PATIENT SAFETY: AN INTRODUCTION

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Objectives

- Increased understanding of the impact of medical errors
- List reasons medical errors occur
- Become familiar with terminology relating to unsafe acts
- Understand that systems approach has advantages over individuals approach to PI/QI
- Identify four behaviors to improve patient safety

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Show of hands…

- Have you or a family member experienced a medical error?
- Studies show **1:3 Americans** have

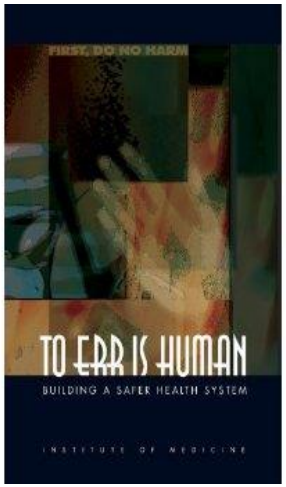
What is patient safety?

According to the World Health Organization (WHO):

- Patient safety is the absence of preventable harm to a patient during the process of health care.
- A focus on safety can prevent errors and reduce the severity of harm, should it occur.

When did America *really* start caring about medical errors?

1999 Institute of Medicine (IOM) Landmark report:



To Err is Human

- Called for swift reduction of medical errors.
- 44,000-98,000 die each year in US hospitals due to medical errors.
- Medical error related deaths were equivalent to three fully-loaded jumbo jets crashing and killing everyone aboard every other day.
- Follow up report *Crossing the Quality Chasm* in 2001.

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Widespread media attention…

- "Medical mistakes in US kill thousands" Toronto Star 11/30/99
- "Medical mistakes 8th top killer" USA Today 11/30/99
- Within days, President Clinton signed…

Healthcare Research and Quality Act of 1999

Tasking the Agency for Healthcare Research and Quality (AHRQ) to prepare the annual **National Healthcare Quality Report.**

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So, are we better now?

- In a 2005 article, “Five years after *To Err is Human:* What have we learned?” co-authors of the original IOM report called the country’s overall progress “frustratingly slow.”

- 2011 study shows **reporting systems** are so **flawed** they **miss** up to **90% of all adverse events in US hospitals.**

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If you keep coming back for more healthcare…

There is an increased chance that you will be a victim of medical error!

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Why do medical errors occur?

Modern medicine involves numerous drugs	• Since 2001, the FDA's Center for Drug Evaluation and Research has averaged 23 new drug approvals per year.
Multiple caregivers and handoffs leads to miscommunication	• One teaching hospital reported 4,000 handoffs daily, for a total of 1.6 million per year.
Weak healthcare culture of safety compared to other high-risk industries.	• According to WHO, industries with a perceived higher risk such as aviation and nuclear plants have a much better safety record than health care.
Diagnosing & treating patients often performed under time pressure and/or with insufficient information.	• According to the Society to Improve Diagnosis in Medicine, diagnostic error (wrong, missed, or delayed medical diagnosis) occurs in up to 15 percent of cases.

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More reasons medical errors occur…

Volume of work

- **Providers are often caring for a great number of patients, all of whom are unique.** A 2012 study of over 13,000 US physicians found more than 40 percent saw over 20 patients each day.

Keeping up with the "new"

- **New medications, new technologies, new procedures, and new research findings to assimilate.**
  - Ex. There are more than 10,000 types of medical devices available today.

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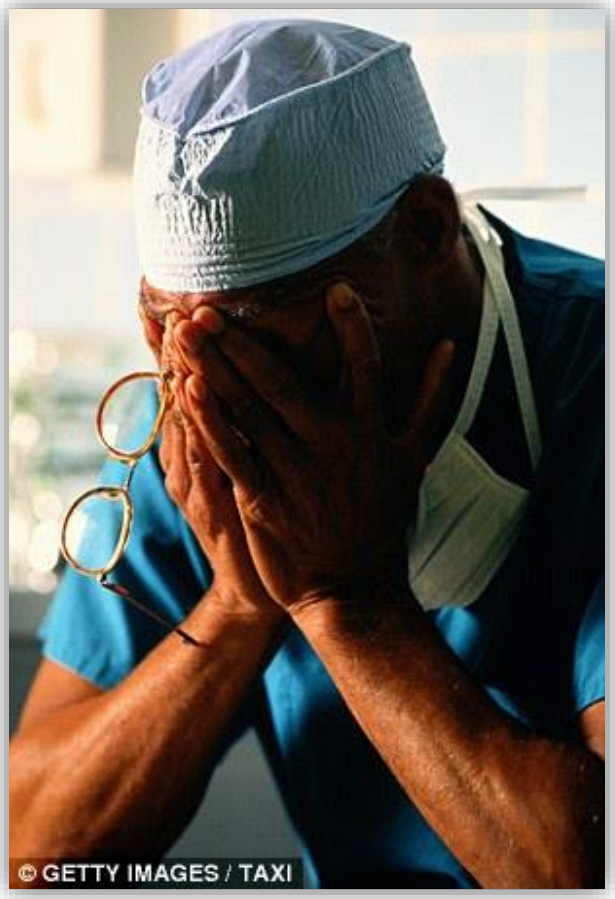
How has the medical profession historically dealt with medical errors?

"Blame and Shame"



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System Errors

- Most errors cannot be linked to the performance of the individual and are instead the result of a **series of system errors** that work together to yield unsafe situations.

- Safe patient care is a "dynamic non-event."
  - '**Dynamic**' because it requires "timely human adjustments."
  - '**Non-event**' because "successful outcomes rarely call attention to themselves."

In other words…

To make "nothing bad happen" requires a lot of good things to be done right.

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To improve patient safety…

Make a commitment to redesign systems to achieve unprecedented levels of safety.

Recognize that most patient harm is caused by bad systems, not bad people.

Individuals alone cannot improve safety; it requires everyone on the care team to work in partnership.

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Have you ever…

- Driven a car and failed to check the rearview mirror?
- Sprinted across a wet pool deck as the lifeguard blew her whistle?
- Used a lawnmower without appropriate footwear?
- Illegally parked “just for a second.”

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Why does this occur?

Hurried

Distracted

Forgetful

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What is considered an ‘unsafe act’?

- An unsafe act is an “error or violation that occurs in the presence of a potential hazard.”- James T Reason, *Human Error*
- Unsafe acts can be either **errors** or **violations**
- Errors are further characterized as **slips**, **lapses** and **mistakes**.

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Unsafe Acts

- Understanding the different types of unsafe acts helps design systems to prevent them.
- If one category of unsafe acts is overlooked, your system may end up less safe than it could otherwise.

Types of Failures

Errors can be divided into two types of failure

Action does not go as intended:

Slip - observable

Lapse – not observable

A failure of execution.

Action goes as intended,

but it's the wrong one:

Mistake - a failure of planning

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Practice…

A nurse, Jessica, oversleeps and is running late to work. As she rushes through her morning routine, she experiences a _____, forgetting she'd promised to call her mother to confirm plans for later in the day.

She makes it out the door in record time and decides to drive toward the highway, thinking it will be faster than her usual route to the hospital. She quickly realizes her _____, however — traffic is backed up for miles!

At last, Jessica makes it to work. As she hurries inside, she finally remembers to call her mom. But in her hurry, she experiences a _____, and accidently calls her boyfriend instead.

Violations

- A violation is a **“deliberate deviation from an operating procedure, standard or rules.”**

- Although deliberate, violations are not necessarily the result of deviant behavior or intended to cause harm.

Example…

At the end of the day, a respiratory therapist is rushing home to cook dinner for his wife.

Because he is in a hurry, he speeds up (instead of slowing down) at two yellow lights. Without realizing it, he exceeds the speed limit both times, and the second time the light turns red before he makes it through.

When he quickly stops at the store to grab one more ingredient for the meal, he parks a little closer to a fire hydrant than he knows he really should.

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Systems, not individuals!

- Expecting providers to be perfect is not a rational or effective approach to preventing human error and patient harm.
- By focusing on the individual, organizations fail to identify and remove the error-provoking properties within the larger systems of care.
- Until you fix the system, the error is likely to happen again.

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When we view unsafe acts as consequences rather than causes of problems, **we can both accommodate the human condition and change the conditions under which humans work.**

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Four Critical Behaviors to Improve Safety

- Follow safety protocols.
- Speak up when you have concerns.
- Communicate effectively.
- Take care of yourself.

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1. Follow Safety Protocols

- To err is human – but so is to violate.
- Safety protocols are often standard throughout industries.
  - Using color coded stickers on patient charts.
  - Allergy alerts in Health Connect.
  - Pre-surgery safety checklist.

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Not all patient safety protocols are created equal

- If a protocol takes too much time or there is a better way to address risk, skipping the safety protocol is not the answer.
- **Speak up** if your organization's safety protocols aren't working for you or your patients.

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2. Speak up when you have concerns

Have you ever been in a situation where you see something not working or something unsafe?

In health care, situations such as this can occur frequently:

- Something spills on the floor of a hallway.
- A coworker fails to wash his or her hands before touching a patient.
- A surgeon skips the pre-surgery checklist.

Deep down, you know you should speak up, but will you?

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Communicate Clearly

An estimated **80 percent** of **serious medical errors** can be linked to **miscommunication between caregivers** when **patients** are **transferred or handed-off**.

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S-B-A-R

A Structured Communication Technique

- Situation
- Background
- Assessment
- Recommendation

See example on your handout.

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Take Care of Yourself

- Have you ever gone to work when you were exhausted, feeling ill, or anxious about something?
- However, going to work when you are not feeling your best can lead to patient harm. For example, a study of fatigue in operational settings found cognitive performance after 24 hours without sleep is equivalent to performing with a blood alcohol level of 0.10

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Think of it this way…

- It's like being allowed to care for patients when you're not functioning well enough to offer them a ride home!
- Unhealthy levels of stress can also degrade performance, and often go hand-in-hand with the health care profession. Depending on specialty, the **prevalence of physician burnout** — characterized by mild to severe exhaustion, cynicism, and inefficacy due to overwork or stress — ranges from **25–60 percent among practicing physicians.**

- Protect yourself:
  - You need three good reasons to say "Yes" and only one mediocre reason to say "No."

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Ways to reduce stress/avoid burnout

- Use self-restraint and try not to overextend yourself.
- Take daily time-outs for exercise, yoga, or meditation.
- Make time to connect with friends and family in a meaningful way.

friends & family

You owe it to yourself and your patients to show up "fit for duty" every day.

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Key Points to Remember:

- 1. Devastating medical errors are common. Many can be prevented.
- 2. Build safe systems of care. Include the different types of unsafe acts in your planning.
- 3. Practice safety-promoting behaviors and encourage others to do the same.
- 4. Just say "no".

References

- IHI Open School. IHI.org. Accessed 7/17/2013.
- AHRQ.gov. Accessed 7/17/2013.

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