



# Professionalism

## Learning from errors

(14)



### Objectives

- Understand the nature of error.
- Define the following terms error, slip, lapse, mistake, violation, near miss, hazard, risk and Risk management.
- Understand how you can learn from errors.
- Identify situational and personal factors that are associated with the increased risk of error.
- Participate in analyses of adverse event and practice strategies to reduce errors.
- Know how to apply risk-management principles in the workplace.
- Know how to report risks or hazards in the workplace.

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**Correction File**

**This work covers:  
Males/Females slides +  
433 teamwork**

- **Hazard:** is any activity, situation or, substance that potential to cause harm, including ill health, injury, loss of product and/or damage to plant and property.
- **Risk:** is the probability that harm (illness or injury) will actually occur

## What is clinical risks?

Is the **chance** of an adverse outcome resulting from: clinical investigation, treatment or patient care

- ❑ **Clinical risk management** is a whole systems approach to identifying, assessing, evaluating, minimising and communicating risks associated with clinical activities in order to maximise safety for all parties

## Purpose of Risk Management:

- ❑ Improve organizational and client safety
- ❑ Identify and minimize the risks and liability losses
- ❑ Protect the organization resources
- ❑ Support regulatory, accreditation compliance
- ❑ Creating and maintaining safe systems of care, designed to **reduce adverse events** and improve human performance

## 4 step process to manage clinical risks:

1. Identify the risk
2. assess the frequency and severity of the risk
3. reduce or eliminate the risk
4. Reviewing the effectiveness of the assessment and action plan **Assess the costs saved by reducing the risk or the costs of not managing the risk**

## Clinical risk assessment tool : (Not important)

			CONSEQUENCE				
			Minor	Moderate	Serious	Major	Catastrophic
			1	2	3	4	5
LIKLIHOOD	Rare	1					
	Unlikely	2					
	Likely	3					
	Expected	4					
	Certain	5					

### Harm occurrence Likelihood levels

- Certain: will occur on every occasion
- Expected: is expected to occur in most circumstances (e.g. more than 2 times a year)
- Likely: could occur in many circumstances (e.g. probable to happen up to 2 times a year)
- Unlikely: could occur occasionally (e.g. possibility of happening once a year)
- Rare: not expected to happen, but is possible (even if no occurrence registered)

### Harm severity levels

- Catastrophic: multiple deaths
- Major: possibility of death or major permanent loss of function (motor, sensory, physiologic, or intellectual)
- Serious: major injury / adverse health outcome (e.g. possibility of permanent lessening of bodily functioning)
- Moderate : moderate injury / adverse health outcome (e.g. increased length of stay)
- Minor: no or minor injury/ adverse health outcome;

Estimated risk levels: -Red: unacceptable risk -Yellow: tolerable risk -Green: acceptable risk

Identify the risk	Assess the frequency and severity of the risk	Reduce or eliminate the risk
<p>Use the following data as a sources for risk identification:</p> <ul style="list-style-type: none"> <li>•Adverse event reports.</li> <li>•Mortality and morbidities reports.</li> <li>•Patient complaints reports.</li> <li>•Assess the frequency and severity of the risk;</li> </ul>	<p><b>SAC (Severity Assessment Code) Score:</b></p> <p>it is a matrix scoring system/ numerical scores are given to the severity and likelihood of risks and these scores are multiplied to get a rating for the risk</p>	<ul style="list-style-type: none"> <li>• extreme risk- immediate action required</li> <li>• high risk-need to notify senior management</li> <li>• medium risk- managment responsibility must be specified</li> <li>• low risk-manage by routine procedures</li> </ul>

**Fitness-to-practice requirements: (important)**

- Accountability
- Competency of healthcare professionals.
- Are they practicing beyond their level of experience and skill? Are they unwell, suffering from stress or illness

Credentialing	Registration (licensure)	Accreditation
<p>The process of assessing and conferring approval on a person’s suitability to provide specific consumer/patient care and treatment services, within defined limits, based on an individual’s licence, education, training, experience, and competence.</p>	<ul style="list-style-type: none"> <li>•Registration of health-care practitioners with a government authority, to protect the health and safety of the public through mechanisms designed to ensure that health practitioners are fit to practise.</li> <li>•E.g Saudi Commission for Health Specialties</li> <li>•Proper registration is an important part of the credentialing and accreditation processes</li> </ul>	<ul style="list-style-type: none"> <li>•Is a formal process to ensure delivery of safe, high-quality health care based on standards and processes devised and developed by health-care professionals for health-care services.</li> <li>•National Accreditation Program: CBAHI</li> <li>•International Accreditation Program: Joint commission (US), Accreditation Canada (Canada)</li> </ul>

# Principal Types of Human errors

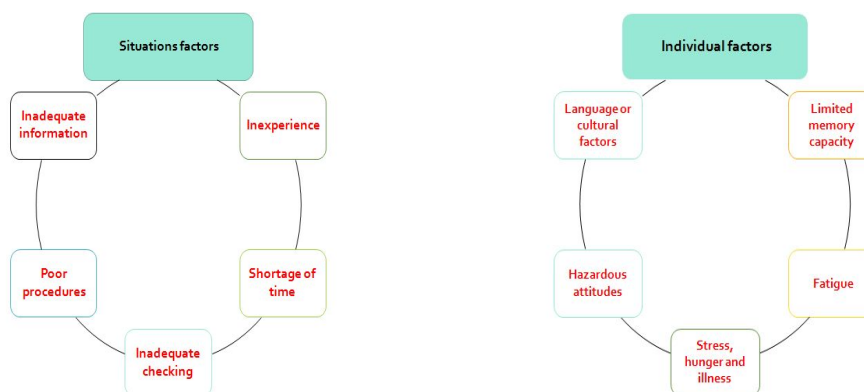
## A- Mistakes: Failure of planning

- Rule-based: E.g: wrong diagnosis end with inappropriate treatment plan
- Knowledge-based : E.g: when physicians are dealing with unfamiliar clinical situations

## B- Skill-based errors:

- Slips error : If the action is observable e.g pushing the wrong button on a piece of equipment
- Lapse error : If the action is NOT observable e.g a memory failure, such as forgetting to administer a medication.

## Factors Associated with an Increased Risk of Error :



## Medical error:

Failure of planned action to be completed as intended or the use of wrong plan to achieve an aim

**Violations:** are errors caused by deliberate deviation by an individual from an accepted protocol or standard of care.

### Types of errors :

<b>Sentinel Event</b>	<p>Is an <b>unexpected occurrence</b> involving death or serious physical or psychological injury ex:operating on the wrong side or wrong patient. e.g. surgery on the wrong patient or body site, incompatible blood transfusion.</p> <p>•Many health-care facilities have mandated the reporting of these types of events because of the significant risks associated with their repetition</p>
<b>Near Miss</b>	Incidence about to happen but by chance didn't occur
<b>Adverse Event</b>	<p>Defined as incidents in which harm resulted to a person receiving Adverse Event health care.</p> <p>They include infections, falls resulting in injuries, (include sentinel event +medication error)</p>
<b>Medication Errors</b>	Is any preventable event that may cause or led to inappropriate Medication Errors medication use or patient harm.

# How to capture error? (Important, try to understand the definitions)

## 1- Incident reporting :

- ❑ Is a form that is filled out in order to record details of an unusual event that occurs at the facility, such as an injury to a patient.
- ❑ the purpose of the incident report is to document the exact details of the occurrence while they are fresh in the minds of those who witnessed the event.

## 2- Patient complain:

**A complaint :** is defined as an expression of dissatisfaction by a patient, family member or carer with the provided health care.

•Complaints often highlight problems that need addressing, such as poor communication or suboptimal decision making.

•**Communication problems are common causes of complaints**, as are problems with treatment and diagnosis.

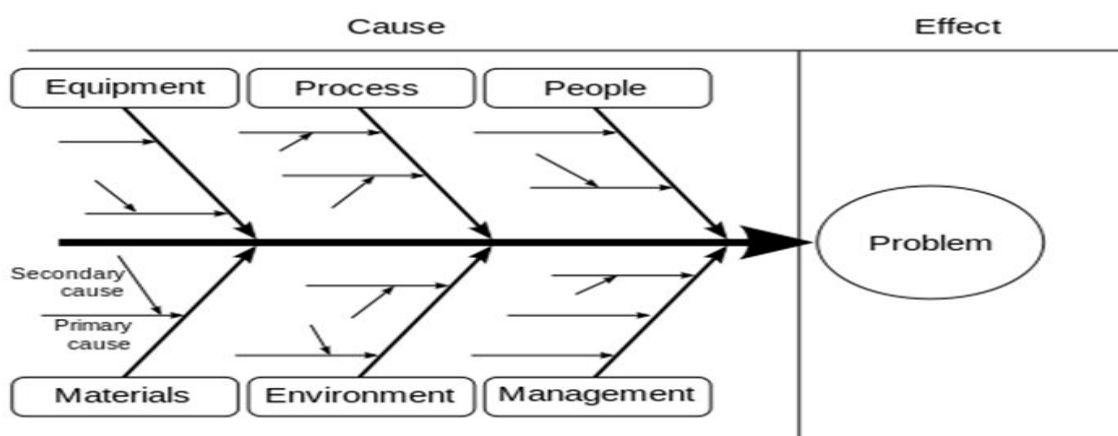
Benefits of complaints:

- Assist the maintenance of high standards;
- Reduce the frequency of litigation;
- Help maintain trust in the profession;
- Encourage self-assessment;
- Protect the public.

## **Root cause analysis (Fish bone analysis)**

is an approach for **identifying the underlying causes of why an incident occurred** so that the most effective solutions can be identified and implemented

\*It's not necessary to fill all of the six it depend on the problem



## Action plan and time frame:

Objective (What)	Actions (How)	Responsible (Who)	Timescale (When)	Progress review regularly) and sign off when (completed)
Patients fall	Handler	Engineering	3months	متابعة القضية

### Summary

- Medical error is a complex issue, but error itself is an inevitable part of being human.
- These tips are known to limit the potential errors caused by humans
- Avoid reliance on memory
- Simplify process
- Standardize common processes and procedures
- Routinely use checklists
- Decrease reliance on vigilance
- Learning from error can occur at both an individual level and an organizational level through incident reporting and analysis.
- Root cause analysis (RCA) is a highly structured systemic approach to incident analysis that is generally reserved for the most serious patient harm episodes
- Health-care professionals are responsible for the treatment, care and clinical outcomes of their patients.
- Personal accountability is important, as any person in the chain might expose a patient to risk.
- One way for professionals to help prevent adverse events is to identify areas prone to errors.
- The proactive intervention of a systems approach for minimizing the opportunities for errors can prevent adverse events.
- Individuals can also work to maintain a safe clinical working environment by looking after their own health and responding appropriately to concerns from patients and colleagues.

## MCQ's

1. Which one of the following is defined as an unexpected occurrence involving serious injury (ex: death):

A. Sentinel Event B. Major event C. Near Miss

2. Which one of the following is an approach for identifying the underlying causes of why an incident occurred?

A. Declaration of Helsinki B. Fish bone analysis

1-A 2-B