Prevention of Medical Errors
2020-2021 Biennium

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Objectives

- Meet biannual CME requirement 64B15-13.001, F.A.C.
  - Discuss medication and surgical errors
  - Misdiagnoses
  - System Failures
  - Creating Safety
    - Root Cause Analysis
    - Error Reduction and Prevention
    - Patient Safety
  - Most Common Errors as defined by the FL-BOOM

Why Bother?

- Medical errors still represent a leading cause of death
- Medical errors lead to suboptimal outcomes, and open the field for liability
- The state can make you take this class…no one can make you listen or learn, but you should want to for your patients!

Medical Errors in Context

- Drug errors vs. adverse events
- Misdiagnosis vs. delays in care
- Misadventures

- Direct causes
- Indirect causes

- Injuries vs. Deaths

5 Common Errors (BOOM)

- Inappropriate prescribing of controlled substances
- Failure to monitor the safety of prescribed medications
- Retained foreign objects in surgery and wrong site/patient surgery
- Failure to accurately diagnose cause of back and leg pain
- Failure to timely diagnose sepsis

Inappropriate Prescribing

- Covered in the two hour Controlled Substances course
- Reminders
  - Check EFORSCE
  - Maintain a high index of suspicion
  - Pay attention to functional status
  - Documentation

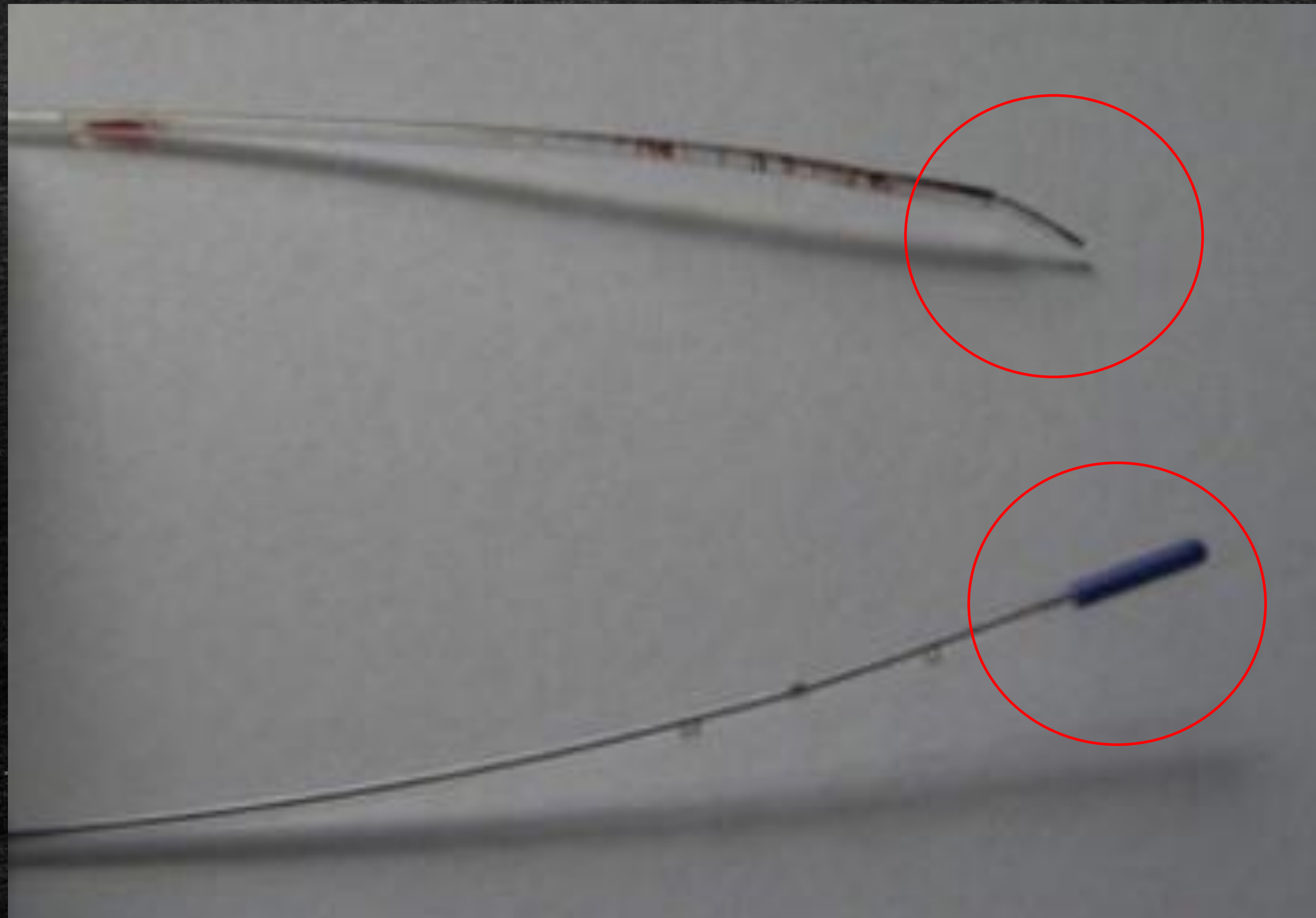
Medication Safety Monitoring

- All drugs have side effects and adverse effects
- At every visit – consider deprescribing (risk / benefit)
  - Any falls or other issues
  - Polypharmacy concerns
- Consider common complications
  - Anticoags – check CBC
  - Amiodarone – LFTs, PFTs
  - QT prolongation - EKG

Retained Foreign Objects / Wrong Site Procedures

- These are NEVER events
- Foreign objects -
  - If the count doesn't match get a C-arm BEFORE you close
  - When you take anything out (PICC line, scope, etc.) inspect to be sure it is intact
- For ANY lateralized procedure
  - Confirm with patient before
  - Ensure the correct side is on the consent
  - Verify during a procedural time out

Missing Epidural Catheter Tip



Accurate Diagnosis of Back / Leg Pain

- Differential is wide
  - Musculoskeletal
  - Neuropathic
  - Cardiovascular
  - Oncologic

- Detailed history AND physical
- Appropriate imaging when appropriate
- Remember: even addicts get sick

Back and Leg Pain Considerations

- Musculoskeletal
  - Range of Motion
  - Strength
  - Palpable spasm
  - Somatic dysfunction
- Neuropathic
  - Reflexes
  - Vibratory sense
  - Warning signs? (sphincter tone)
- Cardiovascular
  - Pulses
  - Hair loss
  - Ulcerations
- Oncologic
  - Lymphadenopathy
  - Pelvic / Rectal exam
  - Pain out of proportion to exam

Back and Leg Pain

- Eliminate lethal and common things first
  - Via history / physical / indicated diagnostics

- Follow up to ensure improvement – if not there, keep digging

- Referral / Consult when needed

- DOCUMENTATION

Timely Diagnosis of Sepsis

- Requires a high index of suspicion – clinical diagnosis
- Vital signs are vital
- Consider testing when it will change your treatment
  - Lactic acid
  - Procalcitonin
- Risk scores (SOFA, SIRS) -- all rely on abnormal vitals

National Patient Safety Goals 2020

- Patient Identification
- Staff Communication
- Medication Safety
- Alarm Safety
- Prevent Healthcare Transmitted Infections
- Patient Suicide Prevention
- Surgical Errors (already covered)

Patient Identification

- Two identifiers
- Many EMRs include photos
- Wristbands
- Be aware of "NAME ALERTS"

- NEVER:
  - Refer by diagnosis
  - Refer by room number or location

Staff Communication

- Test Results and Critical Test Results
  - Follow up logs
  - Critical flags and reporting
- Logging phone calls / Documenting all patient conversations
- Use EMR functions

Medication Safety

- Labels on all products – syringes, etc.

- Caution with anticoagulants and P450 medications

- Medication Reconciliation at EVERY care transition / encounter

Alarm Safety

- Alarm fatigue is real

"A Death in the ICU"

Infection Prevention

- Handwashing
- Controlling MDROs
  - Judicious antibiotic use, even with COVID
- Reducing CAUTI / CABI infections
  - Take things out
- Reducing post operative infection

Reducing Patient Suicide

- Risk assessment
- Be suspicious
- It's not your fault, but make sure you have done your job.

"My Patient's Story"

Learning from History

- We learn from each other
- Peer review
- Some things to consider

"The IVF Clinic"

- A Korean American couple from New York had previously stored embryos in an IVF clinic in LA…
- When they were ready they flew back to LA…
- The wife was implanted with two of their girls…
- When she gave birth they made a discovery…

Uh oh…

- To their surprise the babies were male, and not of Asian decent, and as it turns out, not related to each other.

- Three families were involved in the mixup. All three are suing…

"Risk Mitigation Goes Awry"

- A pathologist mixed up tissue sample slides from two patients in January 2017.
- The pathologist said that the barcode scanner used to match patient slides with patient records inadvertently scanned a barcode from another patient's form.
- The patient's urologist read the pathology report, told the patient he had prostate cancer, and removed the prostate.
- Another pathologist examined tissue from the prostate after it was removed and found no evidence of cancer.
- The patient, having suffered from incontinence and other sequelae from the surgery, was awarded $12.25 million in damages.

Why so much? (From the Des Moines Register)

- Judy Huitt repeatedly teared up as she told jurors how her husband felt diminished as a husband because of his impotence. She echoed his earlier testimony that they had an active love life until his mistaken surgery. “It’s changed our world forever,” she testified Thursday.
- The Huitts said his incontinence has improved, but he still uses two to three urine-absorbent pads per day. The experience can be humiliating, they said. Judy Huitt said she cleans their house and uses Febreze air freshener to mask the smell. But their granddaughters notice the scent, she said. “I blame it on the dog, because I don’t want them to think it’s Grandpa,” she testified.

- Defense lawyers contended medical records showed that Rickie Huitt sometimes had “urgency” issues with urination in the past, and that his other health issues could have led to erectile dysfunction in the future.
- Rowley cast doubt on that claim by asking Rickie Huitt about his current urological issues. “Did you ever have those problems before they cut an organ out of your body?” he asked Huitt during testimony Tuesday. “No,” Huitt replied.
- Judy Huitt said they understood Trueblood made a mistake, but she said the doctor and the clinic needed to take responsibility for it and ensure it can't happen again. *"They never told us they were sorry. Never once," Judy Huitt said*. She said she and her husband were relieved the trial was over. It was embarrassing and stressful to testify about such personal problems, she said.

Right Med, Wrong Route

"The Anaphylactic Physician"

Reddit Stories from Our Peers

- My brother is a surgeon, and during part of his residency, he had to work in the pediatric unit. He was working with two newborns. One was getting much better and fighting for life. He was going to make it just fine. The other baby was hours from [passing]. He wasn't going to make it. My brother was in charge of informing the families.
- My brother realized about 15 minutes later that he had mixed up the families. He told the family with the healthy baby that their baby wasn't going to make it, and he told the family with the dying baby that their baby was going to be just fine. He then had to go back out to the families and explain the situation to them.
- How devastating. To be given a glimmer of hope and have it ripped away from you not even an hour later. That was most upset I've heard my brother. He felt destroyed.

Reddit Stories from Our Peers

- My parents are nurses. They knew a doc who'd been on a 36-hour shift. Patient came in with a punctured lung (I think) and the doc had to collapse the lung to fix whatever was wrong with it.
- Through tiredness, he collapsed the wrong lung, and the patient [perished]. Doc ended up [taking his own life] after being fired.

Reddit Stories from Our Peers

- Several years ago, my sister and I were in a car accident. I had visible injuries. She did not and was walking around without any problems, so we thought. Nine days later, she was preparing dinner, began to feel ill, vomited, and then passed out. She was taken by ambulance to the hospital emergency, and after talking to my brother-in-law for only a couple of minutes, he rushed my sister into surgery and removed her spleen immediately. It had ruptured in the accident, but was a slow bleed.

- My sister was in ICU for a couple of weeks, but survived and is in good health today. Later, the admitting trauma surgeon said he recognized what was happening because of a mistake his college professor told the class she made as a surgeon years earlier.

- A teenage boy had fallen from a cliff and hit rocks below. Other than being bruised, he was fine, so did not seek medical help. Seven days later he was brought unconscious into the ER, where the college professor was working as a surgeon at the time. She and her team were not able to quickly identify his symptoms of a ruptured spleen that had happened seven days ago. The teenage boy [passed] about an hour later.

- She was always sure to share this particular incident with her students, thus saving my sister's life.

Two Sides of a Story

- Dr. R, a Hawaiian surgeon has featured prominently in many blogs and articles about the fact that he implanted parts of a surgical screwdriver into a patient's spine when the rods that were supposed to be implanted were not able to be located.
- The screwdriver shaft failed after a few days and the patient needed to be reoperated.
- Ultimately there was a suit, and the physician lost his license.

Dr. R’s Side

- Dr. are wrote a kevinmd article about his side of the story.
  - The nurse had confirmed everything was ready before the surgery
  - The patient had lost 1,500 ccs of blood prior to the fusion because of “an undiagnosed platelet disorder”
  - The replacement rods were more than two hours away so it was his judgement that rather than wait on the table or close and reopen, he should do this because surgical steel was as good as titanium and if it worked no further surgery would be needed.
  - He admitted to not documenting his conversations with the family well
  - He stated the only reason the implant failed was because the patient fell
  - He stated the only reason this became “such an issue” was that a nurse brought the screwdriver remnants (after they were removed) to a news station instead of pathology.

What lessons should the doctor have learned?

- Check before you cut
- Abort rather than do a poor job
- Being the leader is ownership of the outcome

What to do when you make a mistake

- You are required to disclose – don’t delay but set up an appropriate time and place.
- The disclosure is an admission of error – so go ahead and apologize; your patients expect it and so would you.
- Do your best to explain why it happened, what the patient can expect both short and long term.
- Do your best to demonstrate what you will do to prevent this from occurring again.
- Empathy and compassion are critical.

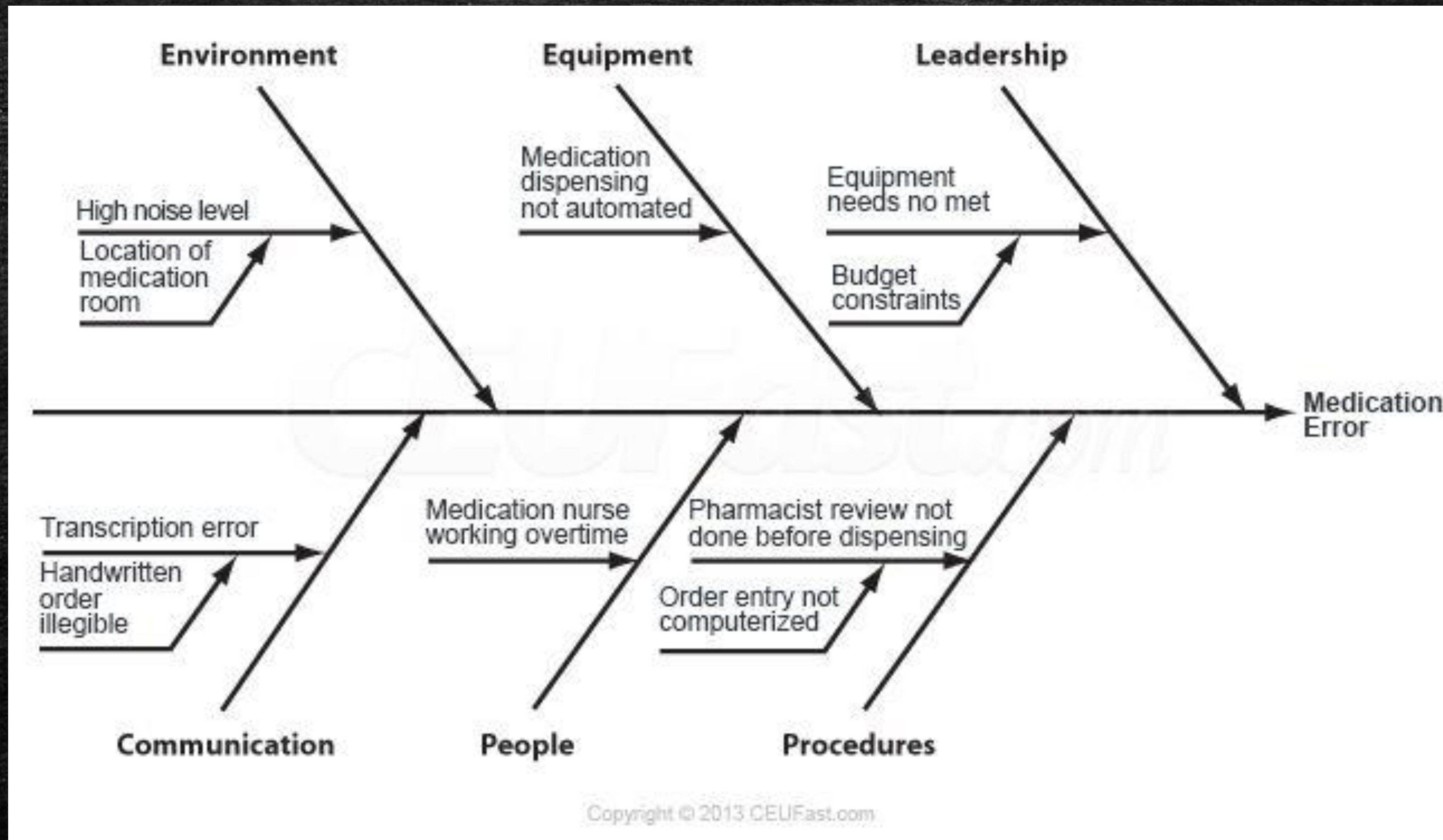
What Not to Do When You Make a Mistake

- Take no responsibility / Blame others
- Show no remorse
- Avoid contact
- Avoid follow up

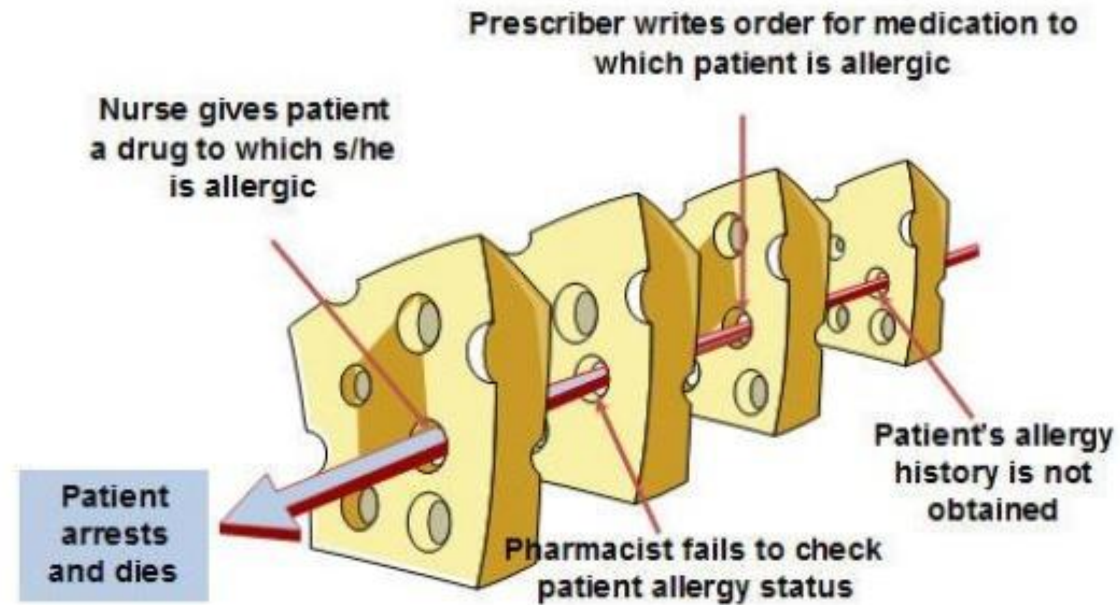
Root Cause Analysis

- Continuous process improvement
- Learning from errors, not seeking blame
- Systemic approach, not a personal approach

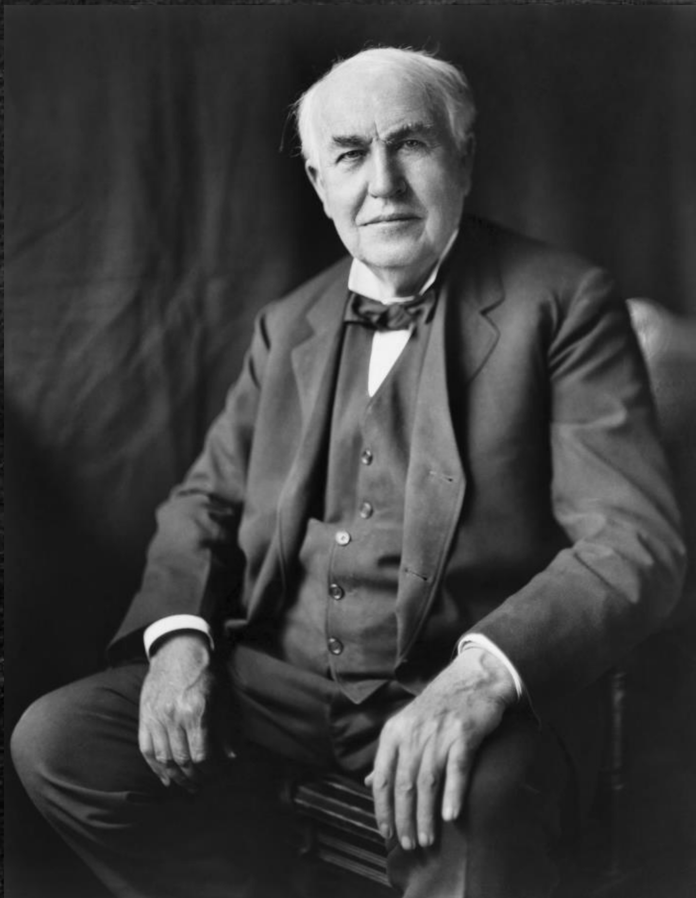
Root Cause Analysis Fishbone



Swiss Cheese Model of Errors



Best Practices – Continuous Process Improvement



- "Thomas Edison" model of best practices
- Don't invent the wheel
- Seek to make things go from "good" to "great"
- New process = new improvement opportunities

Electronic Health Records

- Source of new and exciting errors
  - Alert fatigue
  - Cross charting
  - Drowning in information
  - Reliance on reports
  - Reliance on electronic communication
- Other concerns
  - Security issues and liability
  - Poorer documentation
  - Less time with patients

Resources

- https://www.ahrq.gov/questions/resources/20-tips.html
- https://www.jointcommission.org/resources/patient-safety-topics/patient-safety/
- https://acmq.org/
- https://www.ncqa.org/

Questions?

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