Professionalism Team
435

PROFESSIONALISM

Lecture 13:
understanding and learning from errors and managing clinical risks

Team members:	Color index:	Important links:
- Nouf altwaijri - Luluh Alzeghayer - Malak Alsharif	- Important. - Extra note.	- Correction file. - Quizzes file. - Lectures file (revised).

Please note that this file contains summaries and important notes only, your original source for studying is the full lectures file made by team 434, which will be revised by team 435 after each lecture. Link: Lectures file (revised).

Summary:

- **Medical error: important**
  An error is a failure to carry out a planned action as intended. or the use of a wrong plan to achieve an aim. Example: Retained surgical instruments
- **Violations:** are errors caused by deliberate deviation by an individual from an accepted protocol or standard of care.
- **A clinical incident:** Is a deviation from standard of care and safety. Examples: Medication errors.
- **Near miss:** Is any situations that did not cause harm to patients (that did not reach the patient), but could have done.

❖ **Types of medical erorrs: important**

Diagnostic	Treatment	Preventive	Other
▪ Error or delay in diagnosis(in the case of the diabetic patient may lead to blindness or glaucoma) ▪ Use of outmoded tests or therapy	▪ Error in the performance of an operation, procedure, or test (inserting a breathing tube into a patient's esophagus). ▪ Error in the dose or method of using a drug.	▪ Failure to provide prophylactic treatment. ▪ Inadequate monitoring or follow-up of treatment (no order for anticoagulant post major orthopedic procedure may lead to PE).	▪ Failure of communication ▪ Equipment failure

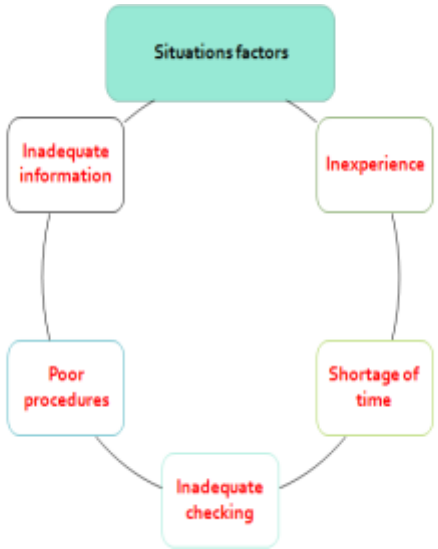
Ways to learn from errors:

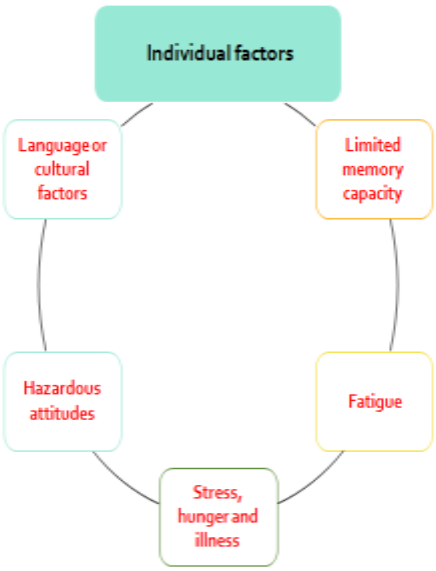
1- incident reporting: Incident reporting and monitoring involve collecting and analyzing information about any event that could have harmed or did harm a patient in a clinical setting or health-care organization.

2- Root Cause Analysis(RCA):

- Is a highly structured systemic approach to incident analysis.
- RCA focuses on the system, not the individual.

Factors Associated with an Increased Risk of Error:





- **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: Organizational effort to identify, assess, control and evaluate the risk to reduce harm to patient, visitors and staff and protect the organization from financial loss.

Activities Commonly Used to Manage Clinical Risk: (Important, try to understand the definitions)

1- Incident reporting:

- **An incident:** as an event or circumstance that could have or did lead to unintended and/or unnecessary harm to a person and/or a complaint, loss or damage.
- **Incident monitoring:** refers to mechanisms for identifying, processing, analyzing and reporting incidents with a view to preventing their reoccurrence

  The key to an effective reporting system is for staff to routinely report incidents and near misses.

2- Sentinel Event:

Is an unexpected occurrence 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.

3- Patient complain:

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

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
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 license, education, training, experience, and competence.	▪ 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 practice. ▪ E.g. Saudi Commission for Health Specialties ▪ Proper registration is an important part of the credentialing and accreditation processes.	▪ 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. ▪ National Accreditation Program: CBAHI ▪ International Accreditation Program: Joint commission (US), Accreditation Canada(Canada).