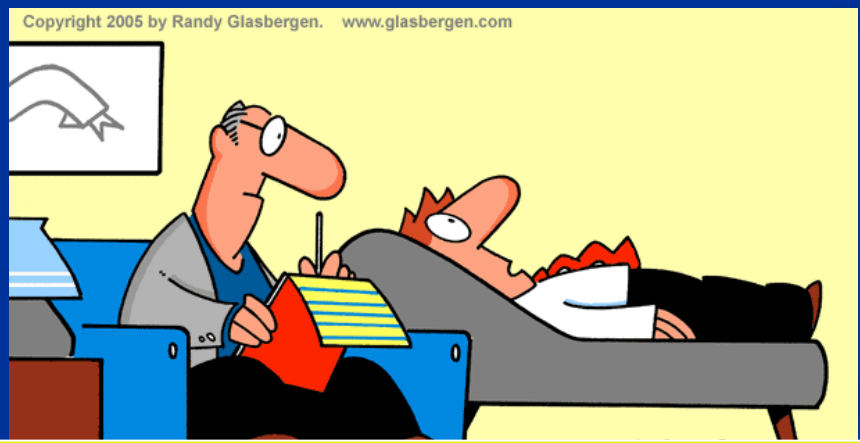
Rantai Efek Perbaikan Mutu Donald Berwick sebagai Kerangka

Seminar Keselamatan Pasien



Am I pretty sure to be treated safely in this health care facility ?????

Pokok bahasan

- Latar belakang
- Pengertian-pengertian yang terkait dengan patient safety
- Risk management sebagai upaya untuk menghilangkan atau meminimalkan risiko
- Rantai efek perbaikan mutu Donald Berwick sebagai kerangka seminar.

Latar belakang

- Keselamatan pasien merupakan isu utama akhir-akhir ini baik di Indonesia maupun di Luar Negeri
- Kepedulian pengambil kebijakan, manajemen dan praktisi klinis terhadap keselamatan pasien
- Berbagai seminar, workshop, dan pelatihan banyak diadakan: patient safety, risk management, clinical audit, patient safety indicators – dg berbagai motif.
- Studi 1999 di Jawa Tengah dan DIY: Prevalensi error berspektrum cukup luas: 1,8 % – 88.9 %.

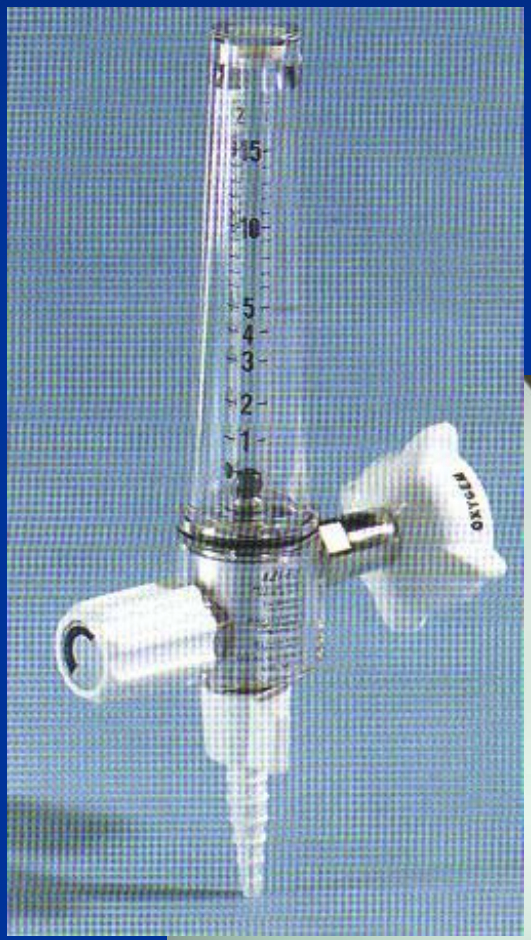
Risiko yang mungkin terjadi pada sarana pelayanan kesehatan

(McCaffrey & Hagg-Rickert, Risk Management Handbook, pp 100-104, 2004)

- Patient care related risk
- Medical staff related risk
- Employee related risk
- Property related risk
- Financial risk
- Other risk (e.g: property & liability losses related to operation of automobiles, trucks, vans, ambulances)

Madu di tangan kananmu
Racun di tangan kirimu,
mana yang akan kau berikan
pada kuuuu……..bu dokter….????

Apa kita peduli ?



Safety dalam pemberian treatment
&
medication ????

Apa kita peduli ?

Safety selama berada di Sarana pelayanan kesehatan

Safety
Selama mendapatkan
Intervensi medis
dan keperawatan ???

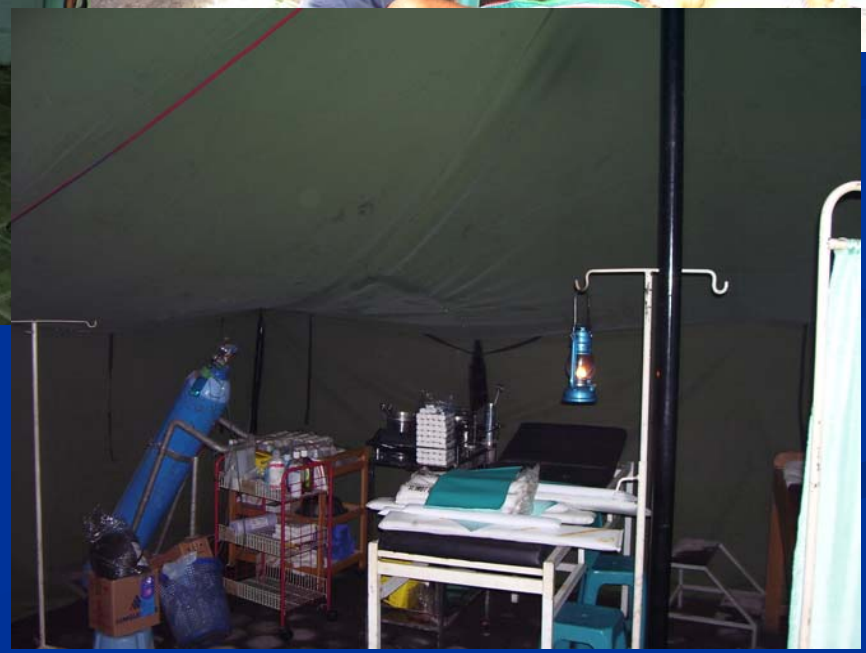
Safety dalam penggunaan & pemeliharaan peralatan ???

Safety
pelayanan
Instalasi penunjang

Safety Pelayanan Instalasi penunjang ???

Safety pelayanan
Instalasi penunjang ???

Safety during disaster ???



Pengertian Patient Safety

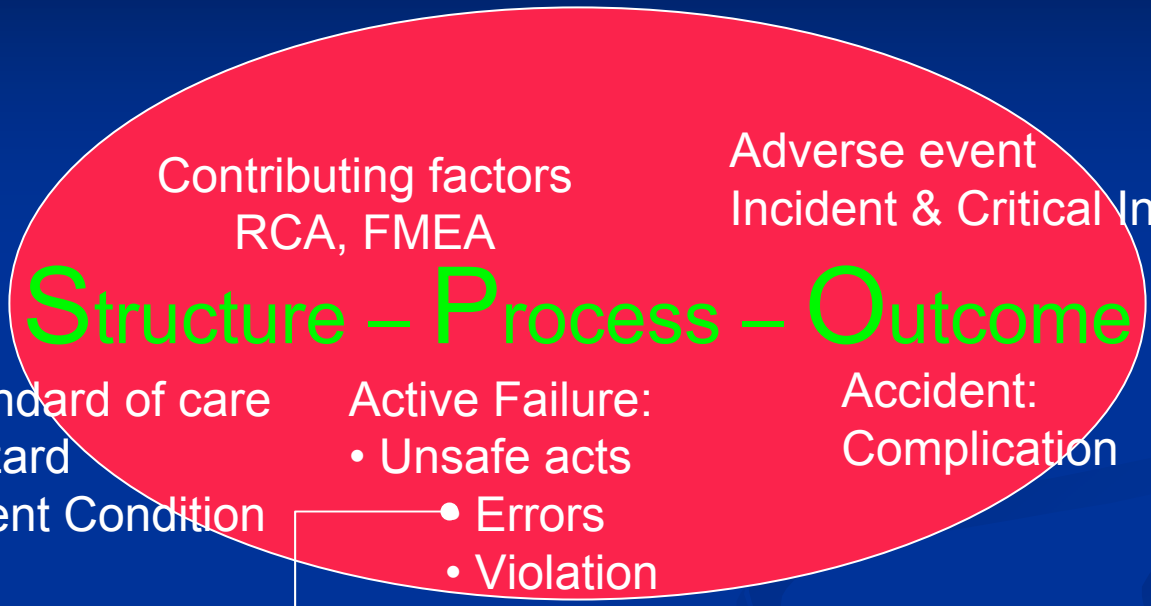
- Patient safety: the reduction and mitigation of unsafe acts within the health care system, as well as through the use of best practices shown to lead to optimal patient outcomes (The Canadian Patient Safety Dictionary, October 2003)
- Keselamatan pasien: reduksi dan meminimalkan tindakan yang tidak aman dalam sistem pelayanan kesehatan sebisa mungkin melalui pratik yang terbaik untuk mencapai luaran klinis yang optimum.

Pengertian Patient Safety

- Upaya upaya yang dirancang untuk mencegah "adverse outcomes sebagai akibat "clinical error"
- Tiga kegiatan yang saling melengkapi dalam mewujudkan keselamatan pasien:
  - **Preventing errors (mencegah errors)**
  - **Making errors visible (membuat errors mudah dilihat)**
  - **Mitigating the effects of errors (meminimalkan akibat dari errors)**

(Quality Interagency Coordination Task Force, 2000: www.quic.gov/report/toc.htm)

System approach to patient safety



Notes:
Term to be avoided:
Blame, Fault, Negligence, Recklessness

Sumber:
The Canadian Patient SafetyDictionary, October 2003

Structure

- **Structure:** a supporting framework or essential parts, including: the health care system that exist before any actions or activities take place. Structure represents all components of the facility, organization or department: administration, physical facility, environment, personnel, equipment.
- **Standard of care:** a set of steps that would be followed or an outcome that would be expected, that can be found in a policy or clinical guideline
- **Hazard**: a set of circumstances or a situation that could harm a person's interests, such as their health or welfare
- **Latent condition**: the structural flaws in the system that predispose to adverse outcomes, and that it be used as a term instead of "latent failure"

Process

- **Process**: a course of action, or sequence of steps, including what is done and how it is done.
- **Active failure**: event/action/process that is undertaken, or take place, during the provision of direct patient care and fails to achieve its expected aims.
- **Three types of unsafe act: error, violation, and sabotage**
- **Error:** the failure to complete a planned action as it was intended or when an incorrect plan is used in an attempt to achieve a given aim
- **Violation:** a deliberate deviation from standards, rules or safe operating procedures
- **Sabotage:** an activity in which the act(s) and the harm or damage are intended
- **Intentional unsafe acts**: any events that results from: a criminal act, a purposefully unsafe act, an act related to alcohol or substance abuse, impaired providers/staff or events involving alleged or suspected patient abuse of any kind

Process

- **Error or medical error**: the failure to complete a planned action as it was intended, or when an incorrect plan is used in an attempt to achieve a given aim
- **3 types of human error**:
  - **Slips**: error related to observable actions and are commonly associated with attentional or perceptual failures
  - **Lapses**: error related to more internal events and generally involves failures of memory
  - **Mistakes**: error related to failures with the mental processes involved in assessing the available information, planning, formulating intentions, and judging the likely consequences of the planned actions (Reason, 1997)
- **Medication error**: the failure to complete a planned action as it was intended, or when an incorrect plan is used at any point in the process of providing medications to patients

Outcome

- **Outcome**: a product, result or practical effect that reflect the health and well-being of the patient and associated costs.
- **Accident**: an adverse outcome that was NOT caused by chance or fate. Most accidents and their contributing factors are predictable and the probability of their occurrence may be reduced throug system improvements.
- **Complication**: a disease or injury that arises subsequent to another disease and/or health-care intervention

Process and outcome

- **Incident**: events, processes, practices, or outcome that are noteworthy by virtue of the **hazards** they create for, or the **harms** they cause, patients
- **Critical incidents**: an incident resulting in **serious harm** (loss of life, limb, or vital organ) to the patient, or the significant risk thereof.
- **Adverse event**:
  - An unexpected and undesired incident directly associated with the care or service provided to the patient
  - An incident that occurs during the process of providing health care and results in patient injury or death
  - Adverse outcome for patient including an injury or complication.

Structure and process

- **Contributing factors**: the reason(s), situational factor(s), or latent condition(s), that played a role in the genseis of an adverse outcome
- **Cause**: an antecedent set of actions, circumstances or conditions that produce an event, effect, or phenomenon
- **Root cause analysis**: a systematic process of investigating a critical incident or an adverse outcome to determine the multiple, underlying contributing factors. The analysis focuses on identifying the latent conditions
- **Failure Mode and Effect Analysis:** Alat untuk mengkaji suatu prosedur secara rinci, dan mengenali model-model adanya kegagalan/kesalahan pada suatu prosedur, melakukan penilaian terhadap tiap model kesalahan/kegagalan, dengan mencari penyebab terjadinya, mengenali akibat dari kegagalan/kesalahan, dan mencari solusi dengan melakukan perubahan disain/prosedur

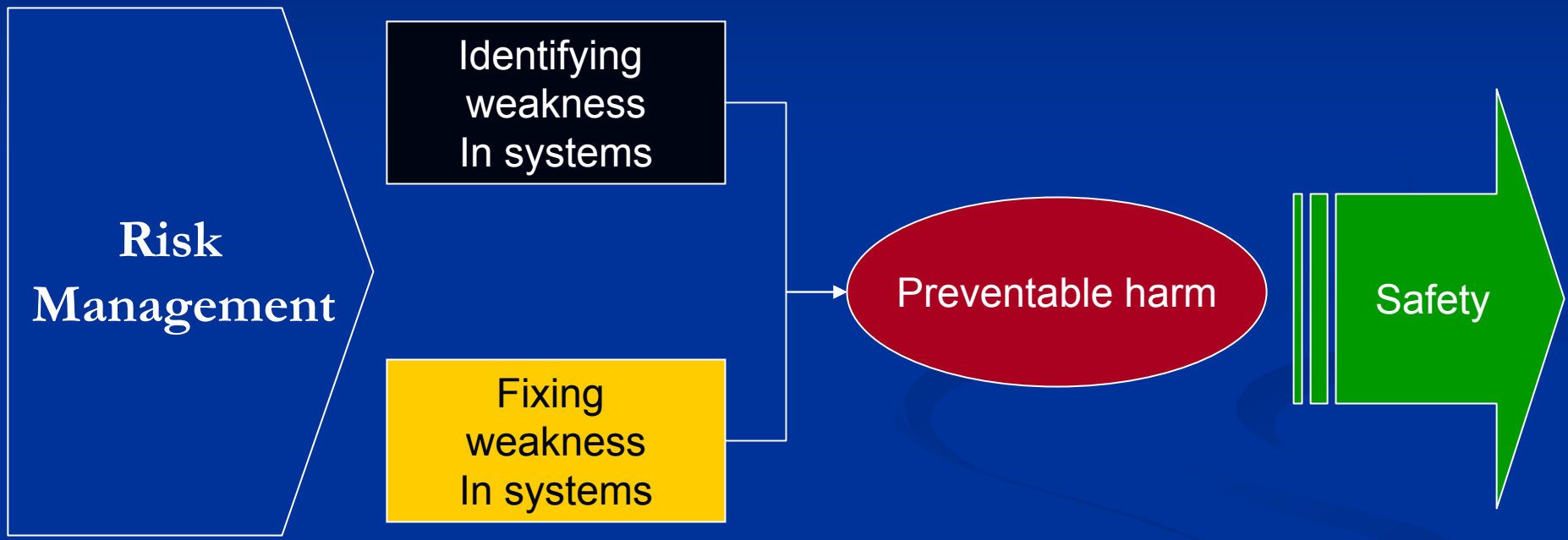
Upaya untuk menghilangkan atau meminimalkan risiko

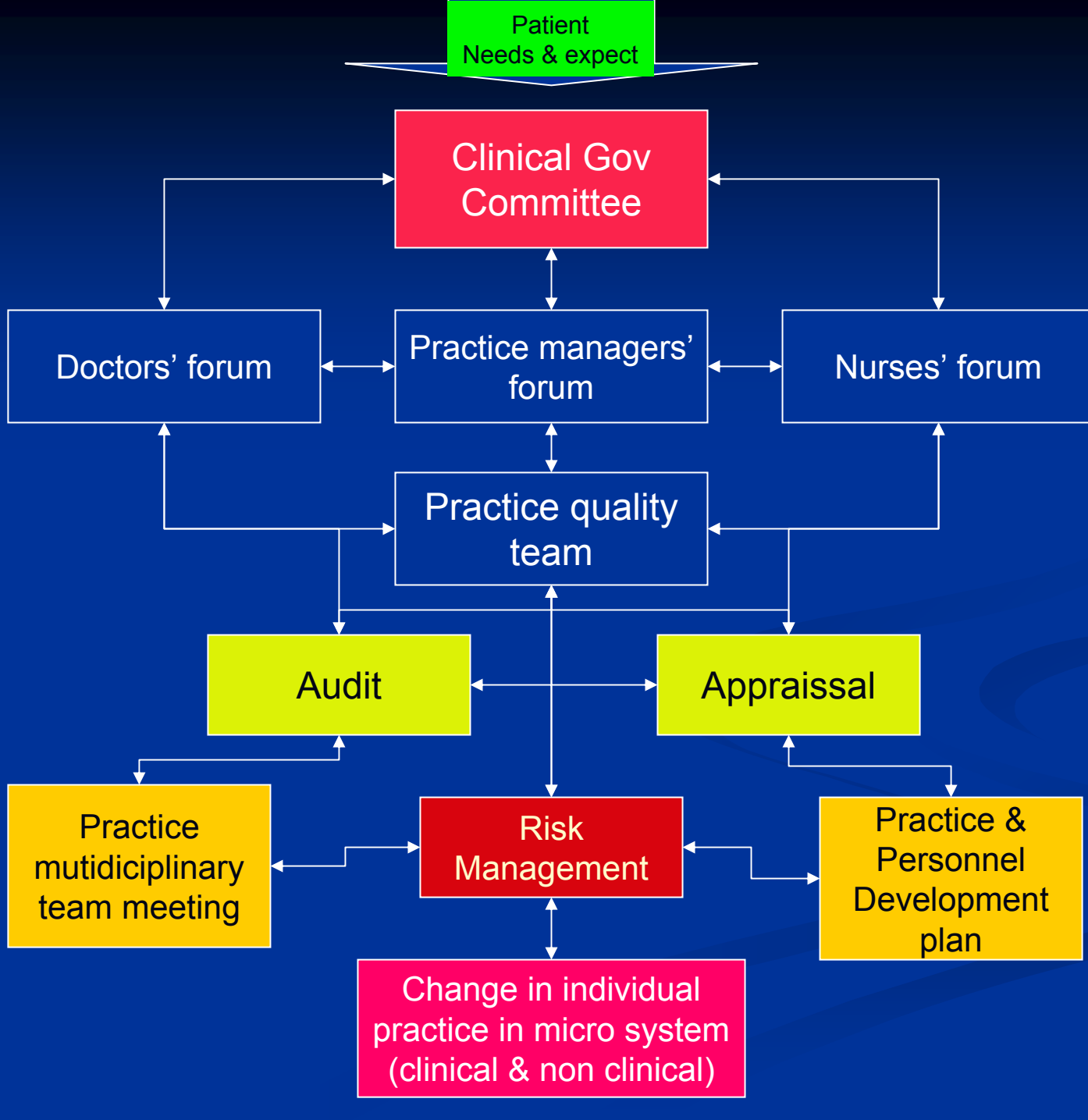
Corrections, Corrective Actions, Preventive Actions

Risk management:

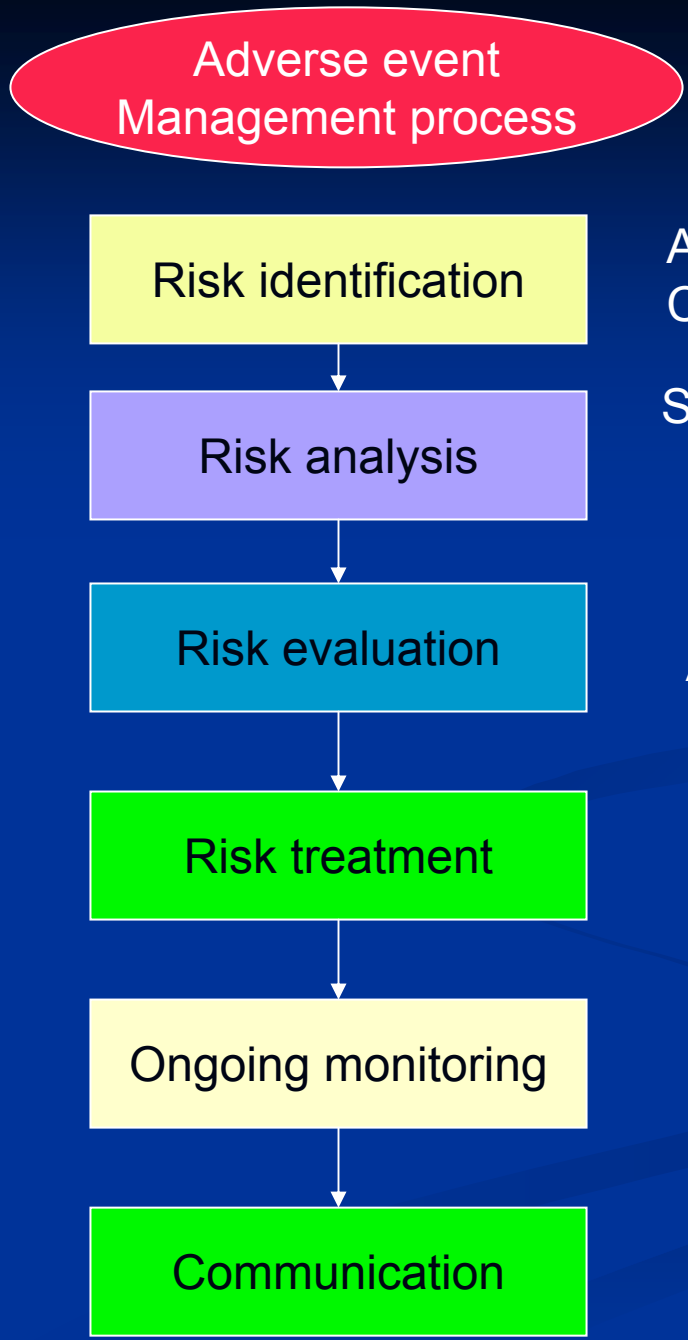
Upaya-upaya yang dilakukan organisasi yang dirancang untuk mencegah cedera pada pasien atau meminimalkan kehilangan finansial sebagai akibat "adverse outcome"

Catatan:
Risiko: kemungkinan bahaya, kehilangan
Atau cedera dalam sistem pelayanan kesehatan


Risk Management
Identifying weakness In systems
Fixing weakness In systems
Preventable harm
Safety


Patient
Needs & expect
Clinical Gov Committee
Doctors' forum
Practice managers' forum
Nurses' forum
Practice quality team
Audit
Appraissal
Practice mutidiciplinary team meeting
Risk Management
Practice & Personnel Development plan
Change in individual practice in micro system (clinical & non clinical)

Risk management process



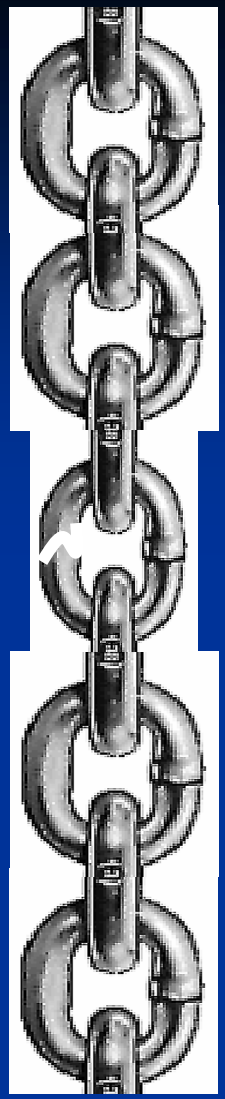
Sumber:
Hunter area health service
Clinical Governance Unit (August, 2003)

Rantai efek perbaikan mutu Donald Berwick

Sumber:

Berwick, D.M., Big issues in the next ten years of Improvement, Academy fro Health Service Research and Health Policy Annual Meeting, Washington DC, June 24, 2002

Berwick, D.M., A user's Manual For The IOM's 'Qaulity Chasm' Report, Health Affairs, Vol 21, No 3, May/June 2002



Patient experience: patient safety

Corections
Corrective Actions
Preventive Actions

Patient care micro system

Corrective actions
Preventive Actions
Support
Risk management

Organizational Context

Risk management
Supports
Policy
Public awareness
& involvement

Environmental context

Rantai efek dalam perbaikan mutu pelayanan (Donald Berwick)

Klien dan masyarakat	**Pengalaman**	**Tujuan (misal: aman, efektif, cocok, Nyaman, terjangkau, ada jaminan)**
↕		
Sistem mikro pelayanan	**Proses**	**Aturan main, disain yang sesuai (sistem atau prosedur yang nyaman, sesuai)**
↕		
Konteks organisasi	**Fasilitator Proses**	**Disain organisasi yang sesuai (misal: kebijakan SDM, insntif, kesempatan berkarir, dsb)**
↕		
Konteks Lingkungan	**Fasilitator dari Fasilitator**	**Lingkungan yang mendukung/tidak Mendukung (sistem pembiayaan kesehatan, regulasi, perda)**

Terimakasih
Selamat mengikuti Seminar