

Patient Safety in Obstetrics & Gynecology

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TO ERR IS HUMAN

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 will make fewer of them.

*The Seven Steps to Patient Safety.NPSA
(2003).*

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 or more patients receiving healthcare.

This is also referred to as an adverse event/incident, mistake or clinical error, and includes near misses.

Definition of Patient Safety

A

- 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

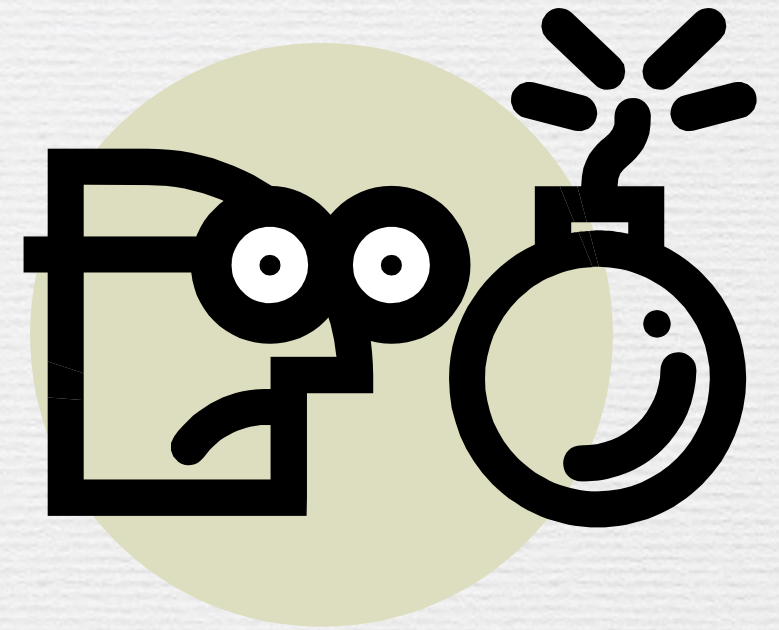
- **Adverse event**
 - injury caused by medical management rather than the underlying condition of the patient.
- **Preventable adverse event**
 - adverse event attributable to error

Definitions

- 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

Discussion point: expected of an “average physician” only?

Definitions



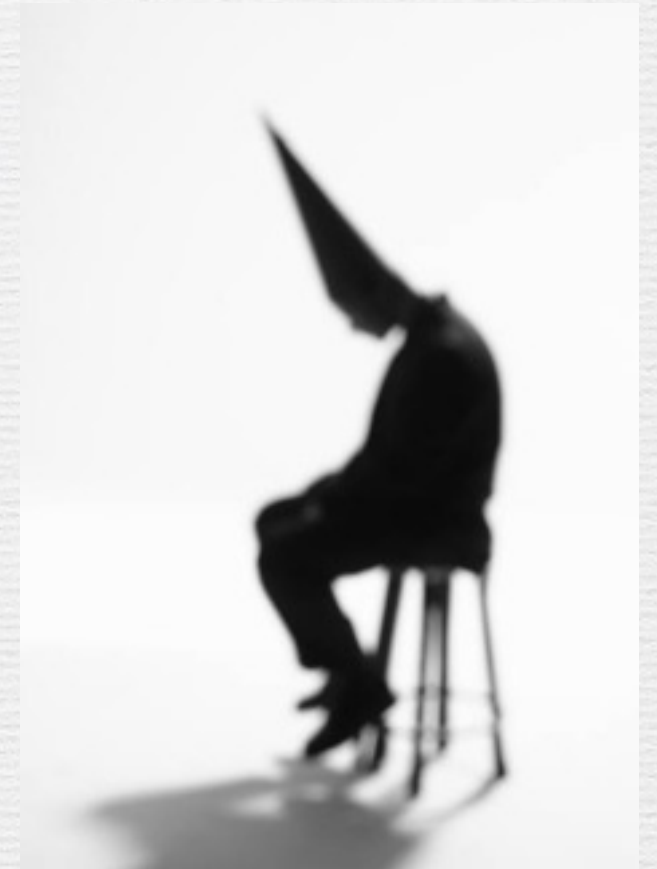
- **Error**
 - the failure of a planned action to be completed as intended (i.e., error of execution)
 - the use of a wrong plan to achieve an aim (i.e., error of planning)

First instinct?

- Blame someone!

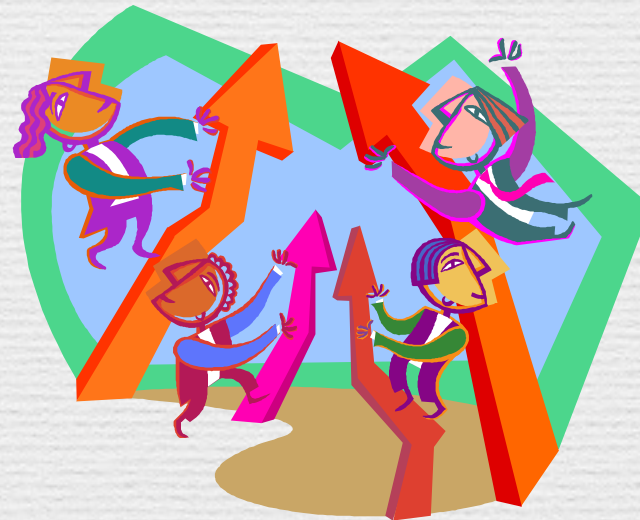
However

- due most often to the contributing factors
- blaming an individual does not change these factors and the same error is likely



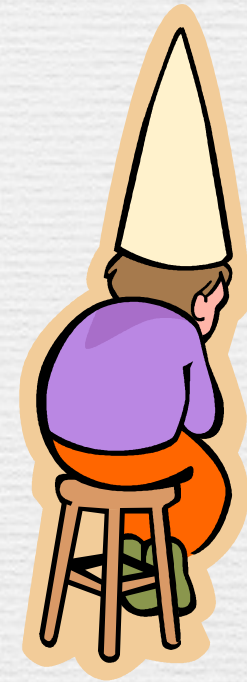
What would work better?

- 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



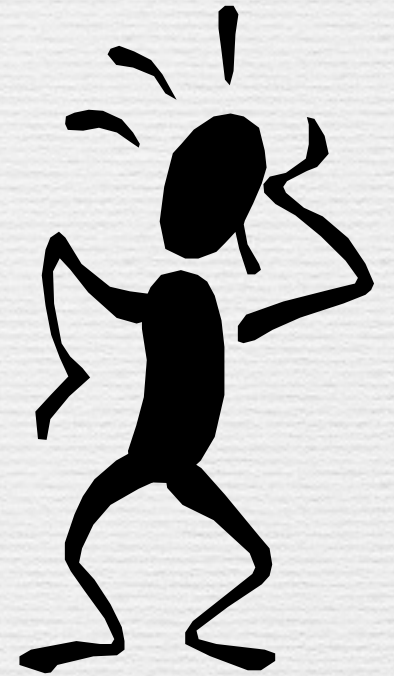
What would work better?

- **The problem is not bad people**
- **The problem is that the system needs to be made safer.**



Americans harmed by medical error

- 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)

- T should be to identify and study 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 the literature
- No blame is the appropriate stance for system related errors
- 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), and required safety steps 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

Just Culture

- You want to create a 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 behavioural

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 seeks 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 in the event of

Key Features of a Culture of Safety

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

Patient Safety Objectives

- Develop a commitment to encourage a culture of patient safety
- Implement recommended safe medication practices
- Reduce the likelihood of surgical errors
- Improve communication with health care providers
- Improve communication with patients
- Establish a partnership with patients to improve safety
- Make safety a priority in every aspect of practice

What does the patient want?

- Don't kill me
- Do help me, and don't hurt me.
- Don't make me feel helpless.
- Don't keep me waiting.
- D

Healthcare provider

- understand the multiple factors involved in failures
- avoid blaming
- practise evidenced-based care
- maintain continuity of care for patients
- be aware of the importance of self-care
- act ethically everyday