Patient Safety in Medicine

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Safety
First

Patient Safety Background

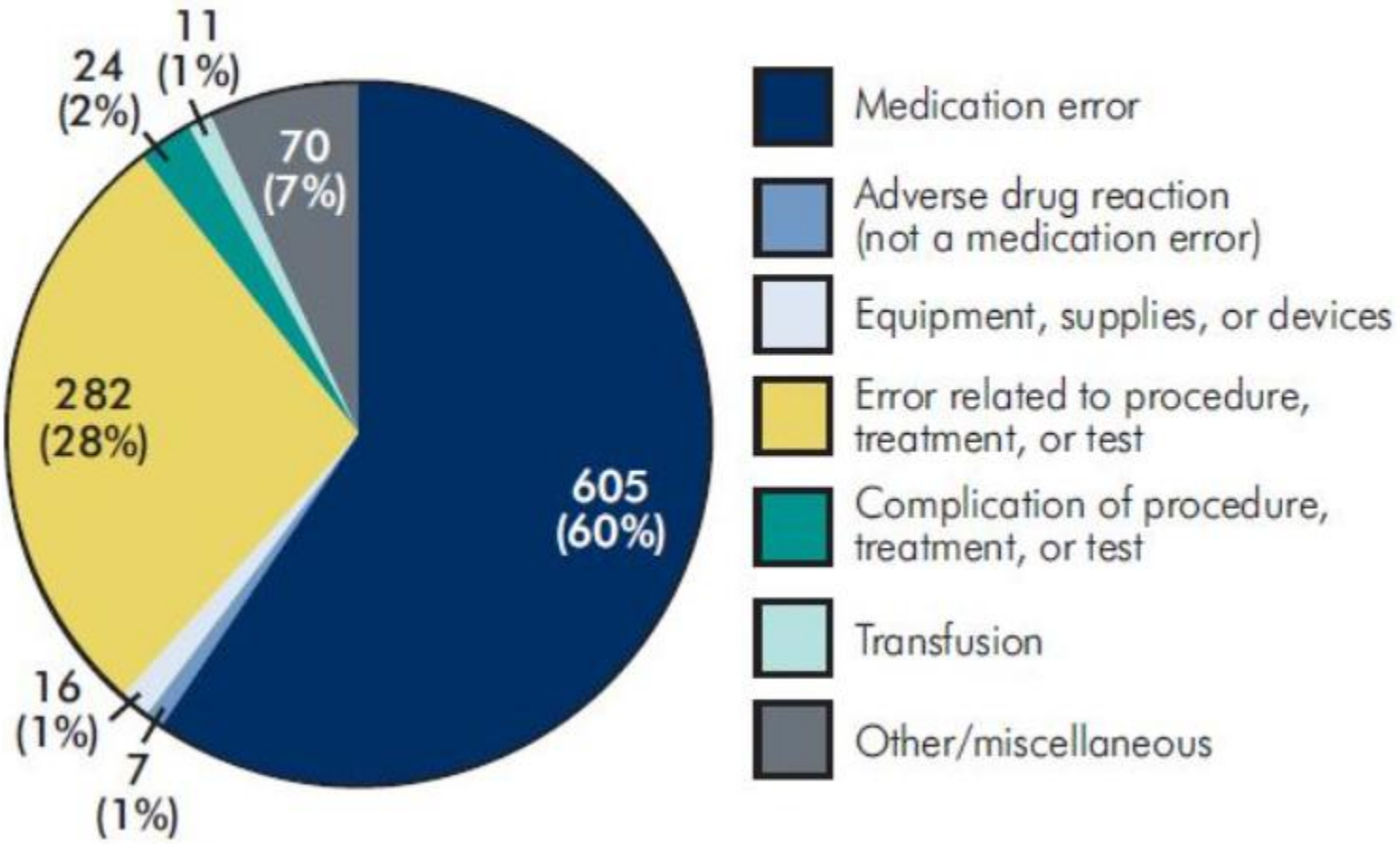
- 44,000 to 98,000 Americans die each year because of errors
- 80% of errors are system derived
- Errors of commission 3 in 1000 = 0.3%
- Errors of omission 10 in 1000 = 1.0%
- Errors are under-reported

Patient Safety
What can go wrong?

- Missed and delayed diagnoses
- Treatment errors
- Medication errors
- Delayed reporting of results
- Miscommunication during transfers and transition of care
- Inadequate post-operative care
- Mistaken identity

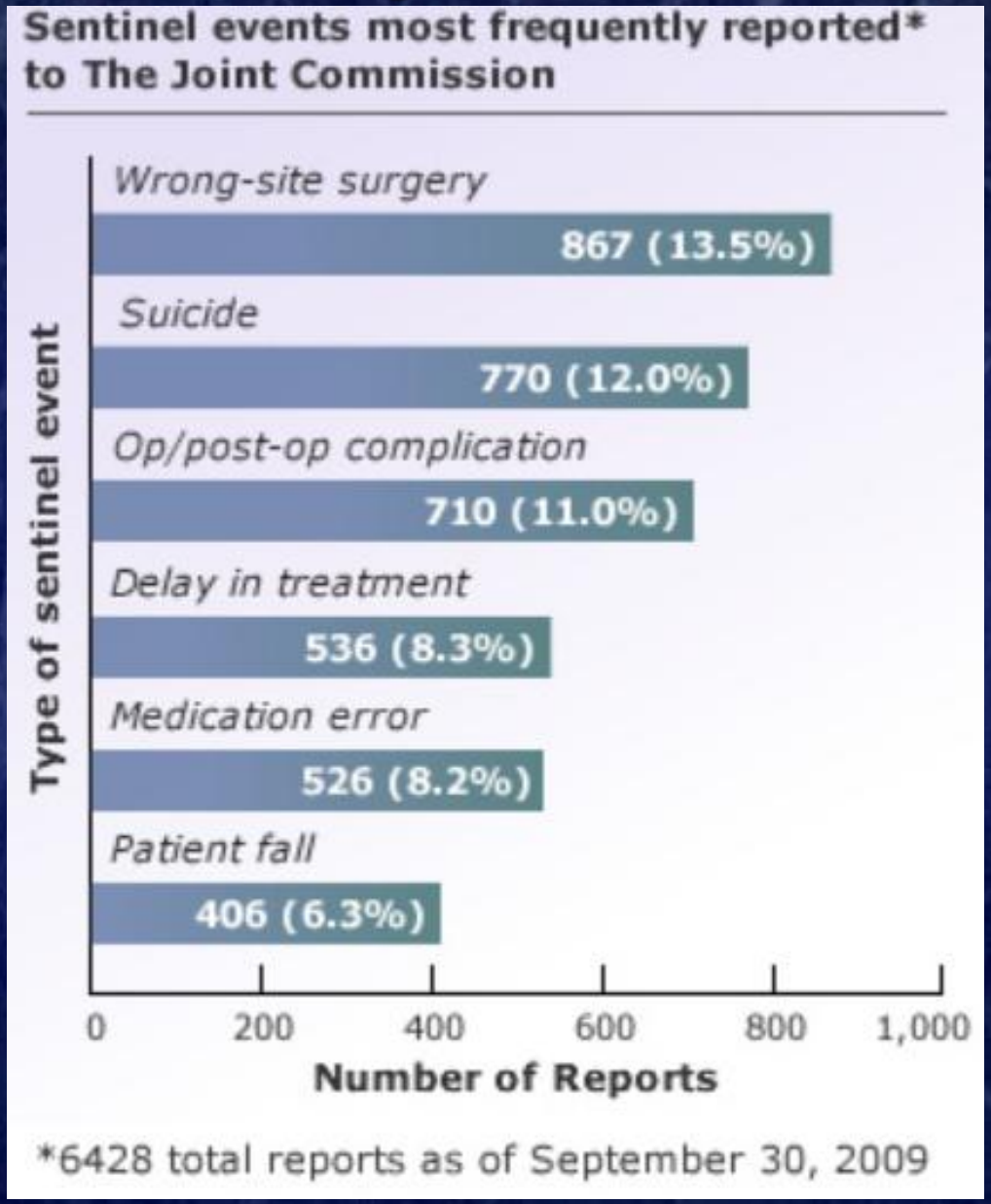
Patient Safety
Type of Errors

Figure. Event Reports to the Pennsylvania Patient Safety Authority Attributed to Distraction, by Event Type, 2010 through 2011



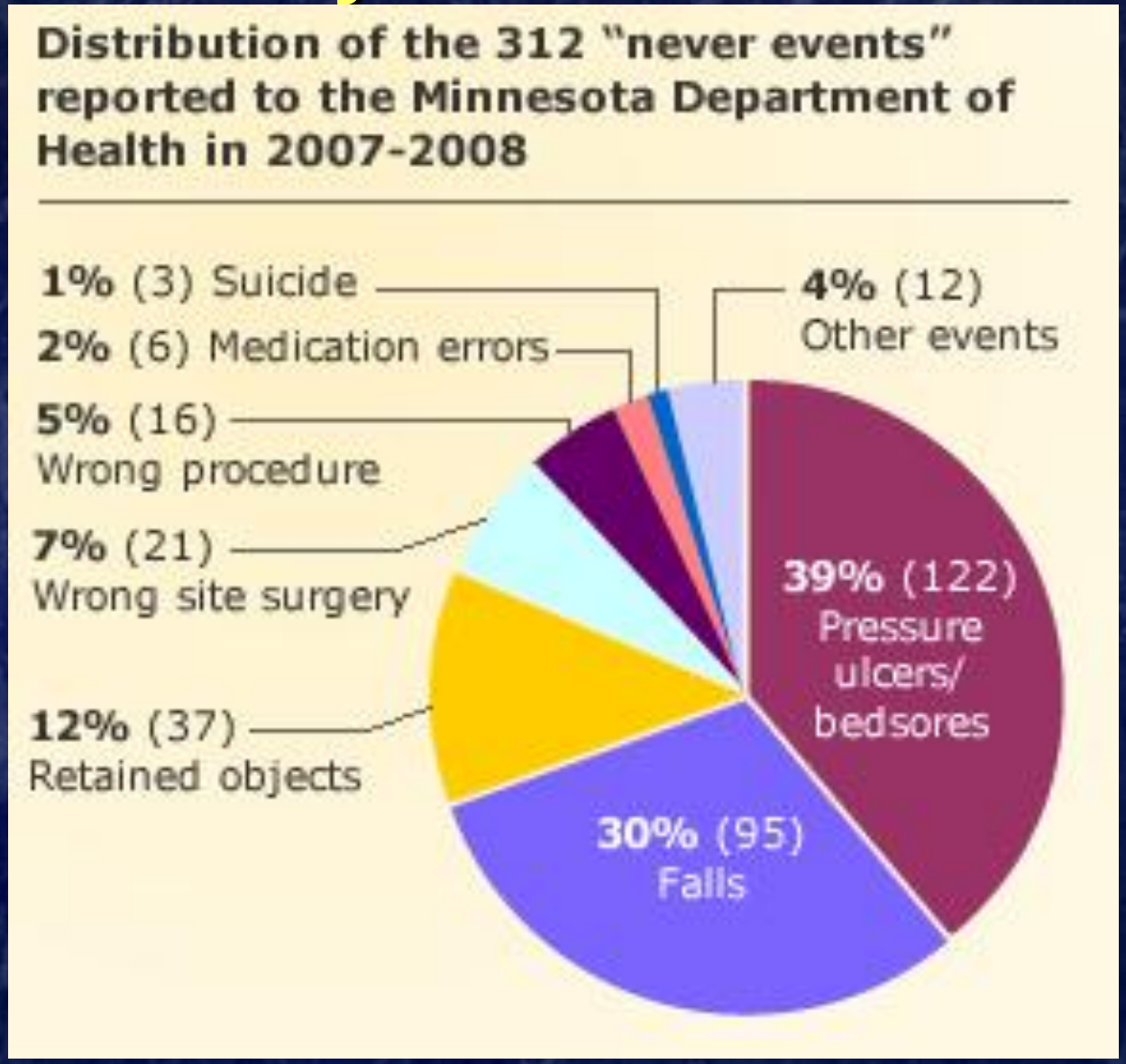
Feil, M:Patient Saf Advis 2013 Mar;10(1):1-10

Patient Safety - ‘Never”-Events



Sentinel Event Statistics. Sept. 30, 2009. JC Web site, acc. Nov. 2013

Patient Safety – 'Never' Events in MN



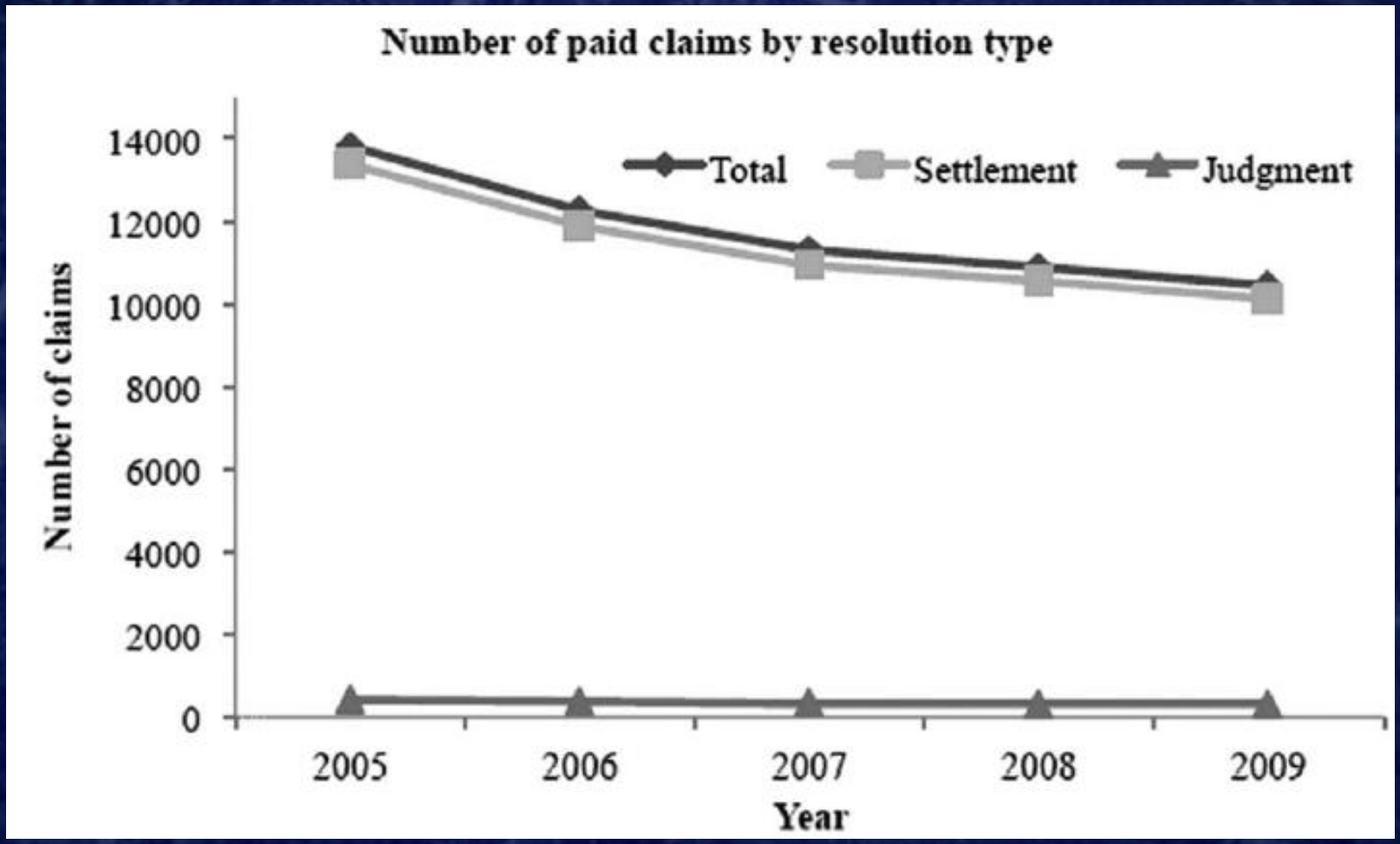
MAYO CLINIC

Adverse Health Events in Minnesota. 5th Annual Public Report. St. Paul, MN: Minnesota Department of Health; January 2009. Available at: http://www.health.state.mn.us/patientsafety/publications/

Patient Safety
The Cost of Medical Errors

- Institute of Medicine estimate $17,000,000,000 – 29,000,000,000/year
- Adverse drug events increase LOS by 4.6 days @ $4,685/day; 6.5 events per 100 admissions, 28% preventable
- NBS infection leads to ~7 days of LOS @ $3,700 - $29,000 per event
- Low nursing turn-over (6.3%) leads to $45,000-$68,000 savings/nurse/year

Patient Safety Settlements



MAYO CLINIC

Rubin JB, Bishop TF. BMJ 2013;3:e002985. doi:10.1136

Patient Safety Conundrum

The Probability of Success

Number of Steps	0.95	0.990	0.999	0.999999
1	0.95	0.990	0.999	0.9999
25	0.28	0.78	0.98	0.998
50	0.08	0.61	0.95	0.995
100	0.006	0.37	0.90	0.990

Filling a prescription ~ 40-60 steps

Botwinick L, et al: Leadership Guide to Patient Safety. IHI Innovation Series; Cambridge, MA: 2006.

The Right Question to Ask

What Happened?

Patient Safety
From Blame to Reliability Concept

- Patients undergoing the intended tests
- Patients receiving the intended medication
- Patient receiving the appropriate and desired information
- Patients undergoing the procedures at the appropriate time AND in accordance with their value and preference

Patient Safety Institutional Initiatives I

- Address strategic priorities, culture and infrastructure
- Engage key stakeholders
- Communicate and build awareness
- Establish, oversee, and communicate system-level aims
- Track/measure performance over time, fine-tune analysis

Patient Safety Institutional Initiatives II

- Support staff and patients /families impacted by medical errors
- Align system-wide activities and incentives
- Redesign systems and improve reliability
- Perform these steps in regular intervals!

Patient Safety
Safeguarding Against Errors

- Analyze processes on regular basis in a culture of learning, not blaming
- Minimize number of steps = simplify!
- Build in checkpoints
- Engage the patient in the health care process, encourage questions

Patient Safety Summary

- Adverse events are rarely intentional
- Errors are more common than anticipated
- Errors of omission occur 3x more often than errors of commission
- Medical errors are costly, not just from the human aspect
- Errors are nearly always system related

Patient Safety Conclusion

- Create a professional environment of psychological stability
- Avoid the ‘blame-game’, instead create an inquisitive state of mind
- Analyze processes regularly, recognize high risk areas
- Involve leadership at highest level
- Make safety a high priority
- Simplify, simplify, simplify, simplify!

Terima kasih untuk kehadiran dan perhatian Anda!