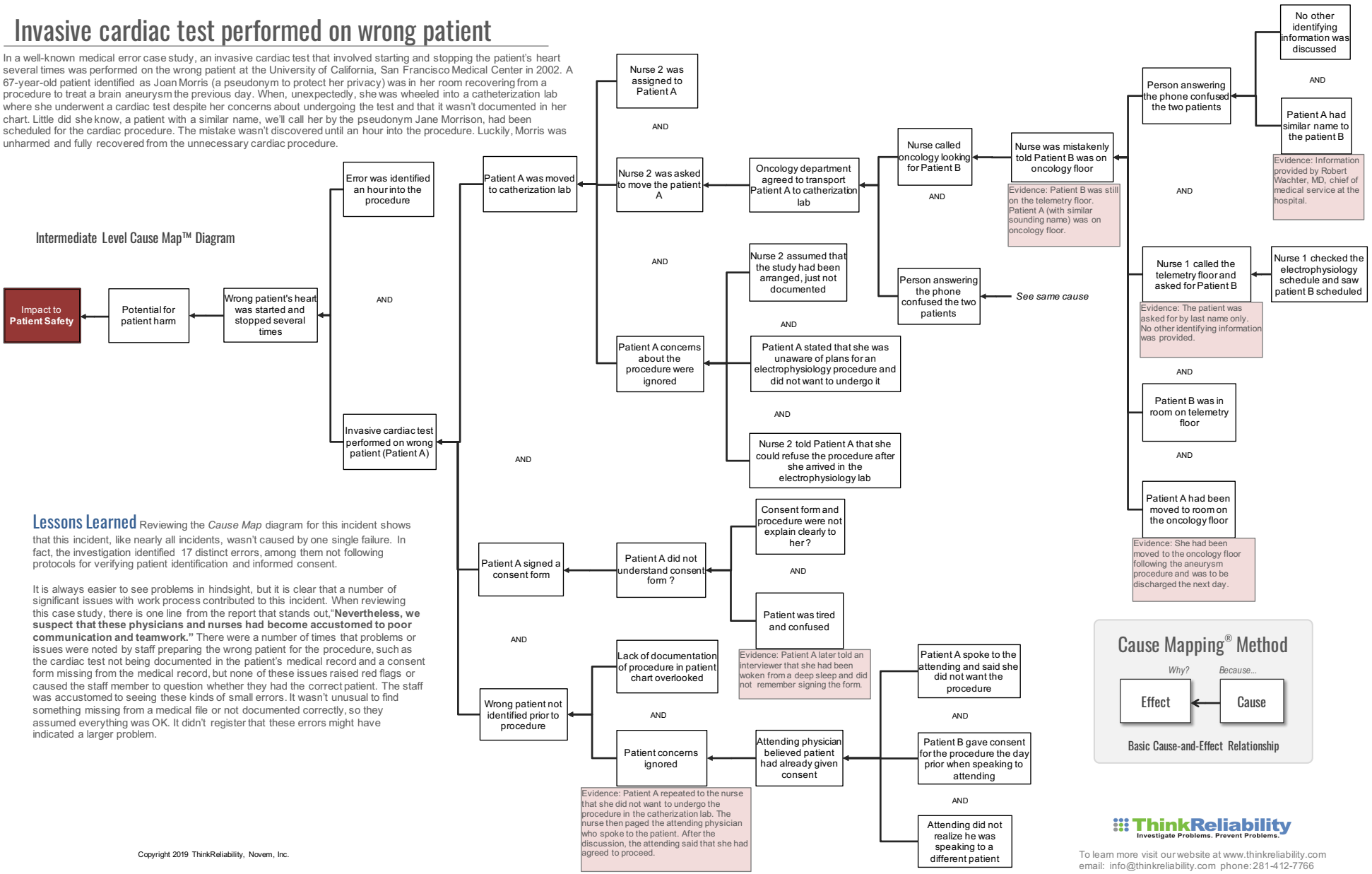
Invasive cardiac test performed on wrong patient

In a well-known medical error case study, an invasive cardiac test that involved starting and stopping the patient's heart several times was performed on the wrong patient at the University of California, San Francisco Medical Center in 2002. A 67-year-old patient identified as Joan Morris (a pseudonym to protect her privacy) was in her room recovering from a procedure to treat a brain aneurysm the previous day. When, unexpectedly, she was wheeled into a catheterization lab where she underwent a cardiac test despite her concerns about undergoing the test and that it wasn't documented in her chart. Little did she know, a patient with a similar name, we'll call her by the pseudonym Jane Morrison, had been scheduled for the cardiac procedure. The mistake wasn't discovered until an hour into the procedure. Luckily, Morris was unharmed and fully recovered from the unnecessary cardiac procedure.

Intermediate Level Cause Map™ Diagram



Lessons Learned

Reviewing the *Cause Map* diagram for this incident shows that this incident, like nearly all incidents, wasn't caused by one single failure. In fact, the investigation identified 17 distinct errors, among them not following protocols for verifying patient identification and informed consent.

It is always easier to see problems in hindsight, but it is clear that a number of significant issues with work process contributed to this incident. When reviewing this case study, there is one line from the report that stands out,"**Nevertheless, we suspect that these physicians and nurses had become accustomed to poor communication and teamwork."** There were a number of times that problems or issues were noted by staff preparing the wrong patient for the procedure, such as the cardiac test not being documented in the patient's medical record and a consent form missing from the medical record, but none of these issues raised red flags or caused the staff member to question whether they had the correct patient. The staff was accustomed to seeing these kinds of small errors. It wasn't unusual to find something missing from a medical file or not documented correctly, so they assumed everything was OK. It didn't register that these errors might have indicated a larger problem.

Cause Mapping® Method

Why? *Because...*

Effect ← Cause

Basic Cause-and-Effect Relationship

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