**PGY1 Scenarios – Patient Safety – Faculty Key**

Show to entire group in orientation (or send as pre-work):

<https://www.coursera.org/learn/patient-safety-systems-view/lecture/H5Fb4/swiss-cheese-model>

Give resident copy of this scenario to read:

*Resident is a member of the clinical investigation team reviewing the recent patient care incident below:*

**Scenario One:**

**Mr. Stevens**, a 76 year old male, is hospitalized after a fall. Marcy is the resident managing his care. After receiving medication, he exhibits signs of increasing respiratory distress. A code is called. After being resuscitated, Mr. Stevens is transferred to the ICU and placed on a ventilator. After receiving treatment, he improves and returns to the floor in stable condition.

**Marcy** is a first year resident. She has young children at home, one of whom has been sick for the past 3 days. Marcy is on Night Float (not having done inpatient Medicine yet), which is very busy. **Scott** is the senior resident who is supervising Marcy and checking in with her regularly, but he is quite busy too. **Brad** is the attending on call as a back-up, who is also very busy. Marcy receives Mr. Stevens as her patient at 2 am. He fell at home and was accompanied by **his partner** to the hospital. He is admitted for a work-up to determine the cause of his fall and to assess his current condition. Marcy is learning the newly implemented **electronic medical record** and managing multiple patient situations in addition to Mr. Stevens. A medication that Mr. Stevens was on at home was not available, so he is changed to a similar formulation of the combination medication, and given a higher dose based on abnormal **lab** findings. Marcy ordered the medication, the **pharmacy** delivered it, and the **nurse** administered it. Within 5 minutes, Mr. Stevens begins to exhibit respiratory distress, and his partner runs to signal the nurse about the change in his condition. A code is called. After being resuscitated, Mr. Stevens is transferred to the ICU and placed on a ventilator. It is discovered he is allergic to one of the ingredients in the substitute medication. After treating his reaction, he rapidly improves and is transferred back to the floor within

6 hours in stable condition.

**Questions for resident:**

1. As a member of the team investigating this incident, what potential contributing factors do you identify by role?
2. What questions do you have/further information you want about the situation and from whom?
3. This is an example of the model described in the video.

What is it called? Swiss Cheese Model. Please summarize the model.

1. What are the *active* errors in operation in this scenario? (use of the wrong medication substitution)
2. Define a *latent* error (condition that has not yet caused harm); give an example of it in this scenario (pt having an allergy)
3. What strategies might help prevent a similar scenario?
4. How would you address Marcy’s fatigue if you were on her team? What resources are available? How would you balance her well-being with the needs of the team and patient care?
5. Discuss “Just Culture” approach to errors at systems level, not assigning individual “blame”

*Marcy* – early in her training, potentially fatigued due to off shift (nights) and ill child, new EMR, very busy. Discussed med with senior/attending? Identified being fatigued?

*Scott - Senior resident* – checking Marcy’s orders? Providing appropriate level of supervision?

*Brad - Hospitalist Attending* – overly busy, adequate review of learner’s orders? Matching level of patient complexity with learner’s level of competence?

*Partner* – did anyone speak with patient or partner about allergies, etc.? Was allergy clearly documented in chart?

*Pharmacist* – overlooked allergy to ingredient in formulation, did not advise physician or nurse – understaffed at night, new EMR

*Nurse* – checked allergies on chart before administering med? Spoke with pt’s partner?

*Lab* – was abnormal lab finding accurate?

*Medical record* – new EMR product to team, allergy documentation?, not clear where to find important information, medication safeguard feature was not completely enabled, no access to pt’s outpatient record regarding medication list, reason for change in formulation documented?

Give resident copy of this scenario to read:

**Scenario Two:**

In clinic, the resident is seeing two patients with similar names (*same pronunciation*) on the same day:

Mrs. **Smith** - A and Mrs. **Smythe** – B, both women in their 50’s in reasonably good health.

Due to their birthdates, the resident orders a Hepatitis C screen on both (per guidelines) in addition to addressing patient’s issues.

Mrs. Smith is not worried, sees it as a routine screening, and has no questions.

Mrs. Smythe is very nervous about it, has lots of questions, and fears having a positive test.

Mrs. Smith’s test (A) comes back ***negative*** and Mrs. Smythe’s test (B) is ***positive***.

By mistake, the resident calls Mrs. Smith (A) and tells her the test is *positive* and she needs to come in for further testing. He/she asks the MA to send a “normal lab” letter to Mrs. Smythe (B), the worried patient.

A week later, Mrs. Smith’s follow up visit is on the resident’s schedule. When reviewing her chart before clinic, the resident sees that her Hep C test was actually *negative*! Being clever, the resident, remembers he/she also saw another patient recently with a similar name and for whom he/she also ordered the Hep C screen.

The resident reviews Mrs. Smythe’s chart and discovers that her test was *positive* but she was sent a “normal lab” letter.

**Questions for resident:**

1. What are you thinking at this point?
2. What is your plan to manage this situation?
3. How would you approach both patients in the initial visit and after discovery? (*give tip sheet*)
4. Would you report the error to anyone? If yes, whom?

Possibilities: Physician Pod leader/clinic advisor, clinical medical director and manager,

practice manager, Risk Management?

Have you completed an iCare? If no, describe how you would access one if needed.

1. What strengths do you bring to this situation, and what might be challenging for you?
2. What strategies could you use to prevent this from happening again? Is there a role for mindfulness in this situation?
3. What could you do proactively - discuss having patients come for follow-up visit regardless of test results, proactively discuss concerns in initial visit/relationship building
4. Have you made any errors that you are aware of since beginning residency?

If yes, what were your thoughts and emotions? What is your mental model about errors?

1. Do you feel comfortable with your skill level with error disclosure? If no, how can we help?
2. Describe how you might care for yourself after an error - can you be compassionate to yourself?
3. What resources would help you manage the impact of this situation on you?

*Patient Safety Milestones*

SBP 2 L1B – Understands that effective team-based care plays a role in patient safety

SBP 2 L2A – Recognizes medical errors when they occur, including those that do not have

adverse outcomes

SBP 2 L2B – Understands the mechanisms that cause medical errors

Prof 2 L2B – Has insight into his or her own behavior and likely triggers for professionalism lapses, and is able to use this information to be professional

Prof 2 Identifies appropriate channels to report unprofessional behavior