Medical Error Prevention and Safety for CNAs

Abstract:

During the course of a healthcare worker's career, a medical error may be made or be discovered. There are some mistakes, medical errors, that can be serious and may cause irreversible harm to a patient and irreparable damage to a healthcare worker's career. Events that lead to a medical error are many, but the end result always involves the patient suffering harm that could have been prevented. Preventable events are defined as those that should not have happened, and, more specifically, should indicate to healthcare workers that gaps in practice exist related to the appropriate levels of attention, communication, knowledge, and planning being followed.

Objectives:

1. Identify medical errors and their causes.
2. Identify ways to prevent medical errors and improve the certified nursing assistant (CNA) judgment.
3. Identify the correct response when a medical error occurs.

Introduction

The pace of work for health clinicians in everyday practice can be very fast and difficult at times. Patients may have serious health issues and all healthcare workers are expected to handle unexpected crises and

emergencies. In addition, there is another level of stress that remains in the background related to the possibility of making a mistake or a *medical error*. Mistakes are inevitable and making a mistake on the job is stressful for anyone; however, when working as a certified nursing assistant (CNA) some mistakes can be serious and may cause irreversible harm to a patient and potentially have a negative impact on a healthcare worker's career.

Identifying A Medical Error

What is a medical error? This may seem like a question with a simple answer but it is not. Not everything that is considered as "wrong" in a healthcare setting is a medical error. Although many people have tried to define a medical error, there is still no universal agreement on the term. In this section, a medical error is "*an adverse effect or harm that could have been prevented*." This is a simple definition, but it has all the essential elements of a medical error.

The typical chain of events that leads to a medical error are several. One or all of these may be in place, but the end result is always the same; the patient suffered harm that could have been prevented with better planning, adequate knowledge, and/or a higher level of attention and communication.

The following five case scenarios help to differentiate a situation where a medical error occurred as compared to other situations where there was no medical error. If these examples are read quickly, they may all appear to be medical errors but some are and some are not.

Case Example #1

The CNA is caring for a male patient who has been having lower leg pain and was admitted to the hospital for diagnostic tests. The patient has a history of hypertension. His blood pressure has been well controlled for many years by his antihypertensive medications, but because he has high blood pressure the physician has ordered routine blood pressure measurements; the physician has ordered measurements of the blood pressure every 12 hours, at 08:00 and 20:00. At 19:55 the CNA begins to walk to the patient's room to do a routine blood pressure measurement. But before the CNA can get there another CNA calls for help; his patient has fallen and the CNA needs assistance. After helping the co-worker, it is now 20:15 and the CNA is 15 minutes late taking the patient's blood pressure. Is that a medical error?

Discussion:

In this example, the patient's blood pressure is well-controlled and has been stable. The measurements are considered routine and the patient did not suffer any harm from the delay, and he would not be expected to suffer any harm from a 15-minute delay in a blood pressure measurement that is scheduled once every 12 hours. Assisting the other CNA was a higher priority than rigidly following a schedule for a routine task. *The 15-minute delay would not be considered a medical error*.

Case Example #2

The CNA is assigned to deliver a tube feeding to an elderly female patient through a percutaneous endoscopic gastrostomy (PEG) tube. The CNA performs the standard handwashing and makes sure the patient is sitting upright, checks to make sure the tube is open and clear, and determines that there is not a large residual in the patient's

stomach by performing the procedure as taught and according to the rules of the workplace. The CNA delivers the amount that was ordered at the proper rate and, after the feeding has been delivered, stays with the patient for 15 minutes to make sure she has tolerated the procedure. The patient seems to have tolerated the feeding, and the CNA makes sure she has the call light within reach and leaves the room.

One hour later the patient vomits. The staff monitors the patient for the rest of the shift and she does not develop signs or symptoms of aspiration or harm from the vomiting. Is this a medical error?

Discussion:

The CNA performed the tube feeding procedure correctly. No mistakes were made in the preparation, performance, or follow-up. Vomiting after a tube feeding is not unusual, it cannot always be prevented, and the patient did not suffer any harm. *This is not a medical error*.

Case Example #3

The CNA is caring for a patient who has had abdominal surgery two days prior. Her post-operative condition has been stable and she has had no complaints. However, at 22:30, which is 30 minutes before the CNA's shift is ending and while trying to "tie up loose ends" and prepare for shift change, the patient tells the CNA she is having pain near the area of the surgical incision. She describes the pain as not too bad, a 4 on a 1-10 scale, and the CNA does not check her vital signs or inspect the surgical dressing because the patient "doesn't look very uncomfortable." The CNA is very busy and forgets to document what happened or to tell the unit supervisor.

The next day when the CNA arrives at work it is reported that during the night the patient's surgical incision had separated and she needed to go back to the operating room to have the incision repaired. The patient lost blood and subsequently developed a wound infection and a fever. When the CNA was asked why she did not report the patient's complaint, she admitted that she forgot to do so, but she also stated that she did not know that pain at a surgical incision could indicate that the incision might be separating. She thought that pain after an operation was "a normal thing." Is this a medical error?

Discussion:

Clearly, the CNA made a mistake in not documenting or reporting the patient's complaint. Separation of a surgical excision is considered to be a very serious problem with potential for harm, and the CNA should have known this. In this case, the error was preventable, the CNA lacked the proper knowledge, the CNA did not communicate important information, and the patient suffered harm.

Pain is common after a surgical procedure, but the CNA did not attempt to find out where the pain was or why the patient was having pain. She also did not report the patient's complaint to her supervisor. *This is a medical error*.

Case Example #4

The CNA needs to provide catheter care for a patient who has just been admitted. Hand-washing is done and disposable latex gloves donned prior to performing the procedure using proper technique, and the CNA documents what has been done. Fifteen minutes later the

patient develops hives and difficulty breathing. She requires oral diphenhydramine and intravenous epinephrine to treat the allergic reaction. Is this a medical error?

Discussion:

The catheter care was performed correctly. But the CNA did not read the patient's chart before doing the procedure and failed to see the warning; the patient has a *latex allergy*. Whenever caring for a patient for the first time, it is advisable to check and see if the patient has any specific medical conditions or allergies that could impact care. Also, latex allergies are relatively common and all healthcare workers should be expected to know this and plan accordingly. A latex-containing product should never be used unless it is certain that the patient does not have a latex allergy. *This is a medical error*.

Case Example #5

A CNA is caring for an elderly male patient who has Alzheimer's disease, and has taken care of this patient many times and knows him well. The patient can ambulate without assistance and does not require a high level of physical care, but frequently forgets his location. He also has poor judgment in terms of his personal safety. Last week he left the hot water running in a sink for over five minutes and then tried to wash his hands and suffered first degree burns.

The CNA checks the patient's vital signs, irrigates his PEG tube, and then starts to leave the room to check on another patient. Before the CNA leaves the room, the patient mentions that he needs to use the bathroom and would like some help as he is feeling a little weak. The CNA tells the patient he will have to wait five minutes before assisting

him. However, as soon as the CNA leaves, the patient wanders off to look for a bathroom (he forgets there is one in his room), mistakenly goes into an exit stairwell at the end of the hall, loses his balance on the steep steps and falls. He suffers a broken hip. Is this a medical error?

Discussion:

The CNA knew that the patient has Alzheimer's disease, and that he frequently became disoriented about his location and that his judgment in terms of personal safety could not be trusted. The patient needed to use the bathroom, and the CNA seemed to rely on the fact that the patient would remember that there was a bathroom close by and that the patient would remember that the CNA would be back in five minutes to help him use it. Given what we know about the patient, these are very poor assumptions and the patient's injury is a direct result of this poor judgment. *This is a medical error*.

Poor planning, lack of knowledge, not communicating and inattention have been discussed in the above case examples where adverse effect or harm to patients resulted and a preventable event was identified. *Preventable event* and *adverse effect* are further discussed below.

Preventable Event and Adverse Effect

A preventable event obviously means that an error occurred that should not have happened but, even more importantly, it indicates that the error should not have happened if someone had been using appropriate levels of attention, communication, knowledge, and planning.

Adverse effect or harm means that the client suffered harm or discomfort because of the error. In the three examples above that are medical errors the patient suffered harm, and the harm was preventable if the CNA had used appropriate levels of attention, communication, knowledge and planning.

Both parts of the definition of a medical error are important. A medical error is not simply any mistake by a health clinician; it is an adverse effect or harm that could have been prevented by a reasonable, properly trained health care worker who was paying attention, planning, *etc.* As a healthcare worker, CNAs will need to focus on what is considered appropriate levels of attention, knowledge, and planning because those are the aspects of a CNAs performance that are evaluated.

An adverse effect or harm is an important part of the definition of a medical error. However, the CNA should not consider errors or mistakes in patient care that do *not* cause harm to be unimportant. Errors and mistakes have the potential to do damage and all healthcare workers are expected to follow rules, procedures, standards, *etc.* A CNA can be disciplined for failing to do so, even if a medical error does not occur.

Common Medical Errors

No one knows how common medical errors are but the evidence clearly indicates that medical errors occur regularly. What *is* known is that there are certain types of medical errors that happen repeatedly.

Common Medical Errors

The common medical errors are explained next.

Falls

Falls are a medical error that CNAs are very likely to be involved with. Patient falls have been extensively studied, and almost all falls can be prevented.

Medication Errors

Medication errors are probably the most common medical errors. An incorrect dose is given, the doses are given too closely together, the patient receives the wrong medication, the drug is given by an incorrect route, drug allergies or drug interactions are not checked - there are many ways that a medication error can occur.

Infections

Infections that are considered to be medical errors happen when healthcare workers do not follow infection control procedures. For a CNA this may occur when performing urinary catheter care or a simple dressing change. If proper infection control techniques were not followed and an infection results, the infection would be considered a medical error.

Laboratory Errors

Laboratory errors can include such things as a test result that is reported incorrectly or a test result that is not reported in a timely manner.

Treatment Errors

Treatment errors occur when procedures and treatments are performed incorrectly. In the second scenario, if the CNA had not made sure the patient's head was elevated and had failed to check for a residual, these mistakes could have lead to a medical error.

Pharmacy Errors

The wrong drug or an incorrect dose is dispensed.

Incorrect diagnosis

Causes of Medical Errors

It is not enough to just say that errors happen because we are all human, and humans make mistakes. That is true and medical errors can never be entirely eliminated. But it has been proven that the number of errors can be greatly reduced. The first step in accomplishing this goal is to identify the four most common reasons why medical errors occur.

Communication Errors

Poor communication is one of the biggest causes of medical errors. Many studies have documented that poor communication or a lack of communication are significant contributors to medical errors. Hospitals, clinics, doctor's offices, skilled nursing facilities, *etc.* (almost all healthcare settings) are very busy places.

Written records have always been used to make sure communication is accurate. Computers have also helped to reduce communication

errors. However, these written records may not be complete or they may be inaccurate, which may lead to poor communication.

The risk of poor communication is compounded by the need for verbal communication. This is often in the form of a conversation or a message delivered from one person to another and then to someone else. Verbal communication is very common in healthcare settings and it happens all of the time. However, it is very easy (especially when the pace of the work day gets hectic) for undocumented, verbal communication to be misinterpreted and forgotten. If the communication among healthcare workers about patient care issues is *not* documented, there are real risks.

There is no reliable way to determine what needs to be done, what should be done, or if a procedure has been performed or a treatment delivered without proper communication. Depending on a one's own memory or on someone else's memory is not a safe way to practice safe healthcare.

Good communication essentially means good documentation, which that is a basic rule CNAs need to remember. All important conversations and information relating to client care need to be documented.

Poor Judgment

Poor judgment is also a very common cause of medical errors. Poor judgment can mean that someone made an incorrect assessment; he/she may have decided that a patient's pain was not serious, or a patient's elevated blood pressure or fever did not represent a risk.

Poor judgment can mean that the CNA had a range of tasks to accomplish, and made a poor choice as to which was the most important. Poor judgment can also mean that the CNA had some warning signs that a dangerous situation was developing, but did not notice them or interpret them correctly, or take the proper course of action.

Poor judgment could mean that a healthcare worker's planning was in error. Medical errors that arise from poor judgment basically indicate that a poor decision was made or an incorrect action was taken *that another healthcare professional who was acting reasonably and prudently would not have made in error.*

In simpler terms, a medical error caused by poor judgment means that if a healthcare worker had to do something over again, a different action would have been taken. Whether or not poor judgment was used can be somewhat subjective but the standard for determining what is and what is not poor judgment is: *What would a reasonable person who had the same level of educational preparation and clinical experience do in the same situation?*

Lack of Knowledge

As a healthcare worker, CNAs are expected to have a certain level of specialized knowledge. Their schooling and training should have provided them with all the information needed to do their job.

When a CNA is working, the CNA needs to apply learned knowledge. But educational preparation is not all the same and not everyone learns everything they need to know because of a variety of reasons. A

CNA will also forget things that have been learned. Or there may not be sufficient reason to remember a specific fact. For example, if the CNA has not worked with a diabetic patient for a while, some of the information needed to provide good care may have been forgotten.

Although most programs teach students the necessary curriculum, and most students do a good job of learning, it is inevitable that the CNA will forget some of what was taught. No one can be expected to know everything, but what CNAs need to know should be clearly outlined in the facility job description for CNAs. The job description should clearly outline what a CNA would be expected to know, and it is the CNA's responsibility to have this knowledge or gain this knowledge if the CNA is lacking it.

Stress

It is a lot easier for the CNA to do a job if there is unlimited time. It is also easier if there is no pressure but there will definitely be times in anyone's career when work is being done under pressure and the time available to do a job will be limited.

Pressure and a lack of time cause stress, and stress is a major reason why medical errors occur. Very few people perform at their best when they are under stress. Although stress is a part of almost every job, being responsible for the health and safety of other people is something that is especially difficult. The CNA can expect a certain level of stress when performing work.

In summary, there are four basic reasons why medical errors happen: 1) poor communication, 2) poor judgment, 3) lack of knowledge, and

4) stress. But underlying all of those is a more basic reason why a medical error would occur: *someone failed to use appropriate levels of attention, knowledge, and planning.* Remember that there is a chain of events that leads to a medical error, as shown below.

Poor planning/Lack of knowledge/No communication/Inattention

↓

Adverse effect/Harm

↓

Preventable Event

Preventing Medical Errors

Knowing how medical errors occur is the first step but the bigger concern is preventing them. The easiest way to do that is to remember those four causes of medical errors and to use the following steps.

Good Communication

As mentioned previously, *good communication basically involves good documentation*: that is the first and most important rule of good communication. Documentation in healthcare is a separate topic. However, in terms of preventing medical errors, documentation can be quickly summed up as: *write it down.*

The CNA should not trust his/her memory, or the memory of someone else. Anything that is important and that must be documented should

be documented as soon as possible; this is crucial and the CNA must be sure to record everything that is important. Healthcare workers should be communicating what has happened, what needs to be done, and what the plans are for the patient, so the CNA should make sure to include all important details.

One of the simplest ways to make sure documentation and communication are being done accurately is to review one's own notes. After having finished documenting, the CNA should go back and make sure everything that needs to be documented was done. The CNA will be surprised how often a quick review will reveal that something was forgotten, such as including some important information in a note that had just been written.

Of course, if the CNA takes too seriously the concept that everything that is important must be documented, documentation would be a never-ending task and if the CNA takes to heart the old saying used in healthcare, "*If it wasn't documented, it wasn't done*," documentation would truly be endless. Documentation is a separate topic. As regards documentation and prevention of medical errors, the CNA should use his/her own professional judgment about what to include and what to leave out and to use the following standard to decide: *is what I am documenting important in terms of patient care*?

Good Judgment

Exercising good judgment can be tricky for several reasons. First, the need for good judgment often occurs in situations in which the CNA does not have all the facts, or the facts may be open to interpretation.

Consider that if the CNA had all of the facts needed and all of the information was clear, making the right judgment would be easy. Second, the need for good judgment often arises when the CNA is faced with a new and unfamiliar situation. It is easy to make the right choice if the CNA is in a situation not encountered before. Many people have pointed out that good judgment comes from experience but experience often comes from bad judgment.

So what is the answer? How does the CNA go about using good judgment to avoid making medical errors? Fortunately, there are some simple things can be remembered to help the CNA make good judgments.

Ask for Help

The CNA may not have the information needed to make a good judgment, but a co-worker may. CNAs should also have supervisors that can provide help so it is important to remember that the CNA almost always has resources.

This seems very obvious, but there is often a feeling among healthcare workers that they should know everything and have all the answers. It is unrealistic but it is surprising how common this attitude can occur. One of the most helpful things to remember when practicing as a CNA is that it is okay to say *I don't know*. If the CNA is unsure, then the CNA should ask. The CNA is not alone.

Being Attentive

Being a healthcare worker is a big responsibility. Part of that responsibility means being vigilant and paying attention. Healthcare workers cannot make good judgments without good information, and that information cannot be obtained without close attention to details. CNAs must constantly be monitoring their own work situation and assigned patients.

The CNA should be looking for changes in patient status, abnormal signs and symptoms, and possible unsafe situations. The CNA is the member of the health team with the most constant and direct contact with the patient. Because of that, the CNA will often be the first one to notice when something is wrong and will need to be watchful at all times.

Planning

Another way for the CNA can make good judgments is to make a conscious effort to plan. Planning involves thinking ahead so that the CNA can be prepared for what might happen and to provide patient care efficiently and safely.

Lack of Knowledge

Preventing medical errors due to a lack of knowledge is relatively simple. Only healthcare workers can determine if they have the knowledge to do a job correctly and safely. CNAs must make an honest assessment of what they know and, if there are areas that need improvement, they need to address deficiencies. Hopefully, the healthcare setting in which CNAs work will have educational resources that can help them learn. If not, there are almost unlimited on-line learning opportunities. Honesty, not avoidance, is the key. It is better

to realize that knowledge is lacking with regard to an important clinical topic to close learning gaps and to improve knowledge and professional growth. Many people will simply hope that they will never have to be in a situation in which they do not have the knowledge they need; however, this approach does not enhance professional development and will eventually fail.

Stress

There has been a lot written about stress on the job, and a lot written about the unique stress faced by healthcare workers. Stress can definitely affect a CNAs job performance. Everyone has a unique way of dealing with stress. How can the CNA deal with the stress encountered on the job?

Take Time

Being advised to slow down and take time when under stress is easy advice to give to a healthcare worker, but is often difficult to put into practice. However, healthcare workers should bear in mind that true health emergencies are actually very rare. An emergency is a situation in which immediate action is needed to prevent a catastrophe. During their entire career, CNAs may never encounter a situation in which only immediate action will prevent a disaster. Most problems that are perceived as "emergencies" are actually simply changes in the daily routine or brief disruptions in the schedule. All healthcare workers need to be prepared for these situations to avoid reacting in a stressed and harried manner.

When involved in an emergency situation, most healthcare workers will feel a self-imposed pressure to do something immediately. However,

99.9% of these "emergencies" are just unfamiliar disruptions. Although something will need to be done, it may not be immediately clear what needs to happen. The best course of action is to *slow down* and take time to *think things through.* Reacting to situations causes mistakes and errors. Generally, there will always be more time to respond to a situation than one might realize.

Collaborative Practice

Co-workers can be a valuable source of support, knowledge, and experience. Dealing with stress alone can actually make a healthcare worker less productive. Co-workers can help through ongoing collaboration to address situations from a variety of angles then one might think of alone and when under stress. In collaboration with co-workers, CNAs can find the assistance needed to complete tasks, to obtain advice, for knowledge sharing, and for moral support.

Understand the Definition of Error

A CNA may feel stressed because of being ten minutes late taking a patient's vital signs. However, the CNA should consider whether such a brief delay is likely to cause patient harm and whether he/she is feeling stressed because of being behind on an unrealistic schedule.

It is possible that a CNA may feel stressed on the job out of concern that a medical error will occur. All healthcare workers need to accept that errors are inevitable. It is not realistic to try to make every day at work a *perfect* performance. Expecting to be 100% perfect on the job will only add to job stress, and this attitude will make mistakes more likely to happen. It is also helpful to keep the correct definition of a

medical error in perspective, as mentioned at the beginning of this course: *an adverse effect or harm that could have been prevented*.

Be Prepared

Being prepared involves having a clear understanding of the challenges and requirements if one's job as a healthcare worker. The most effective way of handling stress on the job is to know the scope of the CNA role and job description. The CNA will not be stressed if informed on the CNA role in the workplace. Remember, a medical error is considered to have occurred if a healthcare worker did not have proper knowledge, did not exercise good judgment, or used poor planning.

When A Medical Error Happens

This section discusses what the CNA should do if a medical error happens. First, the CNA needs to report the error immediately. This is often not easy for some to do. The first instinct for many people is to feel shame and embarrassment. By definition, an error is a failure on the part of a healthcare worker to be attentive, to plan, or to have the knowledge needed to perform a job. And the predominant healthcare culture has traditionally been a somewhat harsh on people who make mistakes. Embarrassment and shame are normal in these situations.

It is absolutely vital that as soon as a healthcare worker discovers a medical error that the error be reported. Delaying the process is the *worst* possible response. Not only will this make it appear as if the healthcare worker is not being honest but there is potential for harm to the patient. If that happens, any potential judgment and

consequences that result from the error will probably be worse than if the error had been reported immediately.

As a CNA, once a medical error is discovered and reported then the next step is to objectively document the error. The CNA should simply document what happened, and avoid adding details about what was felt upon discovering the medical error or adding facts that are felt provide an excuse for why the error happened. If there is any doubt about how to document after a medical error is made, the CNA should obtain advice from a supervisor.

Once the CNA's supervisor has been notified of the error and the documentation has been completed, the patient should be informed. Most experts agree that patients have a right to know if a medical error has occurred, and it is recommended that patients be told of medical errors. However, the CNA should *not* do this alone, and the CNA's supervisor and a physician should make the decision as to when and how the patient is informed.

The CNA may be required to be present when the patient is informed, and may be required to explain what occurred. If the situation is handled, and the CNA is present when the patient is told of a medical error, an apology should be offered. Research has clearly shown that, if a medical error occurs, what most patients feel is most important and what they want is an apology.

Summary

Patients will often have serious health issues that require healthcare workers to manage unexpected crises and emergencies. When a medical error occurs there can be significant harm caused to the patient and to the CNA's career.

Although many people have tried to define a medical error, there is still no universal agreement and a medical error has been defined here as *an adverse effect or harm that could have been prevented*. Typically, events that lead to a medical error where the patient has suffered harm could have been prevented with better planning, adequate knowledge, and/or a higher level of attention and communication.