Healthcare Mistakes and Their Impact

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TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER

Learning Objectives

- **Describe how a medical error can impact a healthcare facility**
- **Describe enhanced impact to Critical Access Hospitals**
- **Describe how a medical error can impact individual employees**
- **Identify ways to assess for system issues that increase risk of error**
- **Describe measures facilities can take to reduce risk of error**
- **Describe your role in the identification of risk and prevention of errors**

- In a typical hospital, approximately what percentage of errors is reported?
  - A. less than 5
  - B. between 25 and 50
  - C. 75
  - D. between 80 and 90

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What barriers would you have to reporting a near miss or actual error in the workplace?

A) Fear of punishment for myself or coworkers involved

B) Shame or guilt over possible mistake

C) Unfamiliar with reporting system in facility

D) I am not sure what should be reported or who I should report to

It could be ……

All of the above!!!

The Impact of Healthcare Errors

Impact of medical harm events

- Approximately 250,000 people die each year from medical errors – 3rd leading cause of death behind cancer and heart disease
- Medical estimated to cost approximately $20 billion each year
  - Some say $35 – 45 Billion for healthcare associated infections alone
- One CAUTI can result in over $10,000 cost to facility
- Average cost of patient fall with injury is around $30,000

Importance to Critical Access Hospitals

- Smaller in size
- Lower acute care inpatient volumes
- Operate with the least amount of resources
- Can’t absorb costs associated with patient harm events
- At greatest risk for closure

Consider this…

- Research shows humans:
  - make 35,000 decisions *everyday*!
  - experience 3-6 errors every hour in “normal” conditions
  - can experience 11-15 errors per hour in “stressful, emergent, or unusual” conditions

What is a medical error?

- Institute of Medicine (IOM) Committee on Quality of Health Care in the US, which performed the first large study on medical errors, defined a medical error as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim."
- Another definition identifies medical errors as a failure in care that may or may not result in patient harm.
  - Failure to complete intended plan
  - Implementing wrong plan
  - Deviation from standard of care process

Omission

actions not taken such as not locking wheels on bed before transfer

Commission

direct action such as administering wrong medication

Adverse Event

Negligent event – failure of average qualified person to meet expected standard of care

Near miss event – could have resulted in harm but did not

Potentially compensable event – event that could lead to malpractice case

Never event – medical errors that should never happen (wrong site surgery)

Noxious episode – diagnostic or treatment modalities that cause adverse event(taking too long to perform tests on unstable patient)

Active vs Latent

Active – involves action on the part of the person

- Not following procedure to correctly identify patient prior to test / procedure

Latent – involves intrinsic failures within the system (accident just waiting to happen)

- Equipment failure
- Poor system design

Types of medical errors:

- Diagnostic errors
- Medication errors
- Patient falls
- Equipment errors
- Healthcare– acquired infections
- Communication errors

Outcomes of errors:

Near miss

- Something almost happened, but we caught it before it did

Injury

- Something actually happened

No harm

- An error occurred, but no harm resulted due to remediation efforts

What does this all mean for your organization?

Financial burden

- Absorbing cost of treating patient for injury
- Potential litigation
- Loss of revenue

Public perception

- Perceived lower quality of care
- Outmigration

Sustainability

We can prevent these events!!

Increased awareness

- Be mindful of potential safety issues

Build culture of safety

- Anticipate potential safety issues
- Be prepared

Increase reporting

See something / say something!

Case Studies

Case #1 – failure to report problem

- Mid 40s female taken to OR for uncomplicated surgical procedure
- Patient sedated without issue
- During surgery, malfunction of anesthesia equipment occurred
- Patient experienced brief episode of poor ventilation, but situation was corrected quickly
- Upon review of case other anesthesia providers had experienced some issue with same equipment but it went unreported
- Previous issues with equipment went unreported

Case #2 – communication error

- Late 20s male, heavily intoxicated and expressing suicidal ideations post break-up with long term girlfriend – patient arrived at change of shift with multiple EMS arrivals occurring at this time
- Patient uncooperative upon arrival and placed in 4-pt restraints in private room.
- Patient continued to yell loudly so staff closed door to room
- Short time later shift supervisor noted increased yelling and opened door to room to find active flames
- Patient suffered burns requiring transfer to burn center
- Lack of communication between off-going and on-coming shifts

Case #3 – skipping a process

- OR staff involved in scheduled open gall bladder surgery when emergent case arrives requiring OR suite
- Emergent situation causes the “hurried” completion of case
- Patient to recovery room and ultimately discharged without incident
- Patient returned to ED later with increased abdominal pain and fever
- Patient ultimately found to have retained sponge in abdomen
- OR staff did not take appropriate counts in haste to clear OR suite on original surgery episode

RaDonda Vaught Overview and Lessons Learned

Where event took place

Vanderbilt University Medical Center

Sees more than 2 million patients each year – 1,000 beds

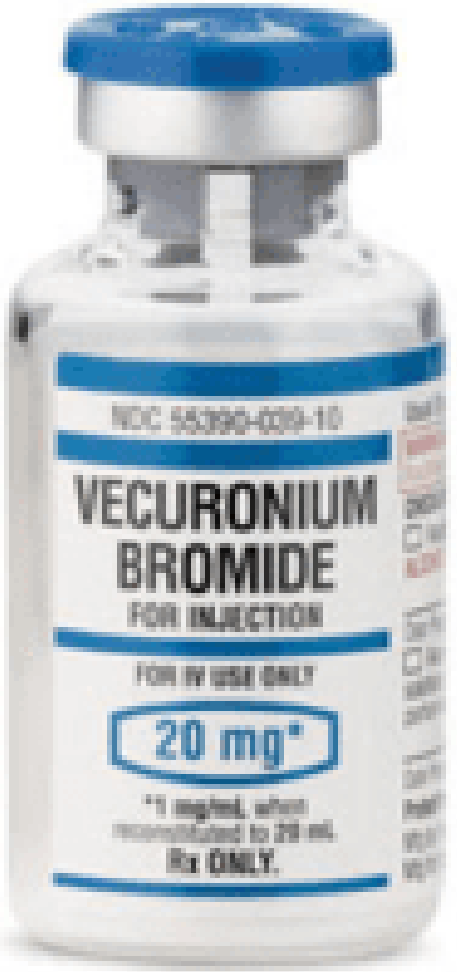
One of the largest academic medical centers in Southeast United States

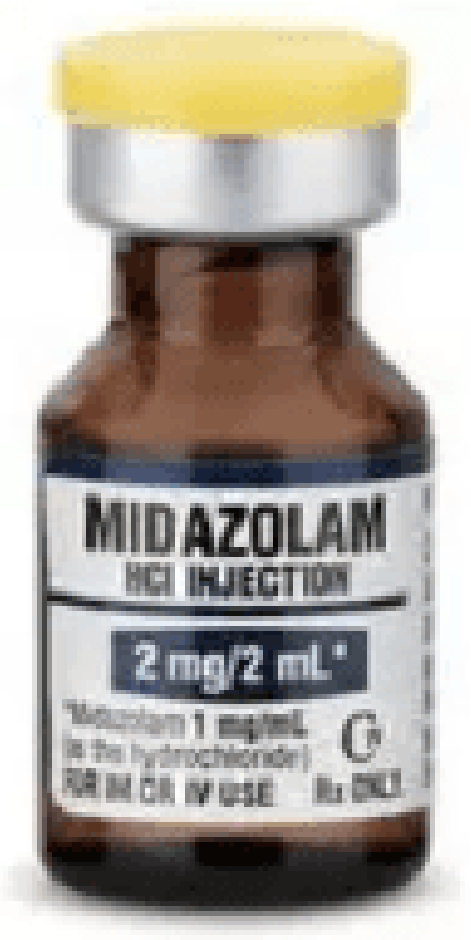
Background

- Medication error in 2017 led to death of a patient
- RN Scheduled for Dec. 25 and 26, 7a-7p shifts.
- Pt was in Neuro ICU which was always fully staffed
- Scheduled as “All-Help” (resource) nurse and assigned an orientee/new nurse during shift.
- Patient transported to Radiology for a PET scan; requested medication for anxiety.
- RN and preceptee were preparing to go to ED to perform a swallow study immediately before being asked to go to radiology first

Background

- Physician ordered Versed and order issued, entered into Automatic Dispensing Cabinet and verified by pharmacy.
- Radiology schedule was busy and RN not available
- Patient primary RN busy and not available
- About 10 minutes after verification, vecuronium withdrawn from ADC, using override feature, instead of Versed. No order to remove vecuronium. Override was not verified by pharmacy.


VECURONIUM
BROMIDE
FOR INJECTION
20 mg*
Rx ONLY


MIDAZOLAM
HCl INJECTION
2 mg/2 mL*

Background

- RN admits searching for Versed (instead of by generic name) under ADC profile and choosing override. RN admits she does not routinely administer Versed.
- Removed vecuronium vial and reviewed back of vial for directions regarding reconstitution; did not check name on the vial.
- Put medication and equipment in a bag, labeled it “Versed” and went to administer to patient. Attempted to use barcode scanning, but none available in procedural area
- Left Radiology after administration – did not monitor patient. Monitoring had been discussed and all parties decided it was not indicated.
- Did not document medication due to understanding that the new system would capture on Medication Administration Record.
- Patient room had cameras, but not of a quality that could monitor breathing.

Background

- Patient suffered respiratory arrest and brain injury and ultimately family withdrew care
- Hospital undertakes investigation and terminates RN.
- “did not validate the five rights of medication administration, per policy, which is part of your responsibility and within your scope of practice…”

Investigation

- State of Tennessee undertakes investigation.

- RN admits to:
  - prior administration of Versed (for other patients) but never administered vecuronium.
  - distraction (trainee) during medication dispensing.
  - Should not have been distracted and focused on “meds.”
  - Should not have overridden system, but was a common act.
  - Unusual circumstance of reconstituting medication.
  - Should have recognized difference in vials, but nothing alerted at the time.
  - This was not an emergency for purposes of override and should have called pharmacy for verification.
  - Did not monitor patient.

Criminal Case

- Determined that 5 warnings were overridden and at least 5 “red flags” were ignored or not responded to.
- Determined that patient should have been monitored and signs of respiratory failure within minutes.
- Criminal case is filed, charged with reckless homicide and abuse of an impaired adult.
- Found guilty of criminally negligent homicide (lesser charge) and abuse of an impaired adult. No issue of intent or malice. Family indicated they did not seek incarceration.
- Sentenced to 3 years probation.

What issues do you identify?

What are some potential Contributing Factors?

- **Busy nurse with quick change of assigned task**
- **Nurse unfamiliar with the radiology procedure area**
- **Patient's primary nurse, nor Radiology Nurse unavailable**
- **Rush to get procedure completed**
- **Assigned as a preceptor with trainee**

How can/do you assess for these vulnerabilities in your own organization?

What are some potential Contributing Factors?

- **Unfamiliarity with drug to be administered**
- **Communicated verbally to nurse by brand name**
- **Only generic name visible in dispensing system**
- **Look-up function required only two letters**
- **Override function utilized to find drug by brand name**
- **Override alert only, no “paralytic” alert**

How can/do you assess for these vulnerabilities in your own organization?

What are some potential Contributing Factors?

- **Distraction during drug prep, discussing next task**

  with
- **Barcode scanning not available in procedure area**
- **EHR Access for documentation not available in**

  procedure area
- **Post-admin drug monitoring does not happen**

How can/do you assess for these vulnerabilities in your own organization?

Questions to ponder

- Could something like this happen in your organization?
- How might this impact the trust within your organization?
- What kind of conversations should you have with leadership?
- Do you understand your reporting mechanisms and procedures?

Action Items to consider

REPORT

- Near miss
- Actual error
- Unsafe conditions

We don’t know there is a problem until someone speaks up!!

Action Items to consider

Get involved!!

Interdisciplinary team to review, assess, redesign processes; define processes and behavioral expectations

- Med administration
- Override reports
- High risk medications, labels, names, warnings, etc.
- Maintenance issues
- Equipment problems
- Non-adherence to policies and procedures
- Anything that can result in patient harm event

Action Items to consider

Help change the culture!!

Review, assess, reconcile intent towards punishment

- Individual blaming vs. system failures
- Be a part of the process to facilitate reporting
- Build a culture of safety
- Be empowered to speak up

REMEMBER….

- Silence is harmful
- Assist with change – contribute your ideas to improve upon patient care


Any
Questions

ACCREDITED CONTINUING EDUCATION

Accreditation Statement

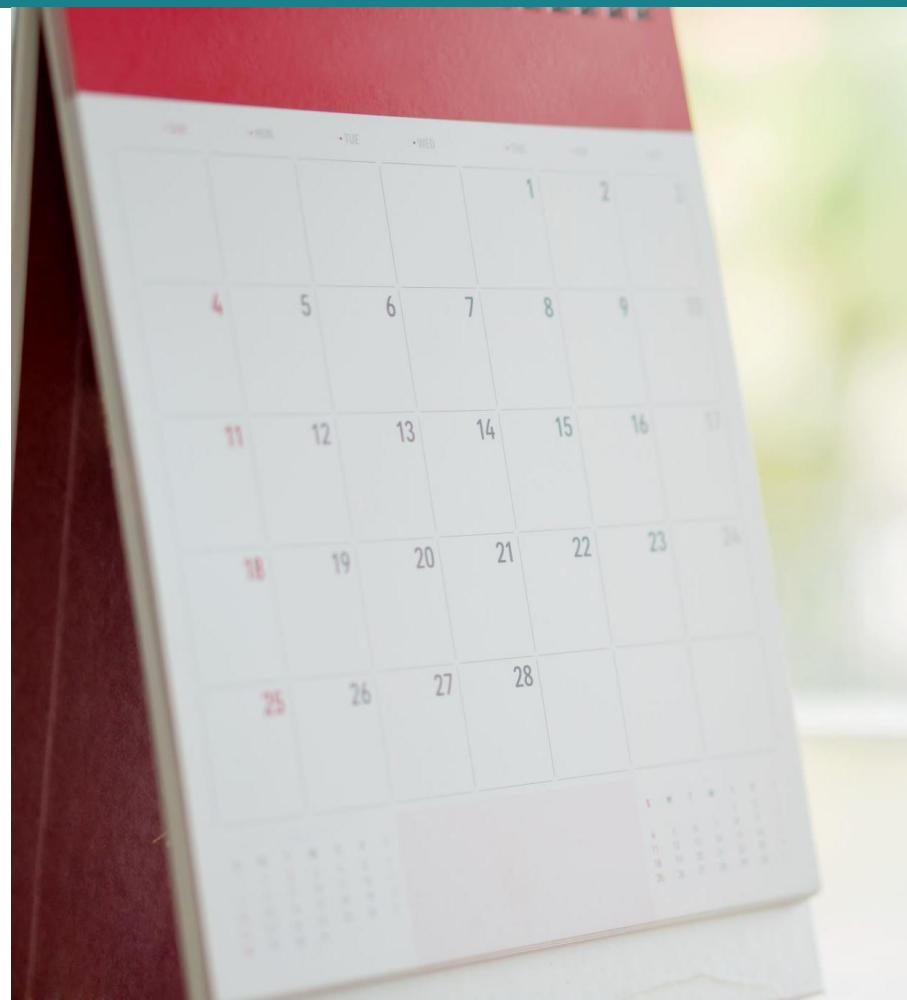
In support of improving patient care, this activity has been planned and implemented by AXIS Medical Education and Texas Hospital Association. AXIS Medical Education is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Course Evaluation / Continuing Education

Upcoming Events

- Aug 14 – Trauma Informed Care
- Aug 21 – Workplace Violence

- August 30, 2024 – Nursing Documentation Workshop
- Austin, Texas



Who To Contact

- Have Questions???
  - **Sheila Dolbow, MSN, RN, CFN, CPHQ**
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  - Texas Hospital Association Foundation
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THANK
YOU!