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Examination of Fatal Error Supports System-Based Approach to Safety

Joint Commission Journal Article Presents ISMP Recommendations

Horsham, Pa---The cause of medication safety is best advanced by focusing on and correcting problems and failures in the medication management system and the entire system of health care delivery, including governance, medical staff, and hospital leadership. That is the message that numerous experts, including The Institute of Safe Medication Practices (ISMP), are sending in the April 2010 issue of *The Joint Commission Journal on Quality and Patient Safety*, which contains a case study of a well-publicized error that resulted in the death of a 16-year-old patient and criminal charges for the nurse involved.

The error occurred at a hospital in the Midwest, where the patient in labor received an intravenous infusion of two drugs that were only intended for epidural infusion to provide pain relief. The consequences were devastating to everyone involved. The case received widespread media attention, as the nurse who administered the infusion was stripped of her nursing license and pleaded guilty to a criminal offense.

These events set in motion intense internal and external scrutiny of the hospital's medication and safety procedures. At the hospital's request a year later, ISMP performed an independent root cause analysis (RCA) of the error that provides a unique view into the circumstances surrounding the error, and identifies multiple latent systems issues and gaps. The RCA, along with ISMP recommendations that health care organizations can use to prevent similar events, is presented in the April 2010 *Journal*.

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The article states, “Although the hospital’s organizational learning was painful, this event offered an opportunity for increasing organizational competency and capacity for designing and implementing patient safety structures and processes...to promote safer behavioral choices and include safety nets and fail-safe mechanisms for patients and providers.”

In addition to the RCA of the error by ISMP, the April 2010 issue of the *Journal* contains editorials supporting a systems-based approach by internationally known patient safety experts Sidney W.A. Dekker, Ph.D., Professor and Director, Leonardo da Vinci Laboratory for Complexity and Systems Thinking, Lund University, Sweden; Charles R. Denham, M.D., Chairman, Texas Medical Institute of Technology, Austin; and Lucian L. Leape, M.D. Adjunct Professor of Health Policy; Department of Health Policy and Management, Harvard School of Public Health, Boston.

For a copy of the RCA by ISMP and accompanying editorials, contact the Joint Commission (Elizabeth Eaken Zhani, 630-792-5914, ezhani@jointcommission.org), or ISMP (Renee Brehio, 704-831-8822, rbrehio@ismp.org).

About ISMP: The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit charitable organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. ISMP represents more than 35 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process. ISMP is a federally certified patient safety organization (PSO), providing healthcare practitioners and organizations with the highest level of legal protection and confidentiality for patient safety data and error reports they submit to the Institute. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit www.ismp.org.

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