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Patient Safety

Dr. Sangeeta N. Kharde,

Prof. and HOD OBG (N),
KAHER INS, Belagavi

Ms. Asmita Chaudhary

PG, KAHER INS, Belagavi

Introduction:

Patient safety is a discipline that emphasizes safety in health care through the prevention, reduction, reporting, and analysis of medical error that often leads to adverse effects to patients associated with health care. Recognizing that healthcare errors impact 1 in every 10 patients around the world, the World Health Organization calls patient safety an endemic concern. While health care has become more effective it has also become more complex, with greater use of new technologies, medicines and treatments.

What is safety?

- S – Sense the error
- A – Act to prevent it
- F - Follow Safety Guidelines
- E – Enquire into accident/Deaths
- T – Take appropriate remedial measure
- Y – Your Responsibility

Why Safety in the Hospital?

- Hospital is a people intensive place.
- Provide services to sick people round the clock/24 hours daily.

- People have free access to enter any part of hospital any time for advice and treatment.
- The atmosphere of hospital is filled with emotions, excitement, life, happiness, death, sorrow.
- Since hospital operates under continues strain, it gives rise to irritation, confrontation, conflicts and aggression.
- Studies have shown a staggering no. of patients harmed by preventable medical errors, causing serious injury or death.
- Resulting in escalation of health care cost.

10 Basic Principles of Patient Centered Care:

i. All team members are care givers.
ii. Care is based on continuous healing relationship.
iii. Care is customized and reflects on patient Needs, Values and Choices.
iv. Knowledge and information are freely shared between and among patients, care patterns physicians and care-givers.
v. Care is provided in a healing environment of comfort, peace and support.
vi. Family and friends of the patients are considered to be essential part of care team.
vii. Patient safety is visible priority.
viii. Transparency is the RULE in the care of the patient.
ix. All care givers co-operate with each other through common focus and personal goals of patient.
x. Patient is a source of control for his care.

Source: ACHE/NPSF

Patient Safety

- Fundamental Principle of Health Care.
- Recognized as a distinct discipline based on scientific principles.
- Its implementation is an art.

Definitions

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.
Canadian Patient Safety Dictionary, 2003

Adverse Event:
An adverse event is an unintended injury or complication which results in disability, death or prolonged hospital stay, and is caused by health-care management.
Wilson et al

Origin of Patient Safety Concept

- Nurses' Oath
- Hippocratic Oath
    - Improving patient safety means reducing patients harm.
    - Hospitals were funded to give care to those who need it and to keep patient safe is their moral duty.

Constitutes of Patient Safety:

1. Physical Safety:
    a) Infrastructure
    b) Electrical Installation
2. Safety Engineering & support services.
3. Fire Safety.
4. Safe Environment in the hospital.
5. Safety of Clinical Care:
    a) Infection prevention practices.
    b) Medical safety.
    c) Identification and Monitoring of vulnerable and high-risk patients.
    d) Proper identification of surgical sites and checklists.
    e) Monitoring and reporting of adverse events and taking preventive action.

Adverse Events:

- Delayed or missed diagnoses
- Wrong side surgery
- Equipment failure
- Transfusion errors
- Retention of foreign object following surgery
- Intravascular air embolism
- Mislabeled specimen
- Time delay errors
- Medication errors
- Wrong patient surgery
- Patient identity
- Lost, delayed, or failures to follow up reports
- Contamination of drugs, equipment
- Failure to treat neonatal hyperbilirubinemia
- Patient falls
- Laboratory errors

- Radiology errors
- Stage lll or lV pressure ulcers acquired after admission
- Deaths associated with restraints or bedrails
- Procedural error
- Wrong gas delivery
- Sexual or physical assault

Root Causes of Errors

- Failure to follow SOPs
- Poor leadership
- Breakdown in communication or team work
- Overlooking or ignoring individual
- Loosing track of Objectives

Human Factors

- Fatigue
- Interruptions
- Inherent Human Limitations
- Multitasking
- Distractions

Patient Safety: Barriers to Action

- Difficulty recognizing errors
- Lack of information systems to identify errors
- Leadership turnover
- Poor capital investment
- Concern about liability
- Simplistic approach to building the EHR (Electronic Health record)
- Relationship of trust with providers
- Fragmentation of care delivery hampers systems thinking
- Shortage of Professionals
- Jurisdictional conflicts
- Culture of patient safety is lacking

Strategies and Activities

- Adverse Event Reporting
- Root Cause Analysis
- Safer Health care Now!
- Learning System
- National Disclosure Guidelines

Steps taken by Govt. of India

- National Quality Assurance Programme for public and Health facilities
- Infection Management and Environment Plan (IMEP)
- MNH (Maternal and Newborn Health) Toolkit for safe delivery
- Indian Public Health Standards (IPHS)
- Adverse Events Following Immunization (AEFI)

LET US JOIN HANDS FOR "SAFE CARE SAVE LIVES"