MEDICAL ERRORS
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MEDICAL ERRORS BASICS

Florida Podiatric Medical Association - June 2018
Stephen M. Meritt, D.P.M.,CSW

The Washington Post

To Your Health

Researchers: Medical errors now third leading cause of death in United States

- Medical errors are 9% of all deaths in in the United States. Third leading cause of death after heart disease and cancer. (John Hopkins Study published in the BMJ 2016; by Makary and Daniel.
- Claiming 251,000 lives every year.
- These are deaths only. There are many more numerous injures from medical errors. They range from minor to long lasting impairments that did not result in deaths.

Objectives today

- Try not to bore you to death.
- Discuss medical errors data.
- How best to prevent medical errors.
- What happens when an error does occur.

Interesting Stats

- The number of physicians in the U.S. is approximately 700,000.
- Accidental deaths caused by physicians per year are 120,000. (Deaths - not just errors)
- Accidental deaths per physician is 0.171.
- Statistics courtesy of U.S. Dept. of Health and Human Services.

More Interesting Stats

- The number of gun owners in the U.S. is 80,000,000. (Eighty Million).
- There were 32,000 gun deaths in 2015.
- 18,500 (58%) were suicides.
- 12,000 (37%) were homicides.
- 1,500 (5%) were accidental deaths (All ages). That's .0000188 per gun owner (Statistics courtesy of FBI.)

Startling Stats

- Statistically, doctors are more dangerous than gun owners.
- FACT: NOT EVERYONE HAS A GUN

But, almost everyone has a doctor. This means you are OVER 9000 times more likely to be killed by your doctor as a gun owner.

Ergo

- We must ban doctors before this gets completely out of control.
- If we can't ban them (after all everyone has one or more) than we must control them by legislation.
- All doctors must be registered, take hours of continuing education, be listed in public data banks and forced to carry insurance.
- **Please alert your friends to this alarming threat.**

NEW LEGISLATION

- Opioid law in Florida will become effective on July 1, 2018.
- Mandatory 2 hours of CME on opioid safety every biennium. 1st Course to be completed by January 31, 2019. (See you at SAM)
- Must be an approved course by the FMA or FOMA.
- Severely limits opioid prescriptions.

CMS Adds Quality of Care Data on Docs to its Physician Compare Site

- For the first time, the Centers for Medicare & Medicaid Services (CMS) is putting quality of care data on individual physicians on its Physician Compare site.
- In addition to launching a searchable database of individual healthcare professionals, CMS added new quality measures to Physician Compare for group practices and Accountable Care Organizations (ACOs). The measures focus on the quality of care provided by Medicare physicians and other health care professionals.
- Source: *Univadis* [12/23/15]

Electronic Medical Records (EMRs)
Electronic Health Records (EHRs)

Government Mandate - EMR

- The government mandated EMRs to improve medical care.
- In theory, to prevent errors and decrease duplication of tests thereby increasing patient health care and portability while reducing costs.
- Physicians signed on because it sounded reasonable and because of incentives.

Love affair is over

- If there was ever a lover affair between physicians and EMRs or EHRs, it's definitely over. (AMA and American EHR Partners 2014 survey of 940 physicians)
- Only 34% of physicians said they were satisfied or very satisfied with their EMR.
- Down from 62% in 2010.

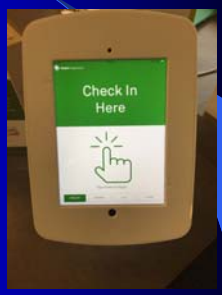
EMRs hurt most practices

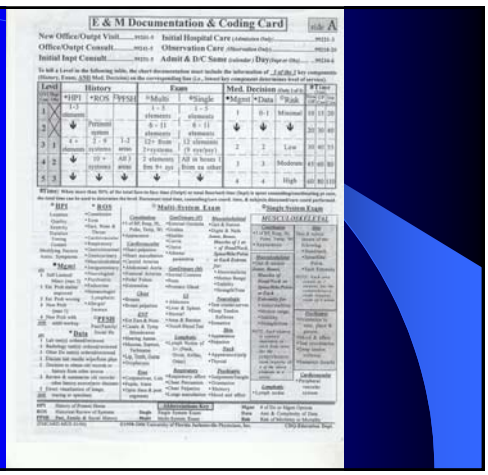
- 72% said EMRs made it more or very difficult to decrease their work loads.
- 43% never returned to their pre-EMR level of productivity.
- 54% complained about higher operating costs associated with their EMR.

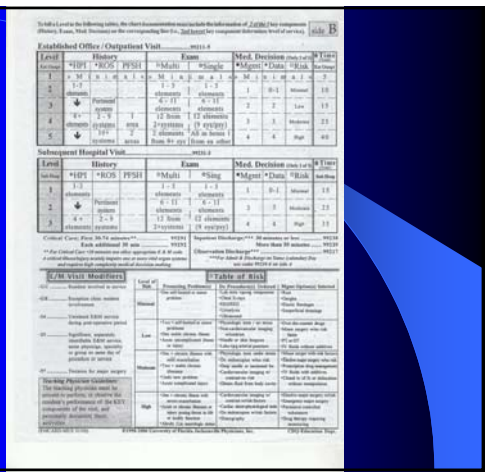
Lets Start at the Beginning

- Office patient sign in. HIPPA compliant.
- Paper or electronic?
- Why do this?

What does your office use?







10 Things EMRs Won't Say
According to the Wall Street Journal

- 1. 'Progress has a price – for doctors and patients.' Government encouraged doctors to ditch messy handwritten paper records and replace them with EMRs. In 2013, 78% of doctor's offices said they were using EMRs, up from 18% in 2001. (according to the CDC.) Critics say EMRs leave doctors less time to see patients and create more opportunities to make record keeping mistakes, which threaten patients' health.

10 Things EMRs Won't Say

- 2. 'Pardon the communications gap.' As more doctors go digital, rules for organizing the data are being set on an ad hoc basis, making it difficult to share information. (March 2015, GAO). For patients seeing multiple doctors, the issue could require them to retake certain exams or wait longer for test results. EMRs were suppose to prevent these kinds of hassles. Recorded data maybe overlooked due to placement.

10 Things EMRs Won't Say

- 3. 'Psst…Your doctor hates us.' While most doctors like the idea of EMRs, many are much less enamored with the reality. A 2014 survey from the AMA showed 34% of doctors using EMRs were "very dissatisfied" with the ability of their systems to decrease workload.

10 Things EMRs Won't Say

- 4. 'You'll get even less face time with your doctor.' Patients often complain that they don't get enough face time with their doctors. And now, because of EMR's , some patients may wind up competing with a computer screen. Doctors who accessed EMRs during a visit spend roughly a third of the time looking at the screen instead of interacting with their patient. (Northwestern University study)

Discussion of an EMR Error

Thomas Eric Duncan

- He arrived in Dallas a 7:01PM CDT on September 20, 2104 and stayed with his partner and her five children in the Fair Oaks neighborhood.
- Four days later, September 24, he began experiencing symptoms and presented to the ER at Texas Health Presbyterian Hospital at 10:37 PM.
- He was seen by a triage nurse one hour later at 11:36 PM.

- The hospital stated that "their triage nurses are trained to look for several red flags of infectious diseases like Ebola: symptoms, exposure to someone who was sick and overseas travel during the last four weeks."
- "When Mr. Duncan was asked if he had been around anyone who had been ill, he said that he had not."
- When asked about travel, Mr. Duncan said he had been in Africa.

- The nurse entered the info including the travel information in the nursing portion of the EMR.
- Apparently it wasn't passed on to a doctor according to the hospital because of "a flaw in the way the physician and nursing portions of our EMR interacted."
- Mr. Duncan was sent home.

- When readmitted the next day. He was seen by another physician.
- Within fifteen minutes, this doctor noted from the EMR that Mr. Duncan had recently been in Liberia and determined the patient needed to be tested for Ebola.
- The doctor ordered strict CDC protocol including wearing a mask, gown and gloves.
- The doctor called the CDC directly about possible Ebola.

Ebola Bulla

10 Things EMRs Won't Say

- 5. 'Pay no attention to that stranger in your exam room.' To avoid cutting into time with patients, some doctors are hiring staff to shadow doctors and document what doctors and patients say. Medical scribes (not usually medical professionals) sit in the exam room recording vitals and history as the patient recites it to the doctor as well as all patient and doctor interactions. Think of them as you would court reporters.

10 Things EMRs Won't Say

- 6. 'We make everything easier-including mistakes.' EMRs enable doctors to place orders for tests and medications with just a few clicks. But that also makes it easier for doctors to mess up. Doctors who use copy and paste functions with EMRs have a greater chance of entering wrong info in records. (Amer. Health Info. Management Assoc.)

10 Things EMR Won't Say

- 7. 'Sometimes, more information is a bad thing.' One of the perks of EMRs is that doctors can be alerted when tests come in, when there is a change in a condition or when drugs they prescribe may not interact well with other medications. But critics say that constant routine alerts set up doctors for information overload – making it possible for doctors to miss important information or to start ignoring updates and alerts.

10 Things EMRs Won't Say

- 8. 'Identity theft is one of our side effects.' Big companies that employ hundreds of security experts have been hit by hackers – so it's hardly surprising that the same thing can happen at your little medical practice.
- In 2013, 276 medical providers experienced data breaches. An increase of 24% from 2012. (Privacy Rights Clearinghouse)

10 Things EMRs Won't Say

- 9. 'We're a gold mine for marketing executives.' Drug makers can use the info to know which doctors are prescribing their products and which doctors are fans of a computer. IMS Health Holding, a firm that compiles Rx info from pharmacies and sell it to Pharmaceutical companies, made $2 billion in the first ¾ of 2013 selling your data.

10 Things EMRs Won't Say

- 10. 'And it's easier for the government to track you.' Some states and local governments are increasing their surveillance of EMRs from pharmacies and doctor's offices hoping the data will help them tract infectious diseases, chronic health conditions and drug use. DEA claims it has the right to subpoena databases containing names of patients treated for acute pain, anxiety and other conditions. (ACLU is suing to stop the DEA)

Institute of Medicine

- In a recent 2015 report, the IOM stated "Most people will experience at least one wrong or delayed diagnosis over their lifetime."
- "Diagnostic errors are a blind spot in modern medicine that sometimes causes devastating consequences."
- Evidenced Mr. Thomas Duncan. "Sinusitis"

Institute of Medicine

- 1 in 20 adults who seek outpatient care each year will experience a diagnostic error.
- Diagnostic errors make up the leading type of paid malpractice claims.
- Diagnostic errors are twice as likely to have resulted in a patient's death.
- "Many of the IOM committee's of medical specialists experienced a diagnostic error"

IOM Recommendations

- Better team work between physicians and staff especially radiology and lab.
- Encourage patients to ask "Could it be something else?"
- Urges providers to make patients and their families an active part of the diagnosis process, including giving them copies of all records and test results.

Check lists

- "Despite strong evidence that medical procedures should start with checklists, like those that pilots use before flying, most doctors did not use them, and to this day many still don't."
- Similarly, some notable hospitals choose not to staff their intensive care units (ICU) at night with a doctor. It's a "danger zone."

Danger Zones

- Areas of a hospital that have high complication rates.
- These areas are known to the administration and staff, but not to the public.
- "Without publicly available metrics of a hospital's outcomes, how can Americans choose where to go. The only thing most people have to compare is the *parking*."

Available Statistics

- There are plenty of statistics available, so why can't you access this data to know where to find the best care in your area.
- Because hospitals make a "Herculean" effort to make sure you can't.
- "Hospitals have merged and transformed into giant corporations with little accountability – and they like it that way."

Surgeons lose tools in 1,500 patients

■ A study estimates that sponges, metal clamps or electrodes are left in hundreds of patients nationally each year.

Associated Press

BOSTON — Surgical teams accidentally leave clamps, sponges and other tools inside about 1,500 patients nationwide each year, according to the biggest study of the problem yet.

The mistakes largely result not from surgeon fatigue, but from the stress arising from emergencies or complications discovered on the operating table, the researchers reported.

It also happens more often to fat patients, simply because there is more room inside them to lose equipment, according to the study.

The researchers and other experts agreed that the number of such mistakes is small compared with the roughly 28-million operations a year in the United States. "But no one in any role would say it's acceptable," said Dr. Donald Berwick, president of the nonprofit Institute for Healthcare Improvement in Boston.

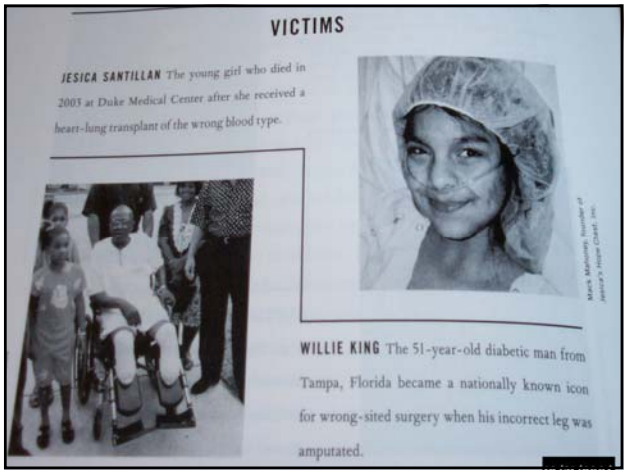
The study was done by researchers at Brigham and Women's Hospital and Harvard School of Public Health, both in Boston. It was published in today's *New England Journal of Medicine*.

The researchers checked insurance records from about 800,000 operations in Massachu-

Please see **SURGERY** Back page

A clamp left in the abdomen of a 59-year-old man during surgery was later removed. The study links surgeon stress, not fatigue, to the problem.

AP



VICTIMS

JESICA SANTILLAN The young girl who died in 2003 at Duke Medical Center after she received a heart-lung transplant of the wrong blood type.

WILLIE KING The 51-year-old diabetic man from Tampa, Florida became a nationally known icon for wrong-sited surgery when his incorrect leg was amputated.

Med Errors—How they Happen


How a fatal error happened

At an Indianapolis hospital, 3 infants die after being given the wrong drug.

California

- In the summer of 2005, a 12-year-old girl with pneumonia died at the Kaiser hospital in Santa Clara., Calif., when nurses accidentally gave her a fatal dose of the powerful stimulant epinephrine. A month later, at the Kaiser hospital in nearby San Jose, a 21-year-old cancer patient was killed when his doctor mistakenly injected his spine with the wrong chemotherapy drug.

Teamwork

- When team work is good, the hospitals have good outcomes.
- Hospitals that score well on the staff survey had lower rates of surgical complications.
- Transparency is the key.
- Hospital administrators fix problems that the public sees or learns about.

Teamwork

- Doesn't apply to just staff.
- Doctor to doctor referrals.
- Know your limitations.
- Willingness to step aside.

DeBakey Debacle

- DeBakey received several awards over the course of his long life, including the American Medical Association Distinguished Service Award (1959), Eleanor Roosevelt Humanities Award (1969), Presidential Medal of Freedom with Distinction (1969), and Presidential National Medal of Science (1987). He also received more than 50 honorary degrees from universities around the world, and served on the editorial boards of many medical journals.

- Performed over fifty thousand operations.
- The Debakey forceps are a standard in any surgical tray.
- Considered by many to be the greatest surgeon the world had known.
- Summoned to operate on Boris Yeltsin and many heads of states. People begged to have him operate on them. The famous pulled strings to get him.

- "In 1978, His Majesty Mohammad Reza Pahlavi, the Shah of Iran, was considered one of the most important figures in the world to the U.S. government.
- He ruled for 33 years.
- When he became ill the U.S. sent a medical team in a chartered Boeing 707. It included David Rockefeller's private physician and Dr. Michael DeBakey.

- The physician diagnosed splenic tumor and Dr. DeBakey recommended immediate surgery to remove the spleen.
- Dr. DeBakey was a cardiac surgeon but felt he could remove the spleen without any problems.
- The operation was one hour and twenty minute operation went "about as smoothly as you could make it."
- Dr. DeBakey was an instant hero and savior of U.S. diplomatic relations.

Death Rate after Pancreas Surgery By Surgeon Experience

	Death Rate
Surgeons who perform fewer than two operations per year	14.7 percent
Surgeons who perform two to four operations per year	8.5 percent
Surgeons who perform more than four operations per year	4.6 percent

Source John D. Birkmeyer et al., "Surgeon Volume and Operative Mortality in the United States," *New England Journal of Medicine* 349, no 22 (2003) 2117-27.

Famous Errors

- Andy Warhol – Died prematurely due to mistreatment of a gallstone.
- Dana Carvey had CABG on the wrong vessel.
- John Wayne's fatal colon cancer was missed at Harvard because his doctor (HADOD) didn't want to inconvenience him with a rectal exam.

MEDICAL ERRORS ARE A SUBSET OF SENTINEL EVENTS

Sentinel Events Reported to Joint Commission

- Unanticipated death or major loss of function, not related to the natural course of the patient's illness or underlying condition,

SENTINEL EVENTS

- Surgery Errors (Reported as code 15)
- Inpatient Suicide
- Restraint Deaths
- Infant Abduction
- Transfusion Events
- Fatal Falls
- Post-procedure complications

SENTINEL EVENTS

- Medical Gas Mix ups
- Needle sticks and Sharps Injuries INCLUDING CONTAMINATION.
- **Medication Errors**
- Rape

Code 15's in Florida

- Required reporting to Agency for Health Care Administration by hospitals, OSC's and HMO's.
- AHCA will report findings to appropriate professional Boards for any possible disciplinary actions.
- Reported to National Data Bank

Joint Commission Data

- Woefully inaccurate!
- More meaningful data comes from required state reporting.
- While Florida has mandatory reporting a lot of states do not.
- Data is often not forwarded to the Joint Commission.

Joint Commission Statement

- "The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn abut the actual relative frequency of events or trends in events over time."

Florida Code 15's 2013 January - September

Hospitals		Ambulatory Surgery Centers	
Death	97	Death	8
Fetal Death	2	Fetal Death	0
Brain Damage	11	Brain Damage	2
Spinal Damage	5	Spinal Damage	2
Wrong Site	28	Wrong Site	19
Wrong Patient	2	Wrong Patient	0
Wrong Procedure	7	Wrong Procedure	1
Sx Unrelated Dx	85	Sx Unrelated Dx	0
Retained object Sx	50	Retained object Sx	2
Repair of Sx injury	15	Repair of Sx injury	8

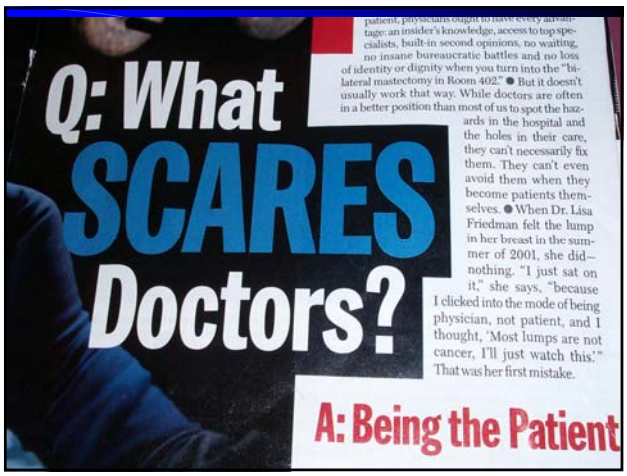
Florida Code 15's Trends

	2007	2008	2010	2011	2013 (3/4)	
Death	x	x	160	144	105	Down
Fetal Death	x	x	8	4	2	Down
Brain Damage	x	x	45	31	13	Down
Spinal Damage	x	x	8	4	7	Up
Wrong Site	33	28	34	32	47	Up
Wrong Patient	3	3	6	4	2	Down
Wrong Procedure	7	7	9	17	8	Down
Sx Unrelated Dx	139	139	137	103	85	Down
Retained object Sx	82	108	101	86	52	Down
Repair of Sx injury	65	58	43	45	23	Down

Traditional response to preventable adverse event

- Blame
- Sue
- Embarrass
- Regulate and inspect
- File an incident report


St Peter
Tim
Abuse panel's hea
Who's to blame for loss of this man's leg?
FIGHTING C



Medical Error Rate

- As reported by The Washington Post
- The overall medical error rate was about 3 percent of all Medicare patients, which works out to about 1.1 million patient safety incidents during the three years included in the analysis.

Study Finds Nearly 238,000 Deaths Annually from Hospital Errors

- August 10, 2009 – Scientific American
- Data released on August 8, 2009 showed 238,337 Medicare patients alone died from 2004 through 2006 because of potentially preventable, in-hospital medical errors, according to a study of 41 million Medicare records released by HealthGrades, a health care ratings organization. (80,000 per year)

Errors Cost Billions

- Preventable deaths of U.S. Medicare patients cost the program $8.8 billion from 2004 through 2006, according to the fifth annual Patient Safety in American Hospitals Study. (The Washington Post)

Chance of Dying

- Patients who experienced a patient safety incident have a 20% chance of dying as a result of the incident.
- While death rates overall fell by 5% in the same period there were increases in post op respiratory failure, post op pulmonary embolism or DVT, post op sepsis and abdominal wound dehiscence. 63% of errors.

Medicare and Medicaid

- On October 1, 2009, the federal Centers for Medicare and Medicaid Services stopped reimbursing hospitals for the treatment of eight major preventable errors, including objects left in the body after surgery, bed sores, and certain kinds of post surgical infections.

Harvard School of Public Health

- 2002 Survey…" More than 1 in 3 doctors reported errors in their own or a family member's medical care"

Airplanes Safer than Hospitals

- December 2, 2005
- Most of us are probably more nervous about flying than about checking into a hospital for a routine procedure. But according to Britians chief medical officer, the risk of being killed in a hospital in a developed country due to medical error is around 1 in 300, while the risk of dying in an air accident is 1 in 10 million. *Consumer Affairs*

U.S. Health Care Most Expensive & Most Error Prone

- November 4, 2005
- Not only do Americans pay much more for medical treatment than anyone else in the world, they also bear the brunt of the most medical errors, according to a survey covering the USA, Australia, Canada, Germany, New Zealand and the United Kingdom. *Consumer Affairs*

Professional Expectations

- Perform assigned tasks safely and competently to maximize patient health and safety, in accordance with performance expectations.
- Demonstrate commitment to excellence and to continuous learning, improvement, and professional development.

5 Most Misdiagnosed Conditions

- 1. Cancer
- 2.Cardiac conditions
- 3. Acute abdomen
- 4. Timely diagnosis of surgical complications
- 5. Stroke and related conditions.

Cardiac Errors

- Most occur in the ED when patients present with acute coronary syndrome (ASC)
- Triage decision to send a patient home
- Errors with treatment, such as the failure to promptly use reperfusion therapy
- Medication errors – wrong medication or wrong dosage

Stroke Errors

- Nearly one million patients admitted each year in U.S. hospitals for stroke
- As many as 100,000 may experience an adverse event related to an error
- Robert Holloway, M.D., M. P.H. University of Rochester Medical Center

No Progress

- Since the highly publicized report, the authors and patient safety advocates believed medical errors could be cut in half in five years.
- But Hearst's "Dead By Mistake" reveals that the federal government and most states have made little or no progress in improving patient safety. Calls for national reporting.

Wrong Site Surgery, JCAHO

- 41% Orthopedic or Podiatric surgery
- 20% General Surgery
- 14% Neurosurgery
- 11% Urologic surgery
- 14% All others

Complex Systems

…and the probability of performing perfectly:

Number of steps	Probability of success, each element:			
	0.95	0.99	0.999	0.9999
1	0.95	0.99	0.999	0.9999
25	0.28	0.78	0.975	0.997
40	0.12	0.66	0.96	0.995
100	0.006	0.37	0.90	0.99

vs.

Percent of Errors

- 76% surgery on wrong body part or site
- 13% surgery on wrong patient
- 11% incorrect surgical procedure

Where Errors Occur

- 58% Ambulatory setting
- 29% Inpatient OR
- 13% Other inpatient areas

Why Errors Occur

- 13% Time pressures
- 13% Multiple surgeons
- 13% OR set up
- 10% Multiple procedures at one time
- 51% All other various factors

Why does it happen?

- "Surgeons may be unaware of simple prevention guidelines or unwilling to follow them"
- "Staffs may simply take it for granted that the surgeon knows what he or she is doing"
- "The frenetic pace of a busy facility may cause everyone to overlook the obvious"

Why does it happen?

- " Lack of standard protocols exacerbate the problem"
- "Patients may have similar names"

Universal Protocol— Pre-procedure Verification

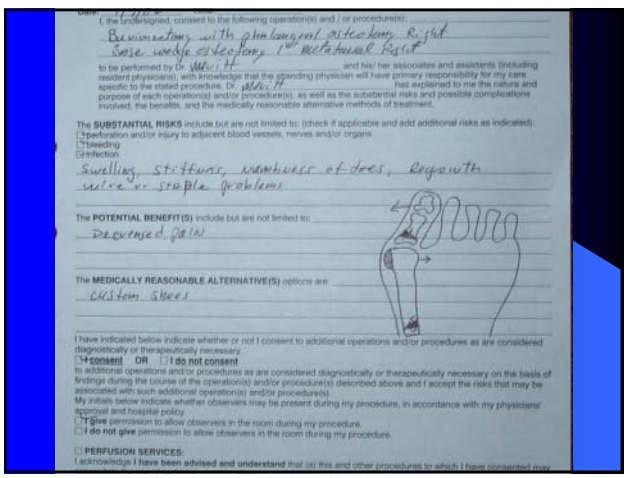
- **A—**verifies patient identification using two identifiers
- **B—**Discusses with patient or healthcare surrogate surgical site marking
- **C&D—**Consent and H&P/progress note are in agreement
- **E—**Site marking and verification—includes patient and/or family/surrogate and staff
- **F—**Time-out X 2 -verbal notification of patient ID, procedure, site, position, implants/equipment and antibiotics, risks

Steps for Prevention/AAOS

- Meet and confer pre-operatively with the patient
- Check the patient release form and the charts, verify the correct side of the x-rays, MRI, etc..
- Mark the site

Consent

- First place to prevent errors
- K.I.S.S. principle (Keep It Simple Stupid)
- Each procedure clearly stated
- Draw a picture of the procedure(s)
- Review the consent with the patient



I, the undersigned, consent to the following operation(s) and / or procedure(s):

Bunionectomy with phalangeal osteotomy Right
Base wedge osteotomy 1st Metatarsal Right

to be performed by Dr. Meritt and his/ her associates and assistants (including resident physicians), with knowledge that the attending physician will have primary responsibility for my care specific to the stated procedure. Dr. Meritt has explained to me the nature and purpose of each operation(s) and/or procedure(s), as well as the substantial risks and possible complications involved, the benefits, and the medically reasonable alternative methods of treatment.

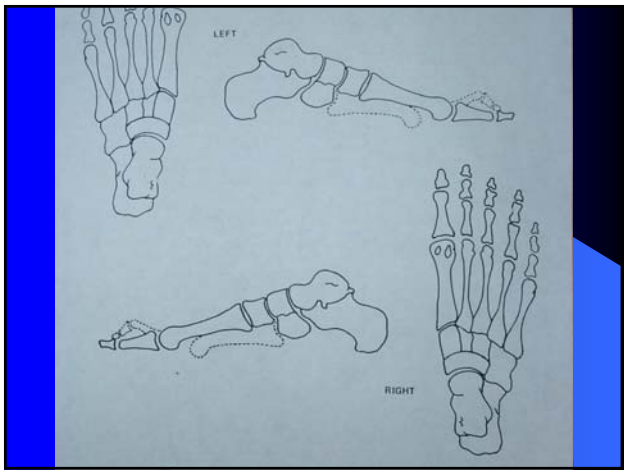
The **SUBSTANTIAL RISKS** include but are not limited to: (check if applicable and add additional risks as indicated)
☐perforation and/or injury to adjacent blood vessels, nerves and/or organs
☐bleeding
☐infection
Swelling, Stiffness, numbness of toes, Regrowth
nerve or staple problems

The **POTENTIAL BENEFIT(S)** include but are not limited to:
Decreased pain

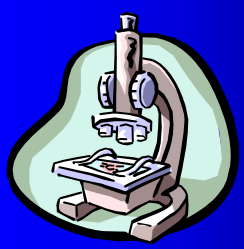
The **MEDICALLY REASONABLE ALTERNATIVE(S)** options are:
Custom Shoes

I have indicated below indicate whether or not I consent to additional operations and/or procedures as are considered diagnostically or therapeutically necessary.
☑I consent OR ☐I do not consent
to additional operations and/or procedures as are considered diagnostically or therapeutically necessary on the basis of findings during the course of the operation(s) and/or procedure(s) described above and I accept the risks that may be associated with such additional operation(s) and/or procedure(s).
My initials below indicate whether observers may be present during my procedure, in accordance with my physicians' approval and hospital policy.
☑I give permission to allow observers in the room during my procedure.
☐I do not give permission to allow observers in the room during my procedure.

☐ PERFUSION SERVICES:
I acknowledge I have been advised and understand that (a) this and other procedures to which I have consented may



Why are we here?



- Public response to publicized medical errors
- Legislative required education 2 hours on medical errors
- Now 2 hours on opioid management

JCAHO Rule "RI 1.2.2:"

- "Patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes."
- "The responsible licensed independent practitioner or his or her designee clearly explains the outcome of any treatments or procedures to the patient and, when appropriate, the family, whenever those outcomes differ significantly from anticipated outcomes."

JCAHO Sentinel Events

- Communication breakdowns remain the primary root cause of more than 60% of the 2034 sentinel events analyzed.
- EMRs have done little to help in communications between physicians.
- The majority of sentinel events (75%) resulted in a patient death.

Root Causes

- 65% of errors related to orientation/education/training
- 55% of errors related to communication between caregivers
  - Medication Errors primary cause? Legibility problem practically eliminated by computerized prescription programs.

Look alike/sound alike

- Lamisil vs. Lamictal
- Pletal vs. Plendil

Look-alike/Sound-alike

Celebrex
vs Celexa
vs Cerebyx

clonidine
vs Klonopin

Zantac
vs Xanax

Primacor
vs Primaxin

Dolobid
vs Dilaudid

Zyprexa
vs Zyrtec

Bretyllium
vs Brevibloc

Advicor
vs Advair

Diabeta
vs Zebeta

Error Reporting Flow

- Error occurs
- Intervention to protect/support patient
- Attending physician notified
- Doctors orders carried out
- Risk Management contacted
- Information/equipment preserved
- Immediate supervisor contacted

Error Reporting Flow

- Facts documented on medical record (MR)
- Interim report (IR)completed
- Forwarded to Risk Management (RM)

Risk Management Action

- Determination of Sentinel Event/Near Miss
- If SE/NM - convenes Root Cause Analysis Group (RCA)
- Reports to regulatory agencies - if required

Root Cause Analysis

Root Cause Analysis Process

- Participants
- Ground Rules
- Information Gathering
- Action plan

Participants

All staff and physicians involved in the event are invited to participate.

Ground Rules

- Confidentiality
- Search for Process Improvements
- Focus is **NOT** on individual
- Open, respectful discussions
- All members encouraged to participate
- 1 - 2 hour meetings
- Not looking for an easy fix but root cause

Information Gathering

- Who?
- What?
- Where?
- When?
- How?
- Why? The most important question asked continually during the process.

Information Gathering Questions

- What are the details of the event?
- When did the event occur?
- What area/service was impacted?
- What are the steps in the process?
- What steps were involved in/contributed to the event?
- What human factors are relevant?

Information Gathering Questions

- How did equipment performance affect the outcome?
- What environmental factors affected the outcome?
- If “uncontrollable” factors - are they truly uncontrollable?
- Are there any other factors that have directly influenced this outcome?

Information Gathering Questions

- To what degree is all necessary information available when needed? Is it complete? Ambiguous?
- To what degree was the physical environment appropriate for the processes being carried out?
- What systems are in place to identify environmental risks?

Information Gathering Questions

- What Emergency and failure-mode responses have been planned and tested?
- To what degree is the culture conductive to risk identification and reduction?
- What are the barriers to communication of potential risk factors?
- To what degree is the prevention of adverse outcomes communicated as a high priority?

Information Gathering Questions

- What can be done to protect against the effects of these uncontrollable factors?

Action Plan - Item #1

- For each of the findings identified in the analysis as needing an action, indicate the planned action, expected implementation date, and associated measure of effectiveness,

OR

Action Plan - Item #2

- If after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time.

Action Plan - Item #3

- Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.

Action Plan - Item #4

- Consider whether pilot testing of a planned improvement should be considered.

Action Plan - Item #5

- Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.

Thomas Eric Duncan

Sentinel Events in Duncan Case

- Failure to note critical information in the EMR resulting in delay of care that may have eventually caused death of the patient.
- Discharged patient with a wrong diagnosis due to failure to access available data resulting in delay of care.
- Contamination of personnel due to failure to properly train in precaution techniques.

RCA

- Initial treating physician failed to read the EMR travel note from the triage nurse.
- In the first press conference, after Mr. Duncan was diagnosed, the hospital had nothing to say about the gap in care or potential mistakes workers made.
- On follow up, they admitted one nurse knew he came from Liberia.

RCA

- But the information was not disseminated.
- They said that "a flaw in the workflow of the hospital's electronic health record was to blame." EMR's require searching for data.
- It turned out both doctors and nurses did have access to his travel history and there was no flaw in the hospital's record system.

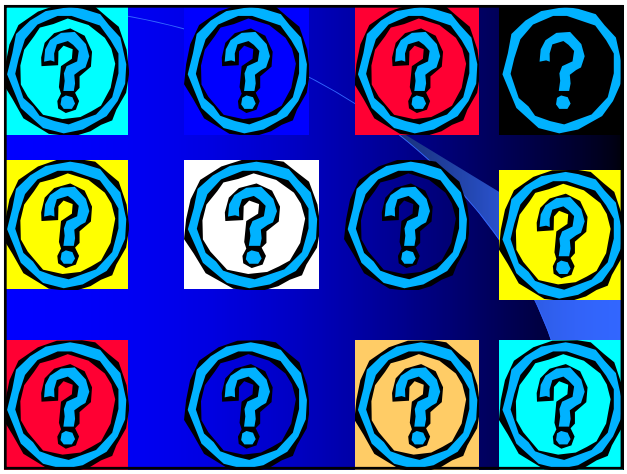
Flaw lead to EMR death

- The EMR didn't have a flaw according to the hospital's EMR company, rather the problem was a communication/reading gap. Different EMRs place the same data in different areas. Charting is made up almost entirely by computer programmers rather than physicians. No two companies use the same formats. The problem is the that government has approved multiple EMRs.

Conclusion

Medical errors are preventable events which are devastating to the patient, their families, the facility and the surgeon. Ultimately, the responsibility lies with the physician to provide the best possible care for his or her patient.

Primum non nocere. First, do no harm.



Test your knowledge

What publicized event led the Florida Legislature to require medical errors CME?

- A. JCAHO rule
- B. The Willie King case
- C. The Rodney King case
- D. The Leapfrog Group

Question?

JACHO Rule 1.2.2 refers to:

- A. Hospital restraints
- B. Informing the patient of family about unanticipated outcomes
- C. Completion of medical records
- D. Hospital accreditation

Know the answer?

A Sentinel Event may be:

- A. Rape on hospital campus
- B. Unanticipated outcomes
- C. Infant abduction
- D. All of the above

Another Test

Medication errors are:

- A. The largest segment of Sentinel events
- B. A small part of medical error problems
- C. Impossible to correct
- D. Not a concern of JCAHO

Last Question

Medication errors most often involve:

- A. Look alike, sound alike drugs
- B. Dangerous abbreviations
- C. Illegible handwriting
- D. All of the above