

LEADERSHIP SKILLS

Survey Emphasizes Need for Team-Based Error Disclosure Process

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Although nurses routinely disclose nursing errors to patients, a new study published in the January 2009 issue of *The Joint Commission Journal on Quality and Patient Safety* reveals that nurses often are not included when physicians tell patients about serious mistakes.

The study, “Disclosing Errors to Patients: Perspectives of Registered Nurses,” explores nurses’ attitudes toward and experiences with error disclosure. Between October 2004 and December 2005, 11 focus groups were conducted with 96 RNs practicing in one of four healthcare organizations in the Puget Sound region of Washington State. Participants reported routinely and independently disclosing nursing errors that did not involve serious harm (such as late or missed medications or treatment), but felt that attending physicians should lead disclosures when patient harm had occurred or when errors involved the team.

The study found that nurses usually were not involved in error-disclosure planning discussions, which led to ethically compromising situations as they attempted to communicate with patients and families. Awareness of existing institutional error-disclosure policies among nurses was also low.

“Nurses are instrumental partners in the therapeutic relationship,” says Paul L. Green, MS RN CPHQ, director of performance improvement at Scripps Memorial Hospital, La Jolla, CA. “Participation in the disclosure of error or harm should absolutely include these partners. Who will be there after the news is given to patients? Nurses! If for no other reason than the continued support of the patient and the patient’s family, nursing needs to be involved in the notification as well as the planning for whatever follow-up care is involved. This is especially true in cases in which there has been a nursing error. Nurses must take part in the disclosure to maintain credibility and trust in the nurse-patient relationship.”

Susan Mellott, PhD RN CPHQ FNAHQ, president and CEO of Mellott and Associates, based in Houston TX, agrees that if nurses are to provide care that meets the specific needs of each patient, they must be aware of all activity related to their patients.

“I am not saying that nurses should be the people to disclose all medical errors,” Mellott says. “But if one member of the interdisciplinary team makes a medical error, the entire team should be made aware of what the error was; what has been done; and when, who, and what the disclosure to the patient will include.”

“Nurses are the professionals who interact the most with patients and significant others,” Mellott continues. “They are the people who can portray the image of a team when they are informed about how the response to an error is to be handled.”

The study’s authors—three nurses and one physician—say that the absence of nurses from discussions to plan for or disclose errors can diminish the quality of the disclosure for patients and families. The authors contend that a lack of collaboration and communication in the disclosure process may lead to moral distress, increased job dissatisfaction, and nursing turnover. They conclude that a team disclosure process is best, and they recommend that healthcare organizations establish policies that permit nurses and other caregivers to participate in and raise concerns about the disclosure process. They also recommend that nurse managers be trained on how to inform patients and families when a mistake has been made.

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