Adverse Events: Consequences of Error

Oh No …. It Happened to Me

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Disclosures

Learner Objectives

- Explain the importance of understanding how healthcare professionals are effected when involved in patient safety incidents, adverse events or near miss situations.
- Discuss common reactions to being involved in a patient safety incident, an adverse event or a near miss situation.
- Identify how organizations could potentially better support health care professionals.
- Describe the next steps in investigating the "*Consequences of Error*"
- Describe how students have been involved in undergraduate student research.

Support Received

- Grant/Research Support:
  - MacEwan University
    - Research, Scholarly Activity and Creative Achievement Fund
      - Project Stream
      - Dissemination Stream
- I have no actual or potential conflict of interest in relation to this program/presentation.

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Image Source:
http://easymodules.net/Media/Default/Images/Blog/Orchard/why-hire-us.jpg

Seattle nurse Kimberly Hiatt takes own life months after accidentally giving baby fatal overdose

BY CORKY SIEMASZKO Follow / DAILY NEWS STAFF WRITER / Tuesday, June 28, 2011, 3:10 PM A A A

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Two tragedies were set in motion when a respected Seattle nurse named Kimberly Hiatt accidentally gave an overdose of medication to a doomed baby.

Five days later the child died.

Seven months after that, a guilt-stricken Hiatt hanged herself. She was 50.

"She was devastated, just devastated," Lyn Hiatt, the dead nurse's partner, told MSNBC.

Adding uncertainty to the agony, doctors can't say for sure that Hiatt's mistake caused the death of 8-month-old Kaia Zautner, who was born with severe heart problems.

Her cardiologist said what Hiatt did "exacerbated cardiac dysfunction" in the baby and led to her decline, according to records obtained by MSNBC.

State lawyers, however, said Kaia was already fragile and proving the overdose killed her would be difficult, the records showed.

Nevertheless, Hiatt was fired from Seattle Children's Hospital, the only place she had worked for 24 years.

Why is this area of Research Important?

Several researchers have concluded that the occurrences of adverse events in complex healthcare environments are inevitable.

(Baker et al., 2004; Sears, Baker, Barnsley, & Short, 2013; Waterman et. al, 2007; Wu & Steckelberg, 2012)

Image Source: http://minnesotaemploymentlawreport.wp.lexblogs.com/wp-content/uploads/sites/315/2012/05/Blog-Pic-Important-Stamp.jpg

What is a Patient Safety Incident?

Definition

"An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient."

(p. 131)

Canadian Patient Safety Institute. (2012) *Incident Analysis Collaborating Parties. Canadian Incident Analysis Framework*. Edmonton, AB: Canadian Patient Safety Institute.

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How we started …

Image Source:
https://cdn.psychologytoday.com/sites/default/files/blogs/1023/2013/03/120195-118343.jpg

Who was included

Registered Nurses

Student Nurses

Pharmacists

Social Workers

Image Source:
http://www.aldermansgreen.coventry.sch.uk/images/inclusion/inclusion.jpg

What were the Participant Experiences?

What Happened

- Medication
  - Analgesic
    - Narcotic and Non-Narcotic
  - Anticoagulants
    - Real dose vs prescribed dose
      - Gave prescribed does in ER – transferred to ICU
  - IV
    - Rate
    - Continuous vs intermittent
    - No one noticed it should have been discontinued – patient had CHF and transferred to ICU
- Fall
  - Patient helped to bed and didn't realize hip was broken – patient died

Reaction

- Anger and frustration
  - Directed at organization
  - Directed at self
- Fear about effect of reputation
- Self-doubt
- Decreased job satisfaction
- Detachment
- Sleep disturbances
- Repetitive memories

When Caring Hurts; Helping Helpers Heal

April 27, 2015

“Mistakes never really leave you.”

Dr. Katrina Hurley is an emergency physician at the IWK Health Centre and research director in the division of pediatric emergency medicine in Halifax Nova Scotia.

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What could Help?

- Information needs to come back
  - Has this happened before
  - What strategies can be tried to reduce the potential occurrence
    - How successful have these strategies been
- Training on what to do when involved in a patient safety incident has generally focused on what paper/forms to fill out.
  - Reactions did not vary depending on what form was used
- Self-care
  - Reflective journaling
- Breaking the Silence
  - This has happened to others
- Debrief with others
- Suggestions provided about curriculum considerations
  - Shift focus beyond teaching how to fill out the forms

Next Steps

Reducing the Stigma of Error

Image Source:
http://powerofpositivity.net/wp-content/uploads/2013/02/footprints-21.jpg

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