A Case of Hospital Care Unintended Harm

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INTRODUCTION

Medicine has become more complex, the diagnosis process relies on many coordinates and guidelines and procedures, laws and media pressure are building up profssional stress for healthcare providers.
The continuous clinical research and the accelerated medical knowlegde published are overwhelhing for the physician trying to optimize the diagnosis and treatment process for the patient.

LEARNING OBJECTIVES:

- A case of medical error reprezents 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

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

Clinical examination upon admitance showed 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, fatigability and drowsiness.

The evolution was favorable after 10 days of treatment, O2 saturation reverting to 96% with 2 LO2/min. The day before her release, at the morning round we found out that she presented a saturation of 87% with same amount of oxygen and while increasing the O2 flow to 3 then 4 L/min, the peripheral saturation was the same.
We found out that after the administration of aerosols the night before, due to the fact that the aerosol mask was connected with a separate tube to the same O2 source with the O2-therapy mask, the nurse mixed the two tubes. She set the O2-mask on the patient but the O2 source remained connected to the aerosols mask, so our patient did not receive O2 for almost 12 hours.

DISCUSSIONS:
Although no permanent physical damage was done, the hospitalization of this patient was prolonged with another 2 days. If there would have been more nurses that had more rounds, this error could have been corrected earlier. We cannot possibly make procedures for every unintended harm we discover but we can have an ongoing process of revision of our currently procedures by communicating this kind of errors.