Reducing Medical Errors for CNAs

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Acknowledgments

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Purpose and Objectives

The purpose of Reducing Medical Errors for CNAs is to educate CNAs about medical errors. This course tells why errors occur, and how to prevent them in the future.

After successful completion of this continuing education self-study CNA course, participants will be able to:

1. Describe the overall problem of medical errors.
2. Identify types of errors
3. Define root cause analysis.
4. Define sentinel event.
5. Identify who is at risk of medical errors.
6. Identify times when errors are more likely to happen.
7. Describe the CNAs role in reducing medical errors.

Glossary

Adverse Drug Events: Any incident in which the use of a medication at any dose, a medical device, or a special nutritional product (for example, infant formula or medical food) may have resulted in an adverse outcome in a patient (Joint Commission, 2010b).

Medical Error: The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim (IOM, 1999).

Near Miss: Any error that did not affect an outcome but that a recurrence could cause a serious adverse outcome (Joint Commission, 2010a).

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Note: The terms “sentinel event” and “medical error” are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events (Joint Commission, 2010a).

Root Cause: The most fundamental reason for the failure or inefficiency of a process (Joint Commission, 2010a).

An Introduction to Medical Errors in Healthcare

In 1999, the government released a report titled: *To Err is Human: Building a Safer Healthcare System.* The report received a lot of publicity, and led to the development of many safety initiatives by professional organizations.

For example, The Joint Commission (TJC) developed National Patient Safety Goals (NPSGs) to guide safe practice, and the Centers for Medicare & Medicaid Services (CMS) identified "Never Events", which are inexcusable medical errors that should never happen.

Did you know that in 2008, the Institute of Medicine (IOM) reported that as many as 6.3 million patients suffered from some kind of medical injury, and 1.5 million of these injuries were due to medical error? (Institute for Safe Medication Practices, 2010).

National Patient Safety Goals (NPSG)

The Joint Commission (TJC) has developed a set of National Patient Safety Goals (NPSGs) that are a series of specific actions that accredited organizations are required to take in order to prevent medical errors (TJC, 2012a).

Examples of these preventable medical errors include miscommunication among caregivers, unsafe use of infusion pumps, and medication mix-ups. An example of a preventable medical error by a CNA could be the failure to report a dangerously elevated blood pressure reading to the RN in a timely manner and the patient experiences a debilitating stroke.

A panel of national safety experts has determined that if organizations follow the National Patient Safety Goals, we will be able to reduce the frequency of devastating medical errors (TJC, 2012a).

NPSGs and the CNA's Role

As a CNA, you are expected to adhere to the National Patient Safety Goals as appropriate for your position. Some NPSGs that relate to your role include:

NPSG 1: Improve the accuracy of patient identification.

This goal requires you to always identify your patient properly before performing any task or activity on or with the patient. The Joint Commission requires you to use at least 2 patient identifiers when providing care. Acceptable identifiers may be the name tag, verbal confirmation of identity or matching the hospital ID number to the patient's wristband (The Joint Commission, 2012b).

NPSG 2: ***Report critical results of tests and diagnostic procedures on a timely basis.***

This goal requires you to report your observations to the nurse as soon as possible so that treatment can be administered promptly (The Joint Commission, 2012b).

NPSGs and the CNA's Role

NPSG 7: Comply with the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines to reduce the risk of healthcare related infections.

This goal requires you to follow your facility's policies and procedures for infection prevention, including good hand hygiene (hand-washing) and following universal precautions when dealing with any body fluid(s).

This NPSG also outlines steps that should be taken to prevent urinary tract infections related to indwelling urinary catheters. This NPSG recommends that all urinary catheters are secured to allow for unobstructed urine flow and drainage, and stresses the importance of maintaining the sterility of the urine collection system, when emptying urine bags or collecting urine samples (The Joint Commission, 2012b).

Never Events

The National Quality Forum (NQF) defines Never Events as errors in medical care that are clearly identifiable and measurable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization (Centers for Medicare & Medicaid Services [CMS], 2008). In simpler terms, Never Events are inexcusable medical errors that should never happen, but must be reported if they do occur.

The concept of Never Events was first introduced to 2001, and over the years, the list of Never Events has grown substantially. Because Never Events are devastating and preventable, health care organizations are under pressure to eliminate them completely. In 2007, the Centers for Medicare and Medicaid Services (CMS) announced that Medicare would no longer pay for additional costs associated with many preventable errors, including those considered Never Events (Agency for Healthcare Research & Quality [AHRQ], 2012).

Never Events are also being publicly reported, with the goal of increasing accountability and improving the quality of care. Healthcare facilities are now accountable for correcting systematic problems that contributed to the event, with some states (such as Minnesota) mandating performance of a root cause analysis and reporting its results (AHRQ, 2012).

There are currently 28 Never Events identified by the National Quality Forum, and each event is classified under one of six categories:

1. **Surgical**
2. **Product or device**
3. **Patient protection**
4. **Care management**
5. **Environment**
6. **Criminal**

(NQF, 2008)

Types of Medical Errors

A **sentinel event** is an unexpected death or serious injury, or the risk of these types of death or injury (The Joint Commission, 2010a). The Joint Commission has developed a Sentinel Event Policy in an effort to decrease the risk of these events occurring in healthcare.

This policy forces healthcare organizations to report serious and unexpected dangers, injuries and deaths. This policy exists to help prevent medical errors by studying each event.

Types of Medical Errors

The Agency for Healthcare Research and Quality identifies five (5) types of errors (AHRQ, 2000):

1. Wrong diagnosis
2. Faulty equipment
3. Infections that come from being in the hospital
4. Blood transfusion reactions.
5. Wrong treatment such as the wrong food or medication

A Culture of Blame

A cultural shift must take place to solve the medical error problem. We are a “name” and “blame” culture. Most people know that humans make mistakes. In healthcare we expect that mistakes should never happen. Healthcare workers want to help people, not harm them. They try for perfection because errors can and do harm patients.

When mistakes happen the first response is to identify who is responsible. We want to deal only with who is to “blame” and start some disciplinary action. This **finger-pointing approach doesn’t work.** It contributes to a fearful work environment. It prevents investigating errors.

In most cases, medical error is related to the system, not an individual. There is usually a chain of events that either causes errors or makes them hard to detect. It is not usually a lack of care or concern on the part of the caregivers (Leape, 1995). When errors occur the question should not be “Whose fault is this?” but rather “What happened?” We need to work together to make a **culture of safety without blame.**

True or False?

Finding out and disciplining who caused an error makes everyone more careful.

Answer:
False!
Blame does not help. “The system has to be reviewed.”

Risk Factors for Medical Errors

Medical errors happen more often when:

- More technology is involved.
- Many different types of equipment are used.
- Many people are involved in the patent's care.
- The patient's illness or injury is critical.
- The care environment is very busy.
- Decisions have to be made quickly.
- There is a high risk connected to tests, treatments or medications.
- There are communication difficulties.
- Students and new caregivers are in the area (Kizer, 2001).

Safety and Quality Improvement

Most healthcare organizations have **Quality or Performance Improvement programs**. These programs don't look at individual factors, but rather support systems and work processes (Rex, 2000).

Obstacles to Improvement

- Lack of awareness that a problem exists.
- A traditional medical culture of individual responsibility and blame.
- The lack of protection from legal liability, so that errors to be concealed.
- Current medical information systems, which hamper information collection and analysis.
- Inadequate resources for quality improvement and error prevention.
- Lack of knowledge about the frequency, cause, and impact of errors.
- Evidence of good methods for error prevention.
- Lack of understanding of systems-based approaches to error reduction (such as those used in aviation safety or manufacturing) and the difficulty of changing those approaches to the healthcare setting.

The Systems Approach

The key part of a systems-based approach is **analysis**. To conduct a systems analysis, one needs to begin by asking "Why" an event occurred, not "who" caused the error.

By asking why an adverse event occurred, we can identify processes in the healthcare system that need to be modified, and we can work together to create a safer environment for nursing staff and patients.

By encouraging the reporting of "near misses" as well as errors, we can identify systems that can be improved before an error happens. This promotes a blame-free environment, and removes fear of punishment for reporting. It helps people to look for areas to improve.

Root Cause Analysis

Root cause analysis is a tool that helps teams **find the main causes** for an error. This occurs by repeatedly asking the question “why.” You keep asking why until the real cause is found.

The Joint Commission has mandated that root cause analysis take place on significant sentinel events. All of the data is confidential and information revealing personal identities is removed.

Some events that your facility may be studying are:

- A suicide.
- An unexplained infant death.
- A blood transfusion reaction.
- Surgery on the wrong patient or wrong body part.
- Wandering off of a patient that ends in death or serious injury.
- Homicide, assault or other crime causing death or serious injury.
- A patient fall that results in death or serious injury.
- A medication error that resulted in death or major permanent loss of function (Joint Commission, 2004).

True or False?

Individual names are removed from information used to investigate a significant event.

Answer:
True!
The focus is on the system and not on individuals involved.

Error-Prone Practices

Healthcare is just beginning a long journey of discovery and change in relation to patient safety. The following are practices that are frequently identified as high risk practices.

Medication Administration

One of the most documented and researched areas of medical errors concerns patient medication. Between two and seven medication errors happen in every hundred patients (AHRQ, 2001).

Healthcare organizations **try to decrease the number of medication errors.** Some success has been reached. As a CNA you do not give medications, but you need to know about what is happening related to medication administration.

Wrong Site Surgery

Joint Commission reports more than 150 cases of wrong site surgery since 1998. These errors happened during emergencies, when unusual situations were present, when there was an unusual amount of busyness, when the physical set-up was changed, or when time pressure was on (Joint Commission, 2001). Usually more than one of these things was involved. Most cases involved a breakdown in **communication** between surgical team members and the patient and family.

Infectious Disease

Infections that start in the hospital affect approximately two million patients every year (IOM, 1999). In long-term care facilities including nursing homes, there is an average of one infection per patient per year (IOM, 1999). Researchers say that one-third of these infections can be prevented by infection control programs (IOM, 1999).

Antibiotics, hand washing, and sterile techniques help to control infection but this is still a big problem. **Hand washing** is the most important thing that you can do (IOM, 1999).

True or False?

All infections
that start in a healthcare facility can be prevented.

Answer:
False!
Infection control programs can prevent many, but not all, of these infections.

Your Role in Reducing Medical Errors

It is expected that healthcare professionals will make mistakes. However, research shows that the **many errors can be prevented**. What can you as a CNA do to make a difference?

Certain situations and times are known to be a problem. They have a high likelihood of error. You can be aware of these and take steps to avoid errors. The times for increased medical error are generally when you or the people around you are fatigued, distracted or stressed, or communication is difficult.

If you experience a "**near miss**," share that information. Ask yourself what contributed to the situation. What could be done differently? Most often, if it almost happened or did happen once, it will happen again to you or someone else.

Understand that it is everyone's responsibility to improve patient safety. Be on the lookout for errors waiting to happen. For example, if your patient is on oxygen therapy, always double-check the medical record to review the ordered oxygen concentration, and ensure that the actual concentration delivered to your patient is correct. Double-check with the RN if you are unsure.

Test Yourself

The risk of a medical error goes up when communication is difficult.

Answer:
True!
Risk increases when patients are very young, very old, confused, or sedated.

Risk Reduction

You must also be aware that certain patients carry an increased risk of medical error. This may be associated with:

- The patient's disease.
- The patient's age (the elderly and children).
- How badly the person was injured or how sick the person is.
- The person's mental status (such as in the Psychiatric unit).
- The care setting (such as an ICU).

One important part of your job is to **correctly identify** your patients. Be sure of your patient's identity.

Another is to listen to your patients, even if you think they are confused or drowsy. Often the patient knows that something isn't right. This needs to be checked out. **Communication** is a big part of your job. Listen, make sure you understand your assignments, and report problems and errors.

Conclusion

You can make a difference in reducing the number of medical errors in your facility. By training yourself to think "**Why?**" instead of "**Who**?" you can be part of a collective effort to make hospital care safer.

True or False?
Reducing medical errors is a collective challenge.

Answer:

True! Be alert to when and why errors happen.

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