



A Case of Hospital Care Unintended Harm



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"All men make mistakes, but a good man yields when he knows his course is wrong, and repairs the evil. The only crime is pride."

Sophocles, Antigone

INTRODUCTION

Medicine has become more complex, the diagnosis process relies on many coordinates and guidelines and procedures, laws and media pressure are building up professional stress for healthcare providers.

In 1999, the Institute of Medicine USA published the famous **"To Err is Human"** (fig.1) stating a disturbing report *"At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented"* (1)

The continuous clinical research and the accelerated medical knowledge published are overwhelming for the physician trying to optimize the diagnosis and treatment process for the patient. (2)

The guidelines are often easily outdated by new discoveries and research and their content and recommendations are biased by their authors. (3)

A research found that in US, at least 210,000 patients hospitalized each year, suffer some type of preventable harm that contributes to their death

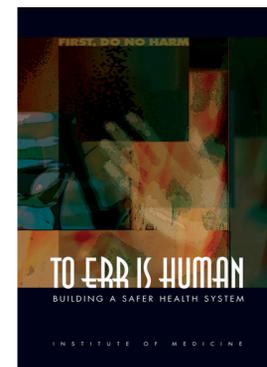


Figure 1. The cover of "To Err is Human" (IOM, 1999)
Picture source: <http://goo.gl/oEp4Vv>

LEARNING OBJECTIVES

- A case of medical error represents a hot media resource
- If resulting in serious patient injury or death – public damnation of the medical personnel
- The lack of personnel, the crowded and overwhelmed hospitals and the increased procedural steps and bureaucracy are contributors to medical errors and unintentional harm
- There is a slight discrepancy between US definition of a medical error and RO definition:
- **US Definition:** A medical error is a preventable adverse effect of care, whether or not it is evident or harmful to the patient.
- **RO Definition:** Unpredictable failure of a normal medical behaviour

CASE PRESENTATION

We present a case of a **78 years old woman**

- Diagnosed with **mixed dementia** and internalized in a permanent mental health sanatorium;
- With a history of COPD and Chronical Respiratory Failure, with long term home oxygen-therapy

She was admitted to the Clinic of Pulmonary Diseases with following symptoms:

- **acute onset and rapidly progressing dyspnea**
- **cough with difficult expectoration**
- **alteration of general status.**



Clinical examination upon admittance:

- Alteration of general status
- Respiration with accessory respiratory muscles
- O₂ peripheral saturation = **81%** corrected with 3 L O₂/min at **95 %**
- Cough and expectoration of purulent sputum
- Bilateral bronchial ralls
- Rhythmic cardiac sounds, Cardiac Freq. = **99 bpm**
- Fatigability and drowsiness

We initiated treatment with:

- **Antibiotics** (Ceftriaxon 3 g/day and Cyprofloxacin 400 mg/day)
- **Aerosols:** Salbutamol and NaCl 0,9%, three times daily
- **Parenteral corticotherapy** (200 mg of HHC daily)
- **Mucolytics:** ACC 600 mg/daily
- **Oxygen therapy** – 3 LO₂/min using simple facial mask

- The evolution was favorable after 10 days of treatment, O₂ saturation reverting to 96% with 2 LO₂/min
- The family and the mental sanatorium were announced of imminent patient release
- The night upon her release, the duty doctor reported normal patient status,.

SOMETHING WENT WRONG ...

The day before her release, at the morning round we found out that she presented a saturation of 87% with same amount of oxygen as before. While increasing the O₂ flow from 2 L/min to 3 L/min then 4 L/min, the peripheral saturation stayed the same

AFTER INVESTIGATIONS

- The aerosol mask was connected with a separate tube **to the same O₂ source** with the O₂-therapy mask
- The patient received aerosols **at 22:00 the night before**
- The **nurse mixed the 2 tubes**
- She set the O₂-mask on the patient but the O₂ source remained connected to the aerosols mask
- Our patient **did not receive O₂ for almost 12 hours**

DISCUSSIONS

- In the night shift there is only 1 nurse for 40 patients. Is the nurse the only one to blame?
- No permanent physical or psychological damage was done
- The hospitalization of this patient was prolonged with another 2 days
- The repercussion could have been disastrous

CONCLUSION

- We cannot possibly make procedures for every unintended harm we discover but we can have an ongoing process of revision of our currently procedures.
- The unintended harm is extremely low (or at all) reported so cases are very hard to be identified and corrected
- Patient involvement in identifying harmful events and participating in rigorous follow-up investigations to identify root causes
- Preventable harm leads to enormous financial costs