SEDATION OVERDOSE

Problem:
Failure to read back physician order causes patient death

Rather than the maximum dose (1.5 milligrams over no less than 2 minutes) of Versed, a powerful sedative, a patient received 4.0 milligrams in 1 minute, causing respiratory depression and eventual death.

“I was shocked when he told me 4 milligrams. I didn’t order that. If [the nurse] had read back the Versed order to me I would have stopped him.” - Attending Physician

Analysis
Basic Level Cause Map - Start with simple Why questions.

1. Problem
   - Overdose of sedative
   - Date: 10:22 AM
   - Place: California Hospital

2. Analysis
   - Patient Safety Goal Impacted
   - Patient death
   - Patient overdose of Versed
   - RN did not read back order
   - Evidence: Medication has black box warning about risk of respiratory depression and arrest with a higher dose

3. Solutions
   - Bedside bronchoscopy being performed
   - Patient suffering from pneumonia
   - Noise environment?
   - Staff unaware that RN misheard order
   - Other staff in OR did not request read back
   - RN did not read back order
   - Order given during procedure

Timeline:
- Day 1: 11:00 - Patient admitted to ED for coughing, difficulty breathing
- Day 2: 10:00 - Bronchoscopy procedure performed at bedside
- Day 2: 10:22 - Patient administered Versed 2 mg IV push
- Day 2: 10:23 - Patient administered additional Versed 2 mg IV push
- Day 2: 10:25 - Code Blue initiated
- Day 11: 10:40 - Patient death

Investigate Problems. Prevent Problems.

For a free copy of our Root Cause Analysis Template in Microsoft Excel, used to create this page, visit our web site.

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