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Errors in Healthcare: Why They Happen and What to Do

Joy Siegel, EdD, MBA
Healthcare Consultant
Joy Siegel Senior Solutions, Inc.
Fort Lauderdale, Florida

Goals

- Understand definition and types of medical error and gain insight into impact of medication error
- Recognize implications and costs relative to medical error
- Gain insight into perspective of medical associations and medical error response

What is a Medical Error?

- Aljabari and Kadhim (2021) define a medical error as, *“an incidence when there is an omission or commission in planning or execution that leads or could lead to unintended result”*

Medical Error Outcomes

- Medical errors are a public health issue and a leading cause of death in the United States (third leading cause after heart diseases and cancer) as stated by Rodziewicz (2022)
- There are approximately 400,000 in-hospital errors annually
- 25% of U.S. adults report a medical error within the past five years (Prentice et al 2020)
- Health systems and providers need to establish ongoing opportunities evaluating and addressing safety needs with solutions, as opposed to a culture of blame

Medical Error Health Implications

- Medical errors are reported to impact:
  - emotional wellbeing
  - financial wellbeing
  - physical health
  - mental health
  - trust of healthcare system
  - healthcare avoidance

Medical Error Impact

- Rodziewicz et al. (2022) unveiled the following about medical errors:
  - while reports vary, medical errors cost an estimated $20 billion annually
  - annually, approximately 100,000 people die from errors in hospitals and clinics
  - most common errors in outpatient settings are incorrect or overlooked diagnoses or reactions from medications
  - of note, cost savings efforts with staff reduction are associated with medical errors resulting in increased mortality
  - some errors (adverse events) may not be preventable (Lapointe-Shaw and Bell 2019)

Prevalent Medical Errors

- Most prevalent errors include:
  - surgical
  - diagnostic
  - medication
  - devices and equipment
  - systems failure
  - infections
  - falls
  - faulty technology

Types of Medical Errors

- **Active error:**
  - occurs at the point of contact between the patient and the aspect of the healthcare setting
  - typically occur by the frontline workers – clinicians and nurses, healthcare technicians

Example: operating on the wrong body part in a surgical unit

Rodziewicz et al. 2022

Types of Medical Errors

- **Adverse event:**
  - adverse events are typically injuries that occur because of an error that occurred due to the medical condition of the person
  - events may be preventable if they occur due to system or policy failure incurred by the clinician
    - only preventable adverse events are because of medical error
    - adverse events can include untended outcomes or complication from other factors – infection, loss of mobility

Example: Patient is unstable and unsupervised in therapy post surgery and falls and breaks a hip

Rodziewicz et al. 2022

Types of Medical Errors

- **Latent error:**
  - latent errors stem from faulty systems, process, maintenance of organizational structure or equipment
  - this type of error may go unnoticed for an extended period of time
  - latent errors can trigger human error and result in a series of problems resulting in greater error

Example: "a hospital with several types of chest drainage sets, all requiring different connections and setups, yet not all frontline clinicians and nurses are familiar with the intricacies of each setup, creating the scenario for potential error"

Rodziewicz et al. 2022

Types of Medical Errors

- Medical Error (as quoted by Rodziewicz):
  - *“The failure to complete the intended plan of action or implementing the wrong plan to achieve an aim”*
  - *“An unintended act or one that fails to achieve the intended outcome”*
  - *“Deviations from the process of care, which may or may not result in harm”*
  - *“When planning or executing a procedure, the act of omission or commission that contributes or may contribute to an unintended consequence”*

Rodziewicz et al. 2022

Medication Errors

- Medication errors
  - incorrect dosage 70.4%
  - wrong medication 9.8%
  - incorrect time 6.5%
  - skipped doses 4.9%
  - monitoring error 4.9%
  - wrong patient recipient 3.2%

Unal and Intepeler, 2020

Medication Errors – World Health Organization

- Medication Without Harm public safety challenge:
  - patients and the public
  - healthcare professionals
  - medicines
  - systems and practices of medication
- Impact:
  - leading cause of preventable errors in healthcare in the world
  - impact varies based on class system, literacy, and accessibility
  - average cost of $42 billion globally for medication errors

Rodziewicz et al. 2022

- **Healthcare Professionals**
  - Education and training
  - Communication and teamwork
  - Capability at point of care
  - Incident reporting and learning
- **Medicines**
  - Right product at point of care
  - Logistics, storage, and disposal
  - Naming, labeling, and packaging
  - Product quality and safety
- **Systems and Practices of Medication**
  - Leadership and governance
  - Prescribing, preparation, and dispensing
  - Administration and patient monitoring
  - Monitoring and evaluation
- **Patients and the public**
  - Involvement of patient organizations
  - Reporting by patients
  - Patient engagement
  - Public awareness and medication literacy

Medical Errors – Barriers to Reporting

- Lack of understanding medical errors and significance of reporting
  - lack of clear definition of errors
  - limited to no protocol for reporting
  - no understanding of significance
- Time consuming
  - high workload can prevent reporting
- Lack of an official reporting system
- Personal reasons/factors
  - younger and less experienced professionals are less likely to report
  - personal experience can limit reporting

Medical Errors – Barriers to Reporting

- Fear of consequences
  - blame
  - losing job
  - patient or family response
  - fear of being seen as incompetent
- Lack of feedback
- Work climate/culture
  - perception of lack of safety and retaliation lead to underreporting
  - strong sense of team leads to stronger reporting

Medical Errors - Reporting

- Some research shows that healthcare professionals prefer to share medical errors rather than have someone else report them (Dimova et al. 2018)
- Identify reporting mechanism in healthcare setting
- Speak to department leadership about reporting process
- Engage team members in conversation about reporting
- Check with professional association about reporting obligations
  - AMA and The Joint Commission have guidelines about ethical reporting
  - AMA and The Joint Commission recognize that medical errors happen

Medical Errors - AMA Code of Medical Ethics

"In the context of healthcare, an error is an unintended act or omission or a flawed system or plan that harms or has the potential to harm a patient. Patients have a right to know their past and present medical status, including conditions that may have resulted from medical error. Open communication is fundamental to the trust that underlies the patient-physician relationship, and physicians have an obligation to deal honestly with patients at all times, in addition to their obligation to promote patient welfare and safety. Concern regarding legal liability should not affect the physician's honesty with the patient"

AMA Medical Ethics
Protecting Patient Safety (8.6)

- Disclose the occurrence of the error, explain the nature of the (potential) harm, and provide the information needed to enable the patient to make informed decisions about future medical care
- Acknowledge the error and express professional and compassionate concern toward patients who have been harmed in the context of healthcare
- Explain efforts that are being taken to prevent similar occurrences in the future
- Provide for continuity of care to patients who have been harmed during the course of care, including facilitating transfer of care when a patient has lost trust in the physician

Mitigating Errors – Creating a Safe Environment

- The Joint Commission 2023 hospital safety goals:
  - identify patients correctly
  - improve staff communication
  - use medication safely
  - use alarms safely
  - prevent infection
  - identify patient safety risks
  - prevent mistakes in surgery

Medical Errors – ARRT

- The *ARRT Standards of Ethics* includes the following ethical violations:
  - fraud or deceptive practices
  - unprofessional conduct
  - scope-of-practice violations
  - improper management of patient records
  - violation of state or federal laws, or regulatory rules
  - failure to report violations or errors

Medical Errors – Next Steps

- Find out how your healthcare setting handles reporting errors
- Learn how your credentialling association handles reporting errors
- Do your part to establish clear communication with patients and colleagues, including oral and written communication
- Support colleagues to mitigate and minimize errors
- If you see something, say something
- Report broken technology and other unstable equipment
- Do your part to avoid errors

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