

7/3/08

A Patient Harmed This Week and What We Learned

Dear BIDMC Community,

This week at BIDMC, a patient was harmed when something happened that never should happen: a procedure was performed on the wrong body part. With the support of all our chiefs of service, we are sharing this information with the whole organization because there are lessons here for all of us.

While respecting the confidentiality of both the patient and caregivers, here are the key facts: it was an elective procedure, involving an excellent team of providers. It was a hectic day, as many are. Just beforehand, the physician was distracted by thoughts of how best to approach the case, and the team was busily addressing last-minute details. In the midst of all this, two things happened: first, no one noticed that the wrong side was being prepared for the procedure. Second, the procedure began without performing a "time out," that last-minute check when the whole team confirms "right patient, right procedure, right side." The procedure went ahead. The error was not detected until after the procedure was completed. When it was, our patient safety division was notified immediately, and they in turn took all appropriate steps including investigation, reporting and corrective action. The physician discussed the error with the patient at the first opportunity, and made a full apology. The patient is now recovering at home from the injury, which is not life-threatening.

What a horrifying story. What important lessons. We learned that when teams are busy and distracted, it makes it easier to overlook something. We learned that key safety steps, like "the time out," need to occur every single time, since even one failure can be serious. We learned that serious events rarely relate to the performance of any single person. We learned that we have vulnerabilities that we were not even aware of, and that there are surely others out there.

Actually, we re-learned all these things, because none of these observations are new and all of them apply to the entire work place. We have already made improvements in our process for side/site marking and procedural time outs; what can you do to apply these lessons to your work?

The strength of an organization is measured not by counting the number of successes, but by its response to failure. We have made an institutional commitment to eliminating harm, and that requires sharing information about cases such as this so that we all have a chance to learn from it. We still have

more to learn from this case, and changes that need to be made, and so will be providing more information in the future.

Sincerely,

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