Risk Control Checklist: The Four Rs Of Medical Error Disclosure

The following risk control checklist is designed to help healthcare business owners gauge their compliance with risk management recommendations in the area of medical error disclosure. For additional risk control tools and information, visit the websites of CNA, NSO and HPSO.

RECOMMENDATIONS	YES/NO	COMMENT/ACTIONS PLAN
REPORTING		
The event involved one or more of the following:		
- Actual harm to the patient.		
- Potential clinical significance.		
- An unexpected safety crisis.		
- An outcome differing from anticipated results.		
The event was reported to a manager or business owner per policy requirements.		
A rapid analysis of the sequence of events is conducted and includes critical information in order to:		
- Explain current known facts to the patient/family in a timely manner.		
- Comment on clinical implications of the event.		
- Apologize for the unexpected nature of the event.		
- Commit to a comprehensive investigation.		
REACHING OUT		
A spokesperson is appointed who:		
- Demonstrates organizational accountability.		
- Acknowledges a possible link between actions and outcome.		
- Prioritizes the patient's care needs.		
- Outlines follow-up actions.		
- Commits to serving the patient's healthcare needs.		
- Avoids assigning blame or becoming defensive.		
A meeting is set up between the spokesperson and the patient, family and/or legal representative to:		
- Report that something unexpected has occurred.		
- Explain the nature and clinical implications of the event.		
- Describe the actions already taken.		
- Acknowledge the patient's/family's feelings.		
- Offer a sincere "I'm sorry" for the situation.		
- Promise a swift and thorough investigation.		
- Suspend charges and expenses.		

RECOMMENDATIONS	YES/NO	COMMENT/ACTIONS PLAN
REVIEW		
Personnel are appointed to:		
- Conduct a root cause analysis to identify major factors that triggered the even, as well as any latent errors.		
- Utilize peer review, quality improvement, risk management and safety experts to:		
– Understand the event and prior actions fully.		
– Verify whether the patient's condition was adversely affected by the event.		
– Determine whether the care provided was reasonable.		
– Evaluate the post-event response.		
– Identify opportunities for improvement.		
RESOLUTION		
A formal meeting is scheduled (following the investigation) with the patient, family and/or legal representative.		
All pertinent findings are imparted at the meeting, including:		
- Proximate cause of the event.		
- Known consequences of the event.		
- System issues that contributed to the mishap.		
- Steps taken to prevent recurrence, including changes in procedures, resource allocation and monitoring.		
- Parties informed of the event, such as regulatory agencies, accrediting organizations and external review bodies.		
Redress is offered for injuries suffered as a result of substandard care, as well as a copy of the patient healthcare information record (if requested).		
A written account of the meeting is prepared, including:		
- Who was present at the disclosure meeting?		
- What was discussed by the participants?		
- What was promised by the spokesperson?		
- What questions were asked and answered?		

Apologizing Dos and Don'ts

DO ...	DON'T ...
1. Think about and discuss with others what went wrong and what could have been done better before composing the apology.	1. Engage in blame-shifting, defensiveness or evasion.
2. Schedule a face-to-face apology whenever possible.	2. Add insult to injury by communicating primarily via voice mail or e-mail.
3. Ensure that the apology includes all significant information.	3. Discuss issues of marginal relevance to the patient.
4. Focus on the established facts and analysis.	4. Speculate beyond what is known to be true.
5. Write out key points before meeting with the patient and/or family.	5. Rush to the bedside and become over-emotional or lose control.
6. Consider the spokesperson's manner and strengths when composing an apology and disclosure statement.	6. Underestimate the importance of non-verbal communication (e.g., tone of voice, expression and posture) in expressing sympathy and candor.
7. Convey deep sympathy for the patient and an awareness of the effects of the event.	7. Seek sympathy for oneself or otherwise shift the focus away from the patient's plight.
8. Use everyday language that conveys both thoughts and emotions.	8. Utilize medical jargon that may confuse, intimidate or irritate the patient.
9. Acknowledge all known consequences of the event, including emotional, familial and monetary impact, as well as the potential effect on the physician-patient relationship.	9. Treat the issue as minor simply because the patient has not suffered a life-threatening injury.
10. Give the patient and family time to consider and respond to the apology.	10. Demand a quick response or ask the patient or family for forgiveness.

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