Investigating a Med Error 101

Karin Terry, PharmD
Medication Safety Officer
OSF Saint Francis Medical Center Peoria, IL

Objectives

- Identify the basic steps needed to perform a Critical Event Analysis on a medication error
- Recognize the types of medication events that may have a system-based cause which can be improved

I declare no conflict or potential conflict of interest in relation to this presentation.

Where do I begin?

- Decide which ones to investigate
  - How events are reported
    - Paper vs computer
  - Number of events
  - Who reviews events
    - One person, department shared responsibility
  - Severity of reported events

The OSF Journey

- Paper system was reviewed by Management
- Computer system in 2006 increased reporting by approximately 300%
- Dedicated Pharmacist (MSO) to review events
- Expanded role to include “zone” pharmacists
- Current state: 2 MSOs, zone pharmacists, management all share responsibility

Near Miss Committee

- Started reviewing all events with supporting documentation
- Determined which events we could trend only
  - Wrong sticker, wrong patient order entry, Technology, Human error, illegible handwriting
- Focused on events with a potential fix
- Starting all over again with new EMR

Just Culture

- You cannot separate event investigation from Just Culture
- You can be the best event investigator, but you have to have the culture to back it up in order for your skills to be best utilized.

Questions to ask when investigating a reported event:

- How did it happen (or almost happen)?
- What normally happens?
- Why did it happen?
- Were any at-risk behaviors involved?
- How can we prevent it?

How/Why did it happen?

- Try to recreate the event, step by step
- Look at computer systems and labels
- Check for storage/location of medication(s) involved
- Usage report…do you even need the drug?
- Staffing/training levels

Were any at-risk behaviors involved?

- Do you have policies and procedures in place?
- Were policies followed?
- Any extenuating circumstances involved?

Will it work?

- At the end of an event investigation, you look at your solution set and ask the following questions:
  - If we had these measures in place beforehand, would the incident still have occurred?
  - Will the root cause still exist?
- The answer to both of these questions should be “No”

Pitfalls to Avoid

- Hindsight is 20/20
- “We just have to be more careful”
- Investigating in a silo – the substitution test is so important
- Investigating “publicly”
- Fixing events in a silo when your “fix” may affect other disciplines

ICHP Spring Meeting 2010
Terry – Medication Safety Pearls: Investigating a Med Error 101
121-000-10-014-L05-P & T

Post Test Question

1. Things to consider when determining which events to investigate versus trend include all of the following except:
   A. Number of events reported
   B. Severity of the specific report
   C. The pharmacist/pharmacy tech involved
   D. Whether or not the event has a “fixable” cause