## **Faculty and Medical Error Curriculum**

Please complete the survey below.

Thank you!

This questionnaire is designed to find out about the current curriculum around medical error and faculty stories that can help learners develop their understanding of error and personal plan for reducing and managing error. Please avoid identifying comments in your free text answers.

If you would like to share a story of a medical error during your career for learning purposes (could be de-identfiied, shared by another faculty, or told personally by you), please contact

If you are personally struggling to process a medical error, please contact <del>stacy riowers</del>,

Please answer the following questions with strongly agree, agree, neutral, disagree, or strongly disagree.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	
Good doctors should be honest about errors they make.	0	$\bigcirc$	0	0	0	
If I am smart enough, I can avoid medical error for myself and my patients.	0	0	0	0	0	
I have made errors in my care for	ve made errors in my care for patients.					

Please answer the following questions with strongly agree, agree, neutral, disagree, or									
strongly disagree.									
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree				
Patient-physician relationships can recover after medical error.	0	0	0	0	0				
Physicians can recover after medical error.	0	0	0	0	0				
l can recover after a medical error.	0	0	0	0	0				
I can be honest about errors that I make as a doctor.	0	0	0	0	0				



l acknowledge when I am at increased risk for making errors (i.e. hungry, angry, late, tired, inexperienced/unfamiliar).	0	0	0	0	0
Have you shared a story with a learned personal medical error?	er about a		⊖ Yes ⊖ No		
Have you shared a story with a peer a medical error?	about a personal		⊖ Yes ⊖ No		
Have you personally been part of a pa where the patient experienced medic			⊃ Yes ⊃ No		
Was the error acknowledged among t	the care team?		⊖ Yes ⊖ No		
How did you personally process this e avoid including identifying informatio					
Did the team debrief or attempt to di for the error?	scuss root causes		⊖ Yes ⊖ No		
How did the team process the error? including identifying information)	(please avoid				
Was the error disclosed to the patient	t?		○ Yes ○ No ○ I don't know		
How did that happen? (please avoid i identifying information)	ncluding				
Did the team or organization learn fro	om the error?		○ Yes ○ No ○ I don't know		
I know what to do at my institution w medical error (I am aware of their pol this topic).			⊖ Yes ⊖ No		
What do you do when you become av error? (Select all that apply.)	vare of a medical		<ul> <li>Acknowledgenot discuss information of the second structure of the</li></ul>	with others mally with peer tient. rief formally wit n the error. y about the error	nd try to learn but do rs but do not engage th the team and faculty or so others can learn.



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You indicated "Other" when you become aware of a medical error. If you are willing, please share what this means for you.	
Have you had training in how to handle the occurrence of a medical error?	○ Yes ○ No
Do you desire more training in any of the following?	<ul> <li>Error management</li> <li>Quality improvement</li> <li>Error disclosure to peers and patients</li> <li>Safety culture</li> <li>Personal stories of error from mentors</li> <li>Culture of safety (versus culture of blame)</li> <li>Legal and malpractice concerns related to medical error</li> <li>Personal coping</li> <li>Patient stories of error</li> <li>Other</li> </ul>

What additional training would you be interested in?

Please answer the following questions with strongly agree, agree, neutral, disagree, or								
strongly disagree.								
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree			
I am able to share stories of error from my career with learners.	0	0	0	0	0			

I am not able to share stories of error from my career because



## **Residents and Medical Error Curriculum**

Please complete the survey below.

Thank you!

This questionnaire is designed to find out about the current formal and informal curriculum around medical error and resident interest in further studies. Please avoid identifying information in your free text answers.

## If you are personally struggling to process a medical error, please use the contact info provided during our session.

	Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
Good doctors should be honest about errors they make.	0	0	0	0	0
If I am smart enough, I can avoid medical error for myself and my patients.	0	0	0	0	0
My mentors have made errors in the patients.		) Yes ) No ) Not sure			
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Patient-physician relationships can recover after medical error.	0	0	0	0	0
Physicians can recover after medical error.	0	0	0	0	0
l can recover after a medical error.	0	0	0	0	0
I can be honest about errors that I make as a doctor.	0	0	0	0	0
I acknowledge when I am at increased risk for making errors (i.e. hungry, angry, late, tired, inexperienced/unfamiliar).	0	0	0	0	0
I can't be honest about errors I make as a doctor because					
Have you had a mentor share a story about a personal medical error?			) Yes ) No		
Have you had a peer share a story medical error?	about a personal		) Yes ) No		
Have you personally been part of a where the patient experienced me			) Yes ) No		



Was the error acknowledged among the care team?	○ Yes ○ No
How did you personally process this error? (please avoid including identifying information)	
Did the team debrief or attempt to discuss root causes for the error?	○ Yes ○ No
How did the team process the error? (please avoid including identifying information)	
Was the error disclosed to the patient?	<ul> <li>○ Yes</li> <li>○ No</li> <li>○ I don't know.</li> </ul>
How did that happen? (please avoid including identifying information)	
Did the team or organization learn from the error?	<ul> <li>○ Yes</li> <li>○ No</li> <li>○ I don't know.</li> </ul>
I know what to do at my institution when faced with a medical error (I am aware of their policies related to this topic).	○ Yes ○ No
What do you do when you become aware of a medical error?	<ul> <li>Hide it/pretend it didn't happen</li> <li>Acknowledge it personally and try to learn but do not discuss with others</li> <li>Discuss informally with peers but do not engage faculty or patient.</li> <li>Work to debrief formally with the team and faculty to learn from the error.</li> <li>Share openly about the error so others can learn.</li> <li>Feel bad about myself</li> <li>Reach out to others to process the error</li> <li>Other.</li> </ul>
You indicated "Other" when you become aware of a medical error. If you are willing, please share what this means for you.	
Have you had training in how to handle the occurrence of a medical error?	○ Yes ○ No

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Do you desire more training in any of the following?	<ul> <li>Error management</li> <li>Quality improvement</li> <li>Error disclosure to peers and patients</li> <li>Safety culture</li> <li>Personal stories of error from mentors</li> <li>Culture of safety (versus culture of blame)</li> <li>Legal and malpractice concerns related to medical error</li> <li>Personal coping</li> <li>Patient stories of error</li> <li>Other</li> </ul>
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What additional training would you be interested in?



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## **Residents and Medical Error Curriculum Post-Survey**

Please complete the survey below.

Thank you!

This questionnaire is designed to find out about the current formal and informal curriculum around medical error and resident interest in further studies. Please avoid identifying comments in your free text answers.

If you are personally struggling to process a medical error, please use the contact info provided during our session to reach out.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Good doctors should be honest about errors they make.	0	0	0	0	0
Patient-physician relationships can recover after medical error.	0	0	0	0	0
Physicians can recover after medical error.	0	0	0	0	0
l can recover after a medical error.	0	0	0	0	0
If I am smart enough, I can avoid medical error for myself and my patients.	0	0	0	0	0

My mentors have made errors in t patients.	heir care for		<ul> <li>○ Yes</li> <li>○ No</li> <li>○ Not sure</li> </ul>				
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree		
l can be honest about errors that l make as a doctor.	0	0	0	0	0		
I acknowledge when I am at increased risk for making errors (i.e. hungry, angry, late, tired, inexperienced/unfamiliar).	0	0	0	0	0		
Have you had a mentor share a story about a personal medical error?		l	○ Yes ○ No				
Have you had a peer share a story about a personal medical error?			<pre>○ Yes ○ No</pre>				
I know what to do at my institution medical error (I am aware of their this topic).			<pre>○ Yes ○ No</pre>				



How many sessions of medical error training with Dr. Adkins have you attended?						○ None ○ 1 ○ 2 ○ 3					
On a scale of 0-10 (0 being not emotionally difficult at all to 10 extremely emotionally difficult) how emotionally difficult was this training?	0		2	3	4	5	6	7	8	9	10 〇
On a scale of 0-10 (0 being not feasible at all and 10 being extremely feasible) how feasible was it to complete this training?	0	0	0	0	0	0	0	0	0	0	0
On a scale of 0-10 (0 being not helpful at all and 10 being extremely helpful) how helpful was this training?	0	0	0	0	0	0	0	0	0	0	0
What do you do when you become aware of a medical error?					<ul> <li>Hide it/pretend it didn't happen</li> <li>Acknowledge it personally and try to learn but do not discuss with others</li> <li>Discuss informally with peers but do not engage faculty or patient.</li> <li>Work to debrief formally with the team and faculty to learn from the error.</li> <li>Share openly about the error so others can learn.</li> <li>Feel bad about myself</li> <li>Reach out to others to process the error</li> <li>Other.</li> </ul>						
You indicated "Other" when you be medical error. If you are willing, pla this means for you.											
Have you had training in how to ha of a medical error?	andle th	ie occui	rrence		○ Yes ○ No						
Do you desire more training in any of the following?				<ul> <li>Error management</li> <li>Quality improvement</li> <li>Error disclosure to peers and patients</li> <li>Safety culture</li> <li>Personal stories of error from mentors</li> <li>Culture of safety (versus culture of blame)</li> <li>Legal and malpractice concerns related to medical error</li> <li>Personal coping</li> <li>Patient stories of error</li> <li>Other</li> </ul>							

What additional training would you be interested in?



Do you have any feedback or suggestions about the training curriculum?

