TRANSCRIPT:

Video: The Impact of Disclosure Second Victim of Harm

[00:00:05] From the time we are young, we are taught to say, “I'm sorry.”

[0:00:09] Whether we have hurt someone's feelings or their being, we are taught that apologizing and accepting apologies with grace is the right thing to do.

I want to say, “I’m sorry.”

[0:00:20] We accept responsibility and we move on with what we have learned and with what we have forgiven.

[0:00:28] I wish I had that chance.

[0:00:31] About 12 years ago, I met you for the first time.

[0:00:35] I'd been a nurse for eight years.

[0:00:36] I loved the critical thinking, the helping, the patient care and the teamwork.

[0:00:41] During this time, I worked in the emergency department.

[0:00:44] I worked part-time and was eager to pick up extra shifts, especially on weekends.

[0:00:49] We still do not know who found you barely alive and sleeping among some trees.

[0:00:56] They knew you were sick, blood coming from your mouth, nobody else around.

[0:01:00] They knew you needed help and they called for an ambulance.

[0:01:09] When the paramedics arrived, they moved quickly.

[0:01:12] Your blood pressure was low; your pulse was fast; they thought you might have a GI bleed.

[0:01:16] They supported your airway, put you on a monitor, started to give you some intravenous fluids, they phoned the ER.

[0:01:23] I was in charge. I asked my team to prepare the resuscitation room, and we alerted the doctor.

[0:01:29] On the way to the hospital, you started to vomit.

[0:01:33] You were only minutes away and everyone was ready to help you.

[0:01:35] It was such a busy day.

[0:01:40] At that time, we didn't have a formal triage process.

[0:01:42] So much going on all over the department and we were short one nurse and had only one physician on call.

[0:01:49] A diagnosis of GI bleed was made by the on-call physician.

[0:01:52] The intensivist and on call surgeon were called.

[0:01:55] Orders were given both verbally and in writing.

[0:01:59] You needed to be admitted to the ICU.

[0:02:01] You needed some surgical intervention to help, but first, you needed some medication.

[0:02:06] I was asked to process the medication order and get the medication stat.

[0:02:12] I hadn't heard of this drug before.

[0:02:15] I couldn't quite make out the drug names, so I asked for confirmation.

[0:02:18] The physician clarified.

[0:02:21] We didn't have the drug on hand, so I had to call the pharmacy quickly.

[0:02:28] When I spoke with the pharmacist and explained what I needed, the pharmacist told me that the drug was not on our formulary yet.

[0:02:35] It was new and could only be ordered by the internists.

[0:02:40] I explained that the surgeon had ordered the drug and the patient was unstable.

[0:02:43] Could he please send the drug right away and we would talk process later?

[0:02:49] It felt like a lot of time had passed and I explained that the drug was on the way.

[0:02:56] The box on the right was sent in the tele lift, didn't look exactly like the order, didn't seem like the right stuff.

[00:03:02] I needed to check.

[0:03:04] I could hear them in the resuscitation room wondering where the drug was.

[0:03:07] Quickly, I searched for information about this drug that I had never given before.

[0:03:14] I searched in many different places, including our hospital specific-IV medication manual.

[0:03:16] I couldn't find anything that clearly provided information to make a good decision.

[0:03:23] I needed to ask someone.

[0:03:24] Was it possible the department was getting busier?

[0:03:30] I checked with my teammates; they weren't sure either.

[0:03:30] One nurse said she thought the drug looked correct and she suggested I show the physician and ask if it was the right stuff.

[0:03:37] I showed the doctor the box.

[0:03:40] The doctor said, “Yes, that's it. Give it all. IV push right now.”

[0:03:45] You were so sick and I moved quickly.

[0:03:48] The syringe was nearly empty when you started vomiting and crying out in pain.

[0:03:53] What was going on?

[0:03:54] More orders were given, more action taken.

[0:03:58] A coworker told me that I was needed on the phone.

[0:04:00] I answered the phone and heard, “Do not give that medication. I sent the wrong drug.”

[0:04:05] I said that not only had I already given it, but I had given the entire five mil vial.

[0:04:12] How could I have done that?

[0:04:12] We talk now of the system in which we work and how sometimes the safeguards do not work or they haven't been developed.

[0:04:18] Now we use science and experience and together we do better.

00:04:21] But what I know is how I felt.

[0:04:23] I had done that to you.

[0:04:26] I had given you the drug.

[0:04:27] I had made you worse.

[0:04:31] I needed to let the doctor know.

[0:04:32] You were being stabilized and prepared for Medivac to a tertiary care center.

[0:04:37] I told the intensivist what I had done.

[0:04:39] He said, “Well, you probably killed him.”

[0:04:42] That was it.

[0:04:42] Nothing else.

[0:04:42] What happens now?

[0:04:42] I filled out an incident report and I finished my shift.

[0:04:47] In the days that followed, I wondered how you were.

[0:04:48] To say I felt guilt and shame was an understatement.

[0:04:54] My manager asked if I had learned anything and I was told, “Well, you won't make that mistake again.”

[0:05:01] I spoke with another intensivist who knew about this case, and together we learned about overdosing with this drug.

[0:05:07] After a short stay in the tertiary hospital, you were transferred back to our intensive care unit.

[0:05:14] I learned that you had died two weeks after I gave you the wrong drug.

[0:05:20] You died of multi-organ failure.

[0:05:23] People said it wasn't my fault.

[0:05:25] You had many health problems.

[0:05:27] You likely would have died anyway.

[0:05:29] But I wonder, what if I didn't work that day? I want to say I'm sorry.

I'm sorry.

[0:05:33] I didn't want to make you worse.

[0:05:36] I feel very responsible for making you sicker.

[0:05:39] I feel responsible for two weeks of suffering and your death.

[00:05:43] Just an incident report and a mountain of guilt.

[0:05:46] I want to say I'm sorry.

[0:05:50] I wish things were different, but they weren't.

[0:05:52] I wish we could have understood all of the facts, all of the processes and intricacies which may have contributed to this.

[0:05:58] Maybe then I wouldn't feel such guilt.

[0:06:01] Maybe then I could have said, “I'm sorry.”

[0:06:07] I promise that this experience has made me better to earn the trust of patients who are vulnerable and their families who are afraid.

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[0:06:16] It has pushed me to commit my career to work with patients, families and providers to make care safer.

[0:06:21] I promise to be informed, apply best practice, stop the line, and to trust my gut.

[0:06:29] The purpose of this slide is to give the message that now in that same facility, that same department, there's a better approach, open conversations, reporting of patient safety incidents.

[0:06:40] Staff are asked to share information and identify solutions to problems.

[0:06:42] Learning from mistakes is facilitated.

[0:06:47] The learning is shared with others.

[0:06:47] Health care providers are asking, listening and talking.

Then and now

[0:06:51] Let's dedicate ourselves here today to hold the hands of our colleagues, our patients and our families with the tenacity to create a very strong net of solid, safe processes where everyone – from those who are closest to the patient to those who are furthest away – know that together we will make care safer.

[0:07:10] I promise and I am sorry.

END