Raising the index of suspicion: Red flags that represent credible threats to resident safety

Disruptive behaviors, intimidation in the workplace, and a culture of disrespect among healthcare professionals have repeatedly surfaced as a significant barrier to resident safety and cause of medication errors. The hierarchical nature of resident care and the autonomy with which healthcare professionals have been taught to practice set the stage for a culture that does not respond well to even the slightest queries about possible problems with resident care, particularly from frontline staff. It’s clear that such a culture needs to be modified, and many healthcare organizations, including long-term care (LTC) facilities, are working to address disrespectful behavior, staff reluctance to speak up about risks and errors, and blatant disregard of expressed concerns. However, there’s a less obvious but no less dangerous risk related to the culture that often goes unnoticed until a serious adverse event happens: staff do speak up about potential concerns, but they are too easily convinced that their concerns are unfounded.

When a person voices a concern, there may be no disruptive, disrespectful, or obvious intimidating behavior involved per se, but rather an explanation from competent practitioners that dispels the initial concern too quickly, before it has been given sufficient consideration. A pharmacist assures a nurse that the strength of the medication is correct when questioned about the final volume; a nurse reassures a resident that the medication is correct when questioned about its appearance; a physician convinces a pharmacist that the prescribed dose is correct when questioned even though it differs from standard guidelines—these are all too frequent examples that have led to fatal adverse drug events. Those who questioned the resident’s care were easily convinced that others knew more than they did, particularly if the provider who was questioned has an otherwise stellar reputation.

Is this a form of intimidation? Perhaps, but it is more akin to “deference to expertise,” meaning it is natural and often reasonable for people to defer final judgment to those who they perceive to be more “qualified.” If the person voicing the concern was reluctant to pursue it, avoided or backed down from the conversation, or felt the provider was not listening, intimidation may play a role. But this is not always the case. Instead, the issue may be that the person questioning the resident’s care has been easily convinced that their concern is unfounded, and the person being questioned was reluctant to pursue it, avoided or backed down from the conversation, or felt the provider was not listening, intimidation may play a role. But this is not always the case. Instead, the issue may be that the person questioning the resident’s care has been easily convinced that their concern is unfounded, and the person being questioned has an otherwise stellar reputation.

Table 1. Responses to Voiced Concerns Considered Red Flags

<table>
<thead>
<tr>
<th>Red Flags</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>“The attending told me to order it that way.”</td>
<td>“It’s on the list of medications the resident gave me.”</td>
</tr>
<tr>
<td>“The resident says that’s how he takes it at home.”</td>
<td>“The resident’s been titrated up to that dose.”</td>
</tr>
<tr>
<td>“It was published in… [e.g., JAMA],” (without the reference)</td>
<td>“The dose is the same as listed on the resident’s old chart.”</td>
</tr>
<tr>
<td>“This is a special case.”</td>
<td>“That’s the way the dose is written in the progress notes.”</td>
</tr>
<tr>
<td>“The resident is on a protocol.” (without providing the protocol)</td>
<td>“It’s on the list of medications the resident gave me.”</td>
</tr>
<tr>
<td>“The dose is the same as listed in the resident’s old chart.”</td>
<td>“We always give it that way.”</td>
</tr>
</tbody>
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Table continued on page 2—Red Flags

SAFETY wires

A failure to communicate. A 46-year-old woman residing at a skilled nursing home was on vancomycin IV 1,250 mg twice daily to treat an infected craniotomy site. The plan was to treat with vancomycin for 2 weeks. A trough level was drawn on the tenth day, which revealed a high vancomycin level of 42.6 mcg/mL. The prescriber called in an order to hold the drug and repeat the trough level the next day. However, the nurse who received the verbal order did not document it in the resident’s record, nor was the order communicated to the nurse on the next shift. As a result, the drug was continued, and a repeat trough level three days later was 93.1 mcg/mL. The resident went into acute renal failure secondary to vancomycin and was transferred to the hospital for treatment.

It is unclear why the nurse who received the order to hold the vancomycin and repeat the trough level did not document it on the resident’s chart. She may have been interrupted or distracted (see the October 2014 issue for more information on errors due to interruptions and distractions). Immediately writing down and reading back verbal orders are important medication safety steps that may have prevented this error. Having a verbal order form that contains key prompts (e.g., fill-in blanks) and placing it directly in the medical record also improves the chances that the information is appropriately documented and communicated to prevent such errors.

Too many numbers. A prescription for “fentanyl transdermal 72h, apply 1 patch 12 mcg/hour externally q3d” was incorrectly dispensed in several increments over 60 days as transdermal fentanyl NYL 75 mcg per hour. The error was discovered when a new prescription was issued and continued on page 2—SAFETY wires >
Red Flags—continued from page 1

Toned has not perceived the voiced concern as a possible, credible resident threat. Neither person possesses a required element to safeguard residents: an appropriately high index of suspicion for errors. A low index of suspicion is particularly problematic in a healthcare system that already is reluctant to acknowledge human error or value the contributions from every person who interacts with the resident.

An index of suspicion is defined as “awareness and concern for potentially serious underlying and unseen injuries or illness.” Suspicion is defined as “the act or an instance of suspecting something wrong without proof or on very slight evidence, or a state of mental uneasiness and uncertainty.” A high index of suspicion requires consideration of a large differential so that a serious possibility is not accidentally discounted; a potential medical error should always be considered one of the possibilities. An appropriately high index of suspicion should lead a person with a concern to pursue it until it’s proven to not be a credible resident threat, even when met with opposition from experts. It should also prompt the provider to be responsive to voiced concerns and to initiate a suitable investigation to determine if there is a credible threat to the resident.

ISMP has previously reported the need to maintain a high index of suspicion for errors in our acute care newsletter. In the March 9, 2006 issue, (www.ismp.org/sc?i=d=430) mindfulness, a defining characteristic of high-reliability organizations (HROs) was discussed. Mindfulness refers to the deep and chronic sense of unease and preoccupation with failure that arises from admitting the possibility of error, even with well-designed, stable processes. People in HROs worry about system failures and human errors. They ask, “What will happen when an error occurs?” not “What will happen if an error occurs?” Like healthcare, HROs are hierarchical, but position and experience do not necessarily dictate who is an important contributor or decision maker. They are wary of complacency and naturally suspicious, so they expect people to speak up about any concerns they may have. Their high index of suspicion is a predominant factor in achieving laudable safety records. Examples of HROs include nuclear power plants, air traffic control systems, naval aircraft carriers, and even amusement parks, where the risks and dangers are high, but adverse events low.

To improve resident safety, LTC facilities need to raise the index of suspicion for errors, always anticipating and investigating the possibility when any person, regardless of experience or position, voices concern or when residents are not responding to treatment as anticipated. Functional (and sometime virtual) resident care teams, in which every person’s perspective, skills, knowledge, and observations are considered important and worthy of mention and investigation, must be developed. Staff need to be mentored on how to resolve potential concerns and to trust in their own experiences to augment the expertise of others. All healthcare practitioners need to encourage, and be receptive to, staff who ask questions, even if staff just have a sense that “something” is wrong or can’t articulate the concern well. When concerns are met with quick answers that initially appear to be “evidence” of safety, caution is recommended. Fifteen years ago, our colleague, Timothy Lesar, PharmD, of Albany Medical Center in Albany, New York, allowed us to publish a list of phrases he called “magic words,” which have been repeatedly offered in explanation to voiced concerns and erroneously accepted as “evidence” (Table 1, page 1).4 No doubt, these still ring true today, along with many others. Such phrases should be viewed as red flags that require more reliable answers and actual proof.

ISMP is not discounting the fact that intimidation may play a role in a reluctance to speak up about possible concerns and a tendency to be easily convinced that a concern is unfounded. We also do not discount the extraordinary courage it may take for many to step up to these conversations. However, healthcare practitioners also need to acknowledge that a natural deference to expertise can lead to unintended complacency and tolerance of risk that goes unchallenged. To combat that, all who interact with residents must reduce their tolerance of risk and raise their index of suspicion of errors.

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The error occurred because the initial drug order unnecessarily contained “72h” which refers to the standard release time of 3 days for all transdermal fentanyl products. The number was misread as 75 and mistaken as the mcg per hour dose. Since a 75 mcg/hour patch exists, pharmacy personnel did not refer to the original typed prescription upon refilling it during the first 60 days, which might have led to earlier recognition of the error. Fortunately, the resident did not exhibit any adverse effects and also reported that his pain was adequately controlled. Upon evaluation, a nurse determined the resident was stable, and the higher dose was ordered and continued. Pharmacy policy now requires pharmacists to refer to the original prescription when handling a refill.

Potential dose confusion. Communicating the proper dose of Spiriva (tiotropium) can be difficult with many computer order entry systems. Spiriva is an oral inhalation product indicated for the long-term maintenance treatment of bronchospasms associated with chronic obstructive pulmonary disease (COPD). The product comes with a HandiHaler device intended to deliver the full contents of the drug, which is contained in a capsule for inhalation. The recommended dose of Spiriva, using the HandiHaler, is 2 inhalations of the powder contents of 1 capsule. Many computer order entry systems will default to a dose of 1 inhalation. If you change the default value to 2 inhalations, confusion can lead to the resident receiving the contents of 2 capsules. If you enter 1 capsule, the resident may receive the capsule orally.

Make sure the dose is expressed in a way that is clear (e.g., 1 capsule = 2 inhalations) in your order entry system and medication administration records (MARs), and on the label to avoid administering the wrong dose or giving it by the wrong route (administering the capsule orally rather than placing it in the HandiHaler to be pierced and inhaled by the resident). Work with pharmacy and information technology departments...
Delay in introducing new feeding tube connectors

Introduction of the new ISO standard ENFit connectors on enteral feeding administration sets, along with the ENFit Transition Connector that connects the feeding tube to the administration set, will be delayed until the first quarter of 2015. A sequential launch has originally planned to begin this month; however, product manufacturers are waiting for US Food and Drug Administration (FDA) clearance. Once they receive FDA clearance, manufacturers will provide further details about their new products, begin to produce and manufacture new products, and be able to offer product samples. This slight delay means that the entire launch agenda has been pushed back. Then new timeline will begin the first quarter of 2015 with introduction of administration sets with the new ENFit female connector and ENFit Transition Connector. In the second quarter of 2015, the new enteral-specific syringes with ENFit female connectors will be released, and in the third quarter, new feeding tubes with ENFit male connectors will be released.

References