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98,000 Preventable Patient Deaths: 9 Patient Safety Solutions

By Catherine D. Bertram, Partner

"No adverse event should ever occur anywhere in the world if the knowledge exists to prevent it from happening." That is a direct quote from the Joint Commission, a national organization that accredits more than 16,000 health care organizations around the country. In fact it is the first sentence in their introduction to what they have dubbed "9 key patient safety solutions" for health care providers in order to prevent inevitable human errors from actually reaching patients and thus prevent patient injuries and death from preventable errors.

Having worked as Director of Risk Management in a major teaching hospital and having studied patient safety, I can verify that harm to patients and "near miss" incidents often involve the issues listed by the Joint Commission below. Those 9 solutions were developed from the data the Joint Commission has regarding patient injuries, deaths and near misses.

Unfortunately, in the recent past I have represented families and patients in the DC area who have been harmed or lost their lives at local hospitals as a result of medical errors from situations that would fall into the categories listed below. (Also, see the links for translations of the 9 patient safety solutions for many other languages at the end of the article.)

1. **Look-alike, Sound-alike medication names**
Confusing drug names is one of the most common reasons for medication errors. With tens of thousands of drugs currently on the market, the potential for error created by confusing brand and generic drug names is a recognized risk that has not been solved.

2. **Patient Identification (PDF)**
The widespread and continuing failures to correctly identify patients often leads to medication, transfusion and testing errors; wrong person procedures; and the discharge of infants to the wrong families.

3. **Communication During Patient Hand-Overs (PDF)**
Gaps in hand-over (or hand-off) communication between patient care units, and between and among care teams, can cause serious breakdowns in the continuity of care, inappropriate treatment, and potential harm for the patient.

4. **Performance of Correct Procedure at Correct Body Site (PDF)**
Considered totally preventable, cases of wrong procedure or wrong site surgery are largely the result of miscommunication and unavailable, or incorrect, information. A major contributing factor to these types of errors is the lack of a standardized preoperative process.

5. **Control of Concentrated Electrolyte Solutions (PDF)**
While all drugs, biologics, vaccines and contrast media have a defined risk profile, concentrated electrolyte solutions that are used for injection are especially dangerous.

6. **Assuring Medication Accuracy at Transitions in Care (PDF)**
Medication errors occur most commonly at transitions. Medication reconciliation is a process designed to prevent medication errors at patient transition points.

7. **Avoiding Catheter and Tubing Mis-Connections (PDF)**
The design of tubing, catheters, and syringes currently in use is such that it is possible to inadvertently cause patient harm through connecting the wrong syringes and tubing and then delivering medication or fluids through an unintended wrong route.

8. **Single Use of Injection Devices (PDF)**
One of the biggest global concerns is the spread of Human Immunodeficiency Virus (HIV), the Hepatitis B Virus (HBV), and the Hepatitis C Virus (HCV) because of the reuse of injection needles.

9. **Improved Hand Hygiene to Prevent Health Care-Associated Infection (HAI) (PDF)**
It is estimated that at any point in time more than 1.4 million people worldwide are suffering from infections acquired in hospitals. Effective hand hygiene is the primary preventive measure for avoiding this problem."

Nine Solutions-Arabic Translation (PDF)

Nine Solutions-Chinese Translation (PDF)

Nine Solutions-German Translation (PDF)

Nine Solutions-Spanish Translation (PDF)

About the author:

Catherine Bertram is board certified in civil trials and was recently nominated as a 2010 Super Lawyer for Washington, D.C. Ms. Bertram has 20 years of trial experience and is unique in that she was formerly the Director of Risk Management for Georgetown University Hospital so she brings a wealth of knowledge to her practice including how hospitals should be run and what doctors and nurses can do to protect patients. She is a partner with the firm and devotes her practice to the representation of patients and families of loved ones who have been injured or lost due to medical errors. Ms. Bertram lectures regularly to lawyers and health care providers, nationally and locally, regarding patient safety, medical negligence and other related issues. She has also recently published a chapter in a medical textbook. She can be reached by email at cbertram@reganfirm.com or by phone 202-822-1875 in her office in Washington, D.C.