Achieving Patient Safety is No More a Wish

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The issue of patient safety is one of the most challenging in healthcare today.
Every year, tens of millions of patients worldwide suffer disabling injuries or death due to unsafe medical care.
10% of hospital patients suffer an adverse event

16.6% of hospital patients suffer an adverse event (Australia)

100,000 hospital deaths/year through medical error (USA)
- **HAI:** 5-10% of hospitalized patients (up to 37% in ICUs)
  - 5 million HAI estimated to occur in Europe/year
  - 100,000 cases of HAI in UK lead to 5,000 deaths a year

- **Medication errors:** 1.5 million harmed in US/year;
  - 67% of patients' medication histories have errors
- **Unsafe Surgery:**
  - 234 m case globally/year: 7 m complications, 1 m death

- **Patient Handovers**
  - 15% of adverse events or errors (USA study)
### Health care systems in the EMRO: Patient Safety Perspective

#### Medical Record Review Study Results

<table>
<thead>
<tr>
<th>Study</th>
<th>Adverse event rate</th>
<th>No. of records</th>
<th>Permanent disability</th>
<th>Percent deaths</th>
<th>Percent AE preventable</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMR</td>
<td>8.1% (2.5-18%)</td>
<td>15,548</td>
<td>0.9%</td>
<td>1.86%</td>
<td>83%</td>
</tr>
<tr>
<td>Australia</td>
<td>16.6%</td>
<td>14,210</td>
<td>2.2%</td>
<td>0.79%</td>
<td>50%</td>
</tr>
<tr>
<td>Canada</td>
<td>7.5%</td>
<td>3,745</td>
<td>0.4%</td>
<td>1.2%</td>
<td>37%</td>
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<tr>
<td>New York</td>
<td>3.7%</td>
<td>30,195</td>
<td>0.24%</td>
<td>0.51%</td>
<td>NA</td>
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</tbody>
</table>

Patient Safe Organization

Patient Safety Model

- Medication Management
- Clinical Safety
- Patient Safety Information
- Environment of Care
- Infection Control

Culture of Safety
Leadership
Challenging areas in Patient Safety

- Creating a Culture of Safety
- Leadership Role
- Medication Management
- Environmental Hazards
- Procedural Complications
- Safety issues in physical design
1. Creating a Culture of Safety

Challenges

• Reporting adverse events
• Analyzing
• Feedback
• Support of staff involved in adverse events
• Communication with patients
• Engagement of patients
• Team work
• Risk assessment
Cultural Barriers

- “Silo” organizational culture
  - Structure inhibits cross organizational change
- Competing professional cultures
  - Physicians and management
- “Culture of Blame”
  - Prevents adverse event reporting
  - Prevents addressing system issues
Tips for Creating a Culture of Safety
Explain to staff the culture of safety
Include physicians at every stage of the process
Share information learned with leaders & clinical staff
Develop and encourage informal methods for communicating
Designate one or two clinical staff members to receive information about safety concerns
Study and learn from adverse events
Train teams of staff members, so that they are aware of the organization's commitment to a culture of safety
Encourage patients and families to be involved in the care process
Know how to put patient safety culture into practice on a daily basis
Annually select at least one high risk process to study how risk can be reduced.
2. Leadership Role

Challenges

• Move toward a more safety-oriented culture
• Allocate the resources required to support safety
• Practice proactive systems analysis & risk reduction
• Standardize processes and equipment
Leadership Role

Challenges

• Promote effective communication
• Ensure adequate and effective staffing
• Implement team training for all staff
• Encourage and support patient involvement
• Recognizing failures in the systems and processes
Tips to Enhance Role of Leadership
Establishing a culture of safety must begin with leaders.
Support open communication among clinical staff about adverse events
Demonstrate that discussion about adverse events does not lead to punishment, which in turn encourages staff participation.
Acknowledge that adverse events do occur
Communicate frequently the importance of safety
Encourage everyone in the organization to focus on safety improvement as an ongoing concern
Communicate to staff when their work improves safety

Reward and recognize those efforts
3. Medication Management

Challenges

- Storage of medications
- Prescriptions
- Dispensing
- Administration of Medications
- Monitoring of Effects
- Dealing with Medication Errors
Tips for Medication Management
Do not prelabel empty containers
Document each patient’s sample medications on his or her medical record
Avoid using technical medical terms or medical jargon
Suggest limiting or removing high-alert medications from floor stock
4. Environmental Hazards

Challenges

- Hazards predisposing to falls
- Hazards predisposing to other injuries
  - Hazardous materials
  - Sharps injuries
- Healthcare Associated Infections
  - From environment
  - From staff or other patients
- Fire Safety
Tips to prevent Environmental Hazards
Use visual clues

- For example, place a sign on the patient’s bed or room door
Use appropriate work methods that could reduce the likelihood of future patient safety problems

E.g.: Using filtered fans units and vacuums to minimize dust
Make other staff members aware of patients at high risk for falls

Consider conducting hourly checks (during awake hours) of geriatric patients at risk for falls
Use covered containers for waste removal
Educate patients about signs of a possible HAI

- For example, encourage them to tell you about any redness or swelling around a catheter insertion site.
Use visual fire alarms, as well as audible fire alarms in each room
Leaders should monitor compliance with the hand hygiene guidelines
5. Procedural Complications

Challenges

• Complications of procedure itself
  • Wrong patient; wrong procedure; wrong site
  • Post procedure infections
  • Hemorrhage
  • Complications of anesthesia
Challenges

- Poor or no post-procedure instructions
- Lack of appropriate follow up
  - Patient generated
  - Practitioner generated
Tips to Prevent Procedural Complications
Patient identification:

Using signs or posters throughout your organization that remind staff of your consistent patient identifiers
Surgical Infections:

Encourage patients to keep their skin and surgical dressing clean and dry

Provide written materials or give a quick lesson on how this is best achieved
Be aware of wrong site surgery risk factors
Make sure the surgical mark is still visible after surgical drapes are in place.
Communicate regularly with staff about the need for good hand hygiene and the results of infection monitoring
6. Physical Design

Challenges

• Design for safety
  • Patient safety
  • Staff safety
  • Infection control

• Design for efficiency
  • IT infrastructure

• Design for compliance
Considerations for Designing a Healthcare Facility
Consider private rooms in the ICU
Eliminate or reduce noise resources
Incorporate nature
Improve air quality
Encourage hand washing
Move towards a decentralized design
Better ventilation systems
Using Evidence based design principles
Tips for Continuous Compliance with Standards that support Patient Safety
Make the standards part of existing efforts
Consider information about known adverse events when deciding which quality improvement efforts to initiate.
Measure and analyze data related to processes that are prone to error
Apply risk reduction strategies and redesign steps to enhance safety systems
Analyze again and test all new or revised safety processes before implementing them
Include safety risks and suggestions for improving safety in surveys of staff and patients
Quality & Safety Practices Embedded

- Leadership
- Culture
- Human Resources
- Systems & Processes
- Structure/Technology/Supplies
- Infrastructure
The International Patient Safety Goals (IPSG) are part of Patient-Centered Standards, however, they are of particular importance because they:

1- Highlight particularly persistent and difficult healthcare problems and

2- Describe evidence and expert-based solutions to these problems and

3- Under the 5th edition of the JCI Hospital Standards, every organization must receive at least a partially met for each IPSG measurable element
International Patient Safety Goals

- **IPSG 1:** Identify Patients Correctly
- **IPSG 2:** Improve Effective Communication
- **IPSG 3:** Improve the Safety of High Alert Medications
- **IPSG 4:** Ensure Correct-Site, Correct-Procedure, Correct-Patient Surgery
- **IPSG 5:** Reduce the Risk of Health Care-Associated Infections
- **IPSG 6:** Reduce the Risk of Patient Harm Resulting from Falls
Speak Up Initiatives

- Speak Up: Know Your Rights
- Speak Up: Reduce your risk of falling
- Speak Up - Kid Power!
- Speak Up: At The Doctors Office
- Speak Up: Take Medication Safely
- Speak Up: Prevent the spread of infection
- Speak Up: Prevent errors in your care

Joint Commission
Speak UP Initiatives
Speak Up Initiatives

- Encourage Patients to express their concerns
- Involve patients in their care
  - Actively involved patients can improve Outcomes
  - Reduce the risk of Mistakes
  - Improve Processes
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Thank You

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