safety

Vignette 7.1

An 8-month-old child required extracorporeal membrane oxygenation (ECMO) due to progressively worsening respiratory status. The child was admitted with a diagnosis of respiratory failure, and the team had increasing difficulty oxygenating the patient. Given the patient's illness severity and potential for a good resolution of symptoms with proper support, the decision was made to place the patient on ECMO.

This patient was located in the pediatric intensive care unit (PICU), and given the instability of the patient, the decision was made to perform cannulation of the blood vessels and initiation of ECMO at the patient's bedside. Per the surgical team's routine practice, the ECMO cart was readied outside the patient's room with the materials that are required for placement of the ECMO cannulas into the blood vessels of the patient. It is routine practice in this institution to place both the size of cannula the surgeon estimates will be required for successful oxygenation and filtration of the patient's blood and the next size down on the cart holding the materials. This estimation is made based on the child's weight,

K. Cummins
Children's Health, Dallas, TX, USA
e-mail: kcummin1@iuhealth.org

K. A. Feley
Indiana State Nurses Association, Indianapolis, IN, USA

M. Saysana (✉)
Indiana University Health; Indiana University School of Medicine, Indianapolis, IN, USA
e-mail: msaysana@iuhealth.org

B. Wagers
Indiana University School of Medicine, Riley Hospital for Children, Department of Emergency Medicine and Pediatrics, Indianapolis, IN, USA
e-mail: bwagers@iuhealth.org

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but anatomical differences can cause this estimation to fail, and at times, a catheter size smaller than originally estimated is required. Both of these cannulas are placed on the cart, so they will be immediately available to the surgeon performing the procedure.

The surgeon verified the cannula size needed outside the room and then returned to the patient's bedside to perform the procedure. It is the team's routine to place the desired size of catheter as well as the next size down on the sterile field so the equipment is at hand should vein size dictate a smaller catheter be placed. The scrub nurse placed the 27 French catheter on the portable table next to her while awaiting the procedure, but this table was moved out of the room unbeknownst to her to make room for the portable fluoroscopy machine. The surgeon took the catheter that remained on the surgical table and proceeded to cannulate the patient. The catheter size was not verified prior to placement into the child's blood vessel. In the operating room, a time-out is completed prior to surgery verifying the necessary materials and procedure to be completed. Outside the operating room, this is not a routine practice. In this case, no time-out was completed, and the patient was cannulated successfully with what the surgeon thought was a 27 French catheter and placed on the ECMO circuit. The actual catheter size was a 23 French catheter. The surgical team then left the PICU to perform another case in the operating room.

It was immediately noticed by the ECMO technician that the catheter placed into the blood vessel was not a 27 French catheter but was the next size down. The decision was made by the cardiac intensivist to attempt to use this catheter to provide adequate therapy. Throughout the night the ECMO technicians had difficulty maintaining appropriate blood flow volume through the ECMO circuit and thus struggled to provide the highest level of care to the patient.

The next morning, the ECMO team relayed the difficulties in achieving proper blood flow to the cardiac intensivist. The surgeon was also notified, and the decision was made to replace the 23 French cannula with a 27 French cannula. The family was notified of the error in placing the incorrect size catheter and the resultant difficulty with blood flow it caused. They agreed to have the second procedure to place the correct size catheter. The team completed this procedure which required the patient to be taken off the ECMO circuit for approximately 5 minutes, and during this time the patient had a medical arrest which required a short period of cardiopulmonary resuscitation with return of spontaneous circulation within 5 minutes. The child did well once the new catheter was inserted and was able to be weaned off ECMO at a later date with no apparent lasting harm.

Many adverse events involve communication difficulties. Approximately 30% of adverse events in the operating room and 70% of sentinel events, in general, involve a breakdown in effective communication [1]. Studies completed in the relatively controlled setting of the operating room still indicate that interruptions, distractions, and provider stress contribute to communication errors [2]. The case in the vignette was performed at the bedside in an inherently stressful environment where the patient required bedside ECMO cannulation. The chaos surrounding emergent cannulation stands in direct contrast to the controlled and planned environment of most procedures completed in the operating room.

This case highlights several communication-related opportunities for improvement among the team during the event itself. The first opportunity is in pre-procedure/event preparation. A team should always prepare prior to an event. Even in an emergent situation, a team has the luxury of

taking a few seconds to brief on the procedure, necessary equipment, possible complications/contingencies, and expected sequence of events. In this case, the team did not have this opportunity to "pre-brief" given the unstable nature of the child and the perceived necessity of a quick decision to place the child on extracorporeal membrane oxygenation. Regardless of the situation, there is always time to ask for quiet in a procedural space and for extraneous conversation to be held outside the immediate procedure area. This strategy of asking for "quiet space" can effectively reduce some of the chaos and distraction common in high-risk situations with clinically deteriorating patients [3]. Some organizations have employed similar strategies regarding medication practices. For instance, it is common to have a "protected zone" around the automated medication-dispensing machine where nurses can focus solely on selecting the proper medication prescribed and drawing up the correct ordered dosage. Often these areas are marked off by signage or tape on the floor, and other staff members are educated to not interrupt or distract the staff member involved in work requiring critical focus in that space (Key Points Box 7.1).

Key Points Box 7.1
A pre-procedural time-out or a pre-event brief can help to orient the team to the expected facets of a procedure, the necessary equipment, and potential areas of risk to the patient. Many studies link pre-procedural time-outs or pre-event briefs to improved outcomes for patients [3].

One communication strategy that the team did not use in this case was a pre-procedural time-out. The pre-procedural time-out reduces intraoperative errors [3]. One component of most time-outs is the inclusion of the specific equipment a practitioner requires to perform the procedure. In this case, had the team used a time-out and specified that the size of ECMO catheter was to be a 27 French, the scrub nurse would have realized that only the 23 French catheter was on the procedure cart and could have ensured the proper size were present (Key Points Box 7.2).

Key Points Box 7.2 Components of the Time-out
1. Verify the correct patient.
2. Verify the correct procedure.
3. Verify the correct site.

A vital aspect of time-outs is the closed-loop communication that they facilitate and require. Had the surgeon asked for a 27 French catheter explicitly and the scrub nurse confirmed they provided a 27 French catheter back to the surgeon, the inadvertent placement of the incorrect size catheter would have been avoided. One must use techniques to decrease error such as reading back an order that is given to the provider or asking clarifying questions to clearly delineate what is being asked of an individual. In this case, if the surgeon had paused to ask their colleague handing them the catheter to confirm that it was, in fact, the 27 French size they desired, the erroneous placement would have been avoided.

When physicians foster an environment in which they are open to others questioning them, this helps breakdown perceived power hierarchies between team members. The hierarchy in medicine can contribute to error because team members may not be comfortable speaking up and reporting problems in a timely fashion [4]. In the apparent cause analysis regarding this case, the team members related that there was no interplay of questions between the involved individuals, some of which may have been due to the hierarchical nature of the service that performed the procedure.

It is well known that hierarchy can be a detriment to safety culture [5]. In the past, the power gradient present between more senior leaders and direct reports have led to deadly consequences in industries outside of healthcare with one of the best-known failures was the KLM 4805 flight col-

lision in the Canary Islands in 1977 that killed 583 people in healthcare [6]. In this example, the junior pilot knew that the pilot's attempt to take off was an error but did not challenge the senior pilot due to cultural norms and deference to seniority. This silence was a contributing factor in this tragedy. Organizations that seek to employ high reliability principles in their safety work must seek to break down hierarchical power structures so that all members of an organization feel empowered to speak up and make patient safety threats known. An organization that encourages all members of the team to make safety threats known immediately can lessen the risk of events occurring and therefore lessen the chance of harm to patients.

Once an error occurs such as using the wrong size cannula in our case, it is our professional duty to disclose this to the patient and family. Many professional organizations such as the Joint Commission and the American College of Physicians endorse the practice of disclosure as a professional and ethical duty after an error occurs [7–9]. Patients and families also expect that we will be transparent and honest with them if an error occurs. It is also important to note that disclosure is a process and usually occurs over time as more information is available to help understand why an error occurred.

Before we go further in the discussion of disclosure, it is necessary to define what disclosure is. Full disclosure includes an acknowledgment that an error occurred as well as an explanation of the error and connection between the error and harm to the patient and further treatment to mitigate the error [10, 11]. Patients and families also want to know how the organization will prevent this from happening again. Of course, disclosure should be done in a way that the patient and family understand the event and its effects.

Studies have shown that barriers are still present to providing full disclosure to patients and families usually because of fear of malpractice [12]. Hospitals and health systems can offer support to physicians through their patient safety, patient advocate, and/or risk management departments to help guide physicians on how to do disclosure. Petronio et al. describe a two-step process called the Mistake Disclosure Management Plan (MDMP) for disclosure. The first step is to prepare the physician and the second step is mistake disclosure strategies. The preparation step considers the emotional impact of the error on the physician and also involves investigating the error to understand how it occurred. The mistake disclosure strategies step considers the timing of the disclosure, the people included in the disclosure, as well as the steps of disclosure including the event and an apology [12]. When an error occurs in a pediatric patient, parents determine whether or not their child should be present for the disclosure [13] (Key Points Box 7.3).

Key Points Box 7.3
Mistake Disclosure Management Plan is a two-step process for disclosure including a preparation step and a strategy step. The preparation step considers the emotional impact on the physician as well as the error investigation. The strategy step includes the timing of disclosure, people included in the disclosure, and the steps of disclosure.

Disclosing an error especially if there was harm to the patient is essentially delivering bad news such as a diagnosis of a new illness. As with delivering bad news, physicians need to prepare that patients and families may react emotionally and need time to process the information. Patients and families should be given time to process the information and the opportunity to seek clarification. This may even happen after the initial disclosure conversation has occurred. The physician should avoid blaming others or making excuses for the error as this may further erode trust in the hospital. The physician should also avoid speculating or jumping to conclusions as to why it happened especially if an investigation is still underway at the time of the initial disclosure conversation. Patients and families feel strongly that the attending physician involved in the error do the disclosure with the patient and family. This helps maintain trust in the physician and team.

Patients and families also want to know that the institution and physician take this event seriously and are committed to improving safety and preventing the error from occurring again. This may mean they want to know about specific improvements put in place to prevent a recurrence of an event for themselves and other patients [14].

Lastly, a key piece of disclosure is an apology. Patients and families appreciate an authentic apology because it is an act of empathy. As of December 2018, 39 states as well as the District of Columbia have apology laws to support medical professionals in apologizing to patients and families when something unexpected happens such as a medical error with harm. These laws help prevent saying "I'm sorry" to be used against a physician in a medical malpractice case [15, 16].

Some health systems including the University of Michigan Health System have adopted a communication-and-resolution program (CRP) to disclose unexpected patient outcomes either from complications or medical error. CRP includes disclosure and apology to the patient and family quickly while also investigating the outcome. If the investigation reveals a deviation in the standard of care, then the institution offers a financial settlement to the patient and family and makes system improvements to prevent the outcome from transpiring in the future. If the care provided was appropriate, then the institution shares the findings with the patient and family and defends the physician if litigation ensues [16].

Vignette 7.2

The members of the team realized several opportunities for improvement in the practice of ECMO cannulation and desired to perform a cause analysis. The team members performed this analysis with all team participants including the surgeon who placed the catheter and the cardiac intensivist. They determined the gaps in practice that allowed the mistake to occur. One key gap identified was the omission of the time-out process. The time-out was not completed because it is not routine to complete a time-out when not in the operating room despite the staff members all being surgical staff. This realization led to an organization-wide decision to require a time-out whenever a procedure is done, regardless of physical location. This decision was disseminated through presentations at the surgical morbidity and mortality conference, the ECMO morbidity and mortality conference, and the hospital-wide surgical quality assurance conference.

Key Points Box 7.4.

Key Points Box 7.4

Response to a patient harm or near miss event should first be to establish patient safety; second to sequester any equipment, devices, or products involved; and to begin an investigation or review of the event [17]. The purpose of an investigation is to gain an understanding of what led to the event's occurrence and to assist in determining an apparent or root cause(s). By identifying the cause, corrective and preventative actions should be set to proactively prevent the recurrence of the same or similar event.

Effective communication plays a crucial role during the investigation and interview process, and also after the root cause(s) has been identified to close the feedback loop. Lack of or insufficient communication can also be a cause of an error. In the apparent cause analysis regarding the case of the wrong size cannula placement, the interviewed team members relayed the lack of communication was part of the root cause of the event that led to a secondary procedure to replace the cannula.

Just as closed-loop communication may have prevented the error from occurring in our case, closing the communication loop, known as a feedback loop of a root cause analysis or apparent cause analysis is just as important. Communicating outcomes of an incident analysis should occur with those involved, those who reported, those that may be affected in the current state and future, and especially team members and leaders held accountable for implementing recommendations as determined in the analysis [18] (Key Points Box 7.5).

Key Points Box 7.5 When Communicating Outcomes of an Incident Analysis, Make Sure to Communicate to

1. Individuals who were involved in the event
2. Individuals who reported the event (if they were not involved in the event)
3. Individuals who may be affected by the current and future state
4. Individuals held accountable for implementing the recommendations from the analysis

Participating in an investigation after being involved in an event can be intimidating, and even frightening. Verbal communication, from the interviewer to interviewee, should explain the purpose of the investigation, not assign blame and clearly communicate that the interview is being conducted to identify system issues or vulnerabilities [17]. Effective communication techniques of the interviewer include active listening, open questioning, and paraphrasing to verify what was heard (Key Points Box 7.6).

Key Points Box 7.6 Interviewer Techniques for Effective Communication Include the Following

1. Active listening.
2. Open questioning
3. Paraphrasing to verify what was heard

Information collected during the interview process is assembled as a visual tool – examples include process mapping and cause and effect or fishbone diagram – used to communicate the event flow and contributing factors, and used to highlight gaps or opportunities for improvement. Clear and concise delegation of action items to responsible parties can be considered part of the feedback loop after an event.

All patient safety issues may not lead to a full investigation and analysis process. Incidents submitted through electronic reporting or paper methods also require feedback loop communication. For example, if actions resulting from submitted incident reports were shared with the original submitters, they would gain a better understanding of the potential benefits to future patients and the health system of increased and timely event reporting. They would also see that these benefits outweigh the challenges of report entry and the associated risks. The timely reporting and resolution of problems is integral to journey to high reliability which is discussed in other chapters of this text [19].

Vignette 7.3

The safety event classification team reviewed this case at a regularly scheduled meeting. The ECMO and perioperative team involved presented their report on the event and made recommendations for practice improvements to ensure this type of error would not happen in the future. These recommendations were publicized throughout the organization. Appropriate reports were made to the state as this case involved an improper implant which requires reporting in this hospital's state.

The importance of communicating medical errors throughout the organization cannot be underestimated. According to the Lucian Leape Institute, established by the National Patient Safety Foundation, transparency is the "most important single attribute of a culture of safety"

[20]. Healthcare organizations with strong safety cultures are transparent in the sharing of medical errors because they aim to prevent future events. In the absence of transparency, distrust and hostility permeate the organization [20]. The landmark publication *To Err Is Human* shed light on medical errors by highlighting that the majority of errors do not result from individual negligence but rather are caused by broken systems that inadvertently set caregivers up to make mistakes [21]. Healthcare leaders must encourage and reward frontline team members for reporting near misses to identify possible broken systems. Early reporting helps prevent future errors which may have devastating effects on patients especially if the error reaches the patient and causes irreversible harm [22]. As healthcare leaders have increased their knowledge around medical error causation, organizations have begun encouraging caregivers to share events to identify necessary system and process improvements [21].

Healthcare leaders must appreciate that organizations often sustain collective harm in self-esteem and confidence following significant medical errors [23]. Witnessing or hearing about medical errors reminds us of our own fallibility and the delicate nature of the procedures and treatments we routinely perform on patients every day. Caregivers must feel safe in their environment to openly discuss medical errors, and they must believe they will be treated fairly for disclosing mistakes [24]. Healthcare leaders contribute to building this environment and earning caregiver trust by compassionately communicating medical errors and supporting those involved. The transparent communication of medical errors is essential to promote healing and performance improvement throughout the organization [23].

When preparing to communicate a medical error throughout the organization, it is vital to consider who will be communicating the message, what will be communicated, and how it will be communicated. Individuals involved in the medical error communication should know the event well and understand the key learnings. The individuals should communicate the medical error in a sincere, compassionate, factual manner. Individuals must reliably communicate the event to build trust and collegiality among team members. Individuals should not invoke their personal opinions or judgments into the report. Ideally, the individual or team communicating the medical error should also understand systems failures to prevent delivering a message of blame and shame. The team communicating the medical error should partner with the hospital or department leadership, quality and safety leadership, as well as risk management and/or the legal team, to provide input into the message. Often, quality and safety leaders communicate medical errors at various councils throughout the organization and are very effective at doing so. However, leaders should not miss the opportunity to allow those involved in the medical error to participate in communicating the event if they wish because doing so keeps them a part of the learning and reduces their feelings of isolation [24]. Team members involved in events often grieve and need to be included in the solution. By involving the affected team members when sharing an event, those involved understand the process better and often find support from their colleagues. This may be critical to keep them engaged in their profession and prevent them from leaving healthcare (Key Points Box 7.7).

Key Points Box 7.7 Event Communication
When communicating an event, ensure that those involved with the event – hospital and department leadership, quality and safety leadership, as well as risk management and/or the legal team – provide input into how to communicate the event and follow up.

The National Patient Safety Foundation advises medical errors should be communicated with the goal of improving care [24]. Therefore, individuals must consider the appropriate places to share the medical error, the purpose of sharing the medical error, and how much detail is needed to effectively communicate. For example, significant medical errors should be communicated to the healthcare organization's executive leadership team and quality board because they are

responsible for prioritizing transparency, safety, and continuous improvement [24]; in the quality improvement parlance, this is referred to as "spread." This can be accomplished by showing pictures or taking them to the clinical space where the event occurred to show them how it could happen. This can be a very powerful experience for leaders and board members. In general, communication at this level involves a general overview of the error, contributing factors, and strategies to prevent the medical error in the future. It is also important to assess the clinical knowledge base of those on the executive team or board when you are communicating. When the ECMO case was presented to the quality board, board members immediately questioned why two different sizes of ECMO cannulas were even available in this situation. From their viewpoint, having only one size catheter available would be an easy fix. However, the clinical leader presenting the case was able to paint a picture to the board of what it looked like to connect a patient to ECMO and how complicated the procedure was. The clinical leader was able to explain how not having both sizes available would be detrimental to the patient if the team had to run throughout the hospital to find another size and how it is not a rare occurrence to need a different size. The board understood the complexity of the situation following the explanation and gained a better understanding of why time-out procedures are critical and need to be hardwired outside of the operating room (Key Points Box 7.8).

Key Points Box 7.8 Spread the Message
Individuals must consider the appropriate places to share the medical error, the purpose of sharing the medical error, and how much detail is needed to effectively communicate.

Medical errors should also be shared with frontline caregivers to promote vigilance and identify system and process improvements [23]. Hospital quality councils or morbidity and mortality conferences often serve as the venues for medical error communication. Some organizations have scheduled quarterly or monthly sharing of events to ensure the learnings are spread. Individuals sharing the case in these venues often provide more detail around the event including a synopsis of the patient's clinical presentation, happenings leading up to the event, the event itself, the patient outcome, causative factors, suggested mitigation strategies, and how the event impacted the clinical team. Caregivers directly involved in the event should be made aware that the case will be discussed in the venue. When medical errors occur, caregivers often lose confidence in themselves and still feel accountable even if the case is treated and discussed from a systems perspective [25]. These caregivers have been referred to as second victims and often experience significant emotional turmoil after the event and need support from their colleagues [26, 27]. Therefore, involved caregivers should be included in the communication process, and their concerns should be addressed before releasing the event information. Not doing so will compromise transparency efforts [21]. Moreover, most caregivers involved in medical errors want to contribute to future prevention efforts, so it is worth the extra effort to ensure they are treated with compassion and respect throughout the communication process [23, 25] (Key Points Box 7.9).

Key Points Box 7.9 Second Victims
Caregivers who were directly involved in the event often lose confidence in themselves and still feel accountable even if the case is treated and discussed from a systems perspective [25]. They often experience significant emotional turmoil after the event and need support from their colleagues.

Event sharing in these venues often leads to a robust discussion about the event and potential system fixes, so these conversations need to be facilitated by informed, well-prepared individuals identified in advance. In today's environment, these discussions are often very supportive and

even therapeutic, but the facilitator must be prepared to address and discourage any comments that are hurtful or discouraging to the caregivers involved. The facilitator's primary focus during these discussions should be to maintain a safe environment for everyone to discuss the medical error; not doing so will quickly erode the trust of the caregivers [23]. Healthcare leaders should keep in mind these discussions are critical to identify future medical error mitigation strategies and to promote a safe culture, but the discussions will only be effective if caregivers feel comfortable discussing cases. When the ECMO event was discussed in the hospital quality council, the clinical team involved in the event presented the case and were relieved to find themselves surrounded with support from their colleagues. The council also agreed to support hardwiring the time-out process throughout the hospital following the discussion of the event.

Quality and safety leaders should also report medical errors to their patient safety organizations (PSOs) if they are involved in one. There is power in reporting significant medical errors to the PSO because the data is compiled and analyzed with other like organizations and trends are often identified that would not have been identified at the individual facility level. The Patient Safety and Quality Improvement Act of 2005 (Public Law 109-41) has enabled the creation of PSOs and provides federal legal protection to information reported to a PSO for the purpose of improving patient safety [28]. The event investigation information gathered and reported to the PSO is called "patient safety work product (PSWP)" [28]. It is important for quality and safety leaders to understand this protection to address any concerns their organization has with sharing this important information with the PSO; of course, we suggest this be done in collaboration and with engagement from your organization's risk management team (Key Points Box 7.10).

Key Points Box 7.10
Caregivers often appreciate knowing their organization shares safety events with other organizations to prevent harm beyond their walls.

Communication is woven throughout healthcare delivery and is critical to ensuring the highest quality and safest care. As illustrated by the case vignette, breakdowns in communication can lead to unintended outcomes and preventable harm. However, communication must be leveraged to help patients, families, and team members recover after the event and be used to help prevent future events. Strong communication only enhances quality improvement and patient safety efforts to make systems safer and more reliable. The communication of medical errors is critically important in promoting a culture of safety. Healthcare leaders should not underestimate the power of transparency in preventing future harm.

Editors' Comments
The prior chapter helped the reader understand how to respond when an event occurs; this chapter builds on the prior chapter by going deep on the topic of communication and disclosure after an event. A key phrase by the authors in Chap. 7 is "bidirectional communication" – by understanding and communicating with front line and families and subsequently listening to them, trust can be built and lead to a successful resolution.

The authors cite the commonly known literature that attributes communication breakdowns to harm. This is perhaps one of the key learnings of the chapter and one that the editors of the textbook have seen time and time again in their institutions and when reviewing events that have transpired in other organizations. As the authors astutely point out, there are myriad forms of communication and breakdowns that can occur. The corollary is that there are many opportunities for communication to help and ameliorate an issue – the chapter highlights several of these (e.g., time-out).

A significant portion of this chapter explains the importance of disclosure and how to properly communicate such. It is not as simple as saying "sorry." The authors explain the role of a Mistake Disclosure

Management Plan which is an excellent resource that organizations should consider having ready to use when necessary.

The chapter also provides a primer on how to communicate through an organization regarding an event that has occurred. In our institutions, we inform the entire hospital as well as the board when a significant error or similar instance occurs. The authors nicely take the reader through steps that need to be considered when reporting through an organization and beyond as well as to when report.

As we have seen in other chapters, the authors do again discuss the importance of communication with regard to those affected or involved with the error, issue, etc. As organizations continue to advance their culture toward high reliability, we must always be aware of those involved with the issue.

Chapter Review Questions

1. Effective communication/interview techniques during an event review include:
   A. Active listening
   B. Using open-ended questions
   C. Paraphrasing what was heard
   D. All of the above

   Answer: D. Explanation: Verbal communication, from the interviewer to interviewee, should explain the purpose of the investigation, not assign blame and clearly communicate that the interview is being conducted to identify system issues or vulnerabilities [17]. Effective communication techniques of the interviewer include active listening, open questioning, and paraphrasing to verify what was heard.
2. Closed-loop communication should be used to:
   A. Reduce misunderstandings.
   B. Keep the conversation between two individuals.
   C. Reduce unnecessary dialogue.
   D. Convey "you" statements.

   Answer: A. Explanation: Closed-loop communication is used to clearly communicate information and should explain the purpose of an event, reduce misunderstandings, and can occur in a team setting. It should be non-judgmental as well.
3. Full disclosure of an error includes the following except:
   A. Acknowledgment that an error occurred
   B. Explanation of the error and harm it caused
   C. Blaming the person who committed the error
   D. Treatment plan if harm occurred

   Answer: C. Explanation: Full disclosure includes an acknowledgment that an error occurred as well as an explanation of the error and connection between the error and harm to the patient and further treatment to mitigate the error. Blaming the individual who committed the error is not productive and not part of the full disclosure process.
4. Response to patient harm involves which of the following:
   A. Establish patient safety.
   B. Sequester any equipment, devices, or products involved.
   C. Begin an investigation or review of the event.
   D. All of the above.

   Answer: D. Explanation: Response to a patient harm or near miss event should first be to establish patient safety; second to sequester any equipment, devices, or products involved; and to begin an investigation or review of the event. The purpose of an investigation is to gain an understanding of what led to the event's occurrence and to assist in determining an apparent or root cause(s).
5. Significant medical errors leading to harm should be shared with all of the following:
   A. Patient involved.
   B. Frontline staff
   C. Executive leadership
   D. Board of directors
   E. Patient safety organization
   F. All of the above

Answer: F. Explanation: Significant medical errors leading to harm should be communicated with all of the above parties to ensure that the patient receives the appropriate treatment in response to the error and to prevent the error from happening again in the institution as well as other institutions.

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