CHRISTUS SANTA ROSA Health Care	PRIMARY FUNCTION: MEDICAL STAFF	POLICY: CO-AD-02-10
	EFFECTIVE DATE: 07/2002	PAGE 1 OF 3
LAST REVIEW DATE: 07/2002	REVISION DATE: 11/2011	
SUBJECT: DISCLOSURE OF MEDICAL ERRORS		

PURPOSE

To define policies and procedures related to disclosure of medical errors to patients and, when appropriate, their families.

POLICY

1. Patients and, when appropriate, their families have a right to be informed about outcomes of care including unanticipated outcomes related to a Significant Medical Error.
2. The patient's attending practitioner or designee (Attending Practitioner) has the responsibility to clearly explain the outcomes of any treatment or procedure to the patient and/or family whenever those outcomes differ from the anticipated outcome secondary to a Significant Medical Error.

DEFINITIONS AND EXAMPLES

1. Medical Error – An unintentional act either or omission or commission. An error occurs when either a correct action is not executed properly or an incorrect action is executed.
2. Significant Medical Error – A significant medical error is a Medical Error which causes a clinically significant, unanticipated adverse outcome resulting in a substantive change or modification of the patient's orders or treatment plan.
3. Examples of clinically significant, unanticipated adverse outcomes include but are not limited to:

    a) Death
    b) Permanent disability or permanent functional impairment
    c) Second-degree burns
    d) Loss of consciousness
    e) Falls resulting in injury
    f) Stage III or Stage IV decubitus
    g) Pulmonary edema
    h) Surgery on the wrong body part
    i) Need for unanticipated surgical procedure
    j) Hemolytic reaction to blood

PROCEDURES

1. If a Significant Medical Error has been identified by the Attending Practitioner, another practitioner, or an associate, The identifying person shall contact the hospital Risk Manager who will arrange a meeting as soon as possible with the Attending Practitioner, the appropriate department chairperson or designee, and the appropriate Vice President or designee.

2. In coordination the Attending Practitioner, the department chairperson or designee, and Chief Executive Officer or designee will discuss the event and determine if a Significant Medical Error has occurred.

   a) If it has been determined that a Significant Medical Error has occurred, it will be the responsibility of the Attending Practitioner to discuss the Significant Medical Error with the patient and/or the patient's family.
   b) If it has been determined that a Significant Medical Error has occurred, the Attending Practitioner, department chairperson or designee, and the Chief Executive Officer or designee will determine what other hospital personnel shall be involved in the Significant Medical Error disclosure discussions with the patient and the patient's family. For example, the patient's nurse or pharmacist could also be present to help answer questions and reassure the patient. The hospital representative chosen would depend on the nature of the Significant Medical Error and the unanticipated outcome and may include other Medical Staff members or administrative personnel.
   c) If the Significant Medical Error is associated with an event meeting the organization's definition of a sentinel event, then the Sentinel Event Policy shall also be followed.

3. When a Significant Medical Error is disclosed to and discussed with the patient and/or patient's family, the Attending Practitioner shall:

   a) Be prepared to answer all reasonable questions the patient and/or family may have about the error.
   b) Involve at least one other hospital representative, as appropriate, and as identified above in the Significant Medical Error disclosure.
   c) Schedule additional follow-up meetings, discussions, or clinical evaluation of the patient as indicated by the nature of the Significant Medical Error.

4. At a minimum, the error disclosure discussion should include information regarding:

   a) The nature of the error which occurred.
   b) Any implications the error has or will have on the patient's care and on the patient's short- and long-term health status.
   c) Point of contact for further questions and/or any necessary follow-up.

5. After notification, the Attending Practitioner must:

   a) Make an entry in the medical record regarding the specific error disclosure and notification which was given to the patient and/or family. The entry in the medical record will also list any family members and/or hospital representatives who were present for the discussion. The entry in the medical record must be dated.

   b) Notify the hospital Risk Manager that the Significant Medical Error disclosure has

occurred.

6. The patient and/or family members should not be asked to sign or attest to any document that purports to limit their rights to pursue further action up to and including legal grievance.

7. Notification of a Significant Medical Error should be performed with empathy and compassion and should provide full disclosure and assumption of appropriate responsibility. Care should be taken to ensure that the hospital staff members involved with the event and/or notification do not intimidate the patient and/or family member.

8. If a potential Significant Medical Error has been identified by a hospital staff member and the patient's Attending Practitioner does not agree that a Significant Medical Error has occurred or does not want the patient and/or family to be notified of the potential Significant Medical Error which has occurred, the hospital staff member identifying the potential Significant Medical Error should follow the hospital "chain of command" policy regarding reporting of the event.

REFERENCES/REGULATIONS/REQUIREMENTS:

1. TJC Hospital Accreditation Standards, Revision 2012

Initial Approval Date: M Committee of the Board July 2002
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APPROVED BY

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