

First, We Must Do No Harm: Medical/Clinical Errors and Patient/Client Safety

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📁 Nursing

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Objectives

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2. Discuss the aspects of the "speak-up" program that has been developed and promoted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
3. Describe the National Patient Safety Goals that institutions need to implement and follow.

Article

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Author: Colleen Symanski-Sanders, RN, Forensic Nurse Specialist

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Introduction and the Medical Error Report

"Patient Safety" – health care professionals cannot afford to underestimate the importance of those two words in the content of delivery of services. From safe school initiatives to national patient safety goals and recommendations, safety is a priority that will continue into 2004 and beyond. The public is being urged to take accountability regarding the health care they receive and to speak up if they are not satisfied or have questions. Information to become better educated about their health care is being provided to them from organizations that oversee the care that providers and agencies offer. This is a good thing. The implications are that as healthcare professionals we need to hone our communication skills not only with patients/clients but also with other members providing services to our clients.

The issue of medical/clinical errors and patient safety has received a great deal of attention since November 1999 when the Institute of Medicine (IOM) released their report, "To Err Is Human: Building A Safer Health System". The report suggested that as many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors and that many errors likely occur outside the hospital in settings such as physicians' offices, nursing homes, pharmacies, and home care. Medical errors cost the Nation approximately 37.6 billion dollars each year. About \$17 billion are believed to be associated with preventable errors. The American public (51% according to a Kaiser Family Foundation study) was attentive to the IOM report on medical errors. In another study regarding a recent investigation of pharmacists, the Massachusetts State Board of Registration in Pharmacy estimated that 2.4 million prescriptions were filled improperly each year in that state alone.

What Are Medical Errors, Where and Why Do They Occur?

The IOM defines an error as "failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim"; the accumulation of these errors can result in accidents. A medical error can cause an adverse event leading to an injury caused by medical management rather than by the underlying disease or condition of the patient. Note – there are adverse events that are not preventable and they reflect the risk associated with treatment (such as a patient who dies from an allergic

reaction for which there was no known allergy). News headlines and disciplinary action reports read like the following:

- "Hospital Infections are killing patients – Study covers 5,810 centers nationwide. Majority of deaths are preventable" (7/31/02)
- "Professional Counselor fined for abandoning clients by failing to give sufficient notice to her employer before resigning from her position" (4/2002)
- "Licensed psychologist reprimanded for engaging in a dual relationship by acting as both a therapist and later as a mediator for a family" (3/2002)
- "RN administers 4 times the adult dose to a pediatric patient" (2002)

Medical/clinical errors take on many different forms. A hospital patient on a salt-free diet given a high-salt meal is an error. A person getting the wrong prescription or dosage is an error. Amputation of the wrong limb is an error. In addition, diagnostic errors, equipment failure, infections, and blood transfusions are categories that may fall into the realm of medical errors.

A recent study supported by the Agency for Healthcare Research and Quality (AHRQ) found that "doctors often do not do enough to help their patients make informed decisions". "Uninvolved and uninformed patients are less likely to accept the doctor's choice of treatment and less likely to do what they need to do to make the treatment work". Breakdown in communications is a contributing factor to medical errors. In summary, errors can be categorized into the following:

1. **Diagnostic Processes:** Misdiagnosis leading to an incorrect choice of therapy; failure to use an indicated diagnostic test; misinterpretation of test results; failure to act on abnormal results.
2. **Treatments:** Technical/skill error in performance; error in preparation of the treatment; delayed treatment or inappropriate care. Infections, such as nosocomial and post-surgical wound infections fall under this category.
3. **Preventive:** failure to provide prophylactic treatment; inadequate monitoring and/or inadequate follow-up of treatment.
4. **Equipment Failures:** Such as defibrillators with dead batteries or intravenous pumps, whose valves are easily dislodged or bumped, causing an increased administration of medication over too short a period of time.
5. **Other:** Failure to communicate in certain environments such as the operating room or intensive care unit.

We usually see with our eyes and our mind. Our eyes, with adequate vision, have the ability to take in all information and our mind learns to process and screen out information that it considers less useful in an attempt to prevent information overload. As experience and confidence is gained, a picture is created in our mind of items that exist in our environment. As we attempt to locate or recognize items through comparison with our mind's picture (such as a medication), often we are unable to see any disconfirming evidence if the wrong product is selected. We see what our mind intends for us to see – this is known as "confirmation bias". The ability to filter information and locate or recognize items using a picture in our mind is vital to correct performance. Yet, it contributes to errors when the mind makes a correction for what the eyes are actually seeing. Confirmation bias causes clinicians to misperceive important information in the environment resulting in selection of the wrong product with a label or package similar to the correct product. Thus, resulting in a medical error.

What do our "Patients/Clients Think?

The general public perceives healthcare to be "moderately" safe overall. Ironically "moderately safe" according to public opinion is that the healthcare environment is safer than nuclear power or food handling but not as safe as the workplace environment. According to a survey conducted by the National Patient Safety Foundation, 42% of respondents had been affected by a medical error; either personally or through a friend or relative, and 23% of the respondents indicated that the error had a permanent negative effect on the patient's health. Americans are "very concerned" about:

- Being given the wrong medicine (61%).
- Being given two or more medicines that interact in a negative way (58%).
- Complications from a medical procedure (56%).

A survey conducted by the American Society of Health-System Pharmacists, found that 95% of the adults surveyed said they would report a medical mistake. Most people believe that medical errors are the result of the failure of the individual provider. When asked in the survey about possible solutions to medical errors, 75% of respondents thought it would be most effective to "keep healthcare professionals with bad track records from providing care" and 69% thought the problem could be solved through "better training of healthcare professionals".

Organized Patient Safety Efforts

While there is some controversy regarding the report, the relevancy is hard to dispute. Healthcare has not been a "safety-conscious" engineered industry. Healthcare is supposed to be safe – the public expects automobiles and airplanes to carry certain risks but not healthcare. The FDA has websites devoted to patient safety, recalls, and drug interactions. The AARP (American Association for Retired Persons) has launched a safe prescription drug use campaign titled "Check Up on your Prescriptions" to address drug misuse, which is believed to be a growing public health problem. In addition, the American College of Physicians / American Society of Internal Medicine held its first patient safety training workshop this year in Philadelphia. It is the opinion of this author that medical/health errors are an area of vulnerability and not necessarily the result of one person, clinician, or patient. However, we are all accountable for reducing the occurrences of errors. This can be accomplished through professional education, improved practice behaviors, and/or patient education.

National Education Campaign Advises Patients To Speak-Up!

Amongst the leaders in a unified effort to address the problem of medical errors and patient safety; the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services joined efforts and created a national education campaign urging patients to get involved in their care as a way to reduce medical errors and improve health outcomes. The program, developed and copyrighted by JCAHO is titled "Speak Up" an acronym as detailed below:

- **Speak up:** If you have questions or concerns, and if you don't understand, ask again. It's your body and you have a right to know.
- **Pay attention:** To the care you are receiving. Make sure you're getting the right treatments and medications by the right healthcare professionals. Don't assume anything.
- **Educate yourself:** About your diagnosis, the medical tests you are undergoing, and your treatment plan.
- **Ask:** A trusted family member or friend to be your advocate.
- **Know:** What medications you take and why you take them. Medication errors are the most common healthcare errors.
- **Use:** A hospital, clinic, surgery center, or other type of health care organization that has undergone a rigorous on-site evaluation against established state-of-the-art quality and safety standards, such as that provided by JCAHO.
- **Participate:** In all decisions about your treatment. You are the center of the healthcare team.

To view the brochure or download the artwork, go to www.jcaho.org and click on the *Speak Up* logo in the upper left hand corner. The brochure is also available by calling JCAHO's Customer Service Center at 630-792-5800.

National Patient Safety Goals And Recommendations Released July 2002

JCAHO released on July 24th, 2002, six National Patient Safety goals and recommendations. JCAHO-accredited health care organizations (including behavioral health) will need to be compliance ready beginning January 1, 2003. A multidisciplinary advisory group developed the national patient safety goals, of which six were released. Each goal has recommendations to consider based on the relevancy to the organization. Five of the six National Patient Safety Goals correlate with safe practices identified by the National Quality Forum (NQF). The 2003 National Patient Safety Goals and Recommendations as printed in the news release are:

Goal 1: Improve the accuracy of patient identification.

Recommendations: Use at least two patient identifiers (neither should be the patient's room number) whenever taking blood samples or administering medications or blood products. Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out", to confirm the correct patient, procedure, and site, using active – not passive – communication techniques.

Goal 2: Improve the effectiveness of communication among caregivers.

Recommendations: Implement a process for taking verbal or telephone orders that require a verification "read-back" of the complete order by the person receiving the order. Standardize the abbreviations, acronyms, and symbols used throughout the organization, including a list of abbreviations, acronyms, and symbols not to use.

Goal 3: Improve the safety of using high-alert medications.

Recommendations: Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, or sodium chloride >0.9%) from patient care units. Standardize and limit the number of drug concentrations available in the organization.

Goal 4: Eliminate wrong-site, wrong-patient, and wrong-procedure surgery.

Recommendations: Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents, (e.g., medical records, imaging studies) are available. Implement a process to mark the surgical site and involve the patient in the marking process.

Goal 5: Improve the safety of using infusion pumps.

Recommendation: Ensure free-flow protection on all general-use and PCA intravenous infusion pumps used in the organization.

Goal 6: Improve the effectiveness of clinical alarm systems:

Recommendations: Implement regular preventive maintenance and testing of alarm systems. Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.

Dr. Henri R. Manasse Jr., Ph.D., chair of the Sentinel Event Advisory Group; executive vice president and CEO of the American Society of Health-System Pharmacists; and past chair of the National Patient Safety Foundation, believes the goals are " high-impact, low- cost targets" and should "really make a difference in improving patient safety." Aggregate data on the achievement of the goals is to be made public annually, and individual organization compliance information will be disclosed when JCAHO performance reports are completed in 2004.

"SPEAK-UP" Campaign – Implications for Clinicians

The "Speak-Up" Campaign is one of several campaigns aimed at educating recipients of health services and there are also education opportunities for professionals as well. JCAHO is a significant player in patient safety standards, and it impacts and often leads the way for acceptable community standards. Two key factors influencing a clinician's decision about adopting new practices are that one, the practice changes have been proven to be the right thing to do, and second, clinicians being asked to change their practices must personally feel it's the right thing to do. Without valid research substantiating the benefits of the new way of doing things, it's hard to create much enthusiasm for change. Acknowledgement that the practice change is beneficial to the clinician and the patient is critical. If one or both of these criteria are not met there is significant resistance to change.

There is sufficient evidence that healthcare needs to be safer both collectively and individually. The following information for healthcare providers supplies details regarding the "Speak-Up" campaign and measures they might consider in improving patient safety. While "Speak-Up" is patient/client driven, there are implications to consider when it is analyzed. In addition, the Committee on Quality of Health Care in America in its book, *Crossing the Quality Chasm: A New Health System for the 21st Century* identified ten rules they believe will fill in the chasm. These rules have been incorporated into the implications seen below. It is up to you to implement and or modify these and other available recommendations based on your practice setting.

1. "Speak-Up" essentially translates into – competent individuals have a right to determine what will happen to their bodies. The care needs to be based on continuously healing relationships.
 - Explain care and procedures to patients/clients in a manner they can understand.
 - In particular is the issue of informed consent and it's essential ingredients of voluntariness, competence, and information regarding risks, complications, and alternatives. Patients/clients are being urged not to accept blindly the healthcare advice or services being offered.
 - Be prepared for multiple and persistent questions when questions are not satisfactorily answered.

2. "Pay Attention" to patient needs and values and be able to anticipate their needs (customize if needed). This essentially translates into capturing the patient's/client's attention by understanding basic learning principles and applying them safely to meet the level and needs of the patient/client. In addition, pay attention to your own actions.
3. "Educate Yourself" – share knowledge and allow the free flow of information including active collaboration and communication between healthcare professionals. Patients/clients should have access to their medical information and clinical knowledge. This behooves the healthcare provider to provide a written treatment plan to the patient in efforts to reduce confusion. Examples can be as follows:
 - When and how test results will be communicated.
 - Instructions for medications or other actions the patient must take.
 - Why and when a follow-up appointment is needed.
4. "Ask for an advocate" – poses confidentiality issues but essentially translates into recognizing and including the patient's/client's support system, as well as, operating within professional boundaries. If consumers follow the "Speak-Up" recommendations, the advocate will even be requested to review consents for treatment prior to the patient signing. Most likely, it is the advocate that calls when the patient's/client's condition is worsening. The patient's advocate is part of their support structure – often a significant other.
 - The advocate may ask questions that the patient/client may not think of, remind patients/clients of answers to questions he or she asked, and speak up for him or her if they are unable.
 - The advocate can help ensure that correct medications, equipment, and treatments are obtained by the patient.
 - In addition, the advocate is a person that is aware of the patient's/client's preferences for care, resuscitation, and life support measures.
5. "Know your Medications" necessitates that healthcare professionals know what medications (including over-the-counter medications and herbal drugs) that patients/clients are taking and observe for side effects regardless of the prescribing individual.
6. Use an accredited / reliable organization – calls for healthcare professionals to adhere to professional standards and acceptable community practices and identify "research practices" as such. In addition:
 - Clinical decisions should be evidenced based.
 - Care should be based on the best scientific knowledge available.
 - Recognize when you may not be the best source for the patient/client and refer them elsewhere.
 - Be proactive and explain your credentials before being asked.
7. "Participate" the patient in the care – the patient is the source of control. This requires health care professionals to elicit involvement from the patient/client and their advocate. Success depends on what health care professionals have termed "compliance". Non-compliance can be a contributing factor in medical errors; whether it is the result of a patient not obtaining medications due to cost or due to the patient's cultural, educational level, or personal preferences not being taken into consideration.

The Committee on Quality of Health Care identified six aims required to improve the quality of healthcare. Their aims (as well as their proposals and rules) are the follow-up to the report "To Err is Human". Their aims for health care in the 21st century are as written below and are consistent with the information provided in this material. Care should be:

1. Safe – avoiding injuries to patients from the care that is intended to help them.
2. Effective – providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
3. Patient-Centered – providing care that is respectful of and responsive to individual preferences, needs, and values and ensuring that patient values guide all clinical decisions.
4. Timely - reducing waits and sometimes-harmful delays for both those who receive care and those who give care.
5. Efficient – avoiding waste, including waste of equipment, supplies, ideas, and energy.
6. Equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status.

Conclusion

To quote Goethe, "Knowing is not enough – we must apply. Willing is not enough – we must do". Change is a slow progress though. Medical and technological advances in the 20th century were abundant and some were released at a pace that was faster than the normal human absorption. Old assumptions and safety measures need to be re-evaluated. A safer healthcare environment is possible over time and through behavioral changes.

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Colleen Symanski-Sanders, RN, Forensic Nurse Specialist, has been a Registered Nurse for over 18 years. She has extended her education into forensic nursing, criminal profiling, and psychopathy receiving a Certificate as a Forensic Nurse Specialist. She has over 16 years experience in public health and home care nursing.

Colleen has been an author of educational material for St. Petersburg College, St. Petersburg, Florida. She has also lectured on a variety of topics at numerous nursing symposiums and conferences across the country. She is on the Editorial Board for "Home Health Aide Digest" and "Private Duty Homecare" publications.

