Patient safety incidents- Reporting- Learning - Safety Culture

OTCHI, Elom Hillary | PhD, MPH, MA(Org. Devt)

ISQua/Lucian Leape Fellow
Consultant/Expert- Health Systems, Quality, Patient Safety & Organizational Devt
Technical Director- AfIHQSA

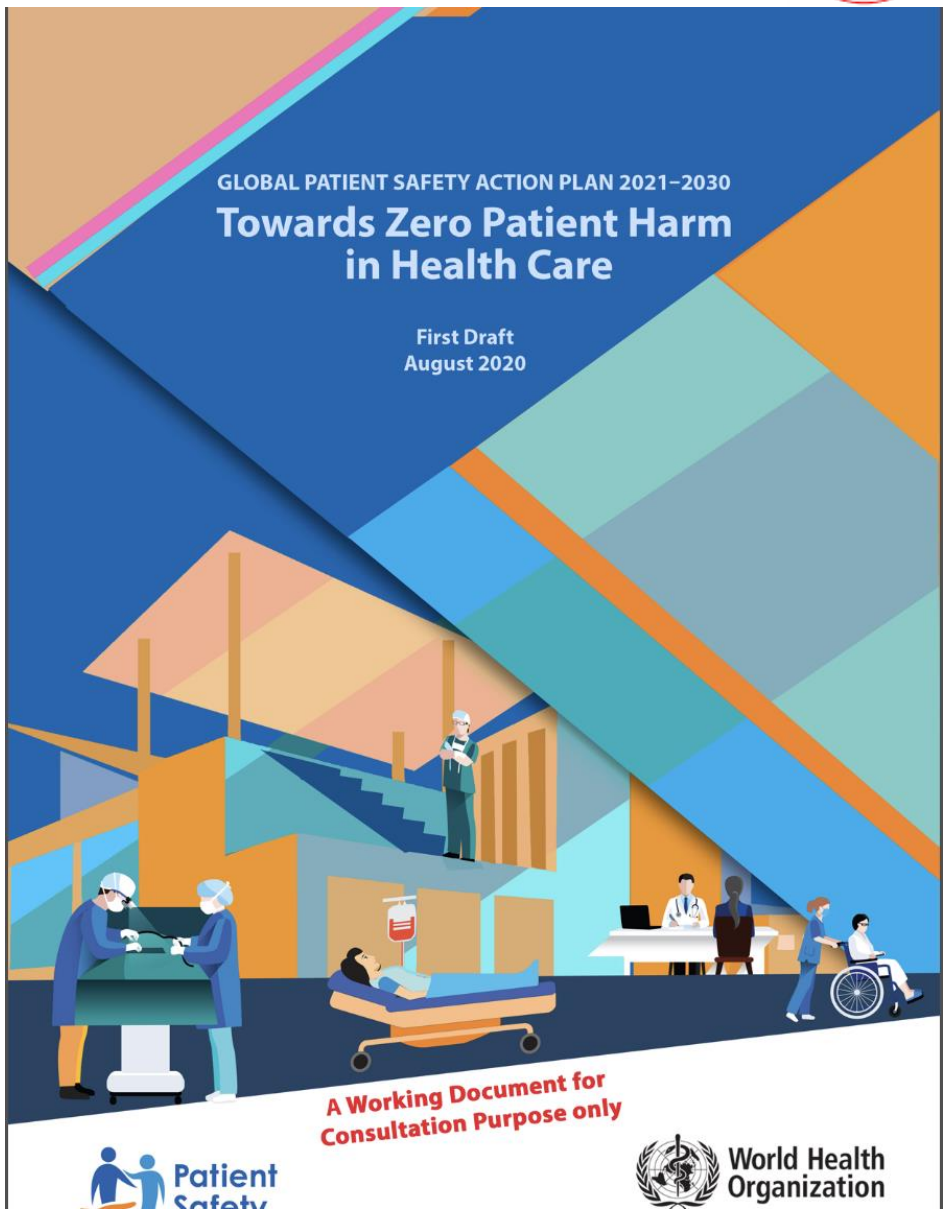
Outline

1. The place of patient safety in the whole quality discussion
2. What is Patient safety?
3. What is the global burden of patient safety?
4. What are some of the common AEs that may result in avoidable harm?
5. What is incident reporting, learning & safety culture?
6. My 10 commandments of Patient safety
7. Way forward
8. Conclusion
9. Q&A

Where does Patient safety fit in the whole quality discussion?

What is Patient safety?

- “It is a framework of organized activities that creates cultures, processes, procedures, behaviours, technologies, and environment in healthcare that consistently and sustainably: lower risks, reduce the occurrence of avoidable harm, make errors less likely and reduce its impact”

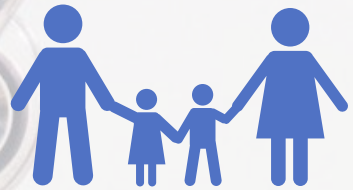


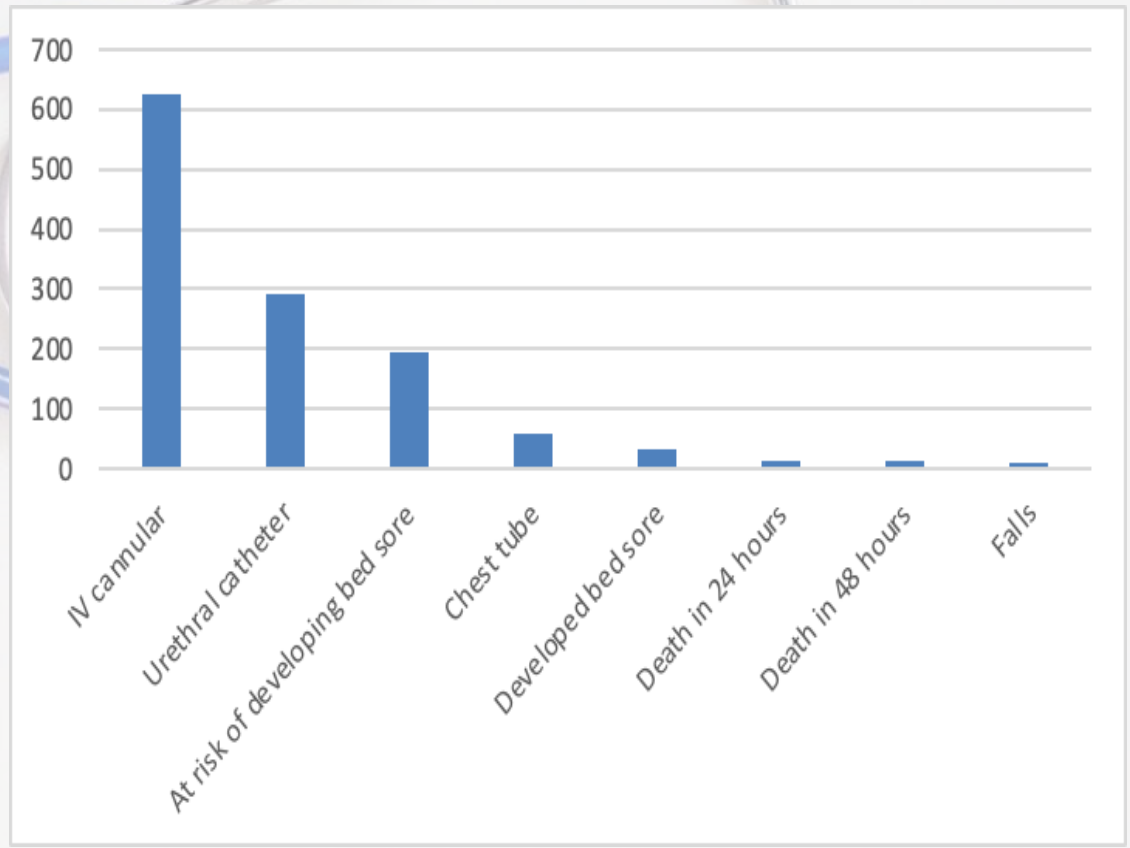
Global burden of unsafe care

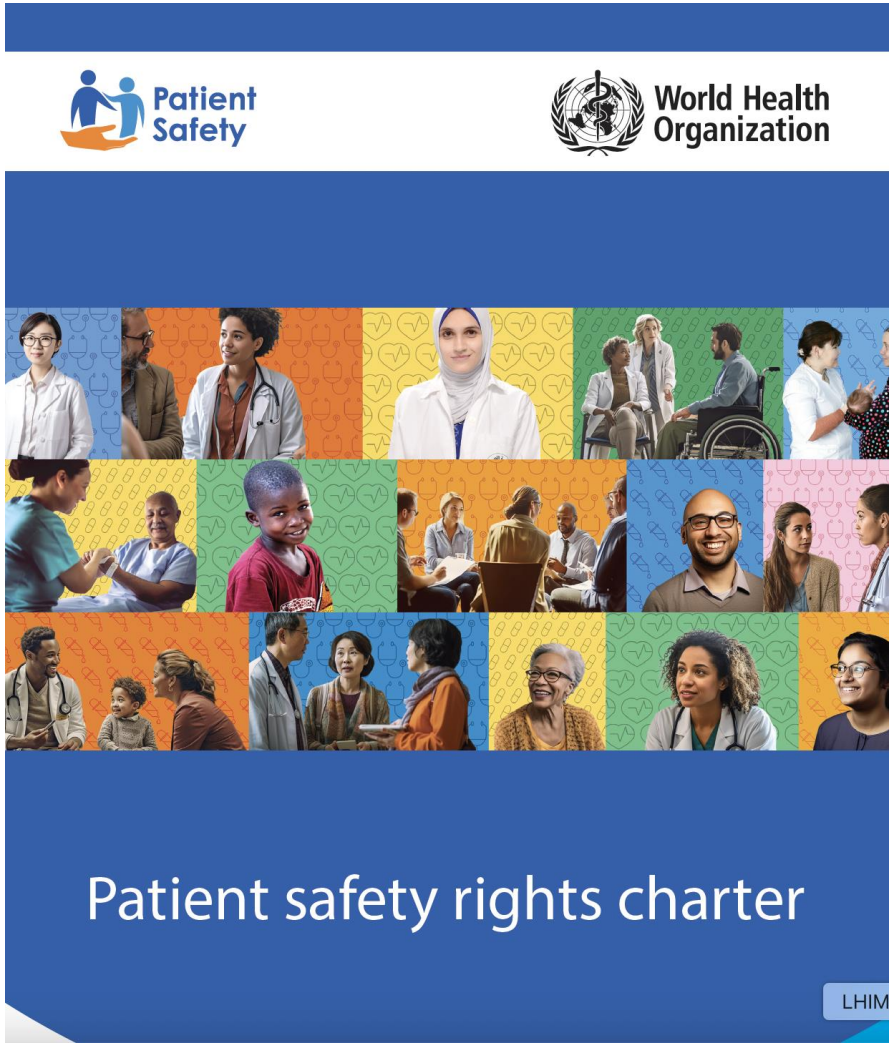
- 1 in 10 patients is harmed in healthcare(1, 4, 11)
  - 4 in 10 patients die from unsafe care in LMICs(1, 4)
- 3 million deaths occur annually due to unsafe care (2)
- 10% of AEs is reported in surgical settings
- Of all sepsis cases managed in hospitals, 23.6% were found to be health care associated, and approximately 24.4% of affected patients lost their lives as a result (1, 10).
- Diagnostic errors occurs in 5-20% of doctor-patient encounters (1,8)
- 134 million AEs in hospitals due to unsafe care contributing 2.6 million deaths in LMICs (1, 4, 8)
- 15% of hospital expenditure is attributed to safety failure
  - NHS in 2017 paid about 1.63 billion pounds sterling as cost of litigation because of safety lapses (1, 4, 8)
- Costs USD1.4 trillion to 1.6 trillion lost in productivity annually (1, 4, 8)
- 50-80% of AEs is preventable (1, 2, 9, 11)

What are some of the common AEs that may result in avoidable harm…

1. Diagnostic errors
2. Unsafe surgical procedures
3. Healthcare associated infections
4. Medication errors
5. Unsafe blood transfusion
6. Patient misidentification
7. Patient falls
8. Pressure ulcers





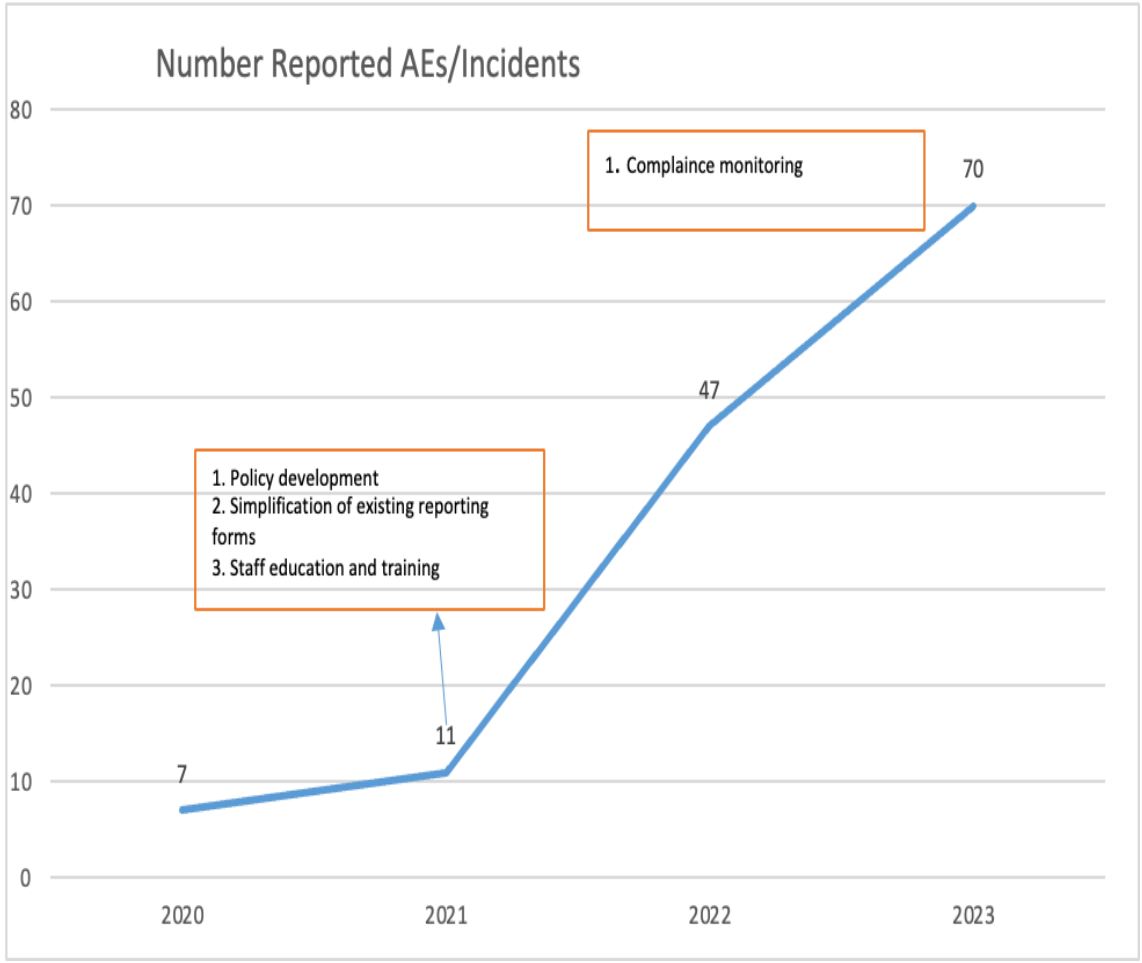


Patient safety represents

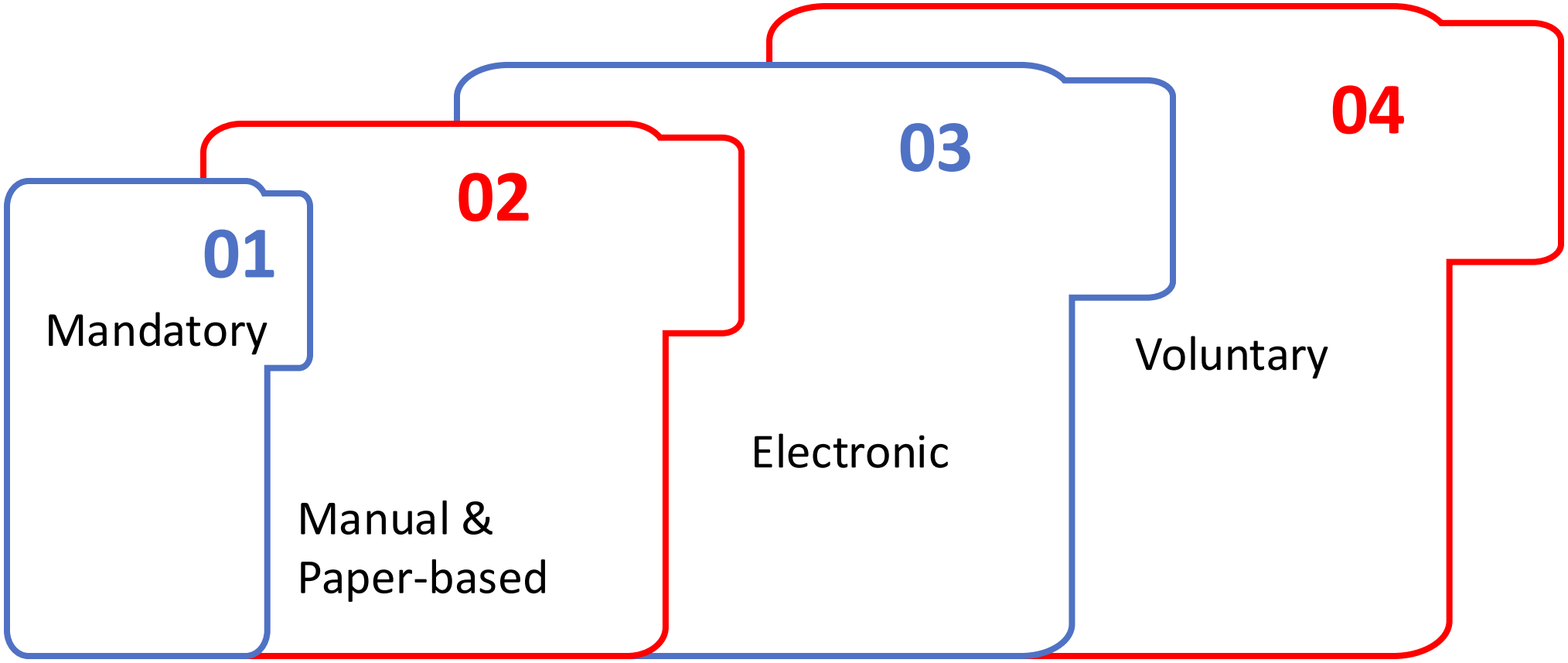
‘a tangible manifestation of realizing health-related human rights and is a litmus test of the global commitment towards respecting, protecting and fulfilling those rights’ (WHO)

What is PS incident reporting?

- the process by which healthcare providers and patients document and report incidents or events that have the potential to cause harm, or have caused harm, to patients via patient safety reporting systems
- *Reporting should be*:
  - timely
  - accurate
  - comprehensive

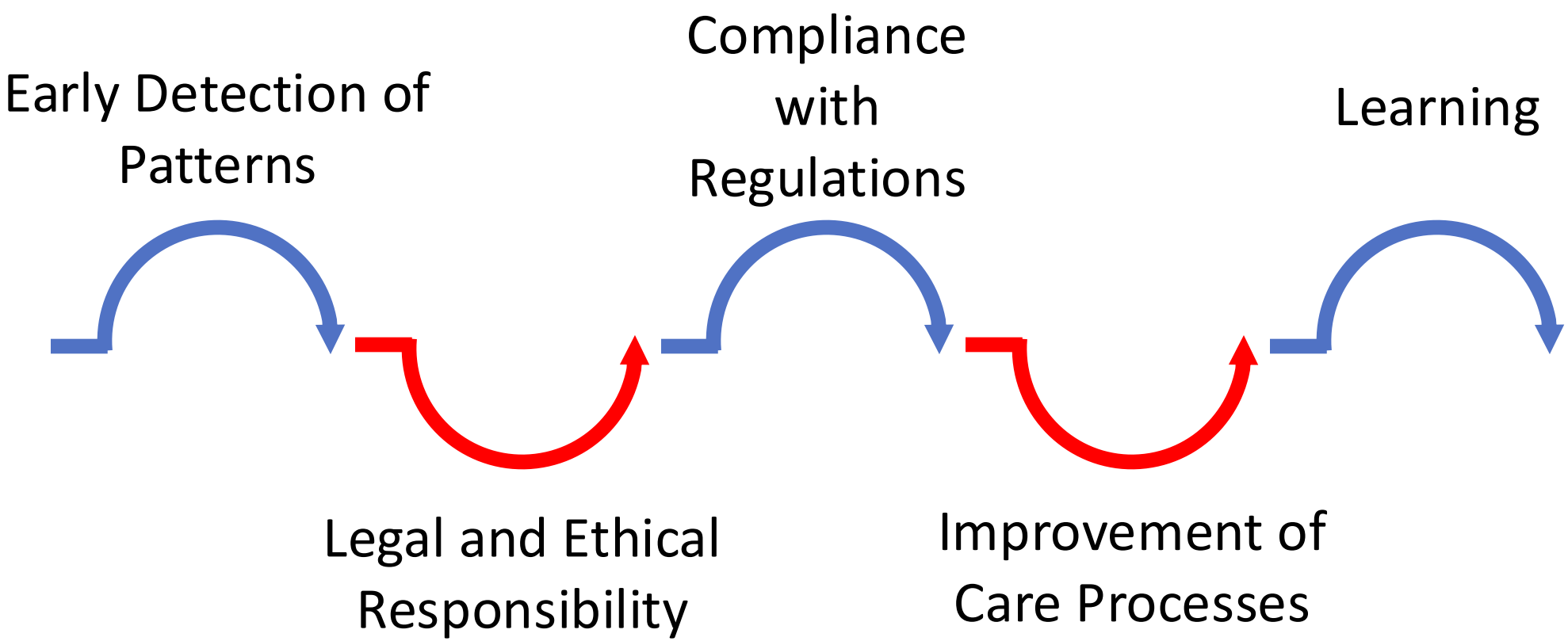


What are the approaches to incident reporting?



What type of reporting system do you have in your facility?

How important is incident reporting?



What are the challenges with incident reporting?

- Absence of reporting systems
- Underreporting
- Time constraints
- Lack of standardization
- Fear of the objective use of the data
- Lack of/inadequate resources

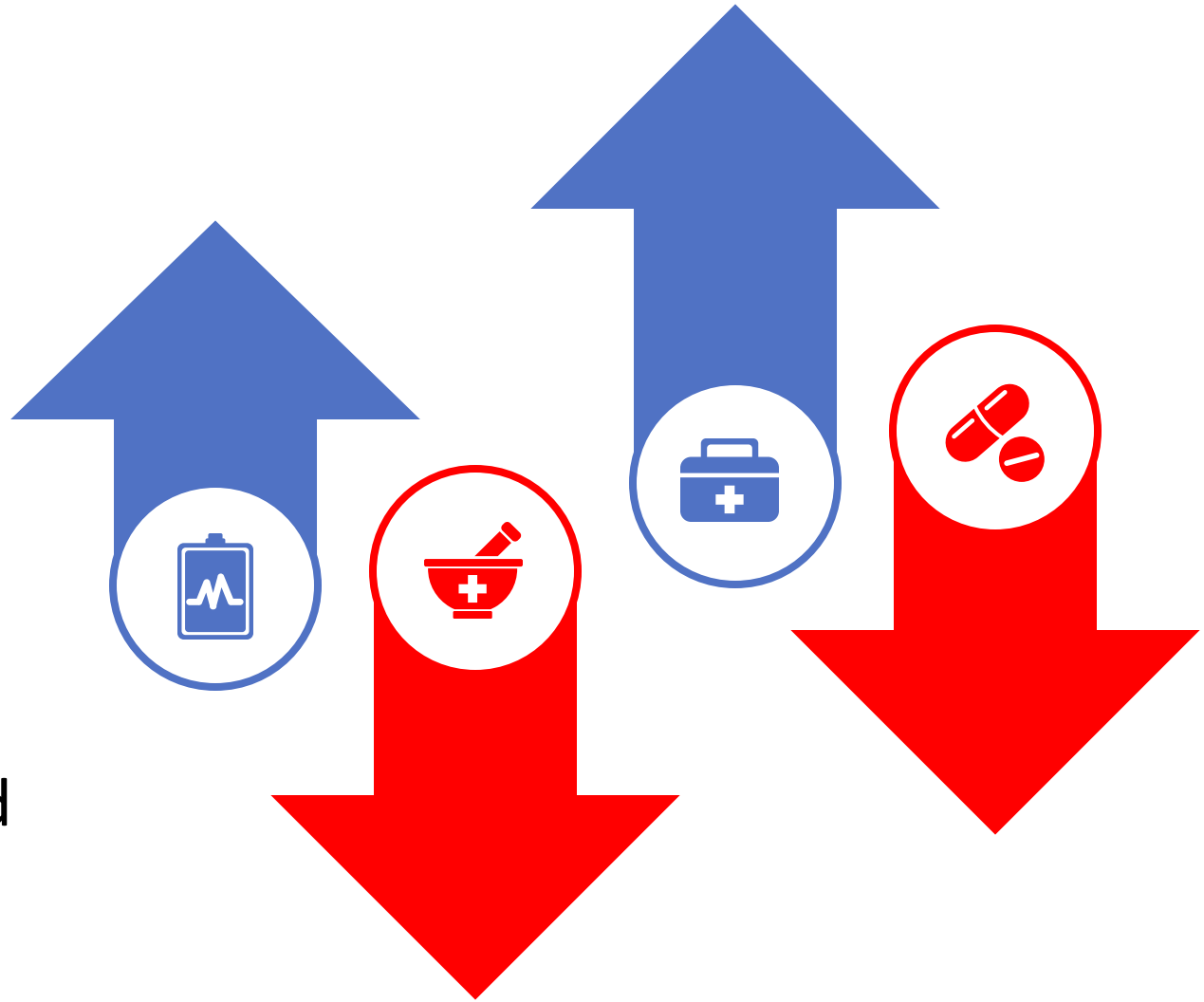
What is PS Learning?

- the processes and practices that healthcare organizations use to analyze reported incidents, identify underlying causes, and implement strategies to prevent future occurrences.
- This typically involves:
  - root cause analysis (RCA)
  - failure mode and effects analysis (FMEA)
  - and other problem-solving methods.

How important is PS Learning?

Continuous Improvement

Accountability



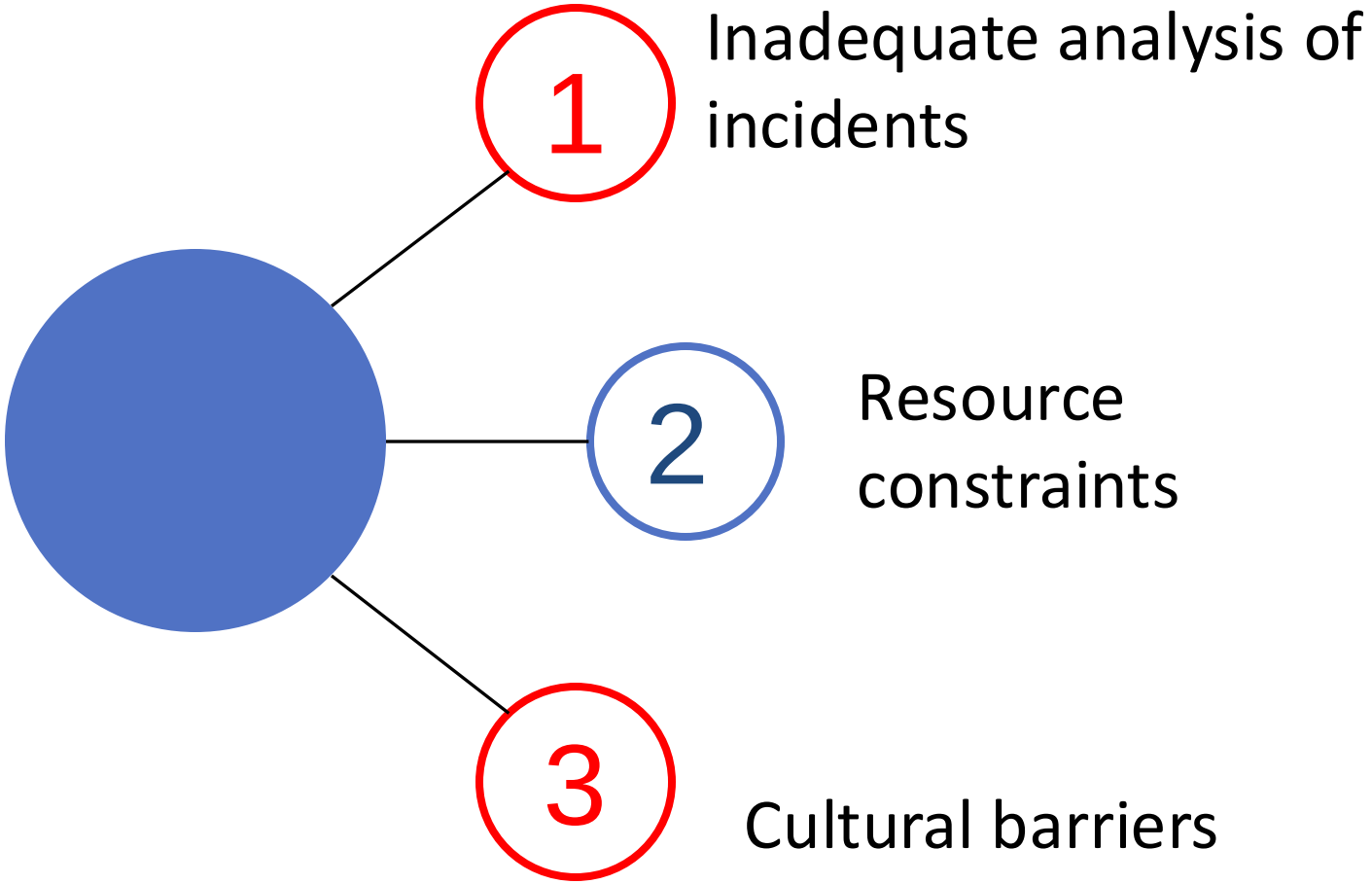
Evidence-Based Practice

Trust Satisfaction

What are the key strategies to Learning?

1. Root Cause Analysis (RCA)
2. Failure Mode and Effects Analysis (FMEA)
3. Regular training and simulation
4. Any others--- drop them in the chart???

What are the challenges to Learning?

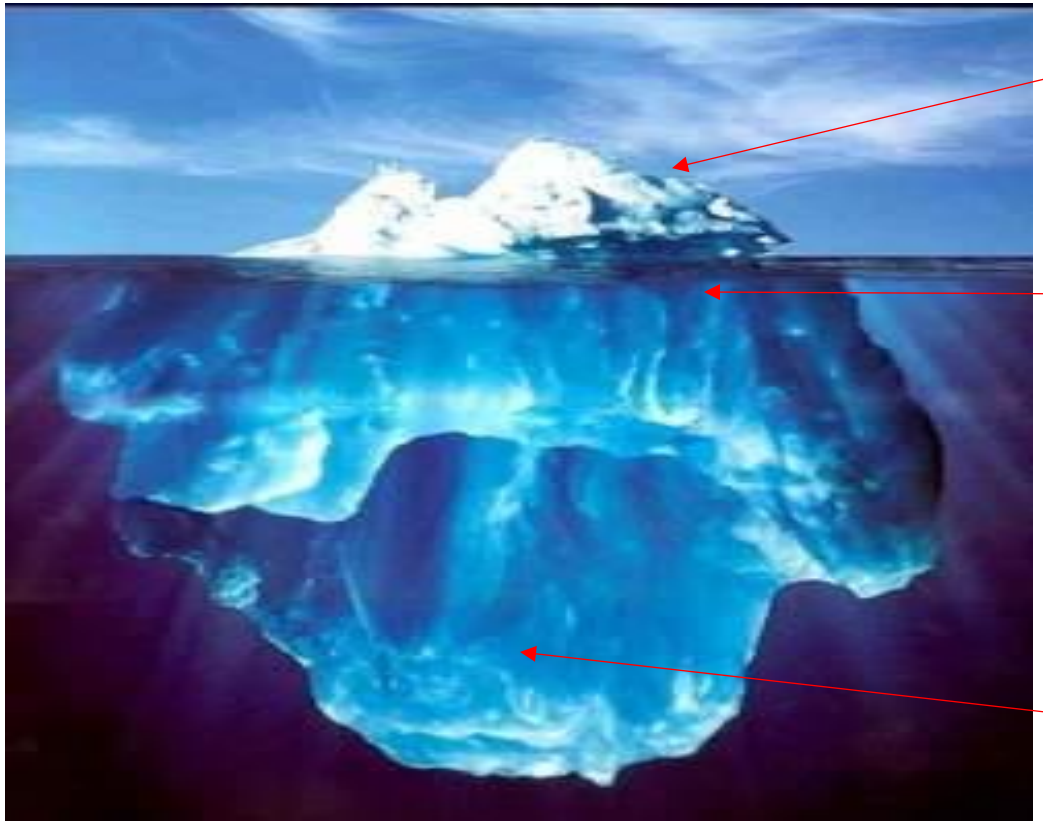


What is Patient Safety Culture?

- the shared values, beliefs, and behaviors within an organization that prioritizes patient safety and fosters a climate of trust, openness, and continuous improvement.

- A strong safety culture supports the reporting of incidents, encourages learning, and ensures that patient safety is consistently prioritized in all aspects of care.

3 levels of organizational culture in healthcare

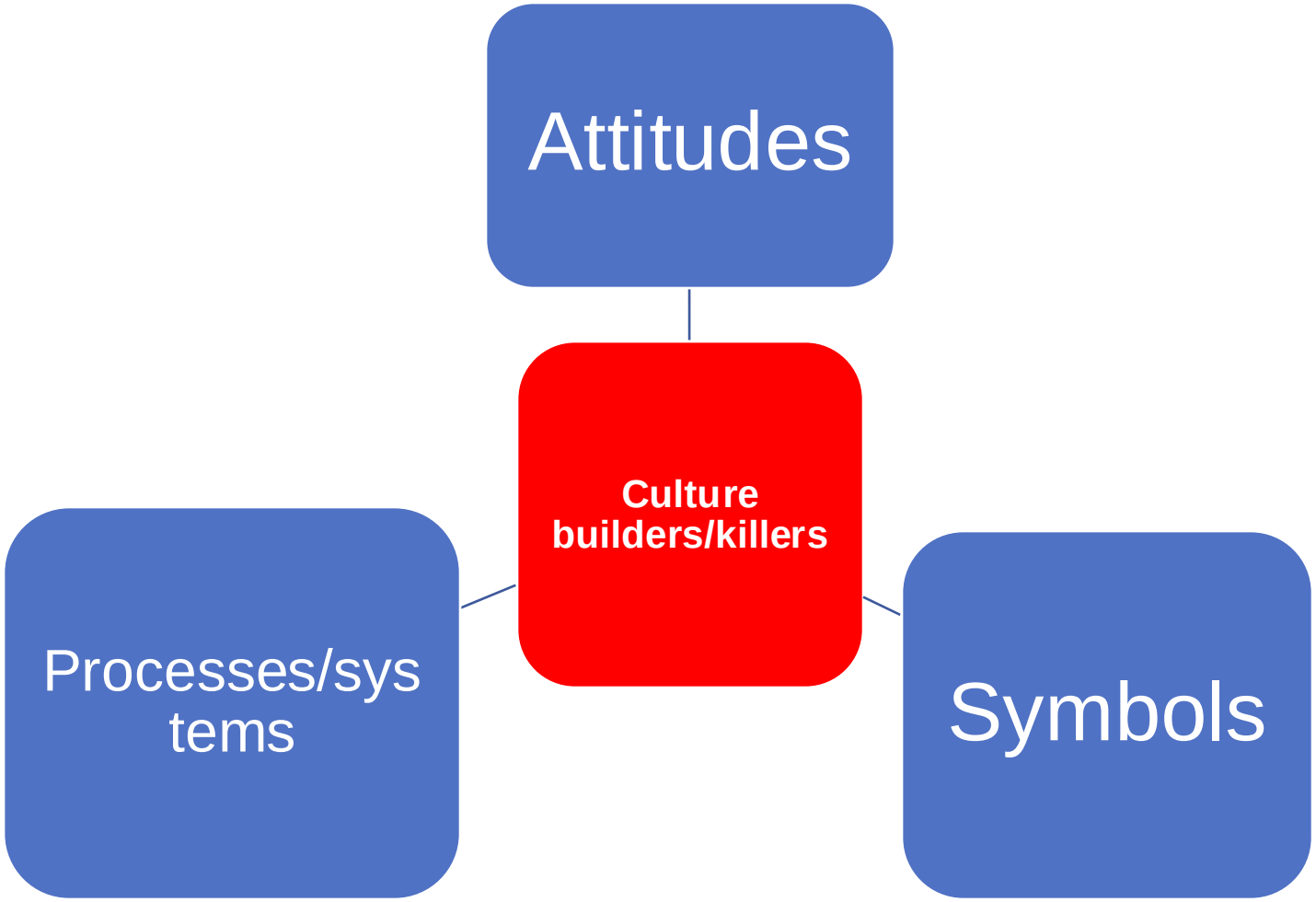


Visible manifestations

Shared ways of thinking used as justification for artefacts

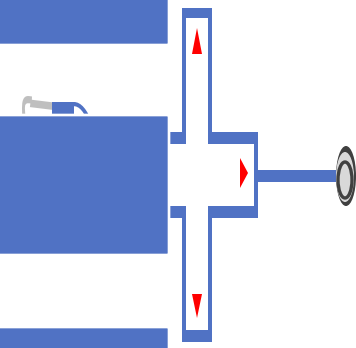
Deeper shared assumptions (unspoken, unconscious & unexamined)

Three (3) things that build or kill an org. culture



What are the Key characteristics of a Patient Safety Culture:

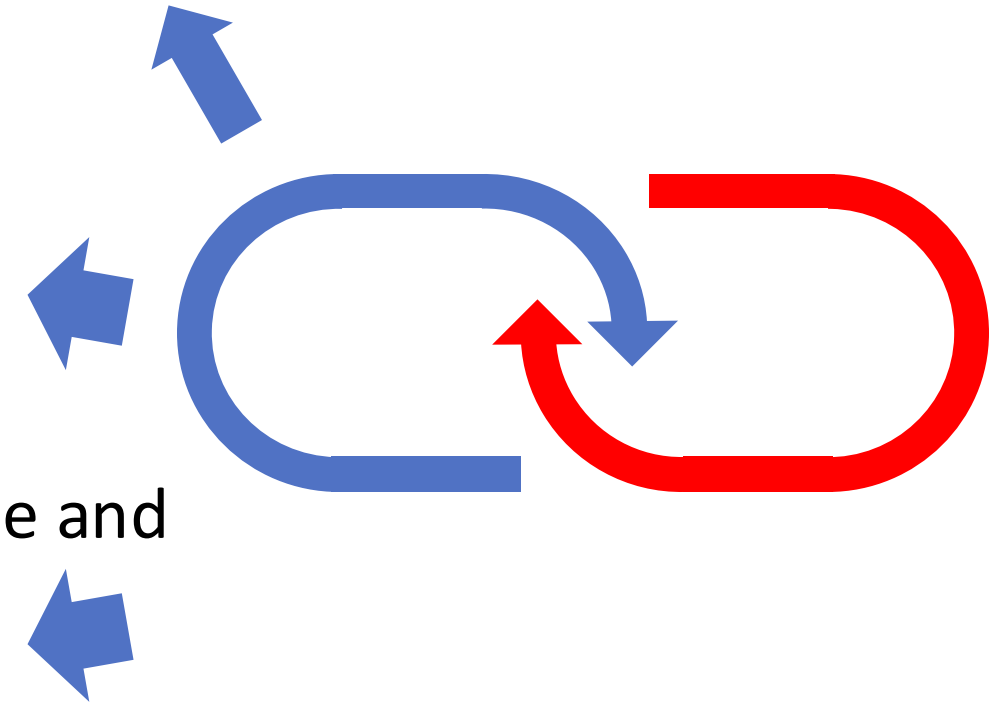
- Open communication
- Leadership commitment
- Teamwork and collaboration
- Patient-centered approach



What are the Benefits of a Positive Patient Safety Culture in -

Improved Reporting

Enhanced Patient Outcomes



Better Staff Morale and Retention

What are the challenges to creating a Patient Safety Culture in Healthcare

What are some of the key barriers to establishing a PS Culture?

My 10 Commandments of Patient Safety 1/2…

1. Thou shalt be authentic and genuine other than being fake, false and deceptive.
2. Thou shalt show compassion and care other than cruelty, disregard, recklessness and lack of attention!
3. Thou shalt collaborate and work together rather than competing and undermining one another
4. Thou shalt be inclined to Emotional Intelligence (EQ) than Intelligent Quotient (IQ)
5. Thou shalt integrate, cordinate

https://isqua.org/world-patient-safety-day-blogs/ten-10-commandments-of-quality-patient-safety.html

My 10 Commandments of Patient Safety…

6 Thou shalt confront and speak up

7 Thou shalt be expressive of your feelings other than bottling up

8 Thou shalt embrace continual learning other than blaming and shaming

9 Thou shalt embed human factors and ergonomics!

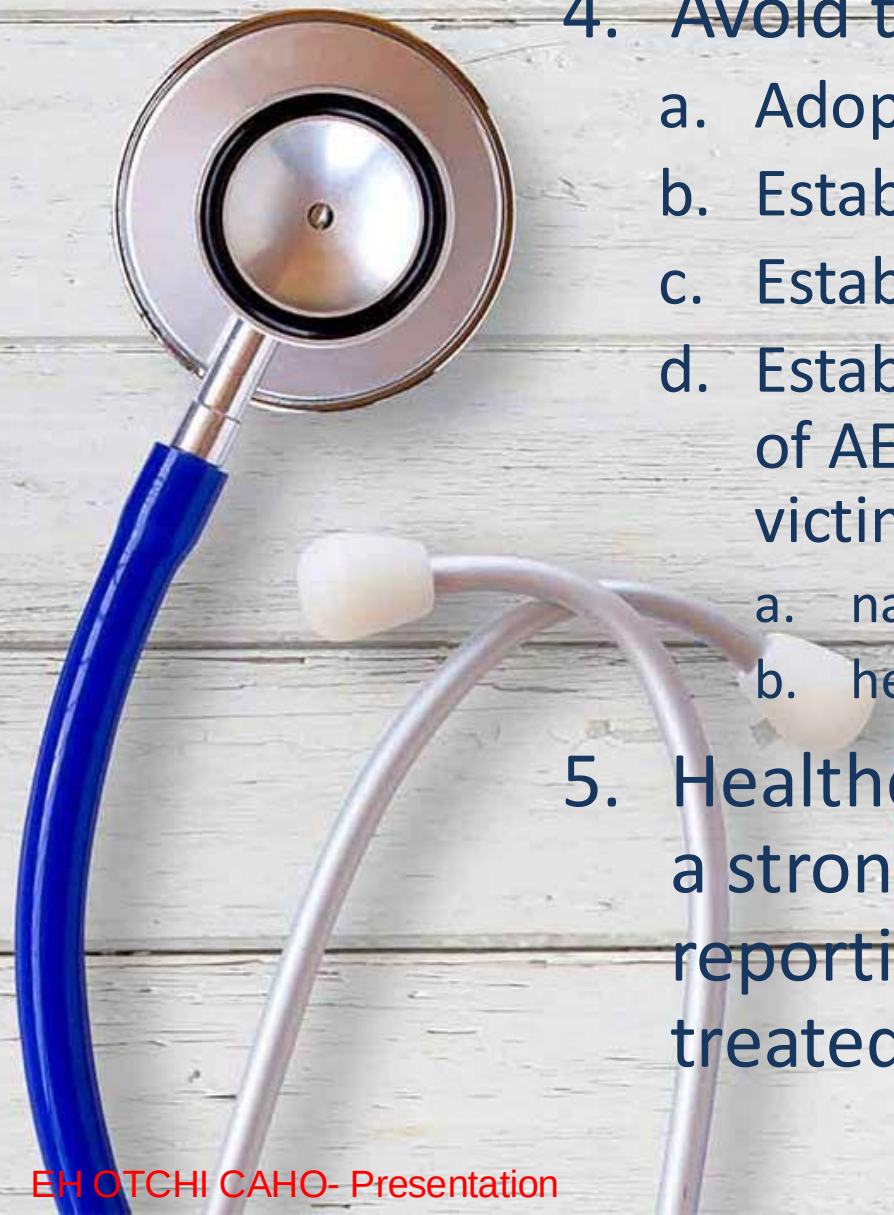
10 Thou shalt love.

Way forward 1/2

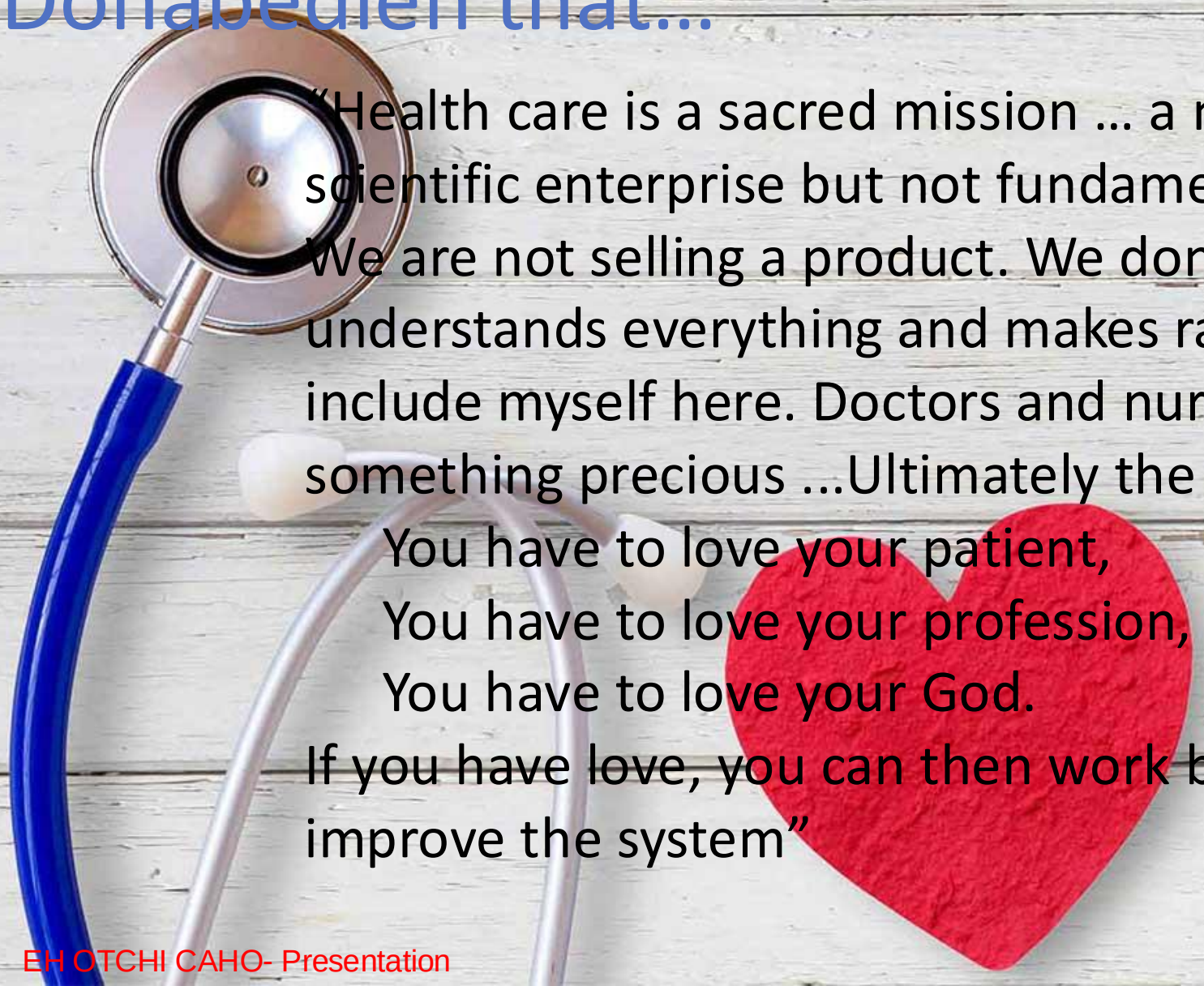
1. Healthcare systems should be humble to admit that things do not always go well as expected
   a. Errors are inevitable
   b. "… to err is human…"
2. Establish robust reporting system allows healthcare organizations to identify risks and learn from mistakes.
3. Integrate patient safety into national health policies

Way forward 2/2

4. Avoid the present legal and adversarial system
   a. Adopt a QI approach
   b. Establish quality management units
   c. Establish ethico-legal departments
   d. Establish a dedicated funding to compensate victims of AEs including providers who become second victims in:
      a. national health budgets
      b. health facility budgets
5. Healthcare organizations must prioritize building a strong safety culture, encourage incident reporting, and ensure that every incident is treated as an opportunity to learn and improve.



Finally… let us always remember this reflection by Donabedien that…



"Health care is a sacred mission … a moral enterprise and a scientific enterprise but not fundamentally a commercial one. We are not selling a product. We don't have a consumer who understands everything and makes rational choices — and I include myself here. Doctors and nurses are stewards of something precious …Ultimately the secret of quality is love:

You have to love your patient,
You have to love your profession,
You have to love your God.

If you have love, you can then work backwards to monitor and improve the system"

Reference

1. WHO (2023). Patient Safety Key Facts. Accessed at: https://www.who.int/news-room/fact-sheets/detail/patient-safety
2. WHO (2021). Global Patient Safety Action Plan (2021-2030).
3. WHO (2024). Global Patient safety report. Available at: https://www.who.int/publications/i/item/9789240095458
4. Slawomirski L, Klazinga N. The economics of patient safety: from analysis to action (2020). Paris: Organisation for Economic Co-operation and Development (http://www.oecd.org/health/health-systems/Economics-of-Patient-Safety-October-2020.pdf).
5. Panagioti M, Khan K, Keers RN, Abuzour A, Phipps D, Kontopantelis E et al. Prevalence, severity, and nature of preventable patient harm across medical care settings: systematic review and meta-analysis (2019). BMJ. 366:l4185. doi:10.1136/bmj.l4185.
6. National Academies of Sciences, Engineering, and Medicine. Improving diagnosis in health care (2015). Washington (DC): National Academies Press (https://doi.org/10.7326/M15-2256).
7. Bergl PA, Nanchal RS, Singh H. Diagnostic error in the critically ill: defining the problem and exploring next steps to advance intensive care unit safety (2018). Ann Am Thorac Soc. 15(8):903–7.
8. Adhikari Neill K J (2013). Patient safety without borders: measuring the global burden of adverse events. BMJ Quality & Safety. 22 (10) https://doi.org/10.1136/bmjqs-2013-002396
9. Hodkinson A, Tyler N, Ashcroft DM, Keers RN, Khan K, Phipps D et al. (2020). Preventable medication harm across health care settings: a systematic review and meta-analysis. BMC Med. 18(1):1–3.
10. Markwart R, Saito H, Harder T, Tomczyk S, Cassini A, Fleischmann-Struzek C et al.(2020;). Epidemiology and burden of sepsis acquired in hospitals and intensive care units: a systematic review and meta-analysis. Intensive Care Med. 46(8):1536–51. doi:10.1007/s00134-020-06106-2.
11. Otchi E-H, Esena RK, Srofenyoh EK, et al. (2019). Types and prevalence of adverse events among obstetric clients hospitalized in a secondary healthcare facility in Ghana. *Journal of Patient Safety and Risk Management*. 24(6):238-244. doi:10.1177/2516043519881524

Thank you

Feel free to get in touch at:
E-mail: elomotchi@gmail.com
WhatsApp: +233244768976