Four cases

1 Medication error. Wrong dose

Edel was an active 78-year-old widow who lived at home without assistance from the health services. She had the misfortune to fall and break her hip, and is staying in the orthopedic ward for a few extra days due to severe pain.The doctor prescribed 5 mg morphine at a strength of 10 mg/ml intravenously every 3-6 hours as needed.

During the night Edel asked for morphine for the pain. There was a lot to do that shift, and the nurse on duty did not get any help to double-check the medication. She was stressed by all the patients who needed help and supervision. The nurse administered the morphine dose, but miscalculated it. Instead of 0.5 ml of morphine, Edel received 5 ml of morphine intravenously.

When the nurse checked on Edel half an hour later to see if the morphine had effect, Edel was unresponsive, her skin pale and clammy, and her breathing rate low. The nurse called the doctor and said she suspected that Edel has been given too much morphine. The doctor prescribed Naloxone repeatedly throughout the night until Edel is stable.

The next day, Edel received information about what had happened and called her daughter. Her daughter asked to meet with the nurse and doctor.

Opening remark from daughter:
"How could something like this happen? It was just luck that this turned out well. Don't you have procedures for double-checking?"

2 Suicide. Man with cognitive impairment

Kjell was 60 years old and had a senior management position. He had been in mental health care for the past three weeks, examined and diagnosed with frontal lobe dementia.This was a great loss and sorrow for Kjell. According to his spouse, he had since this been restless, irritable, slept little and eaten little.

He was discharged at his own request. He wanted to go home, explaining he had things to do in order to finish his job properly. He also wanted nothing more to do with mental health care.

Kjell took his own life two days after being discharged.

You invite the family members to follow-up conversations, in order to express regret/apologize for the patient being discharged without further action.

You and head of the mental health center meet with the son (27) from a previous marriage. He is angry and wants an explanation as to why there was no follow-up after discharge.

Opening remark from son:
"How could you discharge Dad without offering any follow-up? The guidelines state that families should be involved in the discharge process, but I heard nothing."

3 Sepsis. Premature child

After premature rupture of membranes, signs of illness appeared in the fetus (low fetal activity and signs of distress during fetal monitoring). The baby was delivered by caesarean section four days after the rupture, treated with antibiotics, but died of sepsis four hours after birth.

Conversation 1
Opening remark from the father:
"How could the hospital let this happen? We are completely devastated."

The hospital then conducted a review of the event and uncovered several weaknesses:
- Courses in fetal monitoring had been held mainly for midwives, but not for doctors.
- In neonatal intensive care units, there may be a lack of awareness or knowledge of guidelines for antibiotics for premature babies after premature rupture of membranes
- 51% versus the recommended 60% of nurses had relevant specialized training (neonatal, intensive care, or pediatric nursing).

Measures introduced by the hospital included:
- read receipt requirement for procedures
- courses in fetal monitoring with written tests for doctors on duty
- an improvement project to reduce the time between the decision to administer antibiotics and actual administration, including time measurements
- monthly review of cases

Conversation 2
The healthcare personnel and manager invite the parents to a meeting in order to express regret/apologize, and inform them of the results of the incident review, and start by saying **"We have now reviewed the incident and ..."**

The case is based on a report from the Norwegian Board of Health Supervision 2023

4 Misdiagnosis. Depression, changed to long COVID

The patient was treated the previous year for fatigue, loss of appetite, sleep problems, and in general low energy. You thought it was depression and started treatment, using psychoeducation and cognitive behavioral therapy. The patient did not improve, but was discharged due to lack of benefit from the treatment offered.

One year later, the patient contacts you, feeling very frustrated and discouraged, and requests a meeting. The patient has now been diagnosed with long COVID as the cause of their symptoms, which they believe should have been considered as part of the differential diagnosis.

Opening remark from the patient:
"When I was undergoing treatment with you, you said the symptoms were only psychological, but now the specialists have concluded that they are due to long COVID. Why didn't you think that could be the case?"