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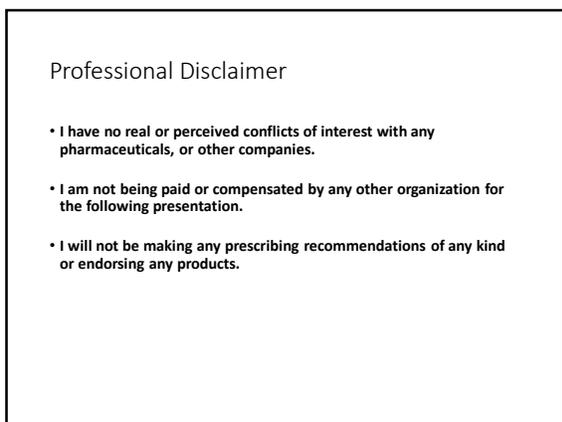
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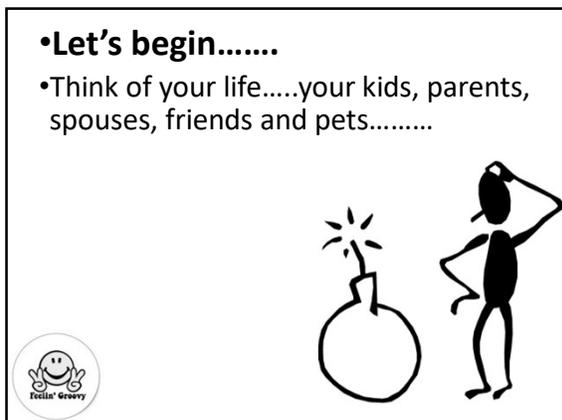
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## Objectives



- Summarize types of medical errors.
- List factors that increase risk for medical errors.
- Define populations of increased vulnerability.
- Identify Mandates for reporting medical errors
- Improving patient outcomes.... error reduction
- Discuss public education measures related to patient safety and caretaker involvement.

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## Why Learn About Medical Errors

- Medical errors injure 1 in every 25 hospital patients and is responsible for tens of thousands of deaths each year.
- Medical errors are more deadly than breast cancer, motor vehicle accidents, or AIDS.
- Medical errors cost the economy as much as \$29 billion each year (IOM, 1999).



The pain will go away when it stops hurting.

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- 1 in 3 people who enter a U.S. hospital will experience an adverse event (an injury or illness from a medical error) (Classen et al., 2011).
- Every week in the United States there are forty wrong-site or wrong-patient surgeries performed (Dentzer, 2011).
- In 2008, nearly 2 million people were harmed by adverse drug events (medication side effects or the wrong type or wrong dose of medication) (AHRQ, 2011a).
- In Florida, 168 patients died in 2010 and another 386 were victims of serious mishaps, including medication errors, wrong-site surgeries, and foreign objects such as tools or sponges left behind after operations (Sun Sentinel, 2011).

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What is a medical error?

- “The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.”  
- Institute of Medicine (IOM)

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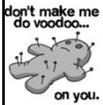
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- Travel through one patient’s life and the medical errors they experienced are they all catastrophic or even bad?.....



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Simple Stupid? People still don't do it right!!.....

- The United States Centers for Disease Control (CDC) reports that “handwashing is the single most important means of preventing the spread of infection”.



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### Excuses For Poor Hygiene

- Hand washing agents cause irritation and dryness
- Sinks are inconveniently located/lack of sinks
- Lack of soap and/or paper towels
- Too busy
- They don't "look" dirty!
- "I was wearing gloves"



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### What to DO...

- Perform hand hygiene after contact with blood, bodily fluids, secretions, and non intact skin.
- Wear disposable gloves when contact with infectious blood or bodily fluids is anticipated.
- Wash hands after the use of gloves.

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In Preop.....



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In 2007 the federal Center for Medicare and Medicaid Services issued a new rule that gave hospitals a powerful incentive to reduce medical errors: this rule denies reimbursement to hospitals for treatment of preventable errors, injuries, and infections. It also stipulates that hospitals cannot pass these charges along to the beneficiary.

The following preventable complications will no longer be reimbursed by Medicare if acquired during an inpatient stay:

- Object left in patient during surgery
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Pressure ulcer
- Vascular catheter-associated infection
- Mediastinitis after coronary artery bypass grafting
- Fall from bed

• Source: Federal Register 2007; 72:47379-47428.



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### Types of Medical Errors

- **Adverse Event (AE)**- an injury caused by medical management rather than the underlying condition of the patient, also called a sentinel event
- **Active Error**- errors made by an individual
- **Latent Error**- errors in system or process design, faulty installation or maintenance of equipment, or ineffective organizational structure
- **Potential Adverse Events**- "near misses" and "close calls", errors that could have caused harm but did not

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### Medical Dental Malpractice

- The most common dental error or act of professional malpractice is improper performance. Forty five percent of malpractice claims will involve some type of performance or dental procedure or dentist personal technique or execution of a procedure that resulted in an injury to the patient.
- **Dental Malpractice | Dental Errors | Dentist Mistakes ...**
- [www.medicalmalpractice.com/resources/medic](http://www.medicalmalpractice.com/resources/medic)

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**Most Common Errors**

- While wrong site/wrong procedure surgery continues to be the most common basis for quality of care violations, the following areas have been determined by the Board of Medicine as the five most mis-diagnosed conditions as demonstrated by disciplinary cases:
- Cancer
- Cardiac
- Acute abdomen
- Timely diagnosis of surgical complications
- Failing to identify pregnancy or stage of pregnancy before beginning treatment or surgery



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- Adverse Drug Event (ADE)- errors caused by the miss administration of medications
- Surgical Adverse Events- include wrong-site, wrong-procedure, or wrong-person surgery and account for a high percentage of all AEs. A study of hospitals in Colorado and Utah found that surgical AEs accounted for two-thirds of all AEs and 1 of 8 hospital deaths (Gawande et al., 1999).
- Inaccurate Diagnosing- attributing the wrong diagnosis to a patient



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- **Problems with Medical Equipment-**  
In 1990, Congress passed the Safe Medical Devices Act (SMDA), which requires that designs be "appropriate and address the intended use of the device, including the needs of the user and patient." The application of human factors principles during a device's design has been demonstrated to reduce user error (Making Healthcare Safer, 2001).

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### Common Dental Treatment Errors

An extremely expensive and painful example of this type of dental error is placing dental implants into the mouth of a person who is not healthy enough or without enough healthy bone for them to correctly implant and subsequently the implants fail leaving the patient with a bill and no implanted teeth.  
A dentist may be liable for dental malpractice if he or she improperly used a formaldehyde based root canal filling material which caused injury to a patient.  
A severe example of this kind of failure to diagnose is where a patient has periodontal disease and the dentist fails to diagnose and treat the condition causing the patient to lose all of his teeth. Dentists are required to develop and follow a treatment plan concerning each patient's dental health.

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This type of dental error usually will involve some kind of post surgical infection and loss of tooth, surrounding tissues and possibly injury to the jaw.  
This kind of error is common and often involves improperly diagnosing gingivitis, periodontal disease, disorders of the hard tissues of the teeth or cavities, disorder of the dental pulp and periapical tissues and malignant neoplasms or cancer of the mouth often resulting in .  
An example of this kind of negligence is a situation where a dentist placed several amalgam fillings in a patient's mouth and a week later pieces of mercury filling is found left in the gum tissue. Mercury is a toxic material that results in toxic reactions if ingested.  
Removal of a tooth, or multiple teeth, without getting patient consent clearly is an example of this kind of negligence.  
An example of this kind of error would be not removing an abscessed tooth to thereby allow a severe infection of the jaw to continue untreated and unabated.  
An example of a contraindicated procedure preformed would be removing a healthy tooth or teeth by negligently misreading an x-ray or removal order.

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- Practice Errors- •Causing physical harm to the patients
- Delaying patient discharge
- Creating unrealistic treatment and/or prognosis expectations
- Providing unneeded services
- Failure to provide needed services (Scheirton et al., 2003)
- Psychosocial errors
  - Showing lack of confidence in front of a patient
  - Withholding information about a patient's prognosis
- Lack of needed equipment
- Incorrect equipment installation
- Poor equipment design
- Wrong or unclear physician orders
- Unclear, insufficient or illegible documentation
- Communication breakdown among service providers
- Productivity pressure
- Lack of experience (Scheirton et al., 2003)

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Factors that Increase Error

- Fatigue
- Drugs/Alcohol
- Illness
- Inattention/Distraction
- Emotional State
- Unfamiliar Situation/Problem
- Equipment Design Flaws
- Communication Problems
- Hard to read handwriting
- Unsafe Working Conditions
- Inadequate Labeling/Instruction




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Root Cause Analysis

- Root cause analysis (RCA) is a widely adopted method of identifying underlying causes of medical error. An effective RCA looks beyond the immediate result and identifies the chain of events or contributing factors which led to the error. It uses a structured and process-focused framework to analyze errors to identify what happened, why it occurred, and what can be done to prevent recurrence. The process looks at both active and latent errors and avoids the tendency of assigning individual blame. Active errors are described as those acts or omissions which are committed by the people in direct contact with the patient. Examples of active errors include administering the wrong medication, deviating from safe operating practices, or cognitive failures such as memory lapses leading to patient injury. Latent errors are those failures which are removed from the direct control of the front line caregiver. Examples of latent errors are those caused by inordinate time pressures, inadequate staff, or equipment failures. A root cause analysis must be credible and thorough to be effective. The factors necessary for both elements are described in the table on the next page.

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- **CREDIBLE & THOROUGH**
- **Multi-disciplinary team** - The review team is comprised of participants from multiple disciplines and backgrounds closely associated with the processes and systems being reviewed. **Identification of all proximate causes** - Proximate causes are those events or occurrences which produce an effect or result. They are the catalyst from which anything proceeds and without which, it would not exist. All of the proximate causes must be identified and considered.
- **Team training** - Necessary training is provided team members. **Review of all related systems and processes** - A review of all of the related or involved systems and processes must be completed. Inherent in this review should be direct inquiry as to "why" all of the steps in the process are done or not done.
- **Consideration of all influences** - Consideration is given to all of the systems and processes that were involved in the event. None of the involved systems and processes can be ignored or left untouched. **A continuous focus on all opportunities to improve systems** - Attention must be given to any opportunities for corrective actions. All opportunities for improvement must be addressed.
- **Review of all pertinent literature** - Relevant literature and written material on the processes and systems are included in the review process. **Plan outline** - An outline of the planned recommendations must be provided which addresses the opportunities for improvement as well as explaining those situations where opportunities are not being pursued.
- **Team endorsement** - The team's findings are consistent and provide conclusions which do not raise questions or contain contradictory information. Additionally, the recommendations should be endorsed by the entire team. **Plan explanation** - The recommendations arising out of the review process should be explained fully, including the assignment of responsibility to specific individuals and a methodology for measuring outcomes and results.
- **Administrative support** - The findings of the review team should be supported and endorsed by the administration. Copies of the recommendations should be made available to all personnel who could benefit from them.

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- The goal of a root cause analysis (RCA) is to find out:
  - What happened
  - Why it happened
  - What to do to prevent it from happening again
- Root cause analysis is:
  - Interdisciplinary, involving experts from the frontline services
  - Involving of those who are the most familiar with the situation
  - Continually digging deeper by asking "why, why, why" at each level of cause and effect
  - A process that identifies changes that need to be made to systems
  - A process that is as impartial as possible
- To be **thorough**, an RCA must include:
  - Determination of human and other factors
  - Determination of related processes and systems
  - Analysis of underlying cause-and-effect systems through a series of *why* questions
  - Identification of risks and their potential contributions
  - Determination of potential improvement in processes or systems
- To be **credible**, an RCA must:
  - Include participation by the leadership of the organization and those most closely involved in the processes and systems
  - Be internally consistent
  - Include consideration of relevant literature (U.S. Dept. Veterans Affairs, 2009a)

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**Populations of Particular Vulnerability**

**The safety of all patients is of paramount concern for all care providers. However, some patients—for example, the very young and the very old—are particularly vulnerable to the effects of medical errors, often due to their inability to participate actively as a member of the healthcare team, most commonly related to communication issues. Nurses and other care providers need to recognize the special needs of these patients and act accordingly.**

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**Older Patients**

- Often have hearing, vision, and some degree of cognitive impairment
- Are at special risk for medication errors
- Are at a higher risk of falls
- Often need extra assistance
- When caring for older patients, communication with a responsible family member or patient advocate is essential.




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**Infants and Children**



- Greater risk of medication errors with digestive complications
- Parents/guardians should know a child's weight in kilograms, and check dosing with a doctor
- Do not have all the necessary communication skills so it is essential to communicate with the parents/guardians
- One research study in two urban teaching hospitals found that errors occurred in 5.7 percent of medication orders during the care of 1,120 pediatric patients admitted during 1999 (Kaushal et al., 2001). In addition, the rate of potential ADEs (close calls or near misses) was three times the rate of potential ADEs found in a similar study of hospitalized adults.

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**Fall Risk and Prevention**



**• FACTORS THAT INCREASE RISK FOR FALLS**

- Age 65 or over
- History of falling
- Impaired mobility or difficulty walking
- Need for assistance in getting out of bed or transferring to/from chair
- History of dizziness or seizures
- Impaired vision, hearing, or speech
- Need for mobility-assistive devices (cane, walker, wheelchair, crutches or braces)
- Weakness or fatigue
- Confusion, disorientation, impaired cognitive function
- Use of medications such as diuretics, laxatives, or consciousness-altering drugs including sedatives, analgesics, hypnotics, antidepressants, tranquilizers.

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**Some common ways to prevent falls from occurring include:**

- Physical Restraints
- Bed Alarms
- Special Flooring
- Bedrails
- Hip Protectors



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Practicing Medication Safety

**Follow the six “rights”**

1. right patient
2. right drug
3. right dosage
4. right dosage form
5. right time
6. right route




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Medication Errors-

- **Omission errors** (failure to administer an ordered medication dose)
- **Improper dose/quantity errors** (any medication dose, strength, or quantity that differs from that prescribed)
- **Unauthorized drug errors** (the medication dispensed and/or administered was not authorized by the prescriber); this category includes dispensing or administering the wrong drug

**System Failure-** “Most systems and most individuals resist change. Systems must have substantial inertia to make them stable, and medicine is no exception. In many ways, medicine is still a “cottage industry” of individuals (both clinical and administrative) who do things their own way, in their own silos.”  
(Pauker et al., 2005)




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- Medication errors are one of the most common types of error and are of primary concern to those who prescribe, dispense, and administer them as well as to providers who work closely with medicated patients. A large international study found that poor coordination of care is a key risk factor for medication errors. Researchers cited the expressed need for “better communication among multiple healthcare providers and more structured organization of care across healthcare settings” (Lu & Roughead, 2011).
- Medication errors are considered preventable **adverse drug events (ADEs)**. According to the IOM (2006), medication errors occur most frequently in prescribing and administering. These errors include:
  - **Omission errors** (failure to administer an ordered medication dose)
  - **Improper dose/quantity errors** (any medication dose, strength, or quantity that differs from that prescribed)
  - **Unauthorized drug errors** (the medication dispensed and/or administered was not authorized by the prescriber); this category includes dispensing or administering the wrong drug

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Patients can:

- Tell physicians about all medications they are taking and responses/reactions to them.
- Tell physicians about any change in their health since the previous visit.
- Ask for information in terms they understand before accepting medications.
- Insist that the physician include the purpose of the medication on the prescription.
- Check to be sure a refill is what it's supposed to be.

Providing organizations and practitioners can:

- Educate patients.
- Put allergies and medications on patient records.
- Stress dose adjustment in children and older persons.
- Limit access to high-hazard drugs.
- Use protocols for high-hazard drugs.
- Computerize drug order entry.
- Use pharmacy-based IV and drug mixing programs.
- Avoid abbreviations.
- Standardize drug packaging, labeling, storage.
- Use "unit dose" drug systems (packaged and labeled in standard patient doses).

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Purchasers can:

- Require machine-readable labeling (barcoding).
- Buy drugs with prominent display of name, strength, warnings.
- Buy "unit of use" packaging ("unit dose").
- Buy IV solutions with two-sided labeling.

To reduce the potential for taking a medication that was not prescribed for them or cannot be safely taken by them, patients should ask the following questions before accepting prescription drugs:

- Is this the drug my doctor (or other healthcare provider) ordered? What is the trade and generic name of the medication?
- What is the drug for? What is it supposed to do?
- How and when am I supposed to take it and for how long?
- What are the likely side effects? What do I do if they occur?
- Is this medication safe to take with other over-the-counter or prescription medications, or dietary supplements, that I am already taking? What food, drink, activities, dietary supplements or other medication should be avoided while taking this medication?

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ISSUES RELATED TO MEDICATIONS IN PEOP'S SETTINGS		Common Medications
<b>Pediatric:</b>	Family education and issues related to pediatric dosing are common problems.	anti-spasmodic seizure cardiac pain chemotherapy medications
<b>Geriatric and Home Health:</b>	<ul style="list-style-type: none"> <li>• Under-medication and over-medication are both common, as are issues related to geriatric dosing.</li> <li>• Less of muscle mass and body fat can significantly alter the absorption and metabolism of many common medications.</li> <li>• Poor communication can affect whether a medication is given or withheld.</li> <li>• Change of condition or transfer to a new setting can result in abrupt medication changes.</li> <li>• Polypharmacy can lead to adverse events such as falls.</li> <li>• Laxatives and stool softeners may affect activity levels.</li> <li>• Alcohol and recreational drugs may cause balance problems, swallowing problems and weakness.</li> <li>• Medications may be stopped or not taken as prescribed due to cost or inability to get to the pharmacy.</li> <li>• Over-the-counter (OTC) medications may be mixed with prescription medications.</li> <li>• Anticholinesterase drugs may cause fatigue, especially in people with disorders that affect muscle strength, such as post-polio syndrome.</li> </ul>	cardiac medications antidepressants narcotics OTC medications alcohol recreational drugs anticoagulants laxatives stool softeners anticholinesterase drugs cough medicines and expectorants antibiotics allergy and motion sickness drugs
<b>Outpatient:</b>	<ul style="list-style-type: none"> <li>• Herbal medication interacting with prescribed medications</li> <li>• Drug and alcohol abuse, recreational drugs</li> <li>• Overuse of pain and anti-inflammatory medications</li> <li>• Performance-enhancing drugs used by athletes can have a variety of physical effects.</li> <li>• Non-narcotic analgesics and OTC medications can cause drowsiness, weakness and fatigue and can mask the effects of overtraining.</li> </ul>	anti-inflammatories narcotics steroids herbal medications alcohol recreational drugs antidepressants

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**High Risk/High Alert Medication :**

- Limit access. When possible, dispense neuromuscular blocking agents from the pharmacy as prescribed for patients. Allow floor stock of these agents only in the OR, ED, and critical care units where patients can be properly ventilated and monitored.
- Segregate storage. When these agents must be available as floor stock, have the pharmacy assemble the vials in a sealed box with warnings affixed as noted below. Sequester the boxes in both refrigerated and nonrefrigerated locations.
- Warning labels. Affix fluorescent red labels that note: "Warning: Paralyzing Agent—Causes Respiratory Arrest" on each vial, syringe, bag, and storage box of neuromuscular blocking agents. Commercially available labels can be purchased from United Ad Label Co. Call 1-800-992-5755 and order item #AM282. (ISMP, 2005)

**Computerized Physician Order Entry :** automates the medication ordering process

- Systems-based analysis of medication errors and ADEs suggest that changes in the medication ordering system, including the introduction of computerized physician order entry (CPOE) with clinical decision support systems (CDSSs), may reduce medication-related errors (Making Healthcare Safer, 2001).

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**PREVENTING ERRORS IN PATIENT-CONTROLLED ANALGESIA (PCA)**

- Include bar codes on all PCA medications in facilities where point-of-care bar code systems or other item identification technology (eg, radio frequency identification) are implemented.
- Conduct a failure modes and effects analysis (FMEA) for existing pumps, as well as for new pumps that are brought into the facility. Consider what default settings are preprogrammed. Consider if the pumps can be programmed by drug (eg, morphine PCA vs. hydromorphone PCA). Consider if the pump resets to a default (other than "000," which would require active entry) after it turns off.
- Perform double-checks for initial setup and maintenance, and dose changes/change orders. Double-check clamp (to open position) before closing the pump. Check that the pump is turned on. Check whether connections are to IV or epidural lines to prevent wrong-route errors. Check for kinked tubing in the pump door.
- Educate staff about sound-alike and look-alike drugs, especially when bar code technology is not part of the existing system. Many drug errors with PCA pumps are due to name confusion (eg, morphine, hydromorphone, meperidine).
- If using preprinted order forms, prohibit writing over information on the form.
- Educate patients, family members, and staff (including physical therapists, x-ray technicians) about the use of the pumps. Written instructions should be provided to patients. Instruct family members NOT to administer PCA doses—PCA by definition should be administered at the patient's perception of need. Document education of patient and family members.

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**Medications in Non-Healthcare Settings**

- Recommendations includes proper storage, written policies and procedures, limitations on the type of medications stored by the organization, training programs, safeguards to prevent theft of controlled medications, and reporting and evaluation of medical errors. (See <http://www.nccmerp.org/councilRecs.html> for more information.)



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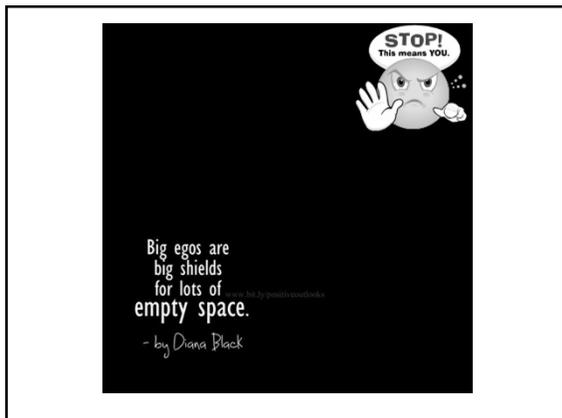
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### Reporting Errors

Joint Commission Error Reporting :

- Have a process in place to recognize sentinel events
- Conduct thorough and credible root cause analyses that focus on process and system factors, not on individual blame
- Document a risk-reduction strategy and internal corrective action plan within 45 days of the organization becoming aware of the sentinel event

Root Cause Analysis (RCA) :

- What happened
- Why it happened
- What to do to prevent it from happening again

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### Beyond Blame

The medical imperative is clear: to make health care safe we need to redesign our systems to make errors difficult to commit, and create a culture in which the existence of risk is acknowledged and injury prevention is recognized as everyone's responsibility.  
—LEAPE ET AL., 1998

**Culture of Safety :**

- Acknowledgment of the high risk, error-prone nature of organization's activities.
- Creation of a blame-free environment where individuals are able to report errors or close calls without punishment.
- Expectation of collaboration across ranks to seek solutions to vulnerabilities.
- Willingness on the part of the organization to direct resources to address safety concerns. (Making Healthcare Safer, 2001)



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System Goals and Strategies

- Pursue patient safety initiatives that prevent medical injury
- Promote open communication between patients and practitioners
- Create an injury compensation that is patient-centered and serves the common good

• (ICAHO, 2005)

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Joint Commission National Public Safety Goals

Improve the accuracy of patient identification.

Improve the safety of using medications.

Reduce the risk of healthcare-associated infections.

Accurately and completely reconcile medications across the continuum of care

Reduce the risk of patient harm resulting from falls.

Encourage patients' active involvement in their own care as a patient safety strategy

The organization identifies safety risks inherent in its patient population.

Improve recognition and response to changes in a patient's condition.

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Clinical Opportunities

- Appropriate use of prophylaxis to prevent venous thromboembolism in patients at risk
- Use of perioperative beta-blockers in appropriate patients to prevent perioperative morbidity and mortality
- Use of maximum sterile barriers while placing central intravenous catheters to prevent infections
- Appropriate use of antibiotic prophylaxis in pre-op
- Asking that patients recall and restate what they have been told during the informed consent process
- Continuous aspiration of subglottic secretions (CASS) to prevent ventilator-associated pneumonia

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### High 5s Project

- Managing concentrated injectable medicines
- Assuring medication accuracy at transitions in care
- Communication during patient care handovers
- Improved hand hygiene to prevent healthcare-associated infections
- Performance of correct procedure at correct body sites.



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### Public Education

- The single most important way patients can help to prevent errors is to be an active members of the healthcare team. That means taking part in every decision about their healthcare. Research shows that patients who are personally involved with their care tend to get better results. Involving family and care takers is also an important part of the safety plan.



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### Institute for Healthcare Improvement (IHI)

- Prevention of ventilator-associated pneumonia
- Prevention of central-line infections
- Prevention of surgical-site infections
- Deployment of rapid-response teams\*
- Assurance of optimal care for patients with acute myocardial infarction
- Prevention of adverse drug events
- Prevention of harm\* from high-alert medications starting with a focus on anticoagulants, sedatives, narcotics and insulin

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**•20 Tips to Help Prevent Medical Errors**

• US Dept. of Health & Human Service's Agency for Healthcare Research and Quality, September 2011

• <http://www.ahrq.gov/images/ahrq-logo.png>

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**• What You Can Do to Stay Safe**

- The best way you can help to prevent errors is to be an active member of your health care team. That means taking part in every decision about your health care. Research shows that patients who are more involved with their care tend to get better results.
- **Medicines**
- **Make sure that all of your doctors know about every medicine you are taking.** This includes prescription and over-the-counter medicines and dietary supplements, such as vitamins and herbs.
- **Bring all of your medicines and supplements to your doctor visits.** "Brown bagging" your medicines can help you and your doctor talk about them and find out if there are any problems. It can also help your doctor keep your records up to date and help you get better quality care.
- **Make sure your doctor knows about any allergies and adverse reactions you have had to medicines.** This can help you to avoid getting a medicine that could harm you.
- **When your doctor writes a prescription for you, make sure you can read it.** If you cannot read your doctor's handwriting, your pharmacist might not be able to either.
- **Ask for information about your medicines in terms you can understand—both when your medicines are prescribed and when you get them.**
  - What is the medicine for?
  - How am I supposed to take it and for how long?
  - What side effects are likely? What do I do if they occur?
  - Is this medicine safe to take with other medicines or dietary supplements I am taking?
  - What food, drink, or activities should I avoid while taking this medicine?
- **When you pick up your medicine from the pharmacy, ask: Is this the medicine that my doctor prescribed?**
- **If you have any questions about the directions on your medicine labels, ask.** Medicine labels can be hard to understand. For example, ask if "four times daily" means taking a dose every 6 hours around the clock or just during regular waking hours.
- **Ask your pharmacist for the best device to measure your liquid medicine.** For example, many people use household teaspoons, which often do not hold a true teaspoon of liquid. Special devices, like marked syringes, help people measure the right dose.
- **Ask for written information about the side effects your medicine could cause.** If you know what might happen, you will be better prepared if it does or if something unexpected happens.
- **Hospital Stays**
- **If you are in a hospital, consider asking all health care workers who will touch you whether they have washed their**

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- **When you are being discharged from the hospital, ask your doctor to explain the treatment plan you will follow at home.** This includes learning about your new medicines, making sure you know when to schedule follow-up appointments, and finding out when you can get back to your regular activities.
- **It is important to know whether or not you should keep taking the medicines you were taking before your hospital stay.** Getting clear instructions may help prevent an unexpected return trip to the hospital.
- **Surgery**
- **If you are having surgery, make sure that you, your doctor, and your surgeon all agree on exactly what will be done.** Having surgery at the wrong site (for example, operating on the left knee instead of the right) is rare. But even once is too often. The good news is that wrong-site surgery is 100 percent preventable. Surgeons are expected to sign their initials directly on the site to be operated on before the surgery.
- **If you have a choice, choose a hospital where many patients have had the procedure or surgery you need.** Research shows that patients tend to have better results when they are treated in hospitals that have a great deal of experience with their condition.
- **Other Steps**
- **Speak up if you have questions or concerns.** You have a right to question anyone who is involved with your care.
- **Make sure that someone, such as your primary care doctor, coordinates your care.** This is especially important if you have many health problems or are in the hospital.
- **Make sure that all your doctors have your important health information.** Do not assume that everyone has all the information they need.
- **Ask a family member or friend to go to appointments with you.** Even if you do not need help now, you might need it later.
- **Know that "more" is not always better.** It is a good idea to find out why a test or treatment is needed and how it can help you. You could be better off without it.
- **If you have a test, do not assume that no news is good news.** Ask how and when you will get the results.
- **Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources.** For example, treatment options based on the latest scientific evidence are available from the [Effective Health Care Web site](#). Ask your doctor if your treatment is based on the latest evidence.
- **\*The term "doctor" is used in this filer to refer to the person who helps you manage your health care.**

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## Summary

As Leape and Berwick (2005) wrote:

...the most important stakeholders who have been mobilized [to advance patient safety] are the thousands of devoted physicians, nurses, therapists and pharmacists at the ground level—in the hospitals and clinics—who have become much more alert to safety hazards. They are making myriad changes, streamlining medication processes, working together to eliminate infections and trying to improve habits of teamwork. The level of commitment of these frontline professionals is inspiring.

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## References and Resources

For your practice, your employees...

Your Patients and you.....

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- [http://www.nytimes.com/2012/01/06/health/study-of-medicare-patients-finds-most-hospital-errors-avoided.html?\\_r=1&ref=health&module=services&department=health&topic=sentinel.com/2011-07-29/health/01-hk-medical-mistakes-overview-20110730-a\\_wrong-site-surgeries-medical-mistakes-wrong-body-part](http://www.nytimes.com/2012/01/06/health/study-of-medicare-patients-finds-most-hospital-errors-avoided.html?_r=1&ref=health&module=services&department=health&topic=sentinel.com/2011-07-29/health/01-hk-medical-mistakes-overview-20110730-a_wrong-site-surgeries-medical-mistakes-wrong-body-part)
- [www.aahrq.gov/qual/adptsafety.htm](http://www.aahrq.gov/qual/adptsafety.htm)
- [www.jointcommission.org/news/1/18/Sentinel\\_Event\\_Policy\\_3\\_2011.pdf](http://www.jointcommission.org/news/1/18/Sentinel_Event_Policy_3_2011.pdf)
- [www.jointcommission.org/standards\\_information/ncps.aspx](http://www.jointcommission.org/standards_information/ncps.aspx)
- [www.jointcommission.org/assets/1/18/SEA\\_09.PDF](http://www.jointcommission.org/assets/1/18/SEA_09.PDF)
- [P Medication Safety Alert: Infant Hepatin Flush](http://search.proquest.com/docview/1178181&query=healthcare+overdose+intentional&search=Search)
- [S. U.S. Census Bureau. Language spoken at home: 2010 American Community Survey. Accessed](http://search.proquest.com/docview/1178181&query=healthcare+overdose+intentional&search=Search)
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