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Preventing Medical Errors

medications that need to be continued while the patient is in a health care facility. Without medication reconciliations, medication discrepancies may occur and essential patient medications might be missed/discontinued, ultimately leading to health care-related complications for patients. When the patient from the case study was admitted into the health care facility, a medication reconciliation was not conducted. Therefore, there is potential that medication discrepancies may have occurred and essential medications were not continued - possibly contributing, at least in part, to the patients declining health.

The patient was never formally identified as an individual at risk for suicide - as the patient's health declined in the case study, she began to show signs of depression and make comments which potentially indicated the presence of suicidal thoughts - however, the patient was never formally identified as an individual at risk for suicide. Similar to the omission of medication reconciliation for the patient, the impact of the lack of suicide risk identification for the patient may not be immediately evident. With that said, the lack of suicide risk identification could lead to several negative health-related outcomes for the patient. An example of a possible outcome that may occur because the patient was not identified as a suicide risk is as follows: the patient was not identified as a suicide risk; the patient began to self-harm; consequently the patient was put in restraints; wounds developed as a result of the restraints; due to the patient's weakened state and declining health, the wounds became worse and eventually infected; the patient's infection intensifies; the patient's health continues to decline.

In addition to the possible outcome highlighted above, the lack of suicide risk identification could lead to a sentinel event. A sentinel event may refer to an unanticipated event in a health care setting that results in death or serious physical or psychological injury to a patient(s), not related to the natural course of the patient's illness. Health care professionals should work to prevent sentinel events whenever possible.

Are there any other ways the potential medical errors impacted the patient in the above case study; if so what are they?

Is it possible that the potential medical errors found in the case study above could have been prevented or avoided; if so how?

It does appear the potential medical errors could have been prevented/avoided. Examples of how each potential medical error may have been prevented/avoided can be found below.

Fall precautions were not applied to the patient - the patient's fall may have been prevented if fall precautions where applied to the patient.

Anticoagulation therapy recommendations were not followed - the potential complications of the patient's Coumadin therapy may have been avoided if the following Coumadin monitoring recommendation was effectively carried out: obtain daily INR determinations upon Coumadin initiation until stable in the therapeutic range; obtain subsequent INR determinations every 1 to 4 weeks.

A medication reconciliation was not completed - any potential complications that may have resulted from a lack of medication reconciliation could have been avoided if a medication reconciliation was carried out upon patient admission.

The patient was never formally identified as an individual at risk for suicide - any potential complications that may result from a lack of suicide risk identification may be avoided if the following Joint Commission recommendations are effectively carried out:

• Identify patients at risk for suicide.

• Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.

• Address the patient’s immediate safety needs and most appropriate setting for treatment.

• When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

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Are there any other ways the potential medical errors found in the case study above could have been prevented or avoided?

Conclusion

Medical errors are one of the leading causes of death in the United States. Thus, health care professionals should understand how to prevent medical errors from occurring. To help prevent medical errors from occurring, health care professionals should follow recommendations made by organizations such as the following: the Joint Commission, the FDA, the United States Department of Health & Human Services, the CDC, and the WHO.

References

1. www.jointcommission.org
2. www.fda.gov
3. https://www.ahrq.gov/
4. www.cdc.gov
5. "WHO Guidelines on Hand Hygiene in Health Care: a Summary," www.who.int

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