Medical Errors

Risk Management in Practice

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Setting the scene

Clinical scenarios

A 35-year-old lady presented to the Practice complaining of painless vaginal bleeding for three weeks.

The patient's last menstrual period began three weeks prior to the visit. Other than uterine fibroids, she had no significant past medical history.

Her general physical examination was unremarkable. No evidence of hypotension or pallor. On pelvic examination, closed cervix and a non-gravid uterus with small masses consistent with fibroid uterus. There was trace of blood on the examining glove.

The doctor thought that a bleeding fibroid was the most likely diagnosis. She advised the patient to come back in two days if still spotting.

The following day, the patient felt very tired and her husband took her to the local hospital Emergency Department. The ER doctor noticed that she had hypotension, tachycardia, and tachypnea.

Pelvic ultrasound showed a ruptured ectopic pregnancy. She had emergency laparotomy.

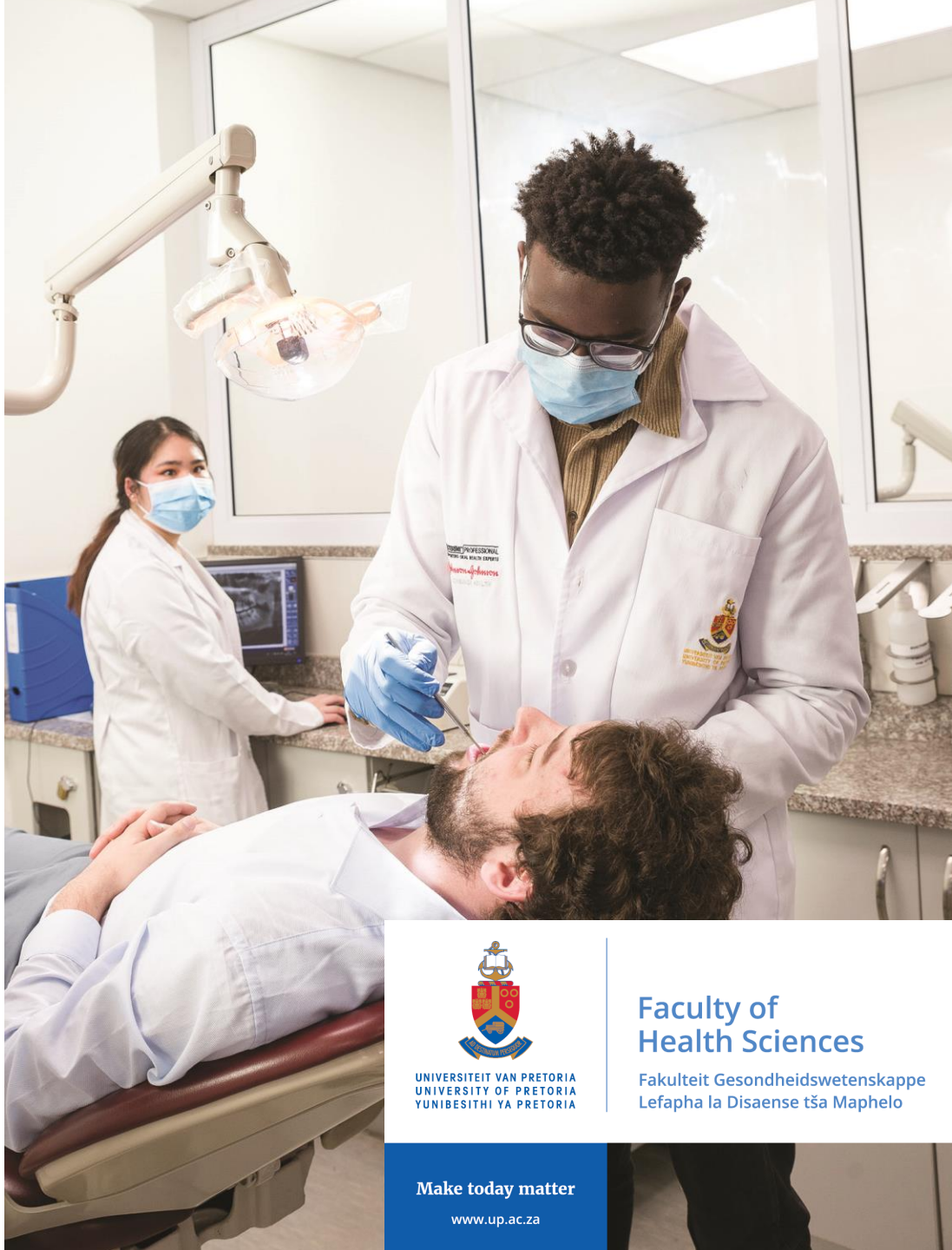
A 13-year-old girl accessed the filing system at the Practice where her mother works and printed a list of patients who visited the Practice for a week

During the weekend, the girl called seven patients, identified herself as a laboratory employee, and told the patients they were HIV positive, pregnant, or both.

The girl called the patients again a few hours later and told them the diagnoses were mistakes, but not before one of the patients reportedly attempted suicide

Layout

- Definitions
- Epidemiology of medical errors
- Classification/types of medical errors in Family Practice
- Prevention/ risk management
- Conclusion



Definitions of a medical error

- Non standardised definitions
- Depends on
  - Hospital versus primary care
  - Speciality
  - Patients safety reports
  - Litigations and insurance
  - Route cause analysis
  - Models

- Wilson T, Sheikh A. Enhancing public safety in primary care. BMJ 2002; 324:584–7.

Medical error

- Error is a failure of a planned action to be completed as intended (error of execution)
- Execution errors may happen by **commission** or **omission**

To Err is Human: Building a Safer Health System. Kohn LT, Corrigan JM, Donaldson MS, editors. National Academies Press (US): 2000

Adverse event

- An error may or may not cause an adverse event.
- Adverse events are injuries/harm that result from a medical error (either by omission or commission)
- Adverse events due to medical errors are preventable

Near-miss

- A near-miss is an adverse event that either resolves spontaneously
- or is prevented by taking action before the complications develop.

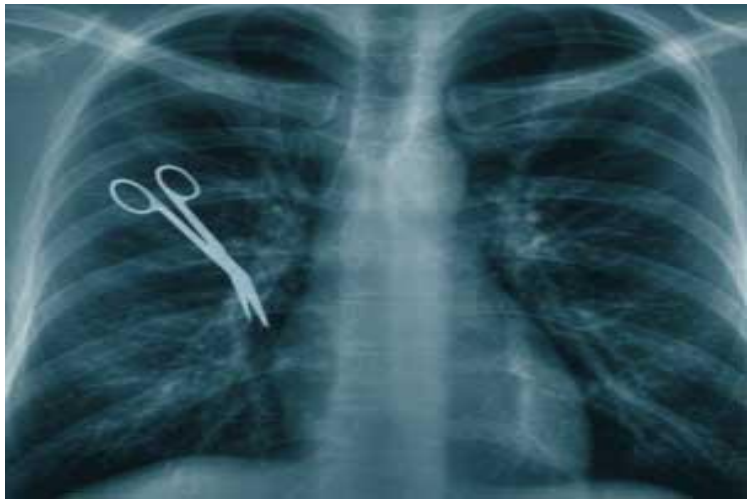
A sentinel event

Adverse event that results in any of the following:

- Death
- Permanent harm
- Severe temporary harm and intervention required to sustain life

Simple definition

A commission or an omission with potentially negative consequences (Wu et al, 1997)

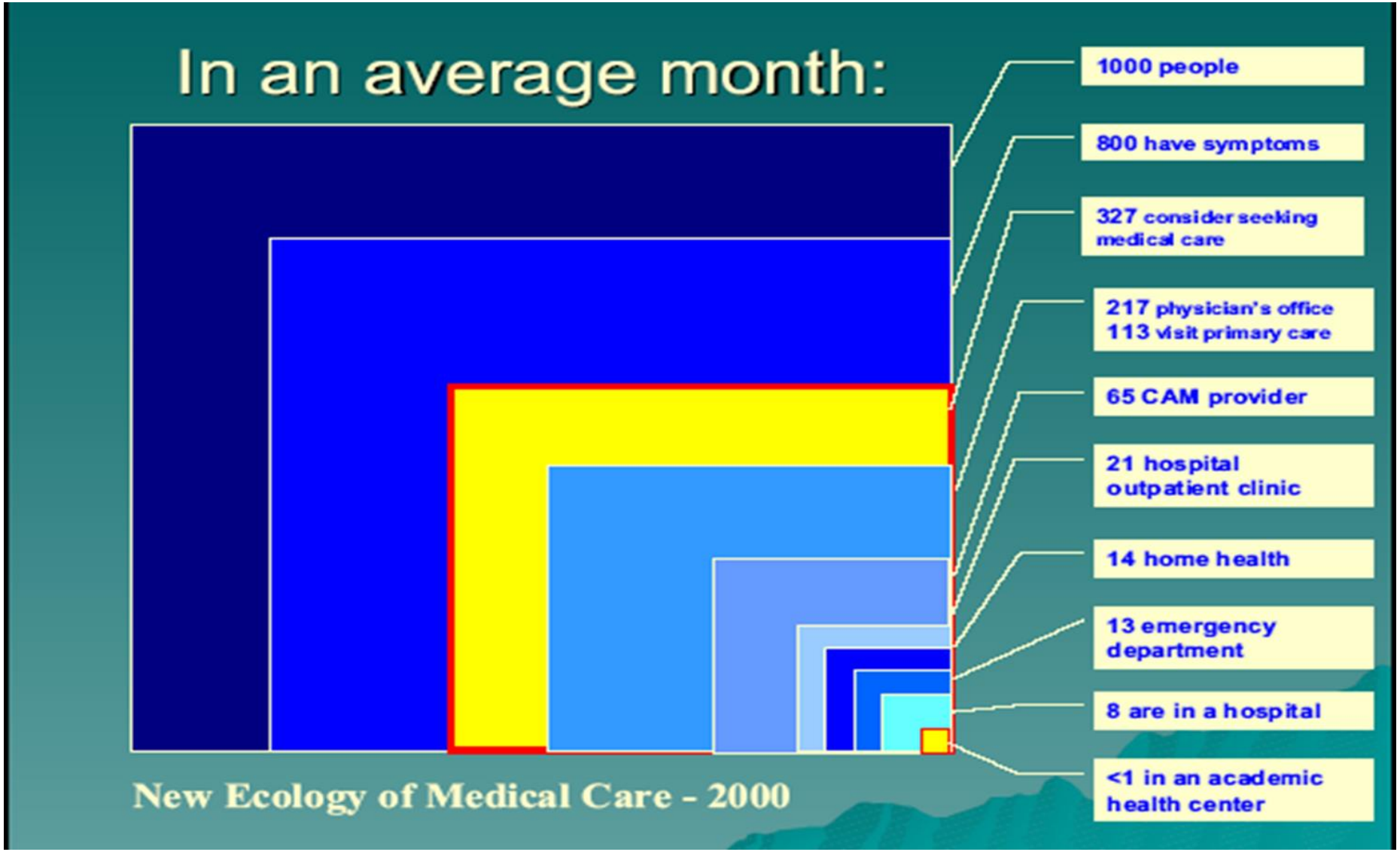


The epidemiology of medical errors

It is difficult to get a full and complete picture of medical errors in primary care/family medicine

Due to paucity of research studies and limited publications

Ecology of Medical Care



Classification

- Mis-classification
- Mis-categorisation
- Misrepresentations
- Non standardization

    - *Dr S Dovey et al. A preliminary taxonomy of medical errors in family practice Qual Saf Health Care 2002;11:233–238*

Categories of errors in Family Practice

Broadly categorised as

- Errors in the process of the healthcare delivery (system)
- and Errors arising from lack of clinical knowledge or skills

- Dr S Dovey et al. A preliminary taxonomy of medical errors in family practice Qual Saf Health Care 2002;11:233–238

Process Errors

- Administration (office)
- Network and ancillary services
- Other important stakeholders

Knowledge and skills errors

- Execution of a clinical task

Types errors in General Practice in SA

Communication

Delayed diagnosis

Prescriptions

Documentation (Charting)

Unethical behaviour

HPCSA

MPS casebooks

Medical briefs reports

Delayed diagnosis

Including:

- failure to diagnose
- failure to examine or investigate
- failure to revise an incorrect diagnosis in light of new evidence

Risk Management

Prevention of errors in Practice

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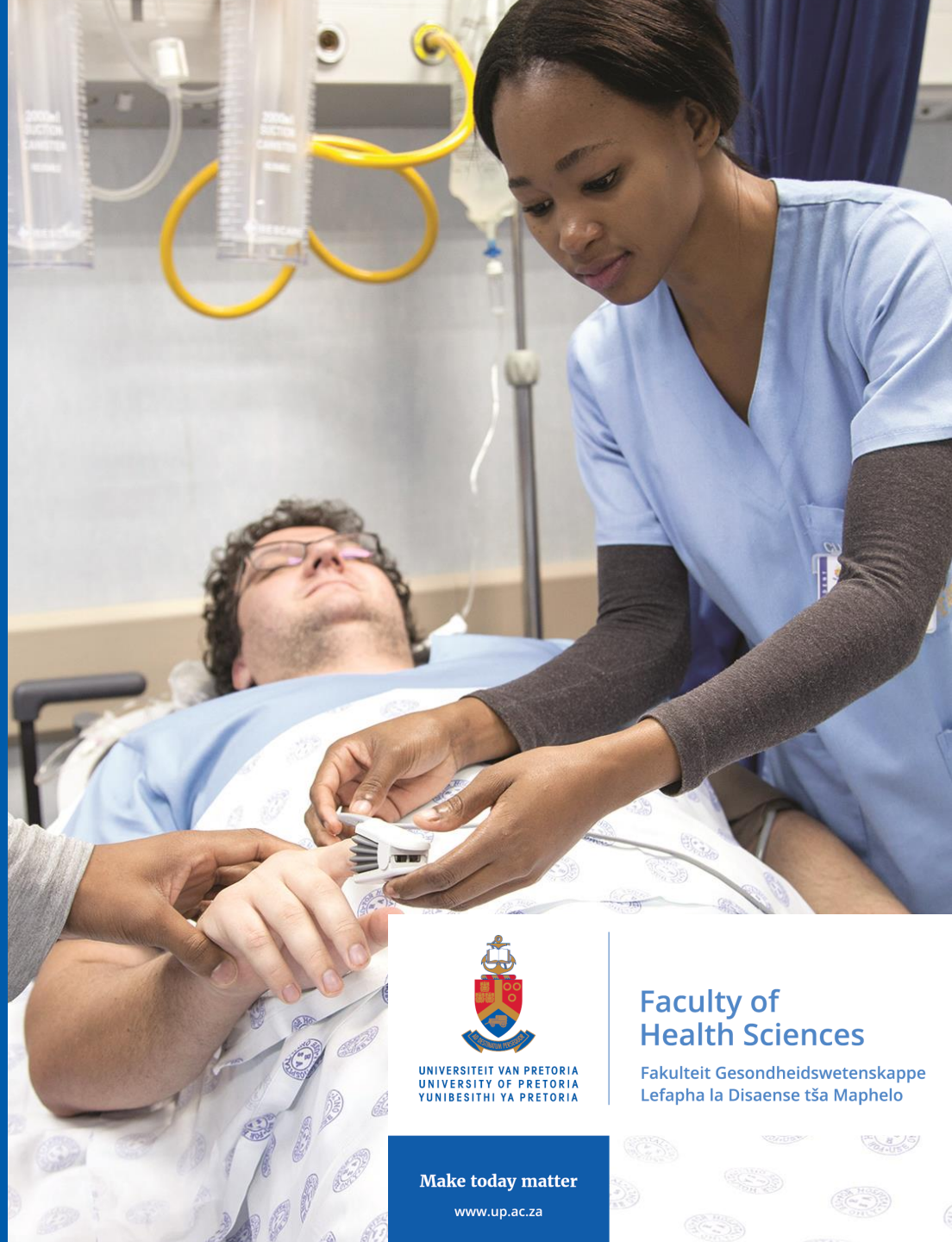
"Human beings, in all lines of work, make errors. Errors can be prevented by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing.

Institute of Medicine,* 1999
*To Err Is Human: Building a Safer Health System**



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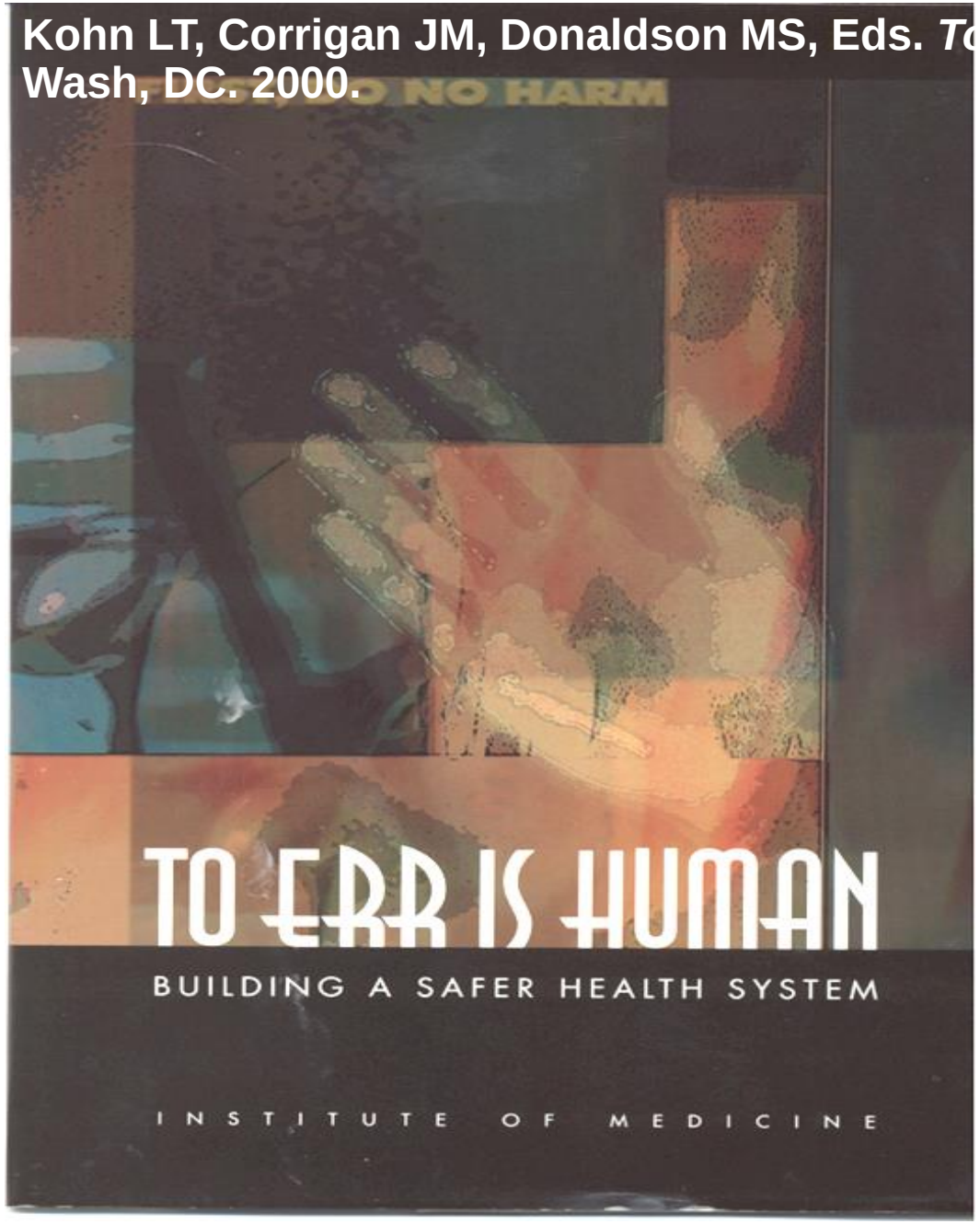

Kohn LT, Corrigan JM, Donaldson MS, Eds. *To Err Is Human*. Washington National Press, Wash, DC. 2000.

Enters six Cs

Six Cs guide can ensure you stay safe

- Charting (medical records)
- Careful prescribing (Medications)
- Communication/consultation
- Competence
- Confidentiality
- Consent (informed)

SAMA guide on professionalism
MPS casebooks
Medical briefs online publications

Keep comprehensive up-to-date records

- A good clinical record enables the doctor to reconstruct a consultation without reference to memory
- There are four crucial components to a good clinical record:
    - legibility,
    - the accurate date and time,
    - a signature
    - and being kept up-to-date

HPCSA Code of conduct booklet 9

Clarity in prescribing medicines and scheduled drugs

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Medication errors

- Inadequate knowledge of patients and their clinical conditions
- Inadequate knowledge of the medications
- Calculation errors
- Illegible handwriting on the prescriptions
- Confusion regarding the name of the medication
- Poor history taking.

Avoiding prescribing errors

Carefully consider the expected benefits against potential risks.

This is very important during pregnancy and in children

Self medication is discouraged, have your own family doctor

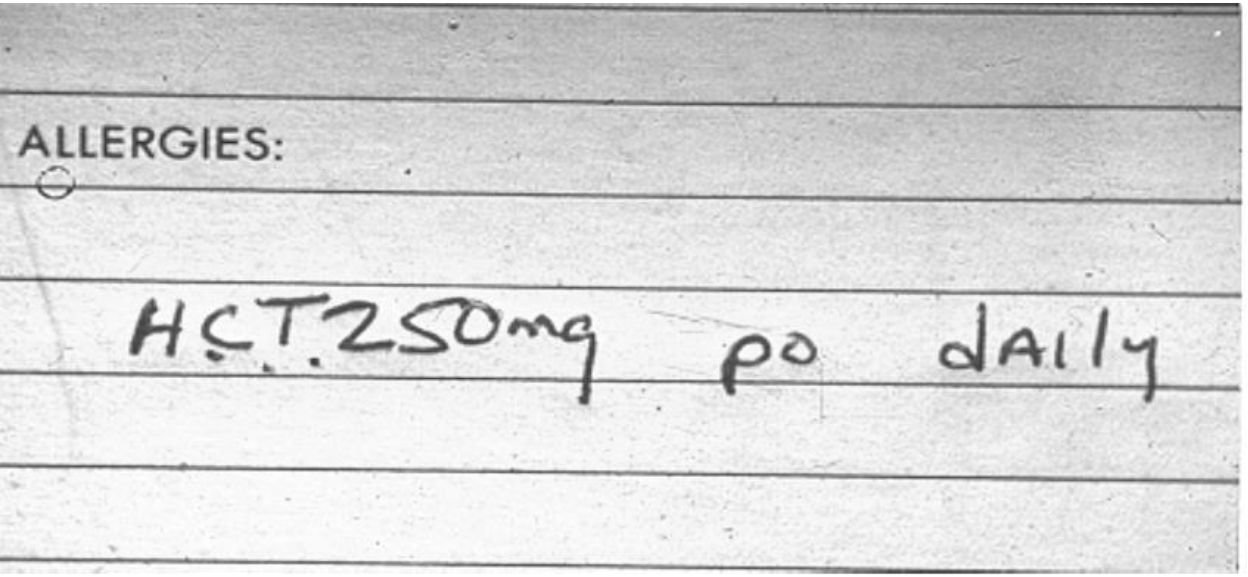
RATIONALE PRESCRIBING

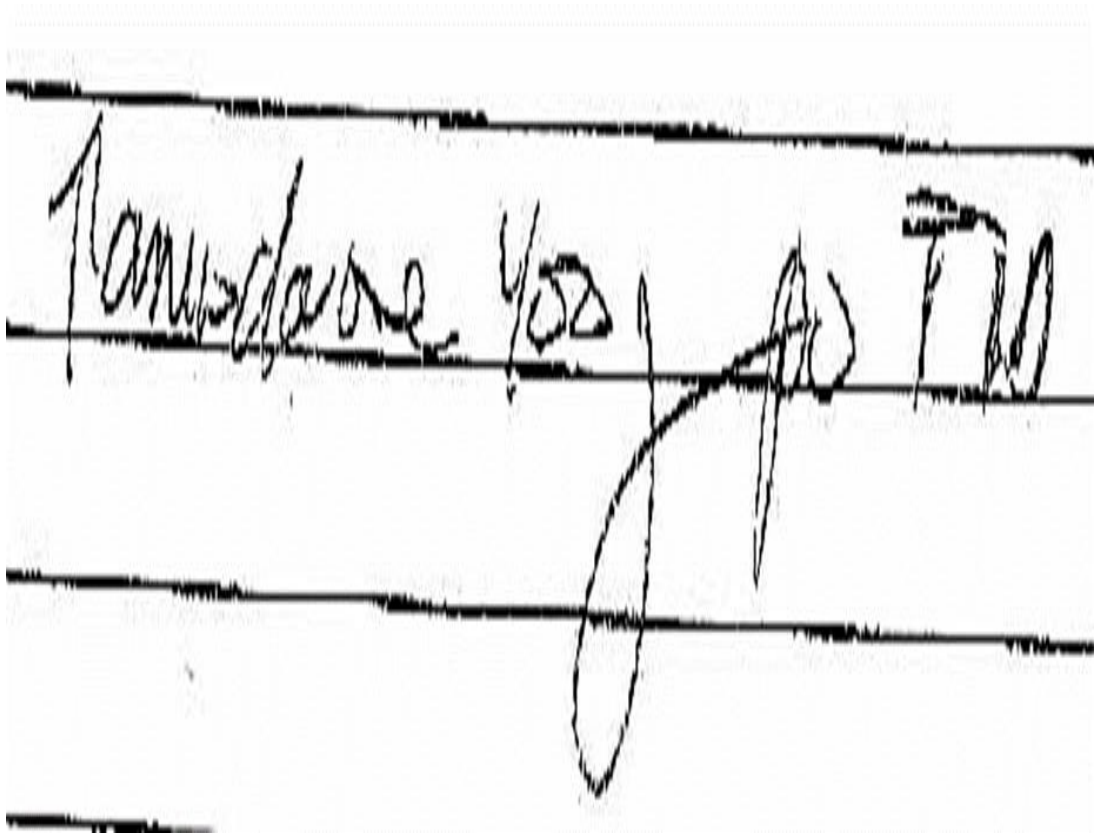
Good references for medications

Please consult the following:

- Department of Health, *Standard Treatment Guidelines and Essential Drugs List for South Africa*
- SAMF (SAMA publication)
- MIMS

You make the call





COMPETENCE

- To keep registration with HPCSA , one is required to continually update professional knowledge and skills.
- keep abreast by reading of relevant journals and published guidelines in your field of practice.
- Attendance to CME events like this one!
- Refer or delegate appropriately
- When in doubt, consult a colleague expert in the domain

Communication

- Consultation

An encounter where a patient seeks help from a doctor s/he trusts

Doctor and patient agendas

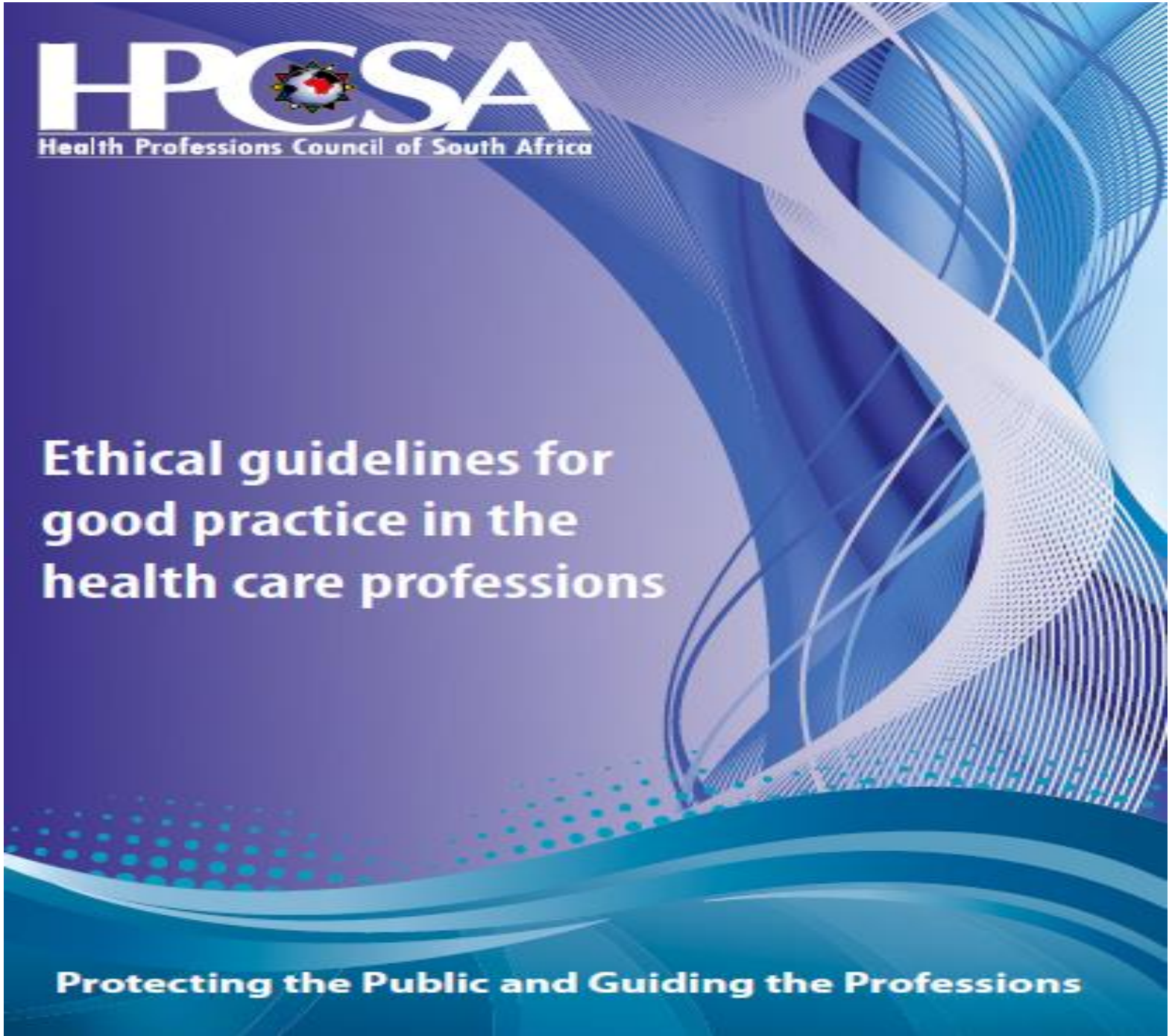
- **The doctor's agenda**
- **The patient's agenda**

-Consultation in Handbook of Family Practice, Oxford publishers (4th edition)

Confidentiality and Consent

Unethical Behaviour

- Office behaviour
- Network
- Practitioner behaviour



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HPCSA

Health Professions Council of South Africa

Ethical guidelines for good practice in the health care professions

The following Booklets are separately available:

Let’s come back to the patients’ scenarios

1. Category of errors?
    1. Patient one = Error arising from the execution of clinical tasks
    2. Patient two = Error from office organisation (healthcare delivery system)
2. Types of errors?
    1. Patient one = Lack of clinical skills (competence in doubt)
    2. Patient two = Unethical (breach of confidentiality, disrespect non truth telling)

Conclusion

- There are important differences between care in hospitals and primary care where most people receive care for most of their health problems
- Errors in primary care occur through commission, omission and unethical behavior.
- Communication is almost always involved
- Observing the 6Cs of good clinical practice would keep one out of troubles.

THANK YOU

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