MEDICAL ERRORS: WHAT THEY ARE AND HOW TO AVOID THEM

Being a medical professional can be difficult at times. The pace of a normal work day can be very fast, the clients may have a lot of serious health issues, and you are expected to be able to handle unexpected crises and emergencies. In addition, there is another level of stress that is always looming in the background: the possibility of making a mistake, of committing a medical error.

Of course, we are all human so mistakes are inevitable. And making a mistake on the job is stressful for anyone. However, when you are working as a certified nursing assistant (CNA) a mistake can have very serious consequences. A mistake could cause irreversible harm to a patient and irreparable damage to your career. Some mistakes are called medical errors, and medical errors can be serious.

In the course of your career as a CNA you will make medical errors. It would be impossible not to do so. But there are definitely ways to avoid medical errors, there are ways to make sure that you learn from the ones you do make, and there are ways to prevent medical error from happening in the first place.

OBJECTIVES

When the student has finished this module, he/she will be able to:

1. Identify a definition of a medical error.
2. Identify an incorrect definition of a medical error.
3. Identify the four causes of medical errors.
4. Identify the basic cause of medical errors.
5. Identify the most important rule of good communication.
6. Identify a definition of poor judgment.
7. Identify a definition of the basic level of knowledge you need a CNA.
8. Identify two ways to improve judgment.
9. Identify two ways of dealing with stress.
10. Identify the correct response to a medical error.
WHAT IS A MEDICAL ERROR?

What is a medical error? This may seem like a question with a simple answer, but it’s not. Read these five scenarios and decide which ones are medical errors and which are not.

- Example #1: The patient you are caring for has been having lower leg pain and he is admitted to the hospital for diagnostic tests. The patient has history of hypertension. His blood pressure has been well controlled for many years by his anti-hypertensive 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 you begin to walk to the patient’s room to do a routine blood pressure measurement. But before you can get there another CNA calls for help; his patient has fallen and the CNA needs assistance. After helping your co-worker it is now 20:15 and you are 15 minutes late taking your patient’s blood pressure. Is that a medical error?

- Example #2: You are assigned to deliver a tube feeding to a patient through a PEG (Percutaneous endoscopic gastrostomy) tube. You wash your hands, you make sure the patient is sitting upright, you check to make sure the tube is open and clear, and you determine that there is not a large residual in the patient’s stomach: you perform the procedure in the way you have been taught and according to the rules of your workplace. You deliver the amount that was ordered at the proper rate and after the feeding has been delivered, you stay with the patient for 15 minutes to make sure she has tolerated the procedure. The patient seems to have tolerated the feeding, you make sure she has her call light within reach and leave 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?

- Example #3: You are caring for a patient who has had abdominal surgery two days ago. Her post-operative condition has been stable and she has had no complaints. However, at 22:30, 30 minutes before your shift is ending and while you are trying to “tie up loose ends” and prepare for shift change, the patient tells you 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 you do not check her vital signs or inspect the surgical dressing because the patient “doesn’t look very uncomfortable.” You are very busy and you forget to document what happened or tell your supervisor. The next day when arrive at work you learn 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?

- **Example #4:** You need to provide catheter care for a patient who has just been admitted. You wash you hands, put on latex disposable gloves, perform the procedure using proper technique, and document what you have 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?

- **Example #5:** A CNA is caring for an elderly patient who has Alzheimer’s disease; he has taken care of this patient many times and knows her well. The patient can ambulate without assistance and she does not require a high level of physical care, but she frequently forgets where she is. She also has poor judgment in terms of her personal safety. Last week she left the hot water running in a sink for over five minutes and then tried to wash her hands and suffered first degree burns. The CNA checks the patient’s vital signs, irrigates her PEG tube, and then starts to leaves the room to check on another patient. Before the CNA leaves the room, the patient mentions that she needs to use the bathroom and she would like some help ass she is feeling a little weak today. The CNA tells the patient to wait; he will be back in five minutes to assist her. However, as soon as the CNA leaves, the patient wanders off to look for a bathroom (she forgets there is one in her room), mistakenly goes into an exit stairwell at the end of the hall, loses her balance on the steep steps and falls. She suffers broken hip. Is this a medical error?

If you read these examples quickly, you might think that all of them are medical errors but some are and some are not.

**Example # 1:** In the first 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.

**Example #2:** 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.

**Example #3:** 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 a 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.

Example #4: This is a medical error. The catheter care was performed correctly. But the CNA did not read the patient’s chart before doing the procedure so he failed to see the warning; the patient has a latex allergy. Whenever you are 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 the care. Also, latex allergies are relatively common and a medical professional should be expected to know this and plan accordingly. Never use a latex-containing product unless you are sure the patient does not have a latex allergy.

Example #5: This is a medical error. The CNA knew that the patient has Alzheimer’s disease, and he knew that she frequently became disoriented about where she is and that her 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 he would be right back to help her 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.

So, not everything that “goes wrong” in a health care setting is considered a medical error. Although many people have tried to define exactly what a medical error is, there is still no universal agreement on the term. In this module, a medical error will be defined as follows:

**A medical error is an adverse effect or harm that could have been prevented**

This is a simplified definition, but it has all the essential elements of a medical error. The typical “chain of events” that leads to a medical error has 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. This is illustrated below.

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Poor planning/Lack of knowledge/No communication/Inattention
  ↓
Adverse effect/Harm
  ↓
Preventable Event
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Notice these two parts of the definition: **preventable** and **adverse effect**. Preventable obviously means that the error 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: 1) attention; 2) communication; 3) knowledge, and; 4) planning. Adverse effect/harm means that the client suffered harm or discomfort because of the error. In the three examples 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 healthcare professional; it is an adverse effect or harm that could have been prevented by a reasonable, properly trained professional who was paying attention, planning, etc. As a health care professional, you will need to focus on what is considered appropriate levels of attention, knowledge, and planning because those are the aspects of your performance that are evaluated.

Learning Break: An adverse effect or harm is an important part of the definition of a medical error. However, you 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 as a healthcare professional you are expected to follow rules, procedures, standards, etc., and you can be disciplined for failing to do so, even if a medical error does not occur.

WHAT ARE THE COMMON MEDICAL ERRORS?

No one knows how common medical errors are, but there is a lot of evidence that clearly indicates medical errors occur regularly. What is known is that there are certain types of medical errors that happen over and over.

Table I: Common Medical Errors

- 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 personnel do not follow infection control procedures. For a CNA or a HHA 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

**HOW DO MEDICAL ERRORS HAPPEN?**

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. If you have already started working as a CNA, you know that hospitals, clinics, doctor’s offices, skilled nursing facilities, etc. - almost all health care 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 accurate and if they are not, that is poor communication. The risk of poor communication is compounded by the need for oral communication. This is often in the form of a conversation or a message delivered from one person to another and then to someone else: this type of communication is very common in health care settings and it happens all the time. However, it is very easy (especially when the pace of the work day gets hectic) for undocumented oral communication to be misinterpreted, forgotten, etc. And if the communication among health care professionals about client 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, etc. Depending on your memory or on someone else’s memory is not a safe way to practice your profession.

**Learning Break:** Good communication essentially means good documentation: that is a basic rule you 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 you had a range of tasks to accomplish, and you made a poor choice as to which was the most important. Poor judgment can mean that you had some warning signs that a dangerous situation was developing, but
you did not notice them or interpret them correctly, or take the proper course of action. Poor judgment could mean that your 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, and another healthcare professional who was acting reasonably and prudently would not have made the error.

To express this in simpler terms: a medical error caused by poor judgment means that if you had to do something over again, you would have done it differently. Whether or not poor judgment was use can be somewhat subjective. But the standard for determining what is, and what is not poor judgment is this: 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 professional, you are expected to have a certain level of specialized knowledge. Your schooling and your training should have provided you with all the information that you need to do your job. When you are working, you need to apply that knowledge. But educational preparation is not all the same and for different reasons, not everyone learns everything they need to know. You will also forget things you learned. Or there may not be sufficient reason to remember a specific fact: if you have not worked with a diabetic client for a while, you may forget some of the information you need to provide good care for them.

Although most programs teach the students the necessary curriculum, and most students do a good job of learning it, it is inevitable that you will forget some of what was taught. You can’t be expected to know everything, but what you need to know should be clearly outlined in your job description. Your job description should clearly outline what you are expected to know, and it is your responsibility to have this knowledge or gain this knowledge if you do not have it.

**Stress**

It is a lot easier to do your job if you have unlimited time. It is also easier if there is no pressure. But there will definitely be times in your career as a CNA when you will be under pressure and the time you have to do your 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. As a CNA you can expect a certain level of stress in your job.

So in summary, there are four basic reasons why medical errors happen: poor communication, poor judgment, lack of knowledge, and stress. But underlying all of those is a more basic reason why a medical error occurred: someone failed to use appropriate levels of attention, knowledge, and planning. Remember: the chain of events that leads to a medical error looks like this.

**Poor planning/Lack of knowledge/No communication/Inattention**
HOW TO PREVENT 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 health care is a separate topic. However, in terms of preventing medical errors, documentation can be quickly summed up: write it down.

Do not trust your 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 you must be sure to record everything that is important. You are communicating what has happened, what needs to be done, and what the plans are for the client, so make sure you include all important details.

One of the simplest ways to make sure your documentation and your communication are accurate is to review your notes. After you have finished documenting, go back and make sure everything that needs to be documented was documented. You will be surprised how often a quick review will reveal that you forgot to include some important information in a note you have just written.

Of course, if you take too seriously the concept that everything that is important must be documented, documentation would be a never ending task. And if you take to heart the old saying used in health care, “If it wasn’t documented, it wasn’t done,” documentation would truly be endless. Documentation is separate topic. As regards documentation and prevention of medical errors, use your professional judgment about what to include and what to leave out and use this 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 you don’t have all the facts, or the facts may be open to interpretation. Think about it: if you had all the facts you needed and all of the information was clear, making the right judgment would be easy! Second, the need for good judgment often arises when you are faced with a new and unfamiliar situation. It is easy to make the right choice if you are in a situation you have encountered before. But as many people have pointed out, good judgment comes from experience, but experience often comes from bad judgment!
So what is the answer? How do you use good judgment to avoid making medical errors? Fortunately, there are some simple things you can remember to help you make good judgments:

- **Ask for help:** You may not have the information you need to make a good judgment, but one of your co-workers may. You should also have supervisors that can provide help. So it is important to remember that you almost always have resources. This seems very obvious, but there is often a feeling among health care professionals that they should know everything and have all the answers. It is unrealistic, but it is surprising how common this attitude can be. One of the most helpful things to remember when you are practicing as a CNA is that it is okay to say: I don’t know. If you aren’t sure, ask; you are not alone.

- **Being attentive:** Being a health care professional is a big responsibility. Part of that responsibility means being vigilant and paying attention: you cannot make good judgments without lots of good information, and you can’t get that information if you are not paying attention. As a CNA and a health care professional, you must constantly be monitoring your work situation and your clients. You are looking for changes, abnormal signs and symptoms, possible unsafe situations. You are, basically, on the “front lines,” acting as a sentinel. You often have the most constant and most direct contact with the client. Because of that, you will often be the first one to notice if something is wrong, so you need to be watchful at all times.

- **Good planning:** Another way to help you make good judgments is to make a conscious effort to plan. Planning involves thinking ahead so that you are prepared for what might happen.

**Lack of Knowledge**

Preventing medical errors that occur because of a lack of knowledge is relatively simple. Only you can determine if you have the knowledge to do your job correctly and safely. You must make an honest assessment of what you know and if there are areas that need improvement, you need to address them. Hopefully, the health care setting in which you work will have educational resources that can help you learn. If not, there are almost unlimited on-line learning opportunities.

But honesty, not avoidance, is the key. It is better to realize that you lack knowledge about an important clinical issue and try and improve. Many people will simply hope that they will never have to be in a situation in which they don’t have the knowledge they need. This approach will work - until it doesn’t.

**Stress**

There has been a lot written about stress on the job, and a lot written about the unique stress faced by health care workers. Stress can definitely affect your job performance.
Everyone has his/her own way of dealing with stress. How can you deal with the stress you encounter when working as a CNA?

- Take your time: Being advised to slow down and take your time when you are under stress is easy advice to give but difficult advice to put into practice. But remember this: true emergencies in health care settings are actually very rare. An emergency is a situation in which immediate action is needed to prevent a catastrophe. In your entire career as a CNA, you 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. However, if you are not prepared these situations may look like an emergency and that is where the trouble begins. If you feel that you are involved in an emergency situation you will feel a self-imposed pressure to do something, and do something immediately. But 99.9% of these “emergencies” are just unfamiliar disruptions. Yes, you may need to do something and it may not be immediately clear what you have to do. But if this happens the best course of action is to slow down and think. Reacting to situations causes mistakes and errors. You almost always have more time to respond than you think you do.

- You are not alone: This was mentioned in a previous section, but it applies here, too. Co-workers can be a valuable source of support, knowledge, and experience. Trying to deal with stress by yourself can actually make you less productive. Your co-workers can help you deal with stress in a variety of ways. They can assist you with tasks, provide advice and knowledge, and give moral support.

- Understand what an error is: Accept that errors are inevitable. Don’t try and make every day at work a perfect performance. It’s impossible, it will only add to your stress, and this attitude will make mistakes more likely to happen. It is also helpful if you keep the definition of a medical error in mind. You may feel stressed because you are ten minutes late taking a client’s vital signs. But ask yourself: is this likely to cause harm? Are you being stressed because there is a possibility you might make a medical error? Or are you stressed because you are behind on an unrealistic schedule that you have set for yourself?

- Be prepared: Being prepared involves having a clear understanding of the challenges and requirements of your job and the most effective way of handling stress is to know your job; you can’t be stressed if you are prepared. Remember, a medical error is considered to have occurred if a healthcare professional did not have proper knowledge, did not exercise good judgment, or used poor planning.

WHAT SHOULD YOU DO IF YOU MAKE A MEDICAL ERROR?

Sooner or later, you will make a medical error. What should you do? It’s very simple: you need to report the error immediately. This is not easy to do. The first instinct for
many people is to feel shame and embarrassment. By definition, an error is a failure on your part to be attentive, to plan, or to have the knowledge you need to do your job. And the “culture” of the health care system has traditionally been a bit harsh on people who make mistakes. Embarrassment and shame are normal in these situations.

But it is absolutely vital that as soon as you discover a medical error, you report it. Delaying the process is the worst possible response. Not only will this make it appear as if you are not being honest, but there is potential for harm to the client. 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. When you do document the error, be objective. Simply document what happened. Don’t add details about how you were feeling or add facts that you feel provide an excuse for why the error happened. If you have any doubt about how to document after you have made a medical error, get advice from your supervisor.

Once your supervisor has been notified of the error and the documentation has been completed, should you tell the patient what has happened? Most experts agree that patients have a right to know if a medical error was committed, and it is recommended that patients be told of medical errors. But you should not do this alone. Your supervisor and a physician should make the decision as to when and how the patient is informed. You may be required to be there, and you may be required to explain. But however the situation is handled, if you are present when the patient is told of a medical error be sure to offer an apology. Research has clearly shown that if a medical error occurs, what most patients want and what they feel is most important is an apology.

**SUMMARY**

This illustration is simple and you can refer to it whenever you have questions about a medical error.

**Did the Patient Suffer Harm or an Adverse Effect?**

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**Was the Harm/Adverse Effect due to Poor Planning, Lack of Knowledge, or Inattention?**

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**Could the CNA have Prevented the Adverse Effect/Harm?**

If the answers to these questions are yes, then a medical error has occurred.