

Open School

Video Activity: Learning from Medical Errors (Part 2)

(<http://www.ihl.org/education/IHIOpenSchool/resources/Pages/Activities/PerspectivesTheMistakePart2.aspx>)

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Facilitator instructions

- Review the learning objectives and description with your group.
- Watch the [video](#) together (7 min 57 sec).
- Lead your group in a discussion using the questions below as a guide.
- Note: You can expand this activity by combining it with “Learning from Errors (Part 1), at <http://www.ihl.org/education/IHIOpenSchool/resources/Pages/Activities/PerspectivesTheMistakePart1.aspx>.

Learning Objectives

At the end of this activity, you will be able to:

- Give examples of mistakes that clinicians have made in their patients’ care.
- Discuss the range of feelings providers can have in the aftermath of a medical error.
- List factors that contribute to errors in the medical setting.

Description

A baby falls gravely ill after a botched blood transfusion. A student nearly commits a medication error. A patient dies after a clumsy surgery. Errors like these, unfortunately, still happen in health care. In this video, current and former clinicians (including IHI’s Former CEO, Don Berwick) describe the errors that still haunt them today — and point out ways those errors could have been prevented.

Related IHI Open School Online Courses

- [PS 100: Introduction to Patient Safety](#)

- [PS 101: Fundamentals of Patient Safety](#)
- [PS 105: Communicating with Patients after Adverse Events](#)

Key Topics

Adverse event, adverse drug event (ade), redesign processes and systems, transparency, and culture of safety.

Facilitator, show the video [on this page](#) then lead your group in a discussion, using the questions below as a guide. Feel free to adjust these questions and/or add your own.

Discussion Questions

1. At the end of his story, Allan Frankel lists “so many things that could [have been] different,” including better communication, teamwork, planning, discussion, checklists, and system reliability. Listen to his story again, and pinpoint all the places where each of these improvements could have made a difference.
2. Imagine you’re in charge of the hospital where Kevin Knoblock works. What will you do to ensure no one misreads medication instructions the way he did? How much should you rely on your staff members’ personal efforts to try harder?
3. Don Berwick says he felt too guilty to discuss his mistake with his colleagues and the hospital’s managers. If you made a serious mistake that affected a patient, what circumstances would make it easier for you to admit it openly? What circumstances would make it harder?