

- Lack of ability to engage parents during rounds (as they were absent) likely contributed to the error occurring/not being discovered sooner

3.1 Explain role within the team

- Team members understood their roles

3.2 Delegation/support/supervision of team members

- Role of ordering wean was delegated appropriately to the pharmacist. The support provided with co-signing was inadequate – the adequate double-check did not occur by the resident, staff physician or charge nurse

3.4 Ask for support when needed

- The pharmacist could have asked for assistance as was ill (not written the order)

3.5 Encourage team members to speak up, question, challenge

- The first 2 bedside nurses caring for the child did not question why a higher dose of morphine was ordered

3.6 Demonstrate leadership when appropriate

- Attending physician lead the disclosure process and team debriefing process

4.2 4.4 and 4.5 Prevent conflicts/Respect misunderstandings/learn from experience as a team

- This situation can place a team at risk for conflict. This was diffused by debriefing the team in an open environment, using the circumstance as an opportunity to learn. Almost every team member propagated this error.

Other Domains Discussed:

Domain 3: Communication

Domain 6: Disclosure of adverse events

- Morning nurse noted higher dose and brought to physicians attention

Issues: New set of fresh eyes! Excellent observation, communication, team work (human/environmental factors, team work)

- Staff physician critically evaluated patient to assess for adverse effects, and adjusted dose, then disclosed the event to the family

Issues: Disclosure of Adverse Events

- Staff physician privately discussed the error with the pharmacist, then with the team in a constructive non-punitive manner

Issues: Just Culture, Team (Leadership, roles, diffusing potential conflict, encouraged learning from the event)

- Pharmacist independently went to speak to the family

Issues: Impact of AE on providers, disclosure, including family in care (Human factors, Disclosure, Communication, Teams)

This event highlights how a team that typically works well together can be a part of an adverse event.

Patients and families are an important part of the care team. Do you think that this error may have been discovered sooner if the family had been present?

Facilitate group brainstorming around how family centered care may facilitate patient safety.

Safety Competencies from Domain 2 addressed by this vignette:

1.1-1.3 Importance of team roles, and respect for individuals in these roles

1.5 & 1.7 Identify/act on safety issues in the context of team/team learning

- Team used the event to learn

1.9 Provide/accept feedback to improve performance

- Team reflected on the event to improve future practice

1.10 Practice effective listening to contribute to optimal teamwork/patient care

- Lapse in effective listening during rounds contributed to this error

2.2 Engage patients in decision-making and management

Team Error: Facilitator's Guide

All teams in hospital settings experience “malfunction” that result in adverse events. This vignette is a true account of a clinical situation encountered by a team at a children's hospital. This experience is a valuable learning tool that highlights many key concepts of patient safety and teamwork.

Using an interactive format, have the group analyze the event using a stepwise “systems” approach:

- Setting: Friday ward rounds/after rounds

Issues: Fatigue (end of week), busy day, continuity going into weekend (Human Factors, Environment)

- Order written by team member with migraine (could have deferred to another team member)

Issues: Illness (Human Factor)

- Order co-signed, not read by senior resident

Issues: Inappropriate “comfort” with procedure, not fulfilling team role (read and co-sign), busy (Human and Environmental factors)

- Order approved by charge nurse as “dose safe”

Issues: Communication – though the dose was safe, it was not appropriate for the situation. There was inadequate communication amongst the team of the purpose of the morphine increase (Communication)

- New inappropriate dose given by bedside nurse (who was present during rounds, and new night nurse as shift change)

Issues: Not adequately attentive during rounds, inexperienced – did not realize such an increase not clinically appropriate (Communication, team roles, human factor)

- Staff physician returned to re-evaluate patient/effect of new dose of morphine

Issues: Inappropriate “comfort” with situation/did not check the dose though child “sleepy” as described by the nurse, busy afternoon (Human/Environmental Factor, Communication)