	The Johns Hopkins Hospital **Interdisciplinary Clinical Practice Manual** **Patient Care**	*Policy Number*	PAT026
		Effective Date	04/01/2009
		Approval Date	03/30/2009
	Subject **Medical Error Disclosure**	*Page*	1of 4
		Supercedes	01/21/2005

Keywords: medical error, systems, error

Table of Contents		Page Number
I.	**OBJECTIVES**	**1**
II.	**INDICATIONS FOR USE**	**1**
III.	**DEFINITIONS**	**1**
IV.	**PROCEDURE AND RESPONSIBILITIES**	**1**
V.	**SUPPORTIVE INFORMATION**	**3**

I. OBJECTIVES

The Johns Hopkins Hospital (JHH) strives for safety in patient care, teaching and research.

II. INDICATIONS FOR USE

A. All health care professionals and trainees have an obligation to report medical errors as a means to improve patient care delivery and to help promote safety and quality in patient care.

B. Since the majority of medical errors can be linked to environmental and systems-related issues that may affect the actions of health professionals, a systems improvement focus will be used in all error analysis.

C. Prompt reporting of a medical error in good faith will not result in punitive action by the hospital against the involved individual(s) except as mandated by law or regulatory requirements. The principles concerning nonpunitive reporting do not eliminate the hospital's obligations to conduct ongoing and periodic performance review, where repeated errors or other issues may lead to personnel action.

D. It is the right of the patient to receive information about clinically relevant medical errors. The JHH has an obligation to disclose information regarding these errors to the patient in a prompt, clear and honest manner. This is consistent with The Johns Hopkins Hospital Code of Ethics.

III. DEFINITIONS

Medical Error	An act or omission with potential or actual negative consequences for a patient that, based on standard of care, is considered to be an incorrect course of action.
Systems	A system is a set of interdependent elements interacting to achieve a common aim. The elements may be both human and non-human (equipment, technologies, etc.)

IV. PROCEDURE AND RESPONSIBILITIES

A. Errors that should be disclosed to the patient or patient's surrogate include those that result in:

1. life-threatening consequences, serious morbidity or death,
2. increased length of hospitalization,
3. initiation of unordered procedure or operation,
4. increased risk of morbidity or mortality related to future medical treatment,

5. significant increase in level of care,
6. significant additional diagnostic testing (invasive or noninvasive),
7. significant therapeutic intervention or significant change in existing therapy,
8. significant unordered test, medication or therapy.

If the attending physician or nurse manager is uncertain as to whether a particular error is "significant", advice may be sought from the Legal Office.

B. Legal Department notification
1. When an error meeting the above criteria is discovered, the Attending Physician, or designee, shall contact the Legal Department with details of the incident within twenty-four hours.

C. Formulation of the error disclosure plan:
1. Upon discovery of an error that should be disclosed to a patient or the patient's surrogate (see above criteria), the Attending Physician and Nurse Manager/designee shall be notified as soon as possible.
2. Under the direction of the Attending Physician and/or Nurse Manager/designee, details of the error shall be reviewed to plan the disclosure to the patient or patient's surrogate.
3. A cohesive, respectful and honest explanation for the patient or surrogate should be formulated.

D. Conflict resolution
1. Any conflict arising among health care team members regarding the content of the planned discussion with the patient should be resolved before the discussion is conducted. Assistance in resolving conflicts can be sought from the Ethics Committee or the hospital Risk Management Department.

E. Components of the conversation shall include:
1. An apology for the error and any associated harm.
2. If appropriate, acceptance of responsibility for the error on behalf of the health care team and the hospital.
3. A statement that an error occurred and a description of the known or expected consequences of the error, including immediate or long-term effects (if any).
4. A brief discussion of how the error occurred (if known).
5. Information regarding any tests, procedures, therapies, change in level of monitoring, or change in level of care that may be necessary as a result of the error.
6. Assurance that the factors that resulted in the error will be investigated and that steps will be taken to reduce the likelihood of similar errors.
7. Answers to patient's questions.
8. An offer to obtain help and support from appropriate health care workers (e.g., social worker, patient representative, clergy) should be made.

F. The conversation shall not:
1. Name any persons involved in the error.
2. Blame any persons or teams involved in the error.
3. Criticize the actions of any persons or teams involved in the error.

G. The Attending Physician and Nurse Manager/designee will determine the specific member(s) of the health care team that shall be designated to disclose the error to the patient or patient's surrogate.

1. It can be helpful to have more than one health care team member present during the conversation; however, care should be taken that the patient or surrogate not feel "outnumbered" by the health care team.
2. At least one of the health care team members present during the error disclosure shall have adequate expertise to conduct and/or oversee the conversation.
3. If there is concern that the team does not possess adequate expertise, consultation should be sought with departmental resources, the Ethics Committee or Risk Management Department.
4. If the relationship between Attending Physician and patient/patient surrogate limits effective communication, Attending Physician should consult with supervising Physician to identify an alternative representative.
5. At the discretion of the Attending Physician and/or Nurse Manager/designee, an involved member of the team without experience in error disclosure may be permitted to make the disclosure. The Attending and/ or Nurse Manager/designee must be present and is obligated to provide support or clarification during the conversation and to provide feedback afterwards.

H. Timing of error disclosure
   1. Disclosure of the medical error should occur as soon as possible after the error has been identified.
   2. Disclosure to the patient should occur when the patient is stable and/or able to comprehend the information.
   3. Disclosure to the patient's surrogate may occur before disclosure to the patient, as appropriate.
   4. Initial disclosure is the beginning of an ongoing dialogue. Discussion related to the error may need to take place over time in a series of conversations.

I. Discussion of the error with the patient or patient's surrogate
   1. The conversation should be conducted in a private location. The tone should be clear, honest, and understandable to the patient, and not defensive.
   2. Any questions regarding compensation for incurred cost related to the event should be referred to the Risk Management Department.

J. Documentation of discussion
   1. The person conducting the conversation shall document the conversation with the patient or surrogate in the progress notes section of the patient's medical chart.

K. Recognize the traumatic effect of medical error on the involved care team members.
   1. If performance of any members of the team is negatively affected by involvement in the error, discuss with supervisor.
   2. Help is available through resources such as Faculty and Staff Assistance Program (FASAP).

V. SUPPORTIVE INFORMATION

Communication & Education:

This policy will be communicated to the appropriate JHH personnel via the following channels:

1. Discussion at Medical Staff Risk Management seminars.
2. Nurse Managers, Physician Advisors, Residency Coordinators, Department Chiefs and Department Management will be responsible to train new employees regarding the policy as appropriate, and to communicate updates to the protocol.
3. Updates and revisions will be communicated via Medical Staff and Nursing publications.
4. This policy will be placed in the Interdisciplinary Clinical Practice Manual on the JHH Intranet site http://www.insidehopkinsmedicine.org/icpm. Paper distributions will be made to the Functional Unit Nursing offices in the event of web access difficulty.

Sponsor:

Patient Safety Committee

Developer:

Patient Safety Committee

Review Cycle - Three (3) years **Medical Board -** Approval Date: 3/30/09; Effective Date: 4/1/09

Vice President for Nursing & Patient Services **Vice President for Medical Affairs**

_____ _____

Date: **Date:**