Term Paper: Medical Errors

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Introduction

Providing high quality patient care is most often an important part of the work nurses do. But even when the patient's well being is of utmost priority medical errors can still occur. The consequences of medical errors range from causing no harm to being fatal. A medical error, as it is defined by the Encyclopedia of Surgery (2011), is an adverse event that could be prevented given the current state of medical knowledge. Medical errors are human errors, which can occur do to a lapse of judgement or a risky choice in the part of the healthcare provider. Following the increase of awareness of medical errors, strategies to decrease their occurrence have been put into place, at different levels of the healthcare system. Many of these strategies include the nurse as an integral part.

Exploring Medical Errors

Medical errors can occur in relation to diagnosis, treatment and prevention. These include but are not limited to; medication errors, surgical errors, falls, and hospital acquired infections. Medication errors include administering medications to the wrong patient, administering the wrong medication, or the wrong dosage and administering a medication at the wrong time. There is an extensive list of possible surgical errors which include wrong procedure, surgical materials being left inside the patient, amongst others. Falls can be a result of safety precautions not being followed, such as failing to toilet the patient at appropriate intervals and call bells being out of the patients reach. Hospital acquired infections are highly preventable, if all hospital staff adheres to exceptional hand hygiene regimes and other infection control policies.

Research on medical errors saw an increase in the 90's, with many studies being published in that decade. (Huston, 2014, p. 230) These studies led to an even more extensive study called *To err is Human* which looked at the effects of medical errors and strategies to decrease its occurrence. This study not only lead to changes within the healthcare community but also policy changes nationwide as well. A summary of the study released by the Institute of Medicine (1999) states; "Congress soon launched a series of hearings on patient safety, and in December 2000 it appropriated $50 million to the Agency for Healthcare Research and Quality to support a variety of efforts targeted at reducing medical errors." (p. 5)

Today, the impact of medical errors on mortality rates varies between reporting sources. But one recurring theme is that the figures are higher than most would expect. Johns Hopkins (2016), after analyzing eight years of death rate data, reports that each year over 250,000 death are due to medical errors. In the other hand, an article by Doctor John T. James, published on the Journal of Patient Safety estimated that yearly, the number of preventable deaths is over 400,000. It is important to note that it is difficult to accurately account for all medical-error-caused deaths and complications because the medical error may have gone undetected.

Most often the types of medical errors that reach news platforms are those that cause extreme impairment or death. For example, in Alexandria, Min. a medication error which made local news was related to the administration of epinephrine which resulted in the death of the patient. (Edenloff, 2018) This was the only fatal medication error in the state between October 2016 and October 2017, according to an annual report released by the Minnesota Department of

Health. In recent history many other unfortunate fatalities have reached the general public causing unease.

Possible Solutions

In my opinion, one of the most intriguing approaches to medical errors is “just culture.” Just culture is heavily based on the idea that most errors occur unintentionally and that when an honest mistake is made, the individual shouldn't be punished. Instead, just culture calls for a review of the system where the error occurred, to identify possible faults and possible systematic solutions. This approach to human error is not new. Industries such as that of aviation have implemented this system for a span of 45 years. (Boysen, 2013 p. 400) It is no secret that the safest means of travel is by air, just culture is highly responsible for this outcome.

An example of a systematic approach to medical errors that adopts just culture includes written checklists, systematic drills and simulation practice and strong advocacy for staff members. (Boysen, 2013 p. 406) In a just culture, it is imperative that nurses feel comfortable to come forward if they feel they have made a mistake. This allows for early identification of flaws in the system. This creates a culture of continuous learning within the facility, which ultimately benefits everyone within it. An obstacle for just culture would be the nursing leadership’s ability to differentiate between three possible types of behaviors; human error, at-risk behavior and reckless behavior. (Reason, 1990) Each behavior calls for a different action. Mistakes, ie, human error call for further teaching and training, risk taking behavior calls for a review of the possible consequences and reckless behavior could call for disciplinary action.

Just culture has gained support of many healthcare organizations, including American Nurses Association, which stated that, “The Just Culture concept is an ideal fit for health care systems… By promoting system improvements over individual punishment, a Just Culture in healthcare does much to improve patient safety, reduce errors, and give nurses and other health care workers a major stake in the improvement process.” (ANA, 2010)

Another interesting approach to medical errors has been the efforts made by the Centers for Medicare and Medicaid. The P4P, pay for performance, initiative was created to do what the name suggests. Under P4P, payment for services is proportional to the quality of the service provided. (Huston, p. 237) This raises the stakes, because it holds healthcare providers not only liable for the care they provide but for the quality of their practice. There are some opposing arguments to this system related to physician and patient participation.“Often, physicians cannot be scored because they have too few patients who are eligible to be scored for a given metric. If a physician only have 2-3 patients eligible, the physician score is not very informative and can be heavily affected by a single outlier.” (Shafrin, 2011)

Summary

Everyday millions of people put their health and wellbeing in the hands of the most trusted profession in America, nursing. Nevertheless, behind our licenses and certifications are just people capable of mistakes. Since nurses are key members of the healthcare team, it comes as no surprise that we are vulnerable to making medical errors. This should not hinder the ability for our communities to put their trust in us. Ongoing research and continued evaluations of possible solutions are key in addressing this concerning state of affairs.

Research leads to a better understanding of the cause of errors and possible resolutions. The publication of *To Err is Human* is a great example of this because although great leaps have been made since its release, more needs to be done. A literary review of the effects of the *To Err is Human* report concluded that the report “was associated with an increased number of patient safety publications and research awards. The report appears to have stimulated research and discussion about patient safety issues, but whether this will translate into safer patient care remains unknown.” (Stelfox, 2006, p. 176) Years later we see that the actions triggered by this report both locally within facilities and nationwide through government involvement have been beneficial. Far-more needs to be accomplished concerning the resolution medical errors but great strides are being made at different levels of the healthcare system.

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