Case Study I (Reporting Medical Errors: Inappropriate Transfusion)

A 62 year old man with colon cancer was undergoing surgery to remove the cancer from his sphincter and have a colostomy placed. Although the patient has had a colonoscopy every year for the previous ten years the cancer was never found until two months ago. The surgeon told the healthcare team the cancer had been growing for six to eight years.

The night prior to surgery all labs were completed, consent was signed and anesthesia had finished their pre-op. The surgery went fairly smoothly however the patient required a great deal of A+ blood. The blood for all three OR rooms was stored together in one refrigerator. The refrigerator held three containers, one for each OR, and each container was labeled with the patient's name. The OR nurse who was the runner for that surgery was sent to get an additional pint of blood. Inadvertently he grabbed the wrong patient's blood, which was B-.

Due to the emergent nature of trying to get the blood into the patient the safety precautions usually followed when hanging blood were not followed. The anesthesiologist, along with the nurse, did not match the information on the label to the patient's chart. Both co-signed the label without reading it.

As the nurse went to remove the empty bag, she noted that name on the label was not the patient's name and immediately notified the healthcare team. A large dose of diphenhydramine was given and the patient was monitored for a transfusion reaction. Fortunately, he only had a slightly increased fever. He went on to recover fully.

Questions for Discussion:

1. As the patient has had colonoscopies for the last ten years, should he be told that the cancer was missed each time?
2. Is it more important to discover *who* caused the blood error or *how* the error occurred? Is there a difference in this case?
3. Should either the nurse or the anesthesiologist (or both) be punished for this error?
4. Aside from following the correct procedures for hanging blood are there any other measures that could be taken to prevent this mistake from happening again?
5. Following the surgery, from the hospital's perspective, who should be notified?
6. Risk Management? Legal? The patient? JCAHO?
7. As the patient did not experience any adverse effects, should he be told about the mistake? Who should tell him? What should be said?

Case Study II (Team Communication & Provider Satisfaction)

Team A views itself to be an interdisciplinary team. The team works on a small oncology unit and has a patient load of 12-15 patients per day. The team members consist of an attending, several residents, a fellow, a pharmacist, the charge nurse and the various bedside nurses, a social worker and a discharge planner.

Each morning the team meets for 30-45 minutes following rounds to discuss the patient load. Each patient is discussed individually and each team member has input into the care plan that is decided for each patient on a daily basis.

This team receives very high patient satisfaction scores and patients frequently say how nice it is that everyone seems to know what is going on. The error rates on the unit are lower than average for the hospital and the length of stay is 2-3 days shorter than the other oncology units in the city. In addition the employee satisfaction on this unit is generally higher than other units in the hospital and staff turnover is lower than would be expected in this city.

Team B is a multi-disciplinary team on a similar unit across town. The physicians round each morning at 7am and the junior resident returns around 9am to write the patient orders for the day. Conversations between the resident and nurse occur on an "as needed" basis. Sometimes the charge nurse joins in rounds but usually receives information from brief notes written in the chart. The other disciplines are called in as needed. Most team communication is done via the chart.

Team B has lower patient satisfaction scores than Team A. Patients and family members are sometimes heard complaining that they don't know what is going on. Error rates are high. People from the different disciplines do not feel especially comfortable approaching one another. Discharges are usually delayed because it is not known by the rest of the team, when the patient is being discharged.

The residents and nurses are frustrated by the miscommunications that take place each day. The residents are frustrated because the attendings tell them to discharge a patient but the nurse informs them that no teaching has been done nor has home health been set up because they did not know the patient was going home. Consequently the length of stay for patients is longer than most and the hospital must absorb the extra cost.

Questions for discussion:

1. It sounds as if the main difference between Team A and Team B is who goes on rounds in the morning. Can all the differences noted above be a matter of such a simple thing?
2. Define interdisciplinary vs. multidisciplinary. Discuss the pros and cons of each.
3. Why is good team communication so important?
4. Why is important that all team members know the patient plan?
5. Describe the types of errors that can take place with Team B.
6. What can each of you do to ensure good communication even if you work in a multidisciplinary environment?

Case III (Team Communication & Outside Institutions)

Mabel is a 72 year old woman with dementia brought to the hospital from a nursing home for a fever of 103.5F. It appears that the fever is related to a severely infected large decubitus ulcer on her sacrum. She is admitted to the surgical service as she requires a PIC line to be placed for IV antibiotics and her wound needs to be surgically irrigated and monitored.

Susan is an experienced nurse on the floor where Mabel is admitted. Susan is reviewing her chart and realizes that this is the fourth patient this month to be admitted from this nursing home for this type of infection. She pages the surgical resident and informs her of this information. The resident replies that she is to place the PIC line, order the antibiotics and debride the wound. She has four other patients to see before the end of the day.

After hanging up the phone Susan is upset and pages the resident again. The resident phones back and tells her again that there is really nothing that they can do about this problem and asks that the nurse not page her again today regarding this observation. Susan now decides to page the attending surgeon with this information. The attending tells her to call social work, who informs her that unless the family makes a complaint there is nothing to do.

Questions for Discussion:

1. Discuss who is responsible for contacting the nursing home.
2. If you are the nurse, what else could you do?
3. If you are the surgical resident, what else could you do?
4. Is the social worker correct about the family needing to file a complaint?
5. Is this considered elder abuse or neglect and what are the legal ramifications of not reporting it?
6. How could the team communication be improved?
7. If she is sent back to the nursing home will she be in a safe environment?

Case IV (Building the Better Health System)

St. Sebastian Health System (SSHS) is a relatively new academic health science center that includes a 500 bed tertiary care hospital, a variety of ambulatory care sites, a medical school, a nursing school, and several training programs for health care technicians and physician assistants. St. Sebastian is competing with several community hospitals that are smaller and simply feel “friendlier” and more “intimate” to patients and families than a large teaching hospital does.

St. Sebastian has retained you, a group of medical students and nursing students, to provide a unique perspective on how it might gain some ground on the community hospitals. The administrators believe that your unique statuses enable you to see the situation from the perspectives of patients as well as providers.

Please make whatever recommendations you think would make St. Sebastian seem a friendlier place to patients and their families (i.e., the clients or customers of SSHS). Here are some issues and questions you might consider:

a. One of the most common issues at a teaching hospital is how hard it is for patients and their families to know “who’s who” on the health care team. There seem to be so many people involved in their care. What things can be done to help offset this problem?

b. Furthermore, even when we know a name and the accompanying position, e.g., Jane Smith, MD, Resident or John Phillips, Advanced Practice Nurse, we might not know very much about their role. How can this be addressed?

c. Give a description of your typical day as medical student on a clinical rotation (as this varies greatly by rotation, several descriptions of days might be appropriate.) Give a description of your typical day as nursing student on a clinical rotation (as this varies greatly by rotation, several descriptions of days might be appropriate.) What aspects of the day might be intimidating or less than friendly from a patient’s perspective? E.g., a large team on rounds coming into the room. What protocols might you put into place to make this routine more tolerable to patients? How can physicians and nurses work together better to improve the day from the patient’s perspective?

d. Is there anything else that attending physicians, nurses, and medical and nursing students should be doing together to make the environment friendlier?

e. Is there any way that medical student and nursing education should be different at this institution than it is at Loyola? How could one make these medical and nursing programs the best possible?