19th International Conference of the International Society for Quality in Health Care

The Anatomy of a Near Miss

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20 Million Americans Admitted to Hospitals in 1999

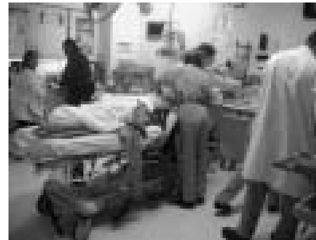
1 Million got the
- Wrong diagnosis
- Wrong drug
- Wrong limb operated on
- or something else wrong

As many as 100,000 may have died as a result of these mistakes.

The Anatomy of a Near Miss

Day 1:

A 58-year-old man from Panama complained of the sudden onset of abdominal pain



Emergency Department:

- Past medical history included surgery for perforated peptic ulcer
- He had mild abdominal tenderness
- A trace of blood in stool
- Minor changes on ECG
- Admitted to the Medicine Service to R/O Myocardial Infarction

Day 2:

- Myocardial infarction ruled out
- GI consultation called to assess bleeding
- Mild abdominal pain persisted
- KUB and upright X rays not reviewed
- Poor communication
- Restraints used for agitation

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Day 3:

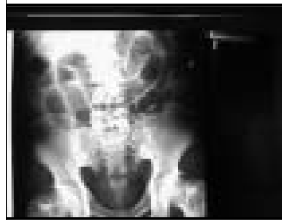
- Communication still minimal
- Abdomen more swollen but feeling a bit better
- Small amount of bright red blood per rectum

Following debate among consultants, flexible sigmoidoscopy scheduled for Day 4

Day 4:

Detailed interview with interpreter yielded a classical history for bowel obstruction

KUB taken on day 2



Distended loops of Small Bowel
No evidence of air in rectum

Air Fluid levels throughout

C.T. Scan

C.T.Scan

Emergency surgery

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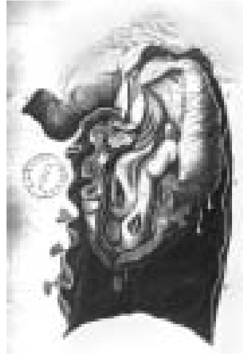
On Introsusception
by John Hunter, Esq., F.R.S.
8/18/1789

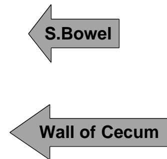
9-month-old healthy boy experienced the sudden onset of severe abdominal pain.

Developed a deep-seated firmness or hardness in the left hypochondrium and abdominal distension over 3 days. He died on the 5th day.



An Exitus Lethalis

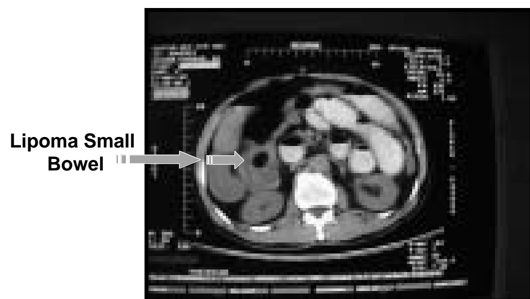
Intraoperative ileocolic Intussusception



Unable to reduce, cecal wall was opened

Excised Specimen

C.T. Scan



Small Bowel Tumor, Serosal view

Small Bowel Tumor, Intraluminal view

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Outcomes of this Case

- In spite of a near miss, full recovery of patient
- Suggested Guideline

Abdominal Pain plus ONE

- fever
- hypertension
- hypotension
- vomiting
- leukocytosis
- guaiac positive stool

Initiates automatic surgical and other consults as indicated while the patient is in the Emergency Department.

Root Cause Analysis I

- No consistent or effective use of interpreters
- No surgical consult ordered in the Emergency Department
- No KUB and upright X rays or CT ordered in Emergency Department
- Poor communication and monitoring on med floor
- Feeding with diagnosis of ? partial small bowel obstruction
- Excessive use of restraints

Root Cause Analysis II

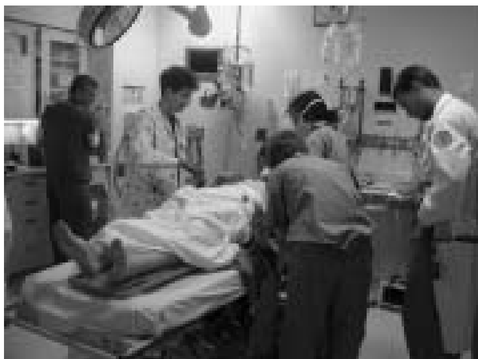
- Interpreters – availability versus utilization
- Competing cardiac and abdominal pain protocols Which guidelines should be primary?
- Specialty consultation in Emergency Department versus after transfer to inpatient floors
- Monitoring of ill patients on non-ICU floors
- Excessive use of restraints – a major Type I JCAHO deficiency

Root Cause Analysis III

Early recognition of ischemic bowel is a recurring problem

Teamwork – between ED physicians, surgeons, internists and radiologists needs sustained improvement

Patient monitoring and interdisciplinary communication on floors needs improvement evidenced by delayed diagnosis and excessive use of restraints



JCAHO Accreditation 2004 Shared Vision – New Pathways

- A focus on critical patient care issues
- Self-assessment to support standards compliance
- Use of organization-specific data
- Use of core measures to improve patient care processes
- Streamlined standards
- Reduce burden of documentation

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Patient Safety

Continuous Quality Improvement
through
Adoption of best practices
The use of core measures
Team training
to make our hospitals
High Reliability Organizations
for the benefit and safety of all

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