Medical Errors

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Abstract

Hoping to reduce medication errors and contain health care cost, policy makers such as the Joint Commission, are mandating accredited healthcare facilities to comply with safety regulations to reduce medical errors. Health care facilities will have polices for reporting of adverse events and such will have to be done within an assigned period of time. Standards and regulations clearly intended to improve patient safety and reduce healthcare cost.

 Medical errors according to Ghimmie (2008) is defined as “incorrect or plans that may or may not cause harm to a patient. There are various terms used to indicate medical errors, for example, unintended consequences, untoward event and non-therapeutic results. Medical errors is the #8 leading cause of death in the United States, surpassing deaths attributed to motor vehicle accident which accounts for 43,458, breast Cancer 42,297 and Aids 16,516. However these figures refer only to hospitalized patients, they do not include patient treated in outpatient and ambulatory clinics, doctors’ offices, nursing homes or military health services. Medical errors occurring outside the hospital was an estimated 2.4 million in 1999 A medical errors is not new to the United States health care system. Medical errors have surely occurred since medicine began. It was until during the mid-1990’s that the US began to receive nationwide attention from publicized cases of medical errors. The statistics contained within the IOM report were startling. Consumers were barraged with the study findings suggesting that the quality of healthcare was inadequate and medical errors were significant problem leading to increase morbidity and mortality rates. The report stated that 45,000 to 98,000 Americans die each year as a result of medical errors within US hospitals.

There is no single universal accepted method of classifying medical errors. In order to describe them more fully, the 2000 IOM reported five different classification schemes that have being used to classified medical errors. The five classifications are; the type of healthcare given, severity of the injury, legal definitions, settings and persons involved. The importance of these different ways to classify medical errors is their indication that different types of errors require different approaches to prevention and problem solving.

 The causes of medical errors are complex and not yet completely understood. Some causes that have been identified include the following: Communication errors, the increasing specialization and fragmentation of healthcare, human error resulting from overwork and burnout, manufacture errors, equipment failure, diagnostic errors and poorly designed buildings and facilities.

Communication errors involve telephone or verbal orders among healthcare professionals. For example, a doctor giving orders to a nurse or to residents and or interns can result in miscommunication and drug mix up due to drugs with similar names.(MSo4 and be misinterpret for Mg sulfate).

The increasing specialization and fragmentation of health care is, the more people involved in patient treatment, the greater the possibility that pertinent information will be missed along the way.

Human errors resulting from overworked or burnout occurs when hospital interns and resident also nurses are expected to work long hours. Studies have shown that due to inadequate sleep and rest periods they were a high percentage of medical errors. With the coming of managed care, many hospitals have cut the size of their nursing staff and require those that remain to work mandatory overtime.

Manufacturing errors; such as blood products being mislabeled during production process, resulting in patients being given transfusions of a different compatible type.

Equipment failure; a typical example of equipment failure might be an intravenous pump with a malfunctioning valve, which will allow too much of the patient medication to be given over a short period of time.

Diagnostic errors; a misdiagnose illness can lead to a patient being prescribed an inappropriate type of treatment. Errors in poor diagnostic imaging have resulted in surgeons operating on the wrong side of the patient’s body. Another common form of diagnostic error is failure to act on abnormal test results.

Poorly designed buildings and facilities; hallways that ends in sharp right angles, for example, increase the likelihood of falls or collisions between people on foot and patients being wheeled to an operating room.

 An IOM study has examined various types of medical errors that were occurring in the US healthcare facilities. Some of the various types of errors are medications errors, adverse events, sentinel events, and identification errors.

Joint Commission (2008) reported that errors associated with medications are believed to be the most common type of medical error and is a significant cause of preventable adverse event.

 A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of a healthcare professional, patient or a consumer. A recent IOM study, confirm a report suggesting that 7000 patients die each year from medication errors and another 450,000 drug event are linked to preventable medication errors. Medication errors can occur during prescribing, dispensing and or administering of a drug, whether there is an adverse consequence or not.

 Adverse event is another form of medical error, and is defined as, injuries to patient occurring during medical management, not necessary because of an error. Nearly five of every hundred patients suffered an adverse event cause by a medical error of omission or commission. Of these adverse events, approximately one in four involves negligence.

 Sentinel events are adverse events that are considered preventable, and are those which signal a need for immediate investigation. A sentinel event is defined further as an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof.

 Identification errors are errors occurring from patients been labeled with the wrong identification band, that is wrong name and medical record number. Another form of identification error is surgical removal of a wrong limb.

 There are several proposal made by federal and state regulators to reduce the rate of medical errors in the American health care system. The Joint Commission requires that accredited healthcare organizations have in place processes to recognize and prevents events that can lead to medical errors. Facilities will have to conduct root cause analysis which will focus on the process and system factors. Facilities will also have within fifteen calendar days to report occurrences and adverse events to its reporting agencies. Joint Commission accredited facilities must have in place a well-developed risk management program which includes an incident reporting system requiring all healthcare providers and employees to report adverse incidents to the risk manager or his or her designee within three business days of the incident.

 Other patient safety methods to reduce medical errors within the US healthcare system are; implementation of a standardized communication format, (a SBAR report), that is a hand of report from caregiver to caregiver, refrain from the use of medication abbreviations, two identifiers to identify patients, (example, name and medical record number), no verbal and telephone orders, time-out during procedures, labeling of the surgical site during operative procedures, mixture of medication in the pharmacy by certified pharmacist, and allowing patients to speak up regarding their medication management.

 In conclusion, medical errors are not the only indicator of quality care. There are however, many other aspects that pose the greatest threat to quality health care. Efforts to reduce medical errors over the last decade have not resulted in the achievement of desired outcomes. There is a plethora of current studies that suggest that the healthcare system continues to be riddled with errors and that patient worker safety is compromised. (Hutson, C).

References

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