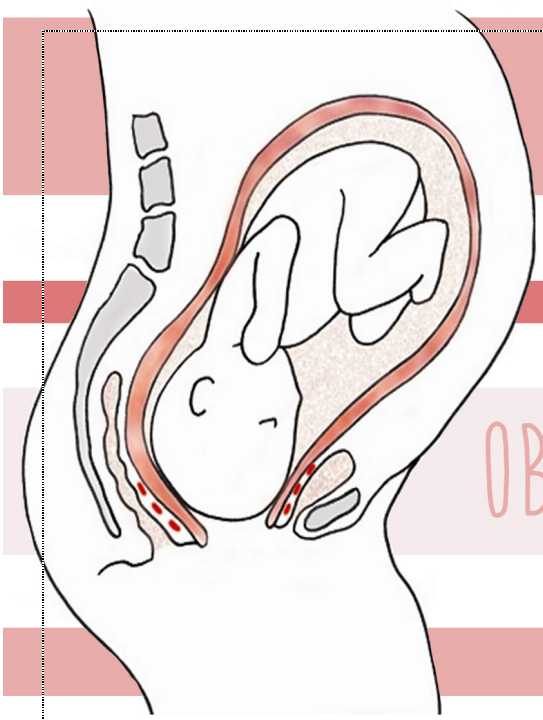

OBSTETRICS AND GYNECOLOGY

(Patient Safety in Obstetrics & Gynecology 1 & 2)

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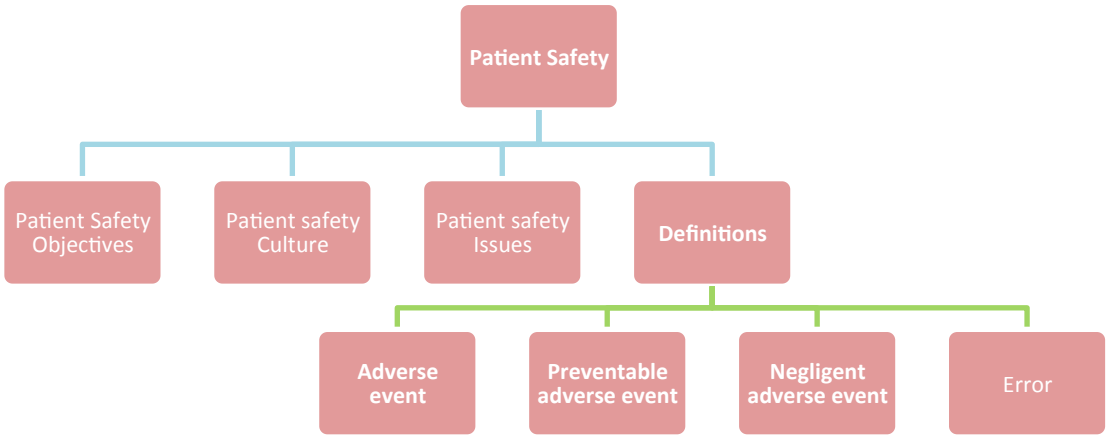
Revised by: Moudi Aldegether & Alanoud Alyousef

Doctor's note Team's note Not important Important 431 teamwork

Objectives:

Not given



TO ERR IS HUMAN

it is a Human nature to make mistakes so instead of thinking how to punish the person who made the mistake ask yourself why it happened and how to prevent it

- Human factors – confront two myths

- **The perfection myth.**

– If people try hard enough they will not commit patient safety incidents.

- **The punishment myth.**

– If we punish people when they make patient safety incidents they willmake fewer of them.

What Is Patient Safety?

Patient safety is the freedom from **accidental** injury in health care.

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one ormore patients receiving healthcare**.**

Definition of Patient Safety :

▪A type of process or structure whose application reduces the probability of adverse events resulting from exposure to the health care system across a range of diseases and procedures

▪Patient safety is the

or adverse events resulting from the processes of healthcare delivery

▪Defined by AHRQ (Agency for Healthcare Research and Quality) and NQF (National Forum for Quality Measurement and Reporting)

Definitions: (imp)

MCQ: the doctor may give us a definition or case scenario(this happened so what do you call it ?is it A) adverse event B) error …

Adverse event

• Injury caused by medical management rather than the underlying condition of the patient.E.g.. A patient came with abortion and then due to some medical treatment that we provided the patient ended having UTI and the abortion is not a cause of UTI, the unnecessary catheterization under aseptic technique is a cause

• Preventable adverse event

• adverse event attributable to error

Adverse event	Preventable adverse event
It just happened by chance E.g. you did a surgery for a patient and you did not cut any blood vessels but she bled because it is a vital organ.	**If it can be prevented if you did the right thing. E.g. you did a surgery for a patient and you injured a big vessels**

Negligent adverse event

• the care provided failed to meet the standard of care reasonablyexpected of an average physician qualified to take care of the patient

Discussion point: expected of an "average physician" only?

It depends how do you define the standard of care in your settings

Error

• the failure of a planned action to be completed as intended (i.e., error of execution)

• the use of a wrong plan to achieve an aim (i.e., error of planning)

Preventable adverse event	Error
You made the right plan but you did a mistake while doing the right plan	**You made the wrong plan from the beginning e.g. pt with ectopic pregnancy 4 cm your treatment plan was to observe the case (and this is a wrong plan) and in the second day she had complications**

First instinct?

• Blame someone!

However

• due most often to the
contributing factors

• blaming an individual does not change these factors
and the same error is likely

What would work better?

• Preventing errors and improving safety for patients
requires

• to modify the conditions that contribute to errors

• which recognizes people working in health care are
among the most educated and dedicated workforce
in any industry**.**

The problem is not bad people the problem is that the system needs to bemade safer.

Americans harmed by medicalerror :

• Two studies of large samples of hospital admissions

• New York using 1984 data

• Colorado and Utah using 1992 data

• Adverse event (injuries caused by medical management)
Were 2.9 and 3.7 percent respectively

• Adverse events attributable to errors (i.e., preventable
Adverse events) was 58 percent in New York, and 53
Percent in Colorado and Utah

• Extrapolated to the over 33.6 million admissions
to U.S. hospitals in 1997

• 44,000 to 98,000 Americans die in hospitals each
year as a result of medical errors

• Exceed the number attributable to the 8th-leading
cause of death

• Exceed the deaths attributable to motor vehicle
accidents (43,458), breast cancer (42,297) or AIDS
(16,516)

based on that the first step in delivering any health care is to be in a safe environment by identifying and studying the patterns and

Causes of error occurrence within delivery systems.

Patient Safety and Just Culture

- The studies show that individual blame is still dominant despite what has been found inliterature.
- No blame is the appropriate stance for system related errors. You shouldn't individually blame someone unless you have had established a system in which everyone is aware of the guidelines.

But what about reckless behavior or intentional acts that lead to harm?

- Certain errors do demand accountability and the Just Culture theory is that balance. Establishes zero tolerance for reckless behavior such as ignoring all of the safety steps put in place.

Just Culture:

▪ Just Culture recognizes the **difference between error** (shortcuts; doing it the easy way) **and ignoring therequired safety steps** (reckless behavior) like bar coding and having second person double check high risk drugs, in contrast to an over reaching "no-blame" approach.

▪ **It is important to note that the response is not based on the severity of the event.**

▪ Reckless behavior such as refusing to do a time out would merit punitive action if the patient was not harmed.

▪ **You want to create an open, fair and just culture**➔ Staff feel comfortable to report and discuss errors.

▪ **You want to create a learning culture**➔We need to learn from our mistakes and make sure staff are aware of what happens at our facility.

▪ **You want to create safe systems**➔ Time outs, bar coding couples with eMAR, double check of high alert medications, do not work nurse over 60 hours a week to prevent fatigue etc.

- **You want to manage behavior.**

Patient Safety Issues:

There are many patient safety issues:

Inpatient suicides, medication errors, wrong site surgery, restraint injuries, elopement, falls, retained foreign objects, delay in diagnosis, infant abduction, misdiagnosis, communication errors, transfusion errors, surgical site infection, Heparin complications, Warfarin complications, critical lab results, skin tears, awareness during OR, OR fires, MRI safety, infections like MRSA and VRE.

Patient safety Culture:

A culture of safety can be defined as an integrated pattern of individual and organizational behaviour, based upon shared beliefs and values, that continuously seek to minimize patient harm that may result from the processes of care delivery. (Kenneth W. Kizer13)

The importance of Patient safety

- ✓ Safety should be viewed as an essential component of a broader commitment to the provision of optimal health care for patients.
- ✓ Promoting safety requires that all those in the health care environment recognize that the potential for errors exists systemically.
- ✓ Health care should be delivered in a learning environment that encourages disclosure and exchange of information.

Key Features of a Culture of Safety

I. Acknowledgment of the high-risk nature of hospital's activities and the determination to achieve consistently safe operations
II. A blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment
III. Encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems

IV. Organizational commitment and resources to address safety concerns

Patient Safety Objectives (imp)

I. Develop a commitment to encourage a culture of patient safety
II. Implement recommended safe medication practices
III. Reduce the likelihood of surgical errors
IV. Improve communication with health care providers
V. Improve communication with patients
VI. Establish a partnership with patients to improve safety
VII. Make safety a priority in every aspect of practice

What does the patient want?

Don't make me feel helpless.

Don't kill me

Don't keep me waiting.

Do help me, and don't hurt me.

Healthcare provider

-Understand the multiple factors involved in failures
-Avoid blaming
-Practice evidenced-based care
-Maintain continuity of care for patients
-Be aware of the importance of self-care
-Act ethically everyday

Summary

Adverse event	Injury caused by medical management rather than the underlying condition of the patient
Preventable adverse event	Adverse event attributable to error
Negligent adverse event	The care provided failed to meet the standard of care reasonably expected of an average physician qualified to take care of the patient
Error	- The failure of a planned action to be completed as intended (i.e., error of execution) - the use of a wrong plan to achieve an aim (i.e., error of planning)

-No blame is the appropriate stance for system related errors.
-Just Culture recognizes the difference between error and ignoring the required safety steps (reckless behavior).
-A culture of safety can be defined as an integrated pattern.
-Health care should be delivered in a learning environment.
-Most important patient safety objectives: commitment, safe medication practice, low surgical errors, better communication, and partnership with the patients.

For mistakes or feedback

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