Medical Error Management - Case Study

Dr. Abdalla Ibrahim

MBA, MSc

Adjunct Business Faculty, GBS

Quality Consultant, Certified Healthcare Surveyor

SMART MANAGEMENT CONSULTANCY

ADDRESS: FAKHRO TOWER, 14TH FLOOR OFFICE 1455, ROAD 1010, BLOCK 410, BAHRAIN

www.smartmcbh.com info@smartmcbh.com

Contact: +97336077750 +97339042859

Objectives

1. *Define steps of managing medical error*
2. *Identify how to do disclosure technique*
3. *Identify how to report medical error*
4. *Analyze root cause of a problem*
5. *Explain how to manage second victim*

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SAFETY CULTURE

Create a culture of safety within the organization

Medical Error Case Study

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The Story: In a Primary Care Setting

On Sunday morning, Mr. XX had attended my clinic due to marked polyuria. His RBS was 29 mmol/L, otherwise he was completely normal.

The Story

I have prescribed Normal saline 1.5 L , IVI, over 2 hours and **5.0 u** of regular insulin by direct IV push / 30 minutes, until his RBS is 9.0 mmol/l.

The Story

- I have requested the nurse to give the prescribed IV injection, Which was easily done.

The Story

- Twenty minutes later, my patient was very much apprehensive, sweating and started shivering.
- His RBS was 0.8 mmol/L.

The Story

My nurse had told me that she pushed **50.0 u** of Regular Insulin in the IV line as seen by her.

WHAT SHOULD I DO?

What You Need to Do

Identify	Identify what happened
Take	Take immediate actions
Notify	Notify superior
Document	Document incident
Disclose	Disclose event to patient and family
Report	Report as per Policy
Investigate	Investigate causes of incident
Change & Improve	Do change and improve process
Monitor	Monitor Change
Evaluate	Evaluate improvement

Take the Immediate Action

- As a Team we immediately took an action
- Started Dextrose 5% and 50% and monitor patient response and frequently measure the RBS till we reach safe reading above 6 mmol/L.

Take the Immediate Action

- We called Ambulance to transfer the patient to secondary care.

Immediate notification

Dr.
In-charge

Senior
On Duty

Quality
Coordinator

Person on
authority

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What Happened?

What Happened?

- On Day Name DD/MM/YYYY, at 00:00 am/pm,
- In the Location (treatment room),
- I had manage Mr/Mrs. XX by doing
- Which resulted in Consequences: ……..
- But I had took he following actions to save the life of patient: ……..

What Happened?

- On Sunday 21/06/2017, at 9:12 am,
- In the treatment room,
- I had injected Mr. XX a doe of **50.0 u** of Regular Insulin intravenously,
- Which resulted in severe hypoglycemia.

What is your immediate action?

I did the followings immediately:

- Stop N. Saline
- Call senior doctor/consultant
- Start 5% glucose 1.0 liter, IV
- Give 50 ml of 50% glucose IV / 30 min until RBS is 9.0 mmol/l
- And transfer patient immediately to econdary care

Who else can notify?

Doctor other than offender.

A Nurse who witnessed the incident

Any other attendant, even a visitor

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HOW TO DOCUMENT?

NHRA ADVERSE /SENTINEL EVENT REPORTING POLICY

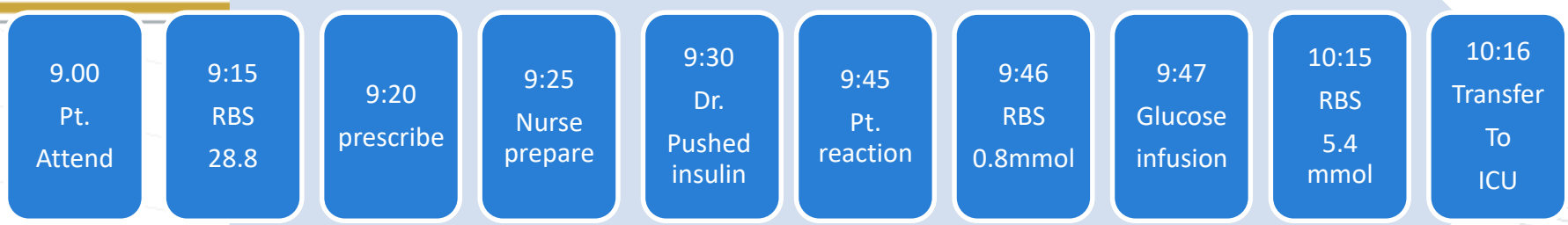
National Health Regulatory Authority (NHRA)

Kingdom of Bahrain

8 January, 2018

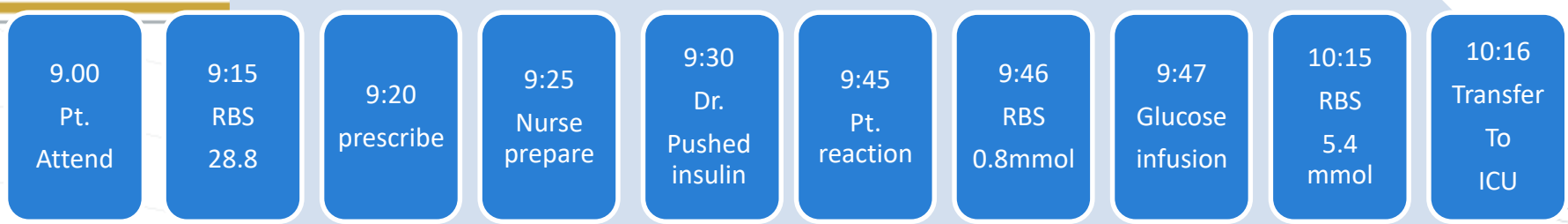
Version 2.0

Time line analysis



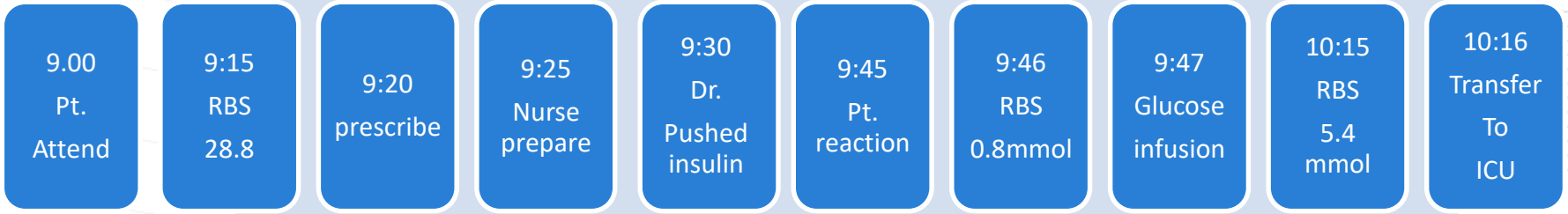
- 9:00 am, Mr. XX had attended my clinic complaining of giddiness.
- 9:15 am, his RBS was tested (28.8 mmol/l).
- 9:20 am, I prescribed Regular Insulin **5.0 u**, iv/30 minutes, until RBS is 9.0 mmol/l and N. Saline 1.5 l/2 hours.

Time line analysis



- 9:25, nurse YY prepared **50.0 u** of regular insulin and kept them in kidney shaped basin at patient's side table.
- 9:30 am I've arrived at the patient side and pushed the dose in the IV line.
- 9:45 am, I was informed that my patient is sweaty and very nervous and shivering.

Time line analysis



- 9:45 am, his RBS retested, found 0.8 mmol/l.
- 9:47 am, 1.0 L of 5% glucose was IV given, 50 ml of 50% glucose iv/30 min until RBS is 9.0 mmol.
- 10:15 am, patient was referred to ICU. his last RBS was 5.4 mmol/l.

In order not to forget the facts!!!

- ***Document only*** the facts of what occurred and treatment given
- ***Do Not document:***
  - Blame
  - Subjective feelings or thoughts
  - Opinions
- Refer to organization ***"Incident Report"*** Form

WHY AND HOW TO ADMIT YOUR MEDICAL ERRORS?

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Which is better!!

Burry the whole thing

Disclose the event

Why disclosure

- Literature shows that after an unanticipated outcome, the patient and family want to know honestly:
  - What happened?
  - How it happens?
  - How hospital will prevent future events?

Why disclosure

- We are our patient's advocates
- Rebuilds trust
- Keep good Doctor-Patient relationship

DISCLOSURE TECHNIQUE

4-L Disclosure Technique

- Location
- Language
- Body language
- Leave

Disclosure Technique

Describe what happened in facts, not opinion

Tell consequences of the event

Tell steps being taken to manage the event

Tell steps being taken to prevent recurrence

Disclosure Technique

Have an open communication with patient and family
Talk in privacy
Keep telephone closed, prevent distraction

Let a colleague attend the discussion
Express your sorrow and regret

No blames
Don't be defensive

Reporting:
Do we have a policy for clinical incidents?

- Follow you own Reporting Policy and process
- Use your own Reporting Form(Incident Reporting Form)

What do you expect next?

- To determine sequence of events that led to consequence
- To take corrective action & recommendations
- To prevent recurrence of the incident

Who can investigate?

Investigation Team

- Employee ‘s supervisor
- Safety officer
- Quality and Safety committee/representative
- Employee involved

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What does investigators want?

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How to investigate?

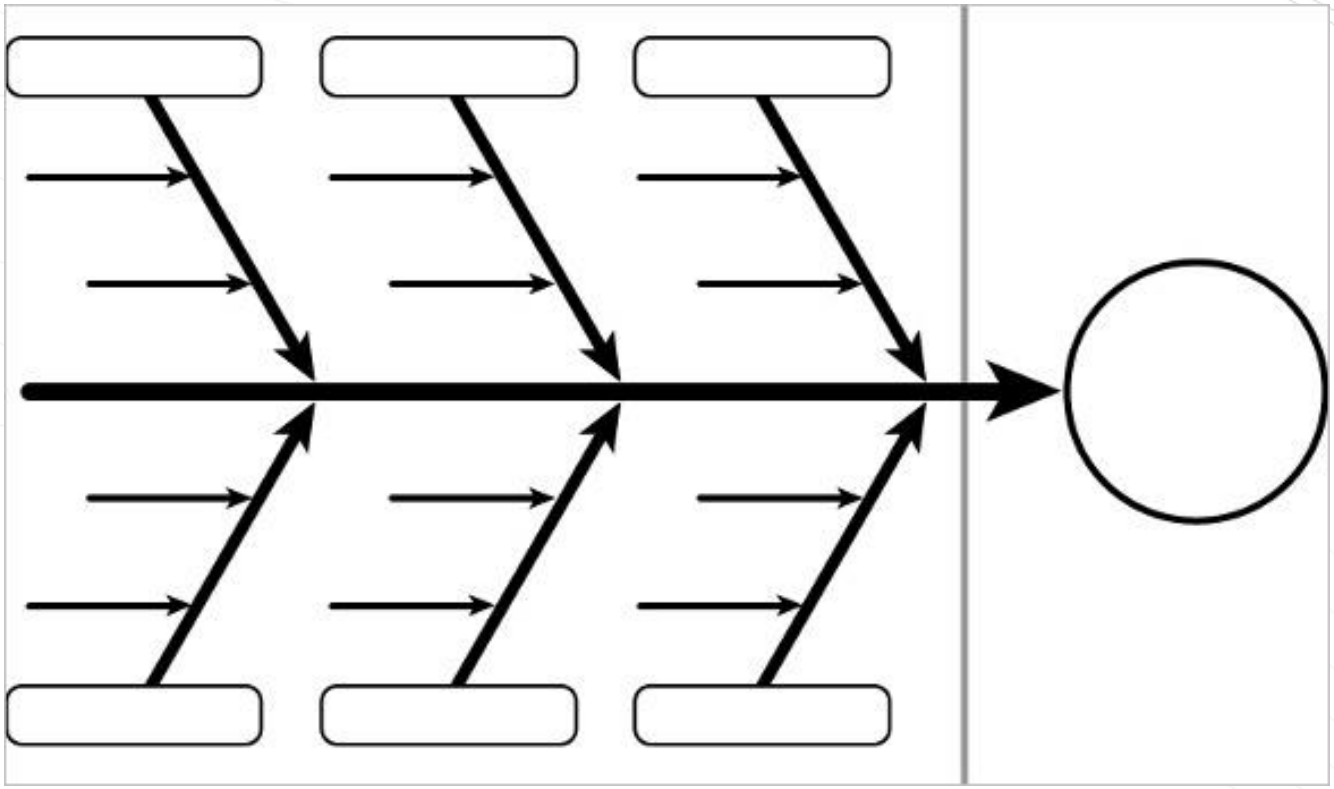
In response to adverse event THREE possible ways of investigations are found:

- Case Review
- Root Cause Analysis
- 5 Way Chart

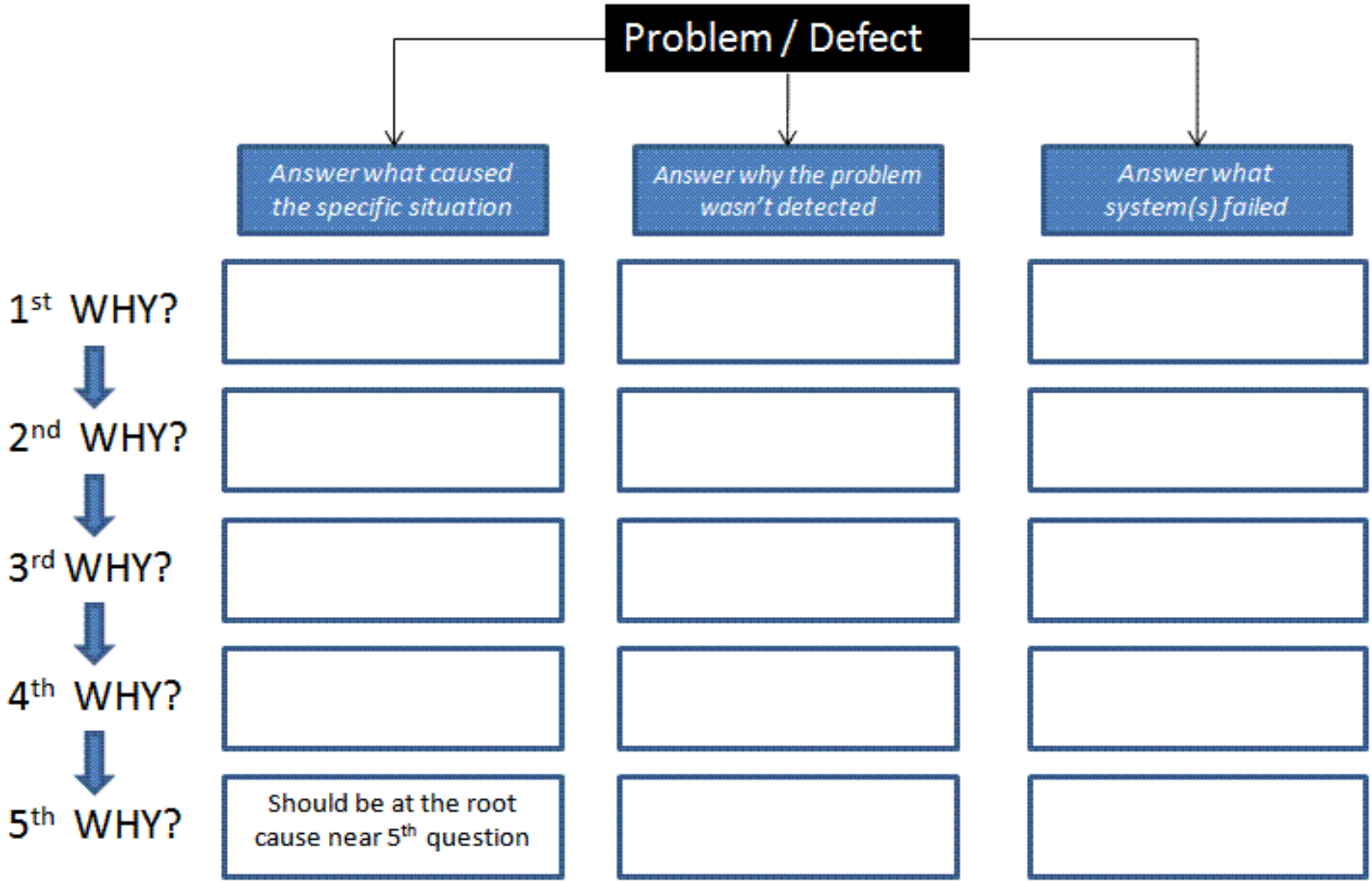
Case Review

- To decide if the medical care offered is of accepted standards?
- If not, the Second Victim may be *offered certain supports*
- To recommend corrective measures such as education and training

Root Cause Analysis (RCA) Fishbone



5 Whys Template for multiple root causes



What are the Root Causes of the event

Physician

Unaware of (*Do NOT DO LIST*).

No Double Check

Nurse

- Mis-interpret Prescription
- No double Check
- Exhausted

Patients

Unaware of the *Speak Up Initiative*

System

- No P&P on Drug Administration
- Overworking Hours for nurses
- No barrier to distraction at work

What are the Root Causes of the event

Physician

Unaware of (*Do NOT DO LIST*).
No Double Check

Patients

Unaware of the *Speak Up Initiative*

System

- No written policy & procedure of drug administration
- Overworking Hours for nurses
- No barrier to distraction at work

Nurse

- No double Check
- Exhausted

What about the Error maker!
The Second Victim

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Error maker!!
How does he feel??

- Shame
- Afraid
- Isolated
- Worthless
- His opinion and advice are not required

How do we respond to error maker?

TRUST:

- **T**reatment in just
- **R**espect
- **U**nderstanding and compassion
- **S**upportive care
- **T**ransparency and opportunity to contribute

What does She/He need?

- Talk to some one for:
  - Reaffirmation of their professional competency
  - Validation in their decision making ability.
  - Reassurance of self worth.

What does She/he need?

- Learning /changing
- Involving in other issues
- Enrol in different activity/distraction
- Seek support e.g. counselling

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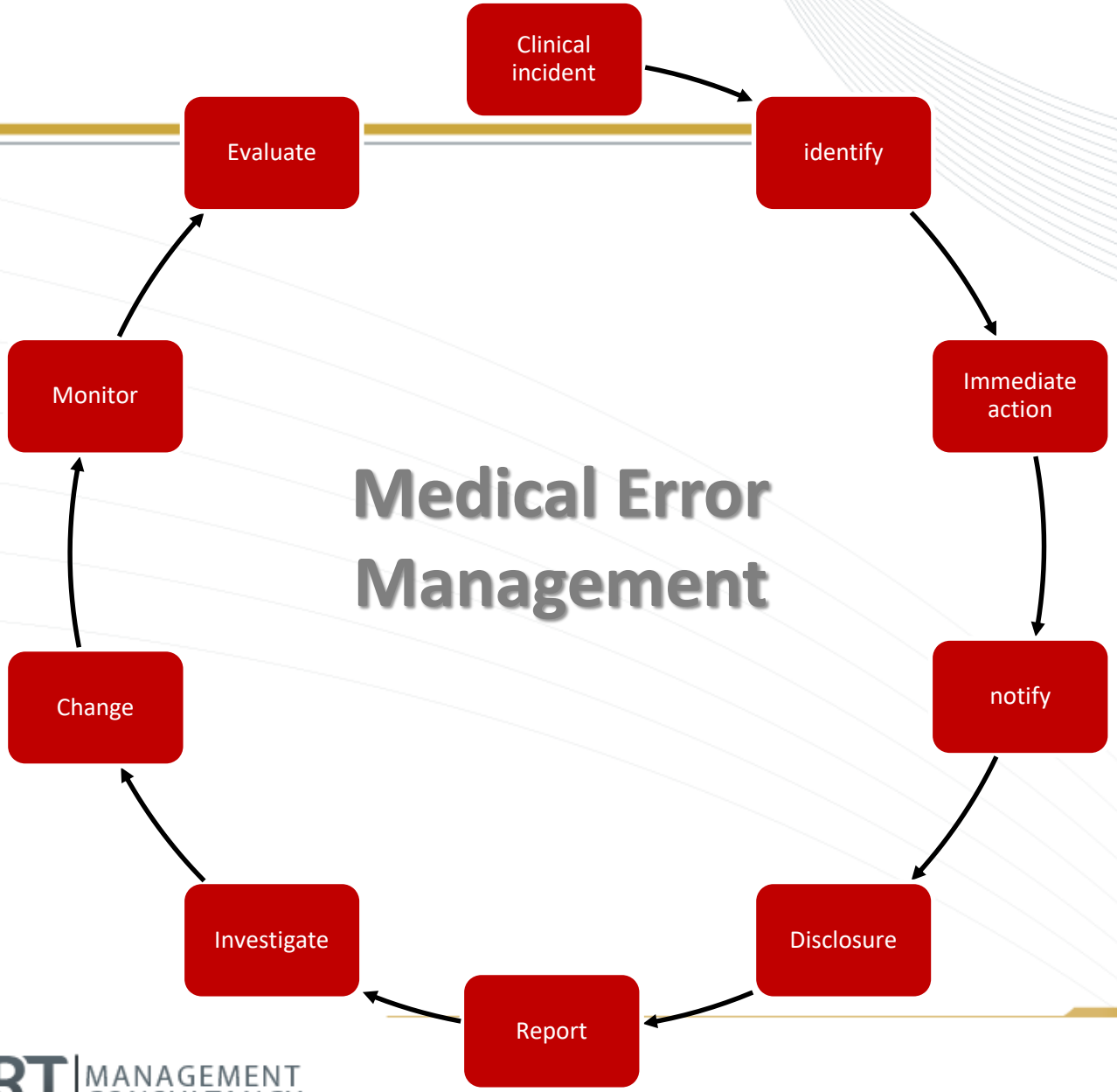

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Any Question

thank you

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