Patient Safety
General Overview

By

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2015
Objectives:

• Define what is the concept of patient safety.

• What is the patient safety culture?

• How to establish the patient safety culture.

• Sentinel events.

• Root Cause Analysis (RCA).
THIS REPORT SAYS MEDICAL ERRORS SUCH AS INDECIPHERABLE PRESCRIPTIONS CAUSE THE DEATHS OF 98 PATIENTS A YEAR, OR IS THAT 98,000? IT'S HARD TO READ THIS. IN ANY CASE, WE'RE SUPPOSED TO REPORT THEM, OR IS THAT REPEAT THEM?
In 1999, the Institute of Medicine in the USA published a famous report, which dropped a bombshell on the medical community by reporting that up to 98,000 people a year die because of mistakes in hospitals.

In 2010, the Office of Inspector General for Health and Human Services said that bad hospital care contributed to the deaths of 180,000 patients in Medicare alone in a given year.

Now comes a study in the current issue of the Journal of Patient Safety that says the numbers may be much higher — between 210,000 and 440,000 patients each year who go to the hospital for care suffer some type of preventable harm that contributes to their death.

That would make medical errors the third-leading cause of death in America, behind heart disease, which is the first, and cancer, which is second.
Basic concept of quality: First do no harm.

Safety: Is the most basic dimension of performance necessary for the improvement of health care quality.

Patient safety: is a new healthcare discipline that emphasizes the reporting, analysis, and prevention of medical error that often leads to adverse healthcare events.

For every patient, family member and healthcare professional, safety is pivotal to diagnosis, treatment and care.

Doctors, nurses and all those who work in the health system are committed to treating, helping, comforting and caring for patients and to excellence in the provision of health services for all who need them.
Safety Culture

Is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to and the style and proficiency of an organization health and safety management.
In a culture of safety, a balance is achieved between not blaming individuals for errors and not tolerating terrible behavior. This balance is currently referred to as a ‘just culture’ (Mitchell, 2008; Yates et al., 2005). In a just culture the focus is on effective teamwork to accomplish the goal of safe, high-quality patient care. Traditionally, a culture of blame has been pervasive in healthcare. The focus has often been on trying to determine who has been at fault so that the offender can be disciplined. This approach has led to the hiding, rather than the reporting of errors; it is the antithesis of a culture of safety. In contrast a patient safety culture should be non-punitive and emphasize accountability, excellence, honesty, integrity, and mutual respect (Association of periOperative Registered Nurses [AORN], 2006). Today, in a culture of safety, when an adverse event occurs, the focus is on what went wrong, not who caused the problem.
**Just culture**

- It is the culture that supports patient safety.
- It supports the discussion of errors, so that lessons can be learned.
- It holds managers and staff accountable for establishing reliable processes and adhering to them.
Factors that oppose patient safety culture

- Lack of leaders’ commitment.
- Lack of team work.
- Seeking out, blaming, and punishing the staff members involved in the event (punitive environment).
- Lack of reporting and transparency about medical errors.
- Lack of communication.
Establishing patient safety culture

• Diagnosing current safety awareness and prioritizing quality strategies.

• Providing an opportunity for internal and external benchmarking.

• Raising patient safety awareness and prioritizing quality strategies.
Role of leaders in creating a culture of patient safety in the organization

• Commitment to safety and quality.
• Taking actions to ensure patient safety by putting programs, processes, policies and procedures.
• Provide information and education about safety to all workers in the organization.
• Using and analyzing data to improve safety.
• Team work.
• Open discussion for all adverse and sentinel events.
Characteristics of organizations adopting a patient safety culture

• Ongoing learning and flexibility to accommodate changes in the technology, science and environment.

• Team work.

• Focus on the system and not individuals.

• Respect people.

• Adopt a proactive, non punitive culture.
Safety action team
Are small cross-functional groups of people within units who meet periodically to discuss patient safety issues.

Role of patient safety teams
• Discuss information from the safety reporting system to identify solutions.
• Provide direct feedback to senior leaders about the impact of their changes.
Hospital National Patient Safety Goals

• Identify patients correctly
• Improve staff communication
• Use medicines safely
• Prevent infection
• Identify patient safety risks
• Prevent mistakes in surgery
A- Identify patients correctly

• Use at least two ways to identify patients. For example, use the patient’s name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

• Make sure that the correct patient gets the correct blood when they get a blood transfusion.
B- Improve staff communication

Get important test results to the right staff person on time.
C- Use medicines safely

• Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
• Take extra care with patients who take anticoagulants.
• Record and pass along correct information about a patient’s medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient.
• Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.
D- Prevent infection

• Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

• Use proven guidelines to prevent infections that are difficult to treat.

• Use proven guidelines to prevent infection of the blood from central lines.

• Use proven guidelines to prevent infection after surgery.

• Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.
Identify patient safety risks

Find out which patients are most likely to try to commit suicide
F-Prevent mistakes in surgery

• Make sure that the correct surgery is done on the correct patient and at the correct place on the patient’s body.

• Mark the correct place on the patient’s body where the surgery is to be done.

• Pause before the surgery to make sure that a mistake is not being made.
# 2013 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

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This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.
SOME IMPORTANT DEFINITIONS
**Adverse event**: Unintended injury to a patient resulting from a medical intervention, generally with a less degree of severity that may be a precursor to a sentinel event.

**Near miss**: Used to describe any process variation that did not affect outcome but for which a recurrence carries a significant chance of a serious adverse outcome.
**Sentinel event**

Is an unexpected occurrence involving death or serious physical or psychological injury, or the risk therefore. Serious injury specifically includes loss of limb or function.
Reviewable Sentinel Events:
Sentinel events include any occurrence that meets any of the following criteria:
- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
Or
- The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition.

  - Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge.
  - Unanticipated death of a full-term infant.
  - Abduction of any patient receiving care, treatment, and services.
  - Discharge of an infant to the wrong family.
  - Rape.
  - Hemolytic transfusion reaction involving administration of blood or-blood products having major blood group incompatibilities.
Some holes due to active failure. Other holes due to latent conditions (resident “pathogens”).
Root Cause Analysis (RCA)
Root Cause Analysis Basics

Symptom of the problem.
“The Weed”
Above the surface
(obvious)

The Underlying Causes
“The Root”
Below the surface
(not obvious)

The word root, in root cause analysis, refers to the underlying causes, not the one cause.
The Root Cause Analysis Process
Root Cause Analysis has five identifiable steps.

Step One: Define the Problem
☐ What do you see happening?
☐ What are the specific symptoms?

Step Two: Collect Data
☐ What proof do you have that the problem exists?
☐ How long has the problem existed?
☐ What is the impact of the problem?
Step Three: Identify Possible Causal Factors
☐ What sequence of events leads to the problem?
☐ What conditions allow the problem to occur?
☐ What other problems surround the occurrence of the central problem?
Use these tools to help identify causal factors:

- Appreciation – Use the facts and ask "So what?" to determine all the possible consequences of a fact.

- 5 Whys – Ask "Why?" until you get to the root of the problem.

- Drill Down – Break down a problem into small, detailed parts to better understand the big picture.

- Cause and Effect Diagrams – Create a chart of all of the possible causal factors, to see where the trouble may have begun.
Step Four: Identify the Root Cause(s)

☐ Why does the causal factor exist?

☐ What is the real reason the problem occurred?
**Step Five:** Recommend and Implement Solutions

- What can you do to prevent the problem from happening again?
- How will the solution be implemented?
- Who will be responsible for it?
- What are the risks of implementing the solution?

**Source:** [http://www.mindtools.com/pages/article/newTMC_80.htm](http://www.mindtools.com/pages/article/newTMC_80.htm)
"The patient in the next bed is highly infectious. Thank God for these curtains."
Now we come to the end of our lecture
Hopefully by now you are able to:
- Define what a patient safety culture is.
- How can we establish a culture of patient safety.
- What is the role of leaders in establishing a patient safety culture.
- What do we mean by a sentinel event.
- How to do RCA.
- What is your role as a health care professional in establishing a patient safety culture.
- What you should do when you are encountered with a medical error in your health care facility.
Thank you