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Hospitals get more open about mistakes

After deadly lapses and threat of financial penalties, hospitals step up safeguards

By Tom Wilemon
The Tennessean

The baby's racing heartbeat set off an alarm. The nurse rushed to his incubator, then realized the horror of her mistake.

During a busy night shift in a neonatal intensive care unit, she had gotten a feeding tube mixed up with an IV tube. The baby formula intended for his mouth had gone into his bloodstream.

The 3-week-old infant died the morning after the medical error.

His case is among more than a dozen serious medical errors reported at Middle Tennessee hospitals over the past three years — and federal statistics indicate probably 80 others occurred but were not reported. Hospitals, doctors and nurses rarely confess their mistakes, according to a study issued last month by the U.S. Office of the Inspector Gener-

» HOSPITALS, 6A

Debbie Roberts, director of quality and risk management at Baptist Hospital, demonstrates a tube system for the Neonatal Intensive Care Unit. The system makes it difficult to confuse the feeding and IV tubes. DIPTI VAIDYA / THE TENNESSEAN

REPORTING MEDICAL MISTAKES

People can file a complaint about a hospital or other state-regulated medical center, such as a nursing home, by calling 1-877-287-0010.
The Tennessee Department of Health has 82 surveyors and 13 fire safety inspectors who check out complaints. All are handled confidentially.
Learn more at http://health.state.tn.us/hcf/complaints.htm.

INSIDE

Recent mistakes at Nashville-area hospitals. **On Page 6A**

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al of the Department of Health and Human Services.

But hospitals, driven by a new federal policy that will punish them financially for their errors, are beginning to openly discuss mistakes so they can avoid repeating them. Medicare and commercial insurers have put hospitals on notice they will no longer pick up the tab when mistakes increase patient stays or lead to readmissions.

In addition, recent tort reforms in Tennessee have limited medical providers' exposure to malpractice lawsuits. While this change makes it more difficult for an individual patient to sue, it also makes doctors less hesitant to acknowledge errors for fear of lawsuits.

Admitting errors puts patient safety problems into the light so they can be corrected. People who go to hospitals may be less likely to suffer falls, have serious illnesses misdiagnosed or be released before they can care for themselves — some of the lapses that occurred over the past three years, according to a review of Tennessee Department of Health investigation reports obtained by *The Tennessean*.

In 2009, University Medical Center in Lebanon failed to diagnose a patient with a heart attack. In 2010, Nashville General Hospital released a suicidal woman right after treating her for an overdose — only to see her wheeled back into its emergency room the same day after she took more drugs. Comatose, she died the next day.

Other hospitals were cited for issues ranging from failing to give prescribed medicines to turning away an uninsured man who had pneumonia. The state put them on notice to make changes, and the hospitals adopted plans of correction.

Baptist Hospital, where the infant died, now uses color-coded tubes that won't cross-connect — two of several measures it instituted to prevent a tragedy similar to the one that occurred in its NICU.

When the medical mistake was made three years ago today, Baptist was just launching an initiative to improve patient safety. Now, it has 50 safety coaches working across all professions and departments, and all employ-

Katie Hudson, a registered nurse on the medical/surgical floor at Baptist Hospital, collects medication for a patient while standing on signage that reminds nurses to be distraction-free while doing certain tasks at th hospital. DIPTI VAIDYA / THE TENNESSEAN

Medicare won't pay for mistakes

"If you were to go back and look at over the last three years what has occurred here, it has been a culture change."

BERNIE SHERRY, CEO of Baptist Hospital, where a nurse's error led to an infant's death three years ago

Bernie Sherry, CEO of Baptist, says a "culture change" has happened at the hospital.

ees are encouraged to identify mistakes, potential safety hazards and areas for improvement.

The lists they compile become fodder for daily leadership huddles, said Bernie Sherry, chief executive officer of Baptist Hospital.

"If you were to go back and look at over the last three years what has occurred here, it has been a culture change," Sherry said.

How it happened

The baby, a twin born prematurely, came into the NICU with his sister on Jan. 23, 2009. The medical mistake occurred three weeks later on Feb. 12.

The nurse, who worked a 7 p.m. to 7 a.m. shift, reported for work on a busy evening just as a new baby was being brought into the unit. She cared for his twin sister and then went to his incubator. She checked his vital signs, changed his diaper, washed him and then went about the task of flushing his IV line and starting his 8 p.m. scheduled feeding.

After reconnecting the tubes, she went to help another nurse with another baby. Two-and-a-half hours later, the alarm went off. The nurse realized then that she had mixed up two tubes that looked alike. The unit called the doctor on duty.

"I knew as soon as I heard it that we wouldn't be able to save" the baby, the doctor later told state investigators.

The NICU team tried blood transfusions, antibiotics, dopamine, adrenaline and other stimulants — all to no avail. Around 8:30 the next morning, the infant was taken from a ventilator and placed in his mother's arms.

The cause of death was "intravenous milk infusion" with a contributing cause of "prematurity." The state reports do not identify doctors, nurses or patients.

"I know I made a mistake and I can't blame it on anything," the nurse told investigators. "I don't know what was going on in my mind when I hooked up."

Accepting responsibility

But responsibility for the mistake went beyond that nurse, said Deborah Roberts, director of quality/risk management for Baptist Hospital.

"There are humans, and there are systems," Roberts said. "We had to look at the system error about what was going on. We had to correct the system there."

Besides changing to color-coded tubing that will not cross-connect, the hospital enacted several other measures. Even with the equipment safeguards, nurses are required to trace the tubes back to the source. They must have an observer. And other staff cannot interrupt. Nurses also are to maintain direct visual contact of all babies.

Nurses now go "In the Zone" at Baptist when they perform important duties, such as preparing medication doses for patients. These are specially marked areas where nurses can flip up a red sign that states, "No interruptions please."

Baptist had hired an outside consultant to help it assess patient safety pitfalls a couple of years before the baby's death. An analysis of records indicated that 17 "serious safety events" had occurred in 2008, Roberts said. As part of its commitment to improving patient safety, the hospital has widened the definition for such incidents. Even so, only one incident merited this red flag last year, she said.

Hospitals, safety consultants, government agencies and accrediting organizations have different names for how they rank mistakes. The most egregious are often referred to as "never events" or "sentinel events." Inspectors with the state Department of Health issue "immediate jeopardy" citations for the most serious lapses.

The death of the baby was ruled an immediate jeopardy — a notice that a health-care institution must make acceptable corrections or no longer qualify for Medicare and Medicaid reimbursements.

Making hospital errors

Another immediate jeopardy incident occurred at University Medical Center when the Lebanon hospital's emergency department failed to diagnose a heart attack in a patient. The patient was treated for acid reflux and pneumonia on Sept. 7, 2009, and discharged. The patient returned two hours later still complaining of chest pain when the heart attack was discovered. The patient, who survived, was transported by helicopter to another hospital for treatment.

University Medical Center came into compliance by making several improvements, which included actions to better identify and prioritize patients with possible heart attacks.

Metropolitan Nashville General Hospital was under a plan of correction for several months last year after the state inspected its emergency department in March and September. Both times, the state found that the hospital had failed to conduct appropriate exams of multiple patients, a number of whom had emotional, psychiatric or substance abuse issues.

The investigations occurred after the Nov. 30, 2010, death of a woman who had been treated for a drug overdose, released and then brought back the same day. Nashville General had the deficiencies removed on Oct. 27, 2011, after its emergency room staff underwent crisis prevention intervention training and the hospital set up referral guidelines for people with mental health issues.

"Basically, what should happen is we would either call a psychiatrist to come in and interview the patient or Mobile Crisis to come in and determine if they are a major crisis to themselves or others," said Lee Holmes, chief compliance officer for Nashville General.

Working to forgive

Human beings make mistakes, but the consequences can be dire with hospital employees. The Rev. Ridley Barron of Thompson's Station says they are too often the forgotten "second victims." As the father of a child who died because of a medical error, he often speaks on the subject.

The Rev. Ridley Barron says hospital employees who make mistakes are victims, too.

"A lot of people seem to assume that forgiveness was easy for me," he said. "It has not been. It has been a daily decision I have had to make."

Isolating or punishing health-care workers for their mistakes actually creates barriers to improvement, Barron said. Punitive actions also could increase the human toll, he added, noting that a Seattle nurse committed suicide last April after she made a medication error that resulted in the death of an infant and then lost her job.

"In the very recent past, the standard response of hospitals has basically been to put these people out on an island by themselves and distance them because they are so afraid of litigation," Barron said.

"There is a growing movement now where hospitals begin to understand the importance of, first of all, supporting that health-care worker and getting them into counseling, doing what they can to help recovery, because they also are victims."

Creating a new culture

The fear of malpractice suits has historically made hospitals reluctant to admit mistakes. But now they are under increased pressure to be accountable from outside the courts.

The Centers for Medicare & Medicaid Services will no longer reimburse for many mistakes. Hospitals also are operating under increasing transparency requirements because the federal government is compiling data, comparing performance and publicly releasing its findings.

The Tennessee Center for Patient Safety is spearheading an effort among state hospitals to reduce hospital-acquired infections by 40 percent and readmissions by 20 percent. Chris Clarke, the organization's project director, said much of that work focuses on preventing mistakes.

Chris Clarke: "Our goal ... is to help hospitals perform better."

The initiatives can range from creating a culture that rewards staff for recognizing errors to reconfiguring rooms and changing equipment, she said.

At the top of the list is medication mistakes. Hospitals have started using bar codes to match patients with prescriptions, installed computerized robotic technology to mix IV solutions in their pharmacies and established special safeguards to better distinguish drugs with similar-sounding names.

"Our goal is to lift up the best of what is out there and seek new and innovative ideas to really accelerate the work and help hospitals perform better," Clarke said.

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Saint Thomas Hospital, Nashville

» Hospital failed to set up a special nutrition plan for a patient who was admitted with existing bed sores. Feb. 2, 2010, report.

Skyline Medical Center, Nashville

» Hospital told uninsured patient he did not have a condition that required emergency room care and gave him the option of following up with a community resource. Patient went to another hospital and was diagnosed with pneumonia. Oct. 18, 2010, report.

Summit Medical Center, Hermitage

» Hospital failed to ensure respiratory therapy followed doctor's orders. Sept. 21, 2011, report.

University Medical Center, Lebanon

» Hospital lacked documentation to show emergency doctors discussed diagnoses with patients and their families. Jan. 7, 2011, report.

» Hospital failed to diagnose a heart attack and discharged a patient from its emergency room Immediate jeopardy notice given Sept. 30, 2009, report.

SOURCE: Tennessee Department o Health, from 2009-11 repor