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Reporting of Medical Errors: Real-Time Tales

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Section A

Reporting Tools
Iceberg Model of Errors

- Misadventure: Death/severe harm
- No Harm Event: Potential for harm is present
- Near Miss: Unwanted consequences were prevented because of recovery
- Actual Harm
- Actually Occurred
- Recovered
“... the Achilles’ heel of error reporting systems: the flawed notion that reporting has any intrinsic value in and of itself”

“... in health care, errors are so frequent, the number of man-machine interfaces are so voluminous, and we have so much catching up to do that the average patient safety officer would have a full plate for the next five years without a single new report”

— Robert Wachter

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JHH Real-Life Reporting Tool

- “Home-grown” medication error reporting tool online since 2000
- UHC Patient Safety Net Reporting Tool
  - Online error reporting tool for all types of events
# The Johns Hopkins Hospital Confidential
**For Peer Review Only**

## Medication Event Data Collection Form

<table>
<thead>
<tr>
<th>Your First Name</th>
<th>Your Last Name</th>
<th>Pt Location / Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Inpatient:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient's First Name</th>
<th>Patient's Last Name</th>
<th>HxNO (DO NOT INCLUDE HYPHENS)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Event</th>
<th>Time of Event (Military)</th>
<th>Service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>06-07-2004</td>
<td>HHMM</td>
<td></td>
</tr>
</tbody>
</table>

**Drug(s) Involved in Event; Maximum of (3) Three; One per line; Use generic name when possible**

- Drug 1.:
- Drug 2.:
- Drug 3.:

**SOURCE OF EVENT (Select as many as appropriate)**

- PRESCRIBING
- DISPENSING
- DRUG ADMINISTRATION
CLINICAL OUTCOME: (CHOOSE HIGHEST APPROPRIATE LEVEL)

0. Event **did not** reach patient.
1. Event reached patient; No treatment or increased monitoring necessary.
2. Event reached patient; Increased monitoring required.
3. Event reached patient; Unplanned treatment or increase in hospital stay (probable or actual) required.
4. Event reached patient; Life-threatening event or serious morbidity or death occurred; Event may have contributed; Contact the JHH Legal Hotline x5-7949

NEAR MISS: A potential or actual medication error that did not harm the patient (level 0, 1, or 2) but would **likely** cause **significant** harm if it occurs again.

Click here if event is a Near Miss.

*Comments* (include MD notification for administration errors)
UHC Patient Safety Net Event Report

Organization: Johns Hopkins Hospital

Training mode

Who was harmed or nearly harmed: (Required)

- Patient
- Visitor
- Other (to report unsafe conditions and suggest improvements) *

* Please do not select this category if the event involves a patient.
Classifying Events

Unsafe conditions
   A. Unsafe conditions

Event, no harm
   B1. Event did not reach the individual due to chance alone (“near-miss”)
   B2. Event did not reach the individual because of active recovery efforts by caregivers (“near-miss”)
   C. Event reached the individual but did not cause harm (an error of omission such as a missed medication dose that does reach the patient)
   D. Event reached the individual and required additional monitoring or treatment to prevent harm

Event, harm
   E. Individual experienced temporary harm and required treatment or intervention
   F. Individual experienced temporary harm and required initial or prolonged hospitalization
   G. Individual experienced permanent harm
   H. Individual experienced harm and required intervention necessary to sustain life (e.g., transfer to ICU)

Event, death
   I. Individual died
Add event

8. Location Where Event Occurred: *(Required)*

9. Date of admission or date of ambulatory encounter: *(Required)*

Date (mm/dd/yyyy):

10. Event description:
   A. Medication error
   B. Adverse Drug Reaction (not a medication error)
   C. Equipment/Supplies
   D. Fall
   
11. Point here:
   E. Error related to
      Procedure/Treatment/Test
   F. Complication of
      Procedure/Treatment/Test
   
   1. Communication inadequate with other providers in organization
   2. Communications inadequate with outside providers/agencies
   3. Communication inadequate with patient or family
   4. Records/chart unavailable
   5. Records/chart incomplete
   6. Access to care problem
   7. Referral information problem
   8. Patient not available
   9. Provider not available
   10. Message handling/response problem
   11. Other
Section B

Sample Reports
Pretend you are the patient safety officer and ask yourself the following questions:

- Do I have to do something immediately about this? (How much of a priority is it?)
- To whom do I need to talk?
- Was this a one-time glitch, or a pattern?
- What follow-up needs to happen?
Samples: Example 1

- Describe event:
  - Patient was finished procedure in Peds Radiology and was sitting on mother’s lap in the waiting room. The staff RT called me, reporting that mom "states patient pulled her G-tube out." Gauze placed over stoma, went to page Requesting MD, and called floor to alert the nursing staff. By the time I went back to the patient and her mother, transport had already taken the patient back to the floor.

- Harm score: E
  - The individual experienced temporary harm and required treatment or intervention
Classifying Events

Unsafe conditions
   A. Unsafe conditions

Event, no harm
   B1. Event did not reach the individual due to chance alone ("near-miss")
   B2. Event did not reach the individual because of active recovery efforts by caregivers ("near-miss")
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   E. Individual experienced temporary harm and required treatment or intervention
   F. Individual experienced temporary harm and required initial or prolonged hospitalization
   G. Individual experienced permanent harm
   H. Individual experienced harm and required intervention necessary to sustain life (e.g., transfer to ICU)

Event, death
   I. Individual died
Samples: Example 2

- Describe event:
  - Specimen submitted to CL for testing was received with no patient identification label

- Harm score: D
  - The event reached the individual and required additional monitoring or treatment to prevent harm
Samples: Example 2

- Describe event:
  - Specimen submitted to CL for testing was received with no patient identification label
- Harm score: D
  - The event reached the individual and required additional monitoring or treatment to prevent harm
Describe event:
  - An RN found that epi was running on an IV pump and tubing labeled “calcium” at the rate at which the calcium should have been running. The patient was also receiving the ordered amount of epi on another pump, which was properly labeled “epi.” The patient received almost twice the amount of epi and no calcium for an unknown length of time. The gtts were hung on day shift, and the error was caught on night shift.

Harm score: D
  - The event reached the individual and required additional monitoring or treatment to prevent harm.
Samples: Example 4

- Describe event:
  - Orders obtained from MD for IV antibiotics and topical cream. Antibiotics transcribed, filled, and administered without an MD signature on the order. Order for PRN Nystatin was never transcribed to MAR, but signed off per RN. Verbal order for topical butt paste obtained by RN but never transcribed or implemented by RN.

- Harm score: C
  - The event reached the individual but did not cause harm. (An error of omission such as a missed medication dose does reach the patient.)
Ideas and Lessons

- Voluntary reporting is the clear first step, BUT . . .
  - Never know the real denominator
  - Does give window onto systems and types of events
  - Still need investigation
  - Coding is imprecise
Can’t Fix What You Don’t Know Is Broken

- Grade for impact of error reporting on health care in last five years = C