

PPIC® Closed Claim Case Review

Adverse Transcription Drug Events

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Abstract

An adverse drug event is a widely encompassing term referring to actual errors, near misses, and adverse drug reactions. In some reporting systems, adverse drug events refer solely to harm caused by an actual error in medication management. Factors contributing to medication error include human fallibility, systems failures, low staff ratios, and lack of education. The prescription stage is an early point at which errors can arise. It has been estimated that 1% of hospitalized patients suffer adverse events as the result of medical mismanagement and that drug-related complications are the most common type of adverse event (Brennan, 1991).

Overview

The claimant was admitted for care and treatment of fractures. Her previous medical history included insulin-dependent diabetes with hypertension and high cholesterol. Humulin (insulin) was among the many medications she received during her hospitalization. After two and a half weeks, the claimant was ready to be discharged to a rehabilitation center. Because of her inability to manage self-care due to the broken ankle and evidence of mental confusion, arrangements were made for her transportation to the facility for an intended 30-day stay and subsequent return home.

The claimant's hospitalist (the insured) wrote discharge orders for insulin as "30u am" and "6u pm." A review of this note indicates that the "u" could easily have been mistaken for a zero, which is exactly what happened when the nurse transcribed the order as 30 units am and 60 units pm. The claimant was given the 60 units at 9 p.m. on her first evening in the rehabilitation center. The next morning she was found unresponsive and returned emergently to the hospital with a blood glucose reading of 35.

Upon arrival, the claimant's chief complaint was a new onset of hypoglycemic seizure. Her blood sugar was 17. She was admitted to the intensive care unit and the seizures were controlled, but she required intubation because of hypoventilation from the medication. After a period of time, the family decided that they no longer wanted extraordinary measures and the claimant was extubated and died shortly thereafter.

Expert Opinion

This case was clearly not defensible. The hospital recognized that there was a nursing error in the order transcription, and the insured also violated the standard of care in two areas. First and foremost, he used the notation "u" for units instead of writing out the word. A "do not use" list was very clearly noted on the order form itself, and our expert was especially critical of the insured for disregarding this. The other standard of care violation was his failure to sign the medication section of the discharge plan after the nurse had added medications. Debatably, this would have been the place for him to notice the nurse's transcription error.

This case settled for \$265,000, releasing the physician and hospital.

Discussion

Improving documentation to prevent errors requires education, communication, and participation on all levels of provider systems. With this structure in place, health care providers benefit from increased patient satisfaction, but above all the patient benefits from improved documentation, with the record serving as a communication tool for all providers. By providing a clear and complete picture to all members of the team, the treatment plan can be better individualized and the appropriate services planned upon discharge.



Risk Prevention Strategies

The following recommendations for preventing medication errors are suggested for physicians and other prescribers:

- Stay knowledgeable through literature review, consults with pharmacists and other physicians, and participation in continuing professional education programs.
- Evaluate the patient's full picture, including all existing medications, before prescribing new or additional medications to determine possible contraindicated or complementary drug interactions.
- Be familiar with the medication ordering system, including the policies and procedures for giving orders.
- Include patient name, generic drug name, trademarked name (if a specific product is required), route and site of administration, dosage form, dose, strength, quantity, frequency of administration, and prescriber's name on all prescribed orders.
- Ensure that the intent of medication orders is clear and unmistakable.
- Do not use abbreviations.
- Legibly write drug or prescription orders (including signatures) Prescribers with poor handwriting should print or type medication or prescription orders if direct order entry capabilities for computerized systems are unavailable.

Summary

Quality improvement programs should provide direction for patient support, staff counseling and education, and risk management procedures when a medication error is identified. Occurrence reporting policies and procedures and appropriate counseling, education, and intervention programs should be established in all hospitals. Risk management procedures for medication errors should include pharmacists, physicians, nurses, risk managers, legal counsel, and social services and others as required. Directors, department supervisors, and appropriate committees should periodically review error reports, determine causes of errors, and develop actions to prevent their recurrence. Error reports should not be used for disciplinary purposes, but to accomplish improvement or change. Information obtained from error reports that document continued failure of prescribing professionals to avoid preventable medication errors would provide an effective educational tool in staff development and education.

References

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