COMMON REASONS FOR FAILURES IN PATIENT SAFETY

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Outline

- Safety
- Human factors
- Solutions
- Culture
- Well informed patients

DO NO HARMS??

FACT FILE

World Health Organization

10 FACTS ON PATIENT SAFETY

Previous Next

1 2 3 4 5 6 7 8 9 10

Fact 2

Estimates show that in developed countries as many as one in 10 patients is harmed while receiving hospital care. The harm can be caused by a range of errors or adverse events.

網際網路 100%

http://www.who.int/features/factfiles/patient_safety/en/ 30 July 2015

DO NO HARM

- United Kingdom
- Consequent additional hospital stays cost about £2000 million a year
- Paid litigation claim cost around £400 million annually
- United States
- National cost of preventable adverse medical events between US$17000 million & US$29200 million annually
- Erosion of trust, confidence and satisfaction among health care professionals and patients

WHO 2004

Safety

- Freedom from hazards

Runciman 2006

Patient Safety?

Is the absence of preventable harm to a patient during the process of health care

WHO (2004)

Errors

- Unintentionally being wrong in conduct judgment.
- Errors may occur by doing the wrong thing (commission) or by failing to do the right thing (omission)

Runciman 2006

Lessons from Cognitive Psychology

- Errors are normal behaviors
- The causes of errors are not obscure
- Human errors result from latent errors

Latent Factors

- System design factors
- Environmental factors
- Organizational factors
- External factors

System Factors

- Task and process
- Equipment
- Educational & training
- Team set up
- Condition of work
- Organizational culture

Environmental Factors

- Sleep deprivation – double shifts , on call then take on day duty
- Excessive workload – high staffing ratios

Organizational Factors

- Hierarchical autocratic leaders
- Lack of teamwork
- Lack of respect and trust
- Shaming & blaming for errors

External Factors

- What is happening in the outside world

What can we do

- Human factors – cognitive psychology ; human factor engineering
- Team effort
- Learn from incidents
- Share reported data among the unit, then the organization
- Perfection as benchmark – make an effort to eliminate risk
- Identify adverse event – look for "trigger tool"
- National effort to ensure competence of professional staff
- Well informed patients

Buerhaus 2007

Human factors

- Mental workload
- Distractions
- Physical environment
- Physical demands
- Device/product design
- Team work
- Process design

Solutions to combat

- Mental workload
- Distractions
- Physical environment
- Physical demands
- Service/product design
- Teamwork
- Process design

Carthey & Clarke nd

Mental workload

- Self aware of stress
- Calculation of dosage of drugs
- Pre-calculated list
- Electronic calculator
- Prefilled syringes
- Do not rely on vigilance and memory
- Reminder list
- Prompts

Distractions

- Alarms
- False alarms
- Staff fatigue
- Staff desensitized
- Medication rounds : designated nurse to do the medication round

Physical environment

- Tidiness, lighting
- Adopt 5 S
- **Structure**
- **Systematize**
- **Sanitize**
- **Standardize**
- **Self-discipline**

Physical demands

- Staff ratio

☒Double shifts – 12 hours shift

- Staff corner

Service/ product design

- Minimize the variability and number of different medical devices available in one unit
- Preventive maintenance
- Proper training and return demonstration
- Speak up when there is a safety concern
- Listen when others do

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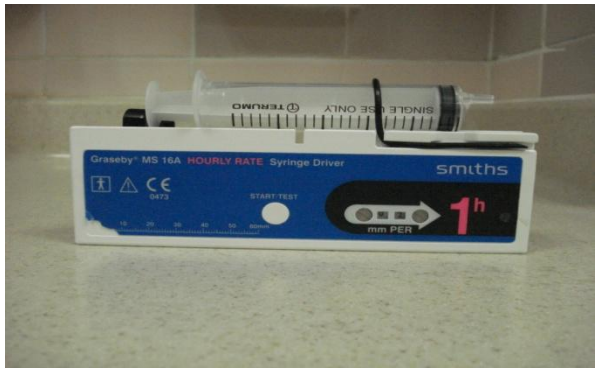

Teamwork

- Avoid multiple handover
- Team training – simulation
- Drills
- Shift and morning briefing
- Surgical Safety Checklist – Sign in, Timeout and Sign out

Process design

- Simplify clinical processes to reduce the potentially negative impact of memory limitations on human performance
- Failure Mode and Effect Analysis
- Prioritize the steps based on assessment of probability of failure & the severity of consequences
- Decide which step must be improved
- Identify all the causes that the step could go wrong
- Make changes to eliminate or control the failure mode causes
- Require the scrutiny of processes at a very fine level of detail

Team effort to assure patient safety

- High level support
- Administrative leadership
- Clinical leadership
- Designated resources
- Life is not a democracy

Shared Responsibility

- Doctors, nurses, every members of the team all assume complete responsibility
- Create atmosphere for communication, questioning and discussion

Communication

- Never enough training
- Between patient and health care workers
- Among health care workers

Communication between patient and health care workers

- Communicate in same language : jargons
- Attend to non verbal cue
- Avoid closed end questions
- Who to proof read written information , in particular consent form
- Professional interpreter service

Communication among health care workers

- Hand over by patient side
- Legible writing and agreed format
- Clear instruction – ask for feedback
- Verbal order – read back

Culture

- Shared beliefs, values, attitudes, institutions and behaviour pattern that characterized the members of a community or organization

Woods 1998

Safety culture

Carthey & Clarke nd

Safety culture

- Acknowledge high-risk and error prone nature of health care
- Widespread shared acceptance of responsibility for risk reduction
- Encourage open communication about safety concerns in non-punitive environment
- Freedom of fear of reporting problems

Safety culture

- Culture in healthcare must undergo transformation and abandon the philosophy of requiring perfect, error free performance from individuals
- Move from 'blame and shame' culture
- Design system for safety
- Learning from errors
- Readily access top information
- Positive culture recognizes inevitability of error and proactively seeks to identify latent threats

Nieva & Sorro 2003

Open culture

- Staff feel comfortable to discuss patient safety incidents and raise safety issues with colleagues, senior managers and board members
- Structure walk round to provide platforms for discussion
- Safety culture measurement tool

Carthey & Clarke nd

Survey on patient safety culture

average % positive response

	HK	AHRQ (2010)
1. Teamwork within units	68	80
2. supervisor/manager expectations & actions promoting patient safety	57	75
3. Organizational learning – continuous improvement	57	72
4. Management support for patient safety	61	72
5. Overall perceptions of patient safety	43	65
6. Feedback & communication about error	43	63
7. Communication openness	31	62
8. Frequency of events reported	50	62
9. Teamwork across units	44	58
10. Staffing	29	56
11. Handoffs & transitions	43	44
12. Non-punitive response to error	16	44

Learning culture

- Committed to learn safety lessons
  - What happened
  - Why
  - What to do to reduce risk
  - How do we know it worked
- Communicate safety lessons to colleagues
- Recommendation and improvement actions been implemented and incorporated in daily practice! Evidence?

Carthey & Clarke nd

Informed culture

- Learn from past experiences and has the ability to identify and mitigate future incidents
- Risk assessment tools and plans in place?
- Result reported and was the assessor informed of the progress?

Carthey & Clarke nd

Just culture

- Self-disclosure of errors, mistakes and near events offers the opportunity to learn from the event, correct flaws in a system design and provide the best possible prospect for preventing mistakes.

Marx 2007

Just culture

- Punishment is NOT the best deterrent to prevent human factors and at-risk behaviors
- "Fair blame" instead of Blame free environment
- Examine events and behaviors in a proactive, productive manner

Griffiths 2007

Carthey & Clarke nd

Reporting culture

- Nurses reported working in a culture where they would be blamed if they made a mistake
- Nurses believed that the negative media coverage of NHS failure further shaped the public's attitude to blame

Currie & Watterson (2007)

Reporting culture

- Ask "do we have a higher proportion of near misses reported?
- ♦ if yes, awareness of staff on the importance of reported near misses.
- Ask "do some department and/or staff groups report more than others?
- ♦ If yes, then needs to promote multi-professional reporting norm across all departments
- User friendly system

Cathey & Clarke nd

Points to consider

- Classification is necessary to provide context
- Data is sensitive; access and control is important to protect individuals
- Timely feedback to stakeholders is important for motivation and learning
- Individuals must have the option to report anonymously

Learn from incidents

- Examples
- Staff support

Share reported data

- Identify indicators/data to be collected
- Workload of data collection huge
- Consensus on definition
- Nosocomial infection rate
- Fall rate
- Pressure ulcer

Sharing data & lesson learnt

- Bulletin
- Poster
- Lectures
- Staff support

What can we do

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Buerhaus 2007

Perfection as benchmark

- Is it possible
- Leader has to make an effort
- Well defined standards
- Team members contribute
- Do not wait for incident report
- Look for “trigger tool”
- Safety walk round
- Staff speak up corner
- Read through medical notes and ask why this test/procedure is being done

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Buerhaus 2007

Trigger tools

- MEWS
- Set critical level

MODIFIED EARLY WARNING SCORE							
Score	3	2	1	0	1	2	3
Systolic Blood Pressure (SBP	≤ 70	71 – 80	81 – 100	101 – 199		≥ 200	
Heart / Pulse Rate		≤ 40	41 – 50	51 – 100	101 – 110	111 – 130	> 130
Respiratory Rate (Resp.)		≤ 8		9 – 14	15 – 20	21 – 29	≥ 30
Temperature (Temp.)		≤ 35	35.1 – 36	36.1 – 38	38.1 – 38.5	≥ 38.6	
Level of Consciousness (LOC				Alert	Response to Verbal	Response to Pain	Unresponsive
MEWS ACTION PATHWAY							
Change of MEWS	Level	(Range 0 – 14)					
Minimal change	I	Continue with routine observations					
Medium change	II	Increase frequency of observations *(depending on previous frequency of observations)*, monitor the trends and inform nurse-in-charge					
Significant change	III	According to action pathway of individual hospital					
CHARTING GUIDE							

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Buerhaus 2007

Staff competency

- Continued professional development
- Simulation lab
- Crew management training

Well informed patient

- Safer and happier
- Treat the patient the way we want to be treated
- When adverse event occurred, full disclosure

Buerhaus 2007

Well informed patient

- Ask question
- Ask for an interpreter
- Know who is providing your care
- Help ensure medication safety
- Ask for help
- Identification band on hand
- Inform visitors

Best results achieved when the patient is a member of the health care team

Safety ??

- Safety is not a destination but journey
- Safety is a way of life
- Focus on people, learning from incidents

Safe Practice Challenge

- What is the right thing to do

Which are the evidence based practice

- Have we done the right thing

Implement the practice

- Have we done the right thing right

Made sure that 100% patients get it, get in on time and get it without mistakes

Excellence is an art won by training and habituation. We do not act rightly because we have virtue or excellence, but we rather have those because we have acted rightly.

We are what we repeatedly do. Excellence, then, is not an act but a habit.

Aristotle

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