Appendix 1. Door Signs for Error Disclosure Exercise with Standardized Patients

A. Adverse event

Ms. Kim (45/F) came to the emergency room due to heartburn and nausea after drinking too much the previous day. At the triage, she told nurse A that she had an antacid allergy, although she was not sure of the name of the drug. Nurse A recorded "antacid allergy" in the memo column in the Electric Medical Record (EMR). I went to the patient to check the medical history and perform abdominal examination, and explained that I would prescribe an injection to relieve symptoms; I then prescribed Urantac® (Ranitidine HCl) and Macperan® (Metoclopramide HCl) injections. I did not check "antacid allergy" in the memo column in the EMR.

After the two injections, the patient experienced shortness of breath and dizziness. Nurse B asked me to look at the patient. Nurse B said that the patient had a history of receiving an injection of antacid and experiencing shortness of breath and dizziness and was now experiencing the same symptoms. Nurse B checked and found that the patient had been injected with Urantac.

Understand the patient's situation as the doctor-in-charge and explain to the patient the process of the error and the future steps.

B. Near-miss

Mr. Lee (39/M) visited the emergency room with dizziness. He habitually drinks alcohol, and he did not consider it a major problem. He had tarry stools or melena for several days, and he felt dizzy. He was brought to the emergency room, and he appeared tired enough to collapse.

You confirmed that the hemoglobin level was 6.0 on a blood test, and you decided to do a blood transfusion. The nurse connected the blood (A+) from the blood bank for the infusion line for transfusion and checked the patient's name, hospital number, and blood type. However, the patient said that his blood type was B+, and it was confirmed that it was different from the patient's recorded blood type. Preparation for blood transfusion was immediately stopped, and the nurse informed you of this situation. In addition, we investigated the process of how the error occurred and determined where the error occurred. Blood samples were collected from interns to check the blood type, and another intern had attached the patient barcode to a different patient's sample. Finally, the blood samples were collected. Now, the patient is receiving fluid therapy.

Understand the patient's situation as the doctor-in-charge and explain to the patient the process of how the error occurred and the future process.