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REDUCING MEDICAL ERRORS

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REDUCING MEDICAL ERRORS

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IN A PERFECT WORLD, MEDICAL ERRORS WOULD NOT OCCUR AND NO ONE WOULD EVER DIE AS A RESULT OF THEM. UNFORTUNATELY, THE WORLD WE LIVE IN IS FAR FROM PERFECT.

According to a study conducted by researchers at Johns Hopkins Medicine that was published in 2016, medical errors are the third leading cause of death in the United States, responsible for up to 250,000 deaths each year. This is up considerably from an estimated 98,000 deaths each year that were attributed to medical errors in the landmark report, "To Err Is Human," which was published in 1998.

PROBLEM IS WORSENING

Despite an increased awareness of the prevalence of medical errors – including surgical errors occurring in the OR – and the toll they're taking in terms of human lives, these statistics seem to indicate that the problem is getting worse, not better.

"The reality is that surgery is a complex, dynamic and stressful environment that serves as a catalyst for error," says Susan K. Banschbach, MSN, RN, CNOR, a former surgical services executive director (retired) and current contracting consultant.

"Errors in surgery do not just happen," adds David L. Taylor, MSN, RN, CNOR, an independent hospital and ambulatory surgery center consultant and principal of Resolute Advisory Group LLC. "They develop from a series of interactions between mul-

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tiple people and equipment used on a particular surgical intervention."

Taylor divides surgical errors into two main categories: errors of omission that occur as a result of actions not taken by the assigned staff, and errors of commission that occur as a result of the wrong action taken.

Examples of the former include things like not securing the patient properly to the surgical bed or not stabilizing a gurney prior to patient transfer to that bed, Taylor explains. Examples of the latter include things like the administration of a medication improperly labeled or administering a medication to which the patient has a known allergy.

Other causes of surgical errors listed by Taylor include:
- Distractions in the OR setting such as music and digital devices
- Incomplete or missing pertinent imaging information, which forces a reliance on memory
- Incomplete pre-operative assessments, such as failing to note abnormal pre-op labs or tests (like EKGs)
- Time pressures that result in OR staff taking shortcuts or not following established infection prevention recommendations or safety precautions
- An attitude that a surgeon's decisions should not be questioned

IMPACT OF COMMUNICATION FAILURES

Alexander A. Hannenberg, M.D., principal consultant-anesthesiology with OR Dx + Rx Solutions for Surgical Safety, believes that the overarching source of medical errors in health care, including surgery, is poor communication among the many providers typically involved in patient care.

"The Joint Commission has estimated that between 70 percent and 80 percent of adverse events are related to communication failures," says Hannenberg. "In addition, more than a third of malpractice actions identify this as an underlying cause of the event."

Medication errors and missing information in patient handoffs are the two most frequently cited manifestations of communication failure, Hannenberg adds.

"Each of these drives mishaps with a range of severity, including death," he says.

Bill Greene, M.D., F-IDSA, F-SHEA, senior quality and patient safety consultant with OR Dx + Rx Solutions for Surgical Safety, concurs. He emphasizes the importance of standardized work – or in other words, using policies, forms, prompts and reinforcement – to minimize variation from best practices.

"Two areas of standardization are especially important," says Greene.

"Pre-operative risk assessment and medical optimization (or pre-habilitation), and perioperative or surgical safety checklists."

One type of medical error that Greene says is not usually characterized as an "error" is the failure to communicate to the surgeon or other practitioner data and analytics relating to the quality and safety of his or her work.

"The prevention of medical errors is enabled by the collection and use of data by the department or institution to measure performance related to quality and safety," he says.

Examples of this type of data include patient/family or staff complaints about a staff surgeon or other provider; objective, risk-adjusted surgical process and outcome indicators; and surgery-specific and surgeon-specific "dashboards" that are formatted for clarity and shared with relevant supervisors and the surgeon.

TOP SENTINEL EVENTS

Amber Wood, MSN, RN, CNOR, CIC, FAPIC, senior perioperative practice specialist with the Association of peri-Operative Registered Nurses (AORN), cites data from The Joint Commission indicating that the top two sentinel events in the surgical setting are: 1) unintended retained foreign objects and, 2) wrong-patient, wrong-site,

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wrong procedure events.

The prevention of both of these types of errors requires a multi-disciplinary approach, says Wood.

"For unintended retained foreign objects, the approach includes accounting for surgical items, preventing retention of device fragments, reconciling count discrepancies, and using adjunct technologies to supplement manual count procedures," she says.

"For wrong-patient, wrong-site, wrong procedure events, the approach includes pre-procedure verification that includes site marking, time out procedures, a standardized briefing process and use of a standardized surgical safety checklist," Wood adds.

Each year, AORN sponsors a National Time Out Day in June to keep this issue top of mind for perioperative personnel, notes Banschbach. "Consistency, redundancy, clear communication and speaking up are the keys to success," she says.

Taylor believes that creating the right patient safety culture is one of the biggest keys to reducing medical errors. "This culture should work toward recognizing safety challenges and implementing viable solutions rather than harboring a culture of blame, shame and punishment," he says.

"Health care organizations need to establish a culture of safety that focuses on system improvement by viewing medical errors as challenges that must be overcome," Taylor adds. "All individuals on the health care team must play a role in making the provision of health care safer for patients and health care workers."

Banschbach stresses the myriad safety procedures that have been implemented to prevent what are referred to as "never events."

"One of the most significant is the use of the Comprehensive Surgical Checklist," she says. "The list covers three phases of patient care: preoperative, intraoperative and postoperative.

"Caregivers in all three phases depend on the list to confirm that everything is accurate and complete," Banschbach adds. "Intraoperatively, it is used in conjunction with a surgical time out prior to the incision or beginning of a less-invasive procedure."

Banschbach acknowledges that convincing members of the surgical team to support and comply with safety protocols can sometimes be challenging, at least at first. "But over time, as team members overcame the awkwardness of the time out and site marking, things became much less difficult."

IT STARTS AT THE TOP

Taylor believes strongly that improving patient safety by reducing medical and surgical errors starts at the top of the health care organization.

"Executive leaders who make safety part of their mission, vision and values realize better outcomes," he says. "Accountability and culture also matter. Designing safe systems that are easily followed helps minimize errors and allow detection before harm begins."

Wood believes that perioperative team members are "ethically and morally obligated to protect patients by preventing medical and surgical errors."

Aside from this ethical obligation, Wood notes that health care organizations face serious ramifications resulting from these errors. "These include financial penalties, legal consequences, mandatory reporting, erosion of trust and potentially irreparable damage to their reputations," she says.

Hannenberg notes that the industries health care most often seeks to emulate, such as aviation and nuclear power, long ago embraced investments in teamwork and communication training in order to prevent human errors.

"Reducing medical and surgical errors moves health care closer to the ultimate goal of high reliability," he says. ■