Common Mistakes Medical Facilities Make

What You Can Do To Help Them

Michelle Foster Earle, President
OmniSure Risk Management Consulting
Objectives

• Describe at least one mistake medical facilities make
• List measures a Risk Manager can take to prevent that mistake
• Identify steps you can take to help the Risk Manager
Mistakes Medical Facilities Make
- Fail to prevent serious complications from opioid use, patient controlled anesthesia, anesthesia awareness
- Fail to listen, fail to communicate
- Implement health information and converging technologies in unsafe manner
- Fail to prevent medications errors – anticoagulants, pediatric, using medication reconciliation to prevent, abbreviations, look alike / sound alike, high alert meds
- Introduce infections
- Fail to implement a fall management and prevention plan
- Allow conditions that lead to worker fatigue
- Fail to prevent unintended retained foreign objects
- Fail to address alarm fatigue
- Fail to prevent surgical fires
Chasing Zero
Medication Errors
### Medication Errors

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for “0” (zero), the number “4” (four) or “cc”</td>
<td>Write &quot;unit&quot;</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number 10 (ten)</td>
<td>Write &quot;International Unit&quot;</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other</td>
<td>Write &quot;daily&quot;</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d, qod (every other day)</td>
<td>Period after the Q mistaken for &quot;I&quot; and the &quot;O&quot; mistaken for &quot;I&quot;</td>
<td>Write &quot;every other day&quot;</td>
</tr>
</tbody>
</table>
Medication Errors

This list of confused drug names, which includes look-alike and sound-alike name pairs, consists of those name pairs that have been published in the ISMP Medication Safety Alert® and the ISMP Medication Safety Alert® Community/Institutional Care Edition. Events involving these medications were reported to ISMP through either the ISMP National Medication Errors Reporting Program (ISMP MERP) or ISMP National Vaccine Errors Reporting Program (ISMP VERP). We hope you will use this list to determine which medications require special safeguards to reduce the risk of errors. This may include strategies such as: using both the brand and generic names on prescriptions and labels; including the purpose of the medication on prescriptions; configuring computer selection screens to prevent look-alike names from appearing consecutively; and changing the appearance of look-alike product names to draw attention to their dissimilarity. Both the FDA-approved and the ISMP-recommended tall man (mixed case) letters have been included in this list.
Opioid, Rx Abuse

• Workers Compensation – medical payments were 46% in 1987. Now 60%.

• Nonmedical use of painkillers result in $72.5 Billion in healthcare costs.

• CDC – Epidemic

• Drug interactions, falls, respiratory depression, addiction

• Rx overdose deaths – tripled in 20 years, ½ million ED visits, leading cause of death (74% are opioids)
Allegations would include:

- Lack of informed consent
- Over prescribing, under prescribing, irresponsible prescribing
- Failure to screen for risk of drug interactions
- *Failure to screen* for opioid addiction or risks
- *Failure to diagnose* opioid addiction
- *Failure to treat* opioid addiction
- *Lax procedures* to protect prescription pads
- *Failure to educate patient* on proper disposal to prevent theft or unintentional overdose by a minor
- Failure to screen for, diagnose, and treat neonatal abstinence syndrome
Opioids, Rx Abuse

Risk Management Tips:

1. If in a state with Prescription Drug Monitoring Program, insist that providers use it
2. Make provider education mandatory form a source other than the pharmaceutical companies
3. Follow medical evidence-based treatment guidelines
4. De-stigmatize addiction
5. Make educational materials and resources readily available
Diagnostic error is the leading cause of medical malpractice claims in the US, and is estimated to cause 40,000-80,000 deaths annually. A study published this month in British Medical Journal Quality & Safety concluded that diagnostic errors affect an estimated 1 in 20 U.S. adults just in outpatient settings, or about 12 million Americans every year, and that a significant fraction involves the potential for harm.”

— Society to Improve Diagnosis in Medicine Addresses IOM Committee on Diagnostic Error, Press Release Newswire, ST. JAMES, N.Y., April 28, 2014
Root Causes of Sentinel Events 1995–2004

n=3,197

Communication
Orientation/Training
Patient Assessment
Staffing
Availability of Info
Competency/Credentialing
Procedural Compliance
Environ. Safety/Security
Leadership
Continuum of Care
Care Planning
Organizational Culture

Over 60% of sentinel events reported to JCAHO attributed, at least in part, to poor communication.
Communication

Hand Offs Across Organizations and Providers

- In-System Transfers
- Housing
- Admission and Discharge
- Tests and Tracking
Team Communications

- Within Discipline – Nursing shift reports
- Across Disciplines – Medical and mental health staff
- Clinician Availability – Limited hours or calls
Communication

Specific communication and handoff training
Use structured standard communication process

<table>
<thead>
<tr>
<th>S</th>
<th>Situation</th>
<th>State what is happening at the present time that has warranted the communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Background</td>
<td>Explain circumstances leading up to this situation. Put the situation into context for the listener</td>
</tr>
<tr>
<td>A</td>
<td>Assessment</td>
<td>Description of the problem</td>
</tr>
<tr>
<td>R</td>
<td>Recommendation</td>
<td>What is needed to correct the problem</td>
</tr>
</tbody>
</table>

Table 1. SBAR Structured Communication Process
Adapted from Haig, Sutton, & Whittington, 2006
Frequency of adverse events decreases following SBAR implementation

Number of adverse events at OSF St. Joseph Medical Center, 2004 and 2005

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of adverse events (Per 1,000 patient days)</td>
<td>89.9</td>
<td>29.97</td>
</tr>
<tr>
<td>Number of adverse drug events (Per 1,000 patient days)</td>
<td>39.96</td>
<td>17.64</td>
</tr>
</tbody>
</table>

Technology

• Implement health information and converging technologies in unsafe manner
Falls, Infections
Surgical Complications

Wrong-Site Surgery
Incorrect Counts
Human Factors & Fatigue

- Fatigue
- Stress
- External Distractions
- Personal Issues

Job Performance
Hierarchy of Corrective Actions

- **Weaker:** *depend on* staff to *remember* training or policy
- **Intermediate:** somewhat *dependent on* staff (to remember) to do the *right thing*; provide tools to assist in recall or communication
- **Strong:** *do not depend* on staff to remember to do the *right thing*; may not totally eliminate the vulnerability but provide very strong controls

Steps Risk Managers Can Take to Avoid Mistakes

• Secure leadership’s commitment to patient safety
• Do not allow behaviors that undermine a culture of safety
• Quality Assessment and Performance Improvement
• Use tools: Checklists, Root Cause Analysis,
• EQ Training
Patient Safety Culture

SpeakUP™

To prevent health care errors, patients are urged to...

Help Prevent Errors in Your Care

The Joint Commission is the largest health care accrediting body in the United States that promotes quality and safety.

Helping health care organizations help patients

The Joint Commission
Quality Assessment and Process Improvement

• Tracking, Trending, Reporting
• Metrics and Dashboards
• Benchmarks
## Tools

### Problem 1:

- **Why:**
  - Why
  - Why
  - Why
- **Action Items:**
  - What
    - What
    - What
  - **Who:**
  - **When:**
    - Date
    - Time

### Problem 2:

- **Why:**
  - Why
  - Why
  - Why
  - Why
- **Action Items:**
  - What
    - What
    - What
  - **Who:**
  - **When:**
    - Date
    - Time

### Problem 3:

- **Why:**

---

**Tools:**

- RCA
- SBAR
- Safety Huddle
- Checklists
- Guidelines
- FEMA
- Time Out
EQ

- Compassion
- Awareness
- Regulation
- Emotional Intelligence (social focus vs. task focus) – ability to read others emotions to achieve positive outcome
What Insurance Partners Can Do To Help

- Rewards for Patient Safety
- Rewards for Transparency
- Awareness - Assessments
- Resources and Training
- Support Compassionate Disclosure
- Confidential Helpline
Questions