DISCLOSURE AND REPORTING OF MEDICATION INCIDENTS

KEY LEARNING POINTS

A 5-step approach to prepare & deliver the disclosure to the patient or family
- Patient-oriented
- Case-by-case basis

B Providing support for "The Second Victim"

C Identify immediate or underlying causes

D Error prevention principles

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Wu AW, Steckelberg RC. Medical error, incident investigation and the second victim: doing better but feeling worse? BMJ Qual Saf 2012;21:267-270.

PREPARING/DELIVERING THE DISCLOSURE TO THE PATIENT OR FAMILY

5 STEPS:

01 Is disclosure of a medication incident appropriate or necessary?
Will disclosure yield meaningful benefits for the patient/healthcare professionals?

02 Preparing the disclosure
Discussion between all relevant healthcare providers.

03 Disclosure
Explain events using clear and patient-friendly terminology.

04 Apology
Offer an apology that communicates genuine sincerity regarding the incident.

05 Continued Feedback
Discuss future steps to avoid similar events from occurring in the future.

Disclosure Working Group. Canadian disclosure guidelines: being open and honest with patients and families. Edmonton, AB: Canadian Patient Safety Institute; 2011.
Ho C, Kawano A. How to handle a medication error. TECH talk CE 2013;May:1-7. Available from: http://www.tevapharmacysolutions.com/sites/default/files/May%202013%20Tech%20Talk%20CE%20ENG.pdf

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ERROR PREVENTION PRINCIPLES

WHEN HARM OCCURS IN A MEDICATION INCIDENT, IT IS IMPORTANT FOR PATIENTS TO KNOW:

The facts

What happened?

E.g. Novolin®ge 30/70 was dispensed instead of NovoRapid®Penfill.

Possible causes

Why did it happen?

E.g. Workload & Interruptions, look/sound-alike drug names.

That the healthcare providers are sorry for what happened

The apology.

E.g. "At this time, I just wanted to say we're very sorry about this situation..."

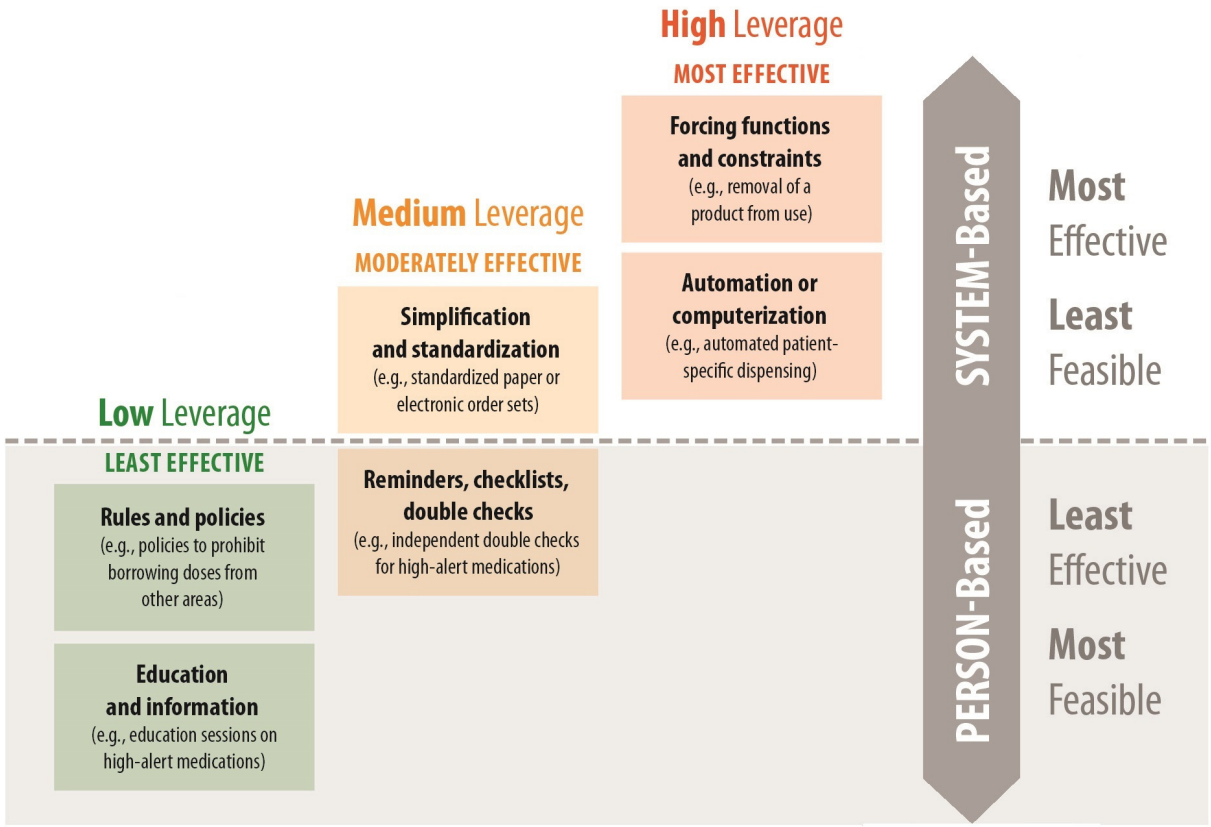
The steps that will be taken to prevent similar incidents in the future

What can be done to prevent incidents from happening again?

E.g. Move products away from each other in the fridge, post a list of commonly confused drugs at each workstation.

Grissinger M. Medication error-prevention "toolbox". P&T. 2003; 28(5):298. Available from: https://ptcommunity.com/system/files/pdf/ptj2805298_1.pdf

HIERARCHY OF EFFECTIVENESS



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