

Reducing Medical Errors for CNAs

**This course has been awarded
One (1) contact hours.**

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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 CNA's 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 (Office of Disease Prevention and Health Promotion, 2015).

Medical Error: The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim (Kalra, 2011; IOM, 1999).

Near Miss: Any error that did not affect an outcome but that a recurrence could cause a serious adverse outcome (Joint Commission, 2013).

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, 2013).

Root Cause: The most fundamental reason for the failure or inefficiency of a process (Joint Commission, 2013).

An Introduction to Medical Errors in Healthcare

Millions of people are harmed in the United States every year as a result of errors in health care (National Patient Safety Foundation, 2015). In 1999, the government released a report titled: *To Err is Human: Building a Safer Healthcare System*, which stated that approximately 98,000 people die each year in the United States due to medical errors (IOM, 1999). 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 National Quality Forum (NQF) identified *never events* (now called *serious reportable events*), which are inexcusable medical errors that should never happen.

Did you know that based on the Institute of Medicine (IOM) reports, it is now estimated that as many as 440,000 deaths occur every year due to medical errors (James, 2013).

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, 2015a).

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, 2015b). This is true for organizations who are accredited by all agencies (not just the Joint Commission).

Test Yourself

Which of the following statements is true?

- A. Approximately 44 million deaths occur each year as a result of medical errors
- B. **National Patient Safety Goals were one example that resulted from the IOM report in 1999.**
- C. National Patient Safety Goals only apply to hospitals who are accredited by the Joint Commission.

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: Identify patients correctly.

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 two patient identifiers when providing care. Acceptable identifiers may be the patient's name, date of birth, or unique hospital ID number on a name tag or wristband, with verbal confirmation (The Joint Commission, 2015b).

NPSG 2: Improve staff communication.

This goal requires you to report your observations to the nurse as soon as possible so that treatment can be administered promptly, such as vital signs or blood glucose results (The Joint Commission, 2015b). As a CNA, you have an opportunity to make observations about your patients, and can report them in a timely manner, which can make a difference in the planning and treatment. Watch the following brief video of some observations which CNAs found and reported quickly:

<https://www.youtube.com/watch?v=y1F35mUk4Oo>

NPSGs and the CNA's Role, con't

NPSG 6: Use alarms safely.

As a CNA, it is important to make sure that alarms are responded to quickly (The Joint Commission, 2015b).

NPSG 7: Prevent infection.

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). The policies should comply with the current Centers for Disease Control and Prevention (CDC) guidelines for hand hygiene.

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, 2015b).

As a CNA, you may also be involved in helping prepare a patient for surgery, such as bathing or hair removal. It is important to follow policies and procedures to help reduce the chance of surgical infection (TJC, 2015).

Interactive Activity

Match the NPSG activity with the correct healthcare professional(s) responsible:

- | | |
|--|----------------|
| A. Using two patient identifiers when providing care | I. RN or CNA |
| B. Prevent infection by providing central line care | II. RN only |
| C. Communicate observations to other team members in a timely manner | III. RN or CNA |

Answers: A= I; B= II; C= III

Serious Reportable Events

The National Quality Forum (NQF) defines *never events*, or *serious reportable events* (SRE), 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 (NQF, 2011). In simpler terms, SRE are inexcusable medical errors that are usually preventable and should never happen in healthcare facilities, but must be reported if they do occur (NQF, 2011).

The concept of never events was first introduced to 2001, and over the years, the list of SRE has grown substantially (NQF, 2011). The list of events may be applied in various settings, such as acute inpatient, long term or skilled nursing, or ambulatory settings. Because SRE 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 serious reportable events (Agency for Healthcare Research & Quality [AHRQ], 2012).

SRE 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. As of today, however, not all states mandate reporting

(AHRQ, 2012).

SRE Categories

There are currently 29 serious reportable events identified by the National Quality Forum, and each event is classified under one of seven categories:

1. **Surgical or invasive procedure**
2. **Product or device**
3. **Patient protection**
4. **Care management**
5. **Environment**
6. **Radiologic**
7. **Potential criminal**

(NQF, 2015)

SREs and the CNA's Role

These negative events cause physical and emotional harm to the patient, as well as financial implications. An SRE will affect reimbursement, and incurs additional costs as a result of the patient harm. As a CNA, you are part of the team who can prevent serious reportable events as appropriate for your position. Some SREs that relate to your role include:

Surgical or invasive procedure events:

Some CNAs are cross-trained to work in the operating room (such as a scrub tech). All team members in the OR are responsible for using a "time-out" prior to the start of any surgery. This is also true when participating in an invasive procedure. This is an important safety process to prevent serious reportable events, such as incorrect patient or wrong site surgery (NQF, 2015).

Product or device events:

There are many products and devices used with patient care. One way CNAs can help prevent a SRE related to a device is to make sure that there is proper training on the use of equipment. Another consideration is to put equipment out of service immediately when there is a problem with it, and contact the appropriate department to make repairs. This is one safety process to prevent serious reportable events, such as patient injury from products or devices (NQF, 2015).

SREs and the CNA's Role, con't

Patient protection events:

The SREs in this category relate to the discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person, patient death or serious injury associated with patient elopement, and patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (NQF, 2015). As a member of the healthcare team, the CNA is an important person to observe patients. If you have concerns about the behavior of a patient or a visitor, report it immediately.

Care management events:

This category of serious reportable events includes stage 3 or 4 pressure ulcers acquired after admission to the healthcare setting (NQF, 2015). CNAs participate in skin care of patients, and can have a significant impact in reducing the risk of acquired pressure ulcers. Another event in this

category is patient death or significant injury as a result of a fall in the healthcare setting. All healthcare team members are important in the prevention of falls (NQF, 2015). Make sure you follow the policies and procedures at your facility regarding fall prevention. In addition, this category includes the SRE of patient injury or death as a result of failure to communicate test results (NQF, 2015). This includes point of care testing, such as blood glucose results, which may be a responsibility of the CNA.

SREs and the CNA's Role, con't

Environmental events:

This category includes events such as electrical shock or burns of patients and staff (NQF, 2015). As discussed earlier, it is your responsibility to make sure you have proper training on use of equipment. It is also important to report any safety concerns with equipment or electrical outlets in a timely fashion. Another SRE in this category is injury or death associated with the use of restraints (NQF, 2015). As a CNA, you may work with patients who are in restraints. It is important to report any concerns with the restraints immediately.

Radiologic events:

This category includes injury or death of an individual as a result of a metallic object in the MRI area (NQF, 2015). All team members are responsible to make sure that metal objects are not brought into an area with an MRI.

Potential criminal events:

This category includes SREs of impersonation of licensed healthcare professionals, patient abduction, and physical or sexual assault of individuals in a healthcare setting (including patients and staff) (NQF, 2015). It is important for all members of the healthcare team to be aware of who they work with, ask questions, and report concerns. For example, if someone appears to become increasingly agitated or angry, let someone know- another team member or security. Facilities have procedures for preventing abductions, particularly with infants and children. Be aware of your role in the policy and procedure at your facility.

It is also important to keep yourself safe when providing care. Everyone is entitled to be safe when they are on the job. The following brief video discusses violence against healthcare workers in the workplace: <https://www.youtube.com/watch?v=N0TWMOcW0Vo>

Test Yourself

Which of the following is considered a serious reportable event?

- A. A patient is admitted with a stage 1 pressure ulcer
- B. A patient is discharged home without a follow-up appointment made
- C. **A healthcare worker is assaulted by a patient at work**

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, 2013). 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 Reviewable Sentinel Events

The Joint Commission identifies the following types of errors as reportable (TJC, 2013):

- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error
- A patient commits suicide within 72 hours of being discharged from a hospital setting that provides staffed around-the-clock care
- Any elopement, that is, unauthorized departure, of a patient from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function
- A hospital performing the wrong invasive procedure or operating on the wrong side of the patient's body, on the wrong site on the patient's body, or on the wrong patient
- Any intrapartum (related to the birth process) maternal death
- Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams
- A patient is abducted from the hospital where he or she receives care, treatment, or services
- Assault, homicide, or other crime resulting in patient death or major permanent loss of function
- Assault, homicide, or other crime resulting in death or major permanent loss of function of a staff member, licensed independent practitioner, visitor, or vendor
- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
- Hemolytic transfusion reaction involving major blood group incompatibilities
- A foreign body, such as a sponge or forceps, that was left in a patient after surgery

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 (Brewer, 2011). 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.

Just Culture

To move into a culture without blame, many healthcare institutions are implementing a “just culture”. This type of culture is supported by national organizations, such as the AHRQ. The just culture concept is widely used in the aviation industry, and now into healthcare. The concept recognizes that human error and faulty systems can cause a mistake, and encourages an investigation of what led to the error instead of an immediate rush to blame a person. Through this process, systems that may cause or contribute to errors can be fixed. It gives employees the opportunity to feel more at ease reporting problems, and help contribute to improving a system.

A just culture discourages blame, but it is not a "no-fault" system. Disciplinary actions are still supported for malicious or purposefully harmful behavior, when there is no concern for the consequences. This culture supports coaching and education if the mistake was in error, or happened as a result of a system that was not supportive of safety (Brewer, 2011).

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 patient'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.

(Garrouste-Orgeas et al., 2012)

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 (AHRQ, 2014).

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 may 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.
- Little 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.

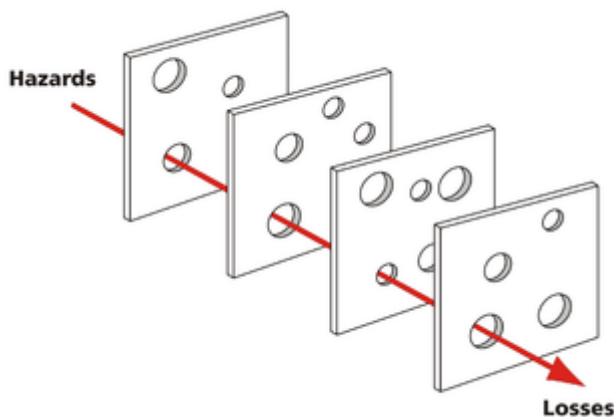
By asking why an adverse event occurred, we can identify processes in the healthcare system that need to be modified, and we can work together to create a safer environment for nursing staff and patients.

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 (AHRQ, 2014).

The Swiss Cheese Model

When evaluating errors, many use the “Swiss cheese model”. This model shows how analyses of major accidents and catastrophic systems failures tend to reveal multiple, smaller failures leading up to the actual event. In the model, each slice of cheese represents a safety barrier or precaution relevant to a particular hazard. Layers can be made up of protocols, policies, procedures, and guidelines. No single barrier is foolproof, and each layer has a “hole” in them (such as the Swiss cheese). When the holes in the layers add up (multiple points of errors in the process), a serious event can occur (AHRQ, 2014).

For example, if the hazard were wrong-site surgery, slices of the cheese might include conventions for identifying sidedness on radiology tests, a protocol for signing the correct site when the surgeon and patient first meet, and a second protocol for reviewing the medical record and checking the previously marked site in the operating room. Many more layers exist. For some serious events (e.g., operating on the wrong site or wrong person), even though the holes will align infrequently, even rare cases of harm (errors making it “through the cheese”) will be unacceptable (AHRQ, 2014).



Root Cause Analysis

Root cause analysis (RCA) 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. An important principle of an RCA is to identify underlying problems that increase the likelihood of errors while avoiding an inappropriate focus on mistakes by individuals. An RCA uses the systems approach to identify both human and system errors. It is one of the most widely used retrospective methods for detecting safety hazards.

RCAs generally follow a protocol which begins with data collection and reconstruction of the event through record review and interviews with participants. A multidisciplinary team should then analyze the sequence of events leading to the error. This includes identifying what happened, what should have happened, and why the event occurred. The ultimate goal of an RCA is to prevent future harm by making system improvements to reduce the risk of errors (AHRQ, 2014).

RCAs, con’t

The Joint Commission has mandated that root cause analyses 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, 2013).

Interactive Activity

Match the following statements with “true” or “false”

- A. Finding out and disciplining who caused an error makes everyone more careful.
- B. Blame does not help. “The system has to be reviewed”.
- C. Individual names are removed from information used to investigate a significant event.
- D. The focus is not on the system, but rather on the individuals involved.

- I. True
- II. True
- III. False
- IV. False

Answers: A= III; B= I; C= II; D= IV

Case Study One: Fall

Mrs. B. was an 81 year old female, admitted to the hospital with pneumonia. She had a history of congestive heart failure and type II diabetes. Her fall assessment on admission at 0900 was low. She was on room air, and her oxygen saturation was 90% at 2100. She had an IV in her arm for fluids and medications. Mrs. B. was pleasant and cooperative, and agreed to ask for help when she needed it.

At 2345, the CNA heard a loud noise from Mrs. B's room. She found Mrs. B. on the floor by her bed, and her patient gown was soaked in urine. The CNA called the RN into the room, and they both assisted Mrs. B. back to bed. Mrs. B. was crying in pain, stating that her hip hurt. Mrs. B. was cleaned up, and vital signs done by the CNA. Mrs. B.'s oxygen saturation was at 79%, and she seemed confused.

The RN obtained orders from the physician for an x-ray, which showed that Mrs. B. fractured her left hip.

Case Study One: What Happened?

Mrs. B. had been given medication to help her sleep at 2200. Vital signs were not due to be redone until 2400. Staff stated that the unit had been busy between 2000 and the time of the fall, so neither the RN nor the CNA had gone in for purposeful rounding with Mrs. B. Staff on the unit stated they knew about a fall policy, but didn't feel any precautions were needed due to Mrs. B.'s low risk on admission.

The environment in Mrs. B.'s room included several chairs for visitors and her IV pole with pump. The room was darkened, with a nightlight on in the bathroom. It was also noted that Mrs. B. had oxygen tubing, which had been tangled during the fall. It was learned that a respiratory therapist had checked on Mrs. B. at 2130 and placed her on nasal cannula at 2L/min for shortness of breath. This was documented in the medical record, but there was no communication with the RN or CNA.

Mrs. B. stated that she had to go to the bathroom, but did not use the call bell because she "knew the staff were busy, and didn't want to bother them". She felt she was able to go on her own, but became dizzy and unbalanced, with difficulty managing the IV pole and oxygen tubing.

Case Study One: Root Causes

As a result of the investigation, several root causes were identified.

- There had been a change to the fall risk assessment policy which had not been well educated to staff. This resulted in the RN not assessing and reassessing Mrs. B. per the new policy, and implementing the appropriate fall prevention strategies.
- Communication between staff also contributed to the fall. The nursing team were not aware that Mrs. B. required oxygen. In addition, the RN and the CNA did not communicate with each other to ensure that purposeful rounding was occurring (each assumed the other was doing it).
- Obstacles in the room also contributed to the fall.

Case Study One: Plans

Because of the root causes identified, multiple action plans were implemented. These included:

- Re-education of staff about the new fall risk assessment policy, including fall prevention strategies
- Implementation of a formal purposeful rounding plan. At the beginning of the shift, RNs and CNAs would identify who would be responsible for patient rounding at each hour, and how they would communicate with one another if he or she could not complete the rounds
- A regular environmental observation for fall and trip hazards was incorporated into purposeful rounding

Case Study Two: Blood Clots

Mr. L. was a 65 year old male, admitted to the hospital with COPD exacerbation. Orders included placement of sequential compression devices (SCDs), and 5L/min of oxygen via nasal cannula. He was short of breath on admission, and angry and abrupt when talking with staff. Within a few hours of admission, the CNA came in the room, she saw the SCDs were off, and Mr. L. told her he was up to the bathroom on his own. During report, both the CNA and the RN told the new staff coming on that Mr. L. was “ambulating”, and so the new team did not place the SCDs back on.

Mr. L. spent most of his time in the chair by his bed, as he stated it was easier for him to breathe. On day three, he began complaining of pain in his right calf. The RN assessed his leg, and discovered it was warm to touch. She contacted the hospitalist, who came in and assessed Mr. L. An ultrasound was done on Mr. L.’s legs, and it was found that he had a deep vein thrombosis (DVT). The physician was angry that the SCDs had been taken off on the first day.

Case Study Two: What Happened?

During the investigation, it was discovered that it was common for SCDs to be removed once patients were considered “ambulatory”. It was also learned that the employees interviewed all had a definition of what “ambulating” meant. Many staff believed that “ambulating” included patients walking in their room or up to the bathroom. Staff who worked with Mr. L. also felt that he did not want to wear the SCDs, although no one had asked him directly.

In speaking with Mr. L., he stated that he would have worn the SCDs if he had known what they did and how important they were. He also admitted that he mainly sat in his chair, only getting up to go to the bathroom. There were no orders for ambulation in the medical record.

It was also discovered that the hospital did not have a policy that discussed venous thromboembolism (VTE) prevention. Orders by physicians were not standardized, and many physicians did order “SCDs until ambulating”.

Case Study Two: Root Causes

As a result of the investigation, several root causes were identified:

- Lack of policy for VTE prevention
- Inconsistent definitions of “ambulation”
- Ineffective education for nursing staff about VTE prevention
- Inconsistent orders
- No education for patients about VTE prevention

Case Study Two: Plans

Because of the root causes identified, multiple action plans were implemented. These included:

- Development of a policy for VTE prevention, including responsibilities of providers, RNs, and CNAs. “Ambulation” was defined within the policy
- A hospital-wide educational initiative was done, focused on VTE prevention
- Consistent order sets for VTE were developed within the electronic medical record
- Patient educational materials were created about VTE prevention

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. Millions of people are affected by medication errors in both inpatient and outpatient settings every year. It is estimated that approximately 7000 people die in the U.S. each year as a result of medication errors in the hospital (Robert Wood Johnson Foundation, 2012).

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, Person, or Procedure Surgery

Surgery that is performed on the wrong site, wrong person, or wrong procedure are not common, with an estimate of one case for every 112,000 (AHRQ, 2015). These errors which have been reported 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. 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 (AHRQ, 2015).

Error-Prone Practices, con't

Infectious Diseases

The CDC healthcare-associated infection (HAI) conducts surveys to provide an updated national estimate of the overall problem of HAIs in U.S. hospitals. Based on a large sample of U.S. acute care hospitals, the survey found that on any given day, about one in 25 hospital patients has at least one healthcare-associated infection. There were an estimated 722,000 HAIs in U.S acute care hospitals in 2011. About 75,000 hospital patients with HAIs died during their hospitalizations. More than half of all HAIs occurred outside of the intensive care unit.

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 (CDC, 2014).

Falls

Falls happen in the hospital setting at an average rate of 3.65 for every 1000 patient days (Everhart et al., 2014). Prevention of falls is an important factor of patient safety, and is a responsibility of healthcare team members. Multiple strategies must be used for patients who are at fall risk. Answering call bells in a timely fashion, performing purposeful rounding and addressing immediate needs (such as toileting), assisting patients when ambulating, using bed alarms, and identifying patients who are at high risk for falls are a few considerations (Mion, 2012).

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 error-prone situations 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 behavioral health 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.

True or False?

Reducing medical errors is a collective challenge.

Answer:

True!

Be alert to when and why errors happen.

Conclusion

You can make a difference in reducing the number of medical errors in your facility. It is important to understand the types of errors that occur, and what your role is in preventing them. By training yourself to think “**Why?**” instead of “**Who?**” you can be part of a collective effort to make hospital care safer.

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