Patient Safety – A Clinician Perspective

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Healthcare Services

(TNS Opinion & Social, 2010)

- Patients expectation (hope & trust)
  - Health-related problems appropriately handled
  - Being well looked after

Quality Standards

(Korn, 2012)

- Patient outcome
- Patient experience
- Coordination of care

Assured Achievement of Quality

- Risk reduction?
- Safety assured?
- Causes of incidents well studied & managed?
- Take incidents as routine occurrence?

Healthcare Quality Measures

(Kelley & Hurst, 2006)

- Encompass process & outcome measures
- Important areas
- Sound scientific quality
- Feasible & cost affordable for data collection

Patient Perception

(TNS Opinion & Social, 2010)

In countries of European Union

- Hospital infection, incorrect/missed/delayed diagnoses likely occur on receiving healthcare
- 25% experience adverse events with healthcare
- Main source of information of adverse healthcare events is from television

Facts of Patient Safety

- 1.4 million people worldwide suffer from infections acquired in hospitals (WHO, 2002)
- ECDC estimates that healthcare associated infections occur in 5% of hospitalized patients ⇨ 37,000 death / year (TNS Opinion & Social, 2009)
- In developed countries ⇨ 1 in 10 patients is harmed while receiving hospital care (WHO, 2002)

- In EU Member States 8-12% patients admitted to hospitals for adverse events whilst receiving healthcare (TNS Opinion & Social, 2009)
- ⇧ concern in the prevention of errors and adverse effects to patients associated with health care (WHO, 2002)
- Patient safety ⇨ serious global healthcare issue (WHO, 2002; Hughes, 2008)

Meaning of Patient Safety

- Result of errors or adverse events, e.g.
  - 1.4 million people worldwide suffer from infections acquired in hospitals (WHO, 2002)
  - ECDC estimates that healthcare associated infections occur in 5% of hospitalized patients ⇨ 37,000 death / year (TNS Opinion & Social, 2009)

- IOM: patient safety ⇨ prevention of harm to patients ⇨ freedom from accidental / preventable injuries while receiving healthcare (http://psnet.ahrq.gov/glossary.aspx#P. Accessed October 20, 2007)
- Prevention & control healthcare-associated adverse events while patients receiving healthcare (TNS Opinion & Social, 2009)
- Cornerstone of high-quality healthcare (Hughes, 2008)

Causes of Patient Safety Issues

- ⇧ pressure on health care system ⇨ overload health care environment (WHO, 2002)
- ⇧ heath care effectiveness ⇨ ⇧ health care complexity ⇨ ⇧ use of technology, medicine & treatment (WHO, 2002)
- Treating older / sicker patients ⇨ ⇧ difficulty in making decision in health care priority (WHO, 2002)

Types of Patient Safety Events

(OECD: HCQI Patient Safety)

- Sentinel events ⇨ should never occur
- Adverse events ⇨
  - Can never be fully avoided owing to risk nature of events
  - Aggregated ⇧ incidents ⇨ system failure

According to Institute of Healthcare Improvement (2014), Patient safety events encompass

- Adverse drug events
- Ventilator associated pneumonia
- Central line-associated blood stream infection
- Surgical site infection
- Surgical site infection for hip / knee arthroplasty

Patient Safety Topics

(National Patient Safety Agency, July 2004)

- Abuse/aggression & patient safety
- Consent, communication, confidentiality
- Documentation & patient safety (checklists/patient records)
- Environment & patient safety (Include cleaning & PEAT)
- Human factors & patient safety culture (risk prevention guidance, team work, staffing)

Patient Safety Issues

(By Nature)

- Reactive verse proactive?
- Reactive to errors, incidents, adverse episodes?

Patient Safety Issues
(By Category)

- Surgical interventions
- Invasive medical interventions
- Hospital acquired infections
- Blood transfusion incidents
- Medication incidents
- Adverse drug events

- Use of physical restraint
- Fall incidents
- Skin integrity

Patient Safety Issues?

- Unintentional drug overdose
- Elderly abuse
- Hydration
- Nutrition
  - Unintentional weight loss
  - Poor nutrition status
- Feeding
  - Enteral ⇨ NGT, PEGT
  - Oral

Root Causes of Harms

- Direct failures
  - Latent failure ⇨ involved decisions affecting organization policies, procedures & allocation of resources
  - Active failure ⇨ direct contact with patients

- Indirect failures
  - Organization system failure ⇨involving management, organization culture, protocol / process, transfer of knowledge, external resources
  - Technical failures ⇨ failure of facilities & external resources

Categories of Causes

- Failure to follow standard operating procedure
- Poor leadership
- Breakdown in communication / teamwork
- Overlooking / ignoring individual fallibility
- Losing track of objectives

Goal of Patient Safety Enhancement

- Keep patients from getting injured / sicker (NHS, 2012)
  - Healthcare-associated infections
  - Adverse events
  - Assure timely & appropriate care for patients

Patient Safety System

(TNS Opinion & Social, 2009)

- Reporting mechanism establishment
- Education & training of stakeholders
- Enhanced stakeholders awareness
- Standardization of measures for continuous monitoring & reporting

- Nurses most likely intercept errors & prevent harms to patients (Hughes, 2008)
- Care delivered
  - Prevent errors occur
  - Learned from errors occurred
  - Built on a culture of safety involving healthcare professionals, organizations & patients (Hughes, 2008)

Patient Safety Practice

- Activities aimed at reducing adverse events related to exposure to healthcare (Hughes, 2008)
  - Appropriate use of prophylaxis
  - Use of pressure relieving bedding material to prevent pressure ulcers
  - Appropriate provision of nutrition to prevent complications
- Simulator, bar-coding, computerized MOE ⇨ enhanced patient safety (Hughes, 2008)

Need for Clinical Guidance

(National Patient Safety Agency, July 2004)

- Technology / knowledge advancement ⇨ complex healthcare system
- Complexity ⇨ risks ⇨ harm patients despite of dedicated / proficient staff
- Checklist guidance ⇨
  - Plan healthcare activities
  - Measure patient safety performance
  - Ensure safe patient care as far as possible / right action when thing go wrong

- Help organization to meet
  - Clinical governance
  - Risk management
  - Control assurance targets

Clinical Alert

- Regular collection of patient safety data
- Analysis of patient safety incident reports / patient safety resources ⇨ develop advice ensure patient safety
- Types of alert
  - Rapid response reports
  - Patient safety alerts
  - Safer practice notices

- Medical devices/equipment
- Medication safety
- Patient accidents (slips, trips & falls)
- Patient admission, transfer, discharge (including patient ID)
- Patient assessment & diagnosis (including tests & scans)
- Patient treatment/procedure (including nutrition)
- Risk assessment & patient safety

Seven Steps to Patient Safety

(National Patient Safety Agency, July 2004)

- Build a safety culture
- Lead & support your staff
- Integrate risk management activities
- Promote reporting
- Involve / communicate with patients / public
- Learn / share safety lessons
- Implement solution ⇨ prevent harm

Nurses Role & Function in Patient Safety

- Focus on risk reduction
  - Hand hygiene
  - Avoid medication errors
  - Prevent patient falls
  - Correct enteral tube placement
  - Use of physical restraint
  - Unintentional drug overdose
  - Elderly abuse

- Focus on collaboration
  - Coordinate & integrate multiple aspects of quality into direct care to patients & care delivered by others in the setting
  - Surveillance ⇨ ⇩adverse patient outcome