

Safety and Errors - Overview



Following a landmark 1999 report by the Institute of Medicine, increasing attention has focused on patient safety and medical errors. Steps have been taken to eliminate or minimize errors, and all policies and protocols aimed at ensuring patient safety must be followed carefully. Nevertheless, occasional errors or unanticipated bad outcomes will occur. In these situations, immediate identification, proper documentation, and full reporting to the appropriate people (attending physicians, hospital administrators, patient, family, etc.) is crucial. Under **no** circumstances may any entry or component of the patient medical record be deleted or altered, except by appropriately documented addendum.

Safety and Errors - Scenario Script

A doctor and a nurse are on opposite sides of patient. The patient is fully reclined on an exam table, has her eyes closed, and is unresponsive during the scene.

Doctor: Okay, Carla, let's get a line in and start her on some cephalosporin, I'll write up the order for 1 gram right now and q6hours, you get it going.

Nurse: Doctor Klein, I thought I saw something on her chart about a penicillin allergy. Shouldn't we check on that first?

Doctor: [Flipping through chart] I don't see anything here...of course her admission workup is in the other part of her chart. Anyhow, I don't remember seeing that, and if she were truly allergic, someone her age would have been flagged or at least had a Med-Ident bracelet. [Quickly checks the patient's wrists, and there are no bracelets.] So, why don't you get it going? That cross reactivity is pretty rare. I will check on it later.

Nurse: Okay, Doctor Klein, but just be sure and write that order....

Safety and Errors - Discussion Questions

1. How is the patient in this scenario at risk?
2. What concern does the nurse raise to the doctor?
3. How does the doctor attempt to address her concern?
4. How should the doctor address this concern?
5. What is a "Med-Ident" bracelet? What is the significance of the fact that the patient does not appear to be wearing one?
6. Are there situations when a physician might knowingly administer a drug that may have potential adverse effects? If so, what are those situations?
7. If administering a potentially dangerous drug, what special precautions should a physician take?
8. How would you rate the nurse's behavior in this case?
9. Is it permissible for a nurse to administer a drug for which a written order has not been entered? If so, what are those circumstances?
10. Who has primary responsibility for patient safety? How does this impact health care team dynamics?

Safety and Errors - Scenario Analysis

This scenario demonstrates a flagrant violation of the most basic principles of safety in patient care. The doctor is ordering an antibiotic for the patient, but the nurse indicates that she thinks she saw something in the patient's records indicating a penicillin allergy, which would put the patient at risk for a cross-reaction with the antibiotic being ordered.

The doctor briefly skims the medical record, recognizing that the record he has is incomplete. Seeing no allergy recorded there, he proposes that if the patient had a serious allergy she should be wearing a "Med-Ident" bracelet, a warning device sometimes—but not always—worn by patients with significant allergies or medical conditions. Finding no such bracelet, the physician dangerously and erroneously assumes that this patient is not likely to have any serious allergies. Finally, conceding that the nurse might be correct, he discounts the seriousness of the risk involved in administering the antibiotic.

The nurse indicates her willingness to comply with the doctor's order, but asks that he be certain to write the order in the medical record.

Both the doctor and the nurse are seriously at fault in this scenario. Even if the question of allergy had not been raised by the nurse, the doctor should have checked for an allergy history before administering any drugs, especially parenterally. Recognizing that the medical record was incomplete, he should have located the rest of the record and reviewed it before proceeding. While a Med-Ident bracelet can provide lifesaving information in an emergency, it is no substitute for careful review of a patient's medical record. That the patient is not wearing a Med-Ident bracelet certainly does not rule out a serious allergy. The decision to use a drug with a very low incidence of cross-reactivity might be defensible but only if the allergic history was well documented, the case could be made that the benefits of using the drug outweigh the risks, and these considerations were entered into the medical record before the drug was administered.

If the nurse suspects that the medication the doctor has ordered is inappropriate or dangerous, she has a professional, ethical, and legal responsibility not to proceed with administration until her uncertainty is resolved. Simply assuring that the physician writes the order in the medical record is merely a way of minimizing her own liability and is an inappropriate response to the situation.

It is not clear why the patient is unresponsive in this scene, and that may imply some urgency in this situation. When patients are responsive, they are a valuable source of information regarding allergies.



Safety and Errors - Scenario Analysis (continued)

Contingencies of emergent care sometimes require that drugs be administered before orders are written, but when they are written, the timing of the previous administration should be noted.

As a result of a landmark Institute of Medicine study published in 1999, there has been a heightened interest in safety issues in medical care. Physicians must make meticulous efforts to avoid errors in patient identity, drug allergies or interactions, and matters as basic as “sidedness,” assuring that procedure is performed on the correct side of the patient’s body. Safety requires the vigilance of all members of the health care team, and when any member raises a question of safety it must be seriously addressed before proceeding.