

Errors in Half of its Surgeries, Mass General Self Reports



By Lila Abassi — October 27, 2015



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In a stunning development that may give some would-be patients pause, an internal study of operating room procedures determined that some mistake or adverse event occurred in nearly half of all surgeries performed during an eight-month period at Massachusetts General Hospital (MGH), one of the nation's most preeminent healthcare institutions.

While that finding seems staggering, it should be noted that some errors were minor -- a delay in treating an abnormal vital sign, for example -- while others were more serious. All in all, less than two percent of the errors were life threatening, and none of the events resulted in a fatality.

The study of 277 MGH operations were observed the perioperative period, meaning the time immediately before, during and after the surgical procedure. Prior to this study, the available literature was comprised of mostly self-reported data.

[The study was conducted](#) [2] by four specially-trained members of a team which observed randomly-selected procedures from November 2013 to June 2014. They documented all medications administered, including medications errors (defined as a mistake in the ordering and administration of a drug), or adverse drug events (harm/injury to the patient related to a drug) whether it was caused by human error or not.

Results showed 124 of the 277 cases included at least one medication error or adverse drug event. They found 80 percent of these errors to have been preventable. The error rate was similar whether the provider was an anesthesiologist, nurse anesthetist or resident.

Most common errors observed were labeling; incorrect dosage; neglecting to treat changes in vital signs; and errors of documentation. Medication errors and adverse drug events were more common if the procedures were longer, and the more medications that were administered. If certain events were not immediately apparent to the observers as errors they were later reviewed as chart data, so as to not miss any errors in their reporting.

Prior to our study, the literature on perioperative medication error rates was sparse and consisted

largely of self-reported data, which we know under-represents true error rates," said Dr. Karen C. Nanji, MD, MPH, of the MGH Department of Anesthesia, Critical Care & Pain Medicine, the lead author of the report. "Now that we have a better idea of the actual rate and causes of the most common errors, we can focus on developing solutions to address the problems.

Dr. Nanji feels that some of these errors are in part due to rapidly changing conditions of the patient in the operating room. That's unlike the ward, where the system of checks and balances allows for medications to be triple checked prior to administration.

Healthcare is constantly struggling to minimize human errors as much as possible. Medications are not only kept under tight control, but are subject to several checkpoints prior to the patient receiving the medication.

Most healthcare professionals abide by a system of the five rights of medications administration: right patient, right drug, right dose, right route and the right time. However where there are humans, there will be human error, especially in more critical settings such as the operating room.

Although the study results are statistically startling, I believe it is better to have a reality check with the truth than rest comfortably in ignorance. It is step in the right direction. Identifying the problems allows for development of intervention strategies to enhance safety protocols - maybe then we would be less hesitant to schedule our next procedure.

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