Healthcare Mistakes and Their Impact on Organizations

State Office of Rural Health and Texas Hospital Association
Frontline First Educational Series
Summer 2022

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TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER

Continuing Nursing Education

- 1 CNE offered for each webinar attended
- Upon completion of all 4 webinars you will receive email with link for CNE
- Evaluation must be completed before you receive CNE certificate

Learning Objectives

- **Describe how a medical error can impact a healthcare facility**
- **Describe enhanced impact to Critical Access Hospitals**
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- **Describe how a medical error can impact individual employees**
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- **Identify ways to assess for system issues that increase risk of error**
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- **Describe measures facilities can take to reduce risk of error**
- **Describe your role in the identification of risk and prevention of errors**

- In a typical hospital, approximately what percentage of errors is reported?
  - A. less than 5
  - B. between 25 and 50
  - C. 75
  - D. between 80 and 90

What barriers would you have to reporting a near miss or actual error in the workplace?

A) Fear of punishment for myself or coworkers involved

B) Shame or guilt over possible mistake

C) Unfamiliar with reporting system in facility

D) I am not sure what should be reported or who I should report to

The Impact of Healthcare Errors

Impact of Healthcare Errors / Patient Harm Events

- **Approximately 250,000 people die each year from medical errors – 3rd leading cause of death behind cancer and heart disease**
- **Medical errors cost approximately $20 billion each year**
- **One CAUTI can result in over $10,000 cost to the facility**
- **Average cost of patient fall with injury is around $30,000**

Importance to Critical Access Hospitals

- Smaller in size
- Lower acute care inpatient volumes
- Operate with the least amount of resources
- Can’t absorb costs associated with patient harm events
- At greatest risk for closure

RaDonda Vaught
Case Presentation and Discussion
Overview and Lessons Learned

Where event took place

Vanderbilt University Medical Center

Sees more than 2 million patients each year – 1,000 beds

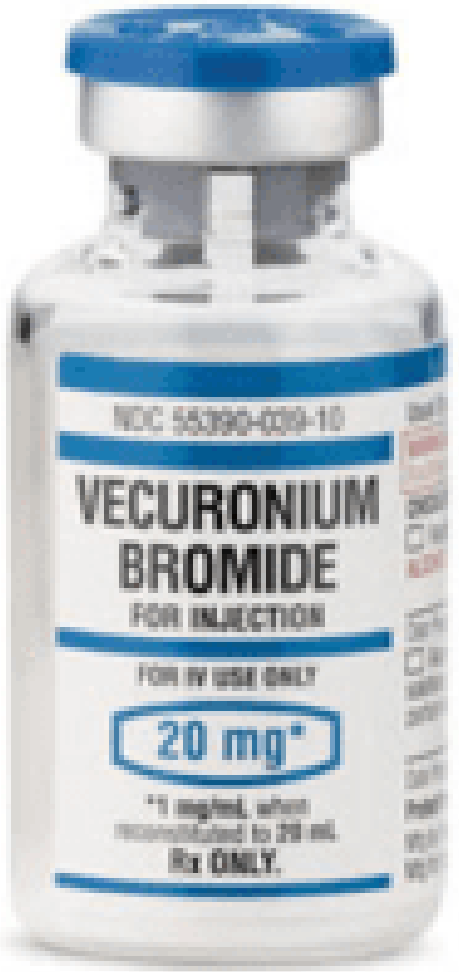
One of the largest academic medical centers in Southeast United States

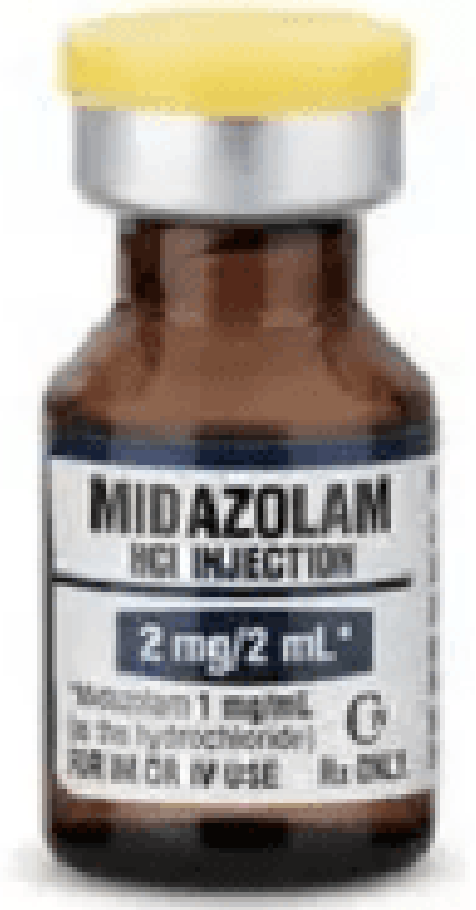
Background

- Medication error in 2017 led to death of a patient under RN's care.
- Scheduled for Dec. 25 and 26, 7a-7p shifts.
- Neuro ICU not understaffed as it was never shorthanded.
- Scheduled as "All-Help" (resource) nurse and assigned an orientee/new nurse during shift.
- Patient transported to Radiology for a PET scan; requested medication for anxiety.
- RN and preceptee were preparing to go to ED to perform a swallow study immediately before being asked to go to radiology first

Background

- Physician ordered Versed and order issued, entered into Automatic Dispensing Cabinet and verified by pharmacy.
- Radiology schedule was busy and RN not available
- Patient primary RN busy and not available
- About 10 minutes after verification, vecuronium withdrawn from ADC, using override feature, instead of Versed. No order to remove vecuronium. Override was not verified by pharmacy.
- No documentation in patient's record regarding vecuronium or administration to patient.


VECURONIUM
BROMIDE
FOR INJECTION
20 mg*
Rx ONLY


MIDAZOLAM
HCl INJECTION
2 mg/2 mL*

Background

- RN admits searching for Versed (instead of by generic name) under ADC profile and choosing override. RN admits she does not routinely administer Versed.
- Removed vecuronium vial and reviewed back of vial for directions regarding reconstitution; did not check name on the vial.
- Put medication and equipment in a bag, labeled it “Versed” and went to administer to patient. Attempted to use barcode scanning, but none available in procedural area
- Left Radiology after administration – did not monitor patient. Monitoring had been discussed and all parties decided it was not indicated.
- Did not document medication due to understanding that the new system would capture on Medication Administration Record. Should have shown up in a different color without scanning.
- Patient room had cameras, but not of a quality that could monitor breathing.

Background

- Patient suffered respiratory arrest and brain insult and ultimately family withdrew care
- Hospital undertakes investigation and terminates RN.
- “did not validate the five rights of medication administration, per policy, which is part of your responsibility and within your scope of practice...”

Criminal Case

- State of Tennessee undertakes investigation.

- RN admits to:
  - prior administration of Versed (for other patients) but never administered vecuronium.
  - distraction (trainee) during medication dispensing.
  - Should not have been distracted and focused on “meds.”
  - Should not have overridden system, but was a common act.
  - Unusual circumstance of reconstituting medication.
  - Should have recognized difference in vials, but nothing alerted at the time.
  - This was not an emergency for purposes of override and should have called pharmacy for verification.
  - Did not monitor patient.

Criminal Case

- Determined that 5 warnings were overridden and at least 5 “red flags” were ignored or not responded to.
- Determined that patient should have been monitored and signs of respiratory failure within minutes.
- Criminal case is filed, charged with reckless homicide and abuse of an impaired adult.
- Found guilty of criminally negligent homicide (lesser charge) and abuse of an impaired adult. No issue of intent or malice. Family indicated they did not seek incarceration.
- Sentenced to 3 years probation.

Hospital CMS Investigation

- After investigation, CMS issues immediate jeopardy letter and requires corrective action plan within weeks.
- Violation of 2 CoPs:

  Patient Rights, 42 CFR 482.13

  - "hospital failed to ensure patients' rights were protected to receive care in a safe setting and implemented measures to mitigate risks of potential fatal medication errors to the patients receiving care in the hospital."

  Nursing Services, 42 CFR 482.23

  - "hospital failed to ensure nursing services administered the correct medications, monitored the patient for any adverse reactions following the administration of a medication and prevented a preventable death."

Hospital CMS Investigation

- Hospital failed to meet reporting requirements, in particular to state:
  - Failed to report medication error to state.
  - Failed to report abuse, neglect and misappropriation at the facility – required a condition of licensure.

- Hospital interviewees could not explain why death was not reported as unusual, but admitted it should have been.

- Medical examiner claimed nothing was documented in record (re: medication error) because there was no document and was “hearsay.” Record shows “bleed” caused death. State law requires reporting of death that is suspicious, unusual or unnatural. ME should determine whether death requires additional inquiry.

- Hospital policy indicates deaths will be reported in accordance with law.

Hospital CMS Investigation

- Hospital policies were deficient:
  - High alert medications were not fully identified and no procedure or guidance regarding monitoring or patients after administration.
  - “Five rights of medication” were identified:
    - Right patient, right time, right dose, right route, right time/frequency, and a requirement to document. No policy regarding monitoring patients.
  - High alert medication chart did not list moderate sedatives, such as Versed.
- Hospital “failed to ensure that the Quality Assurance and Performance Improvement (QAPI) program thoroughly analyzed a critical adverse event and all the causes, and implement preventive actions that included adding additional safety parameters associated with overriding paralytics and other High Alert medications from an automated dispensing cabinet (ADC) to ensure that a similar critical adverse event could not reoccur.”

Hospital CMS Investigation

- Hospital undertook RCA and made changes to procedures. Override procedure changed and vecuronium removed from units. Rocuronium could still be accessed by override due to emergent need of drug during a rapid response.
- However, there was no documentation that the error was discussed in the Med Exec. meetings or the Exec. Committee meetings.
- There was also a delay in education for staff and nurses.

What are some potential Contributing Factors?

- Busy nurse with quick change of assigned task
- Nurse unfamiliar with the radiology procedure area
- Patient's primary nurse, nor Radiology Nurse unavailable
- Rush to get procedure completed
- Unfamiliarity with drug to be administered
- Communicated verbally to nurse by brand name
- Only generic name visible in dispensing system
- Look-up function required only two letters
- Override function utilized to find drug by brand name
- Override alert only, no "paralytic" alert
- Distraction during drug prep, discussing next task with
- Barcode scanning not available in procedure area
- EHR Access for documentation not available in procedure area
- Post-admin drug monitoring does not happen

How can/do you assess for these vulnerabilities in your own organization?

Questions to ponder

- Could something like this in your organization?
- How has this case affected the trust within your organization?
- What kind of conversations have you had with staff?
- How does staff understand reporting requirements?

Action Items to consider

REPORT

- Near miss
- Actual error
- Unsafe conditions

We don’t know there is a problem until someone speaks up!!

Action Items to consider

- Get involved!!
- Interdisciplinary team to review, assess, redesign processes; define processes and behavioral expectations
  - Med administration
  - Override reports
  - High risk medications, labels, names, warnings, etc.
  - Maintenance issues
  - Anything that can result in patient harm event

Action Items to consider

- Help change the culture!!
- Review, assess, reconcile intent towards punishment
  - Individual blaming vs. system failures
  - Be a part of the process to facilitate reporting
  - Build a culture of safety
  - Be empowered to speak up

Action Items to consider

Review, assess, reconcile processes and policies for patient and family notification and for hospital processes

- Silence is harmful and inhuman
- Assist with change – contribute your ideas to improve upon patient care

Resources

- Lopez, C. (2022). RaDonda Vaught Case Presentation and Discussion: Overview and Lessons Learned. *Presentation, Texas Hospital Association Patient Safety Organization.*
- Olsen, B. and Jew, R.K. (2022). It's about Five Behaviors, Not Five Rights: Using a Just Culture Framework to Drive Fair Accountability. *Presentation, IHI Patient Safety Congress.*

Sheila Dolbow, BSN, RN, CFN, CPHQ
Quality Improvement Project Manager
Texas Hospital Association Foundation
512-426-1026(o)
sdolbow@tha.org

Nina Costilla, MSN, RN, NEA-BC, RN-BC
Quality Improvement Project Manager
Texas Hospital Association Foundation
512.465.1016 (o)
ncostilla@tha.org


THANK
YOU!