BACKGROUND: In July 2006, a 16-year-old patient came to the hospital to deliver her baby. During the process of her care, an infusion intended exclusively for the epidural route was connected to the patient’s peripheral intravenous line and infused by pump. The patient experienced cardiovascular collapse. A cesarean section resulted in the delivery of a healthy infant, but the medical team was unable to resuscitate the mother. The media attention surrounding the error accelerated through the national provider and safety community when the nurse was charged with a criminal offense. These events set in motion intense internal and external scrutiny of the hospital’s medication and safety procedures.

ROOT CAUSE ANALYSIS (RCA): To further understanding about latent systems gaps and process failure modes, an independent RCA of the event was conducted in June 2007. An external consultant team conducted a one-week evaluation of the medication use system and the organization’s current environment, systems and processes, staffing patterns, leadership, and culture to help shape the recommended improvements. For each of the four proximate causes of the event, performance-shaping factors were identified. Although the hospital’s organizational learning was painful, this event offered an opportunity for increasing organizational competency and capacity for designing and implementing patient safety.
Structures and processes, including safety nets and fail-safe mechanisms, were implemented to promote safer behavioral choices for providers.

ACTIONS TAKEN: The hospital took a number of clinical steps to improve the safety of medication administration, including removing the barriers to scanning medication bar codes, implementing consistent scanning-compliance tracking, and providing teamwork training for all nursing and physician staff practicing in the birth suites.