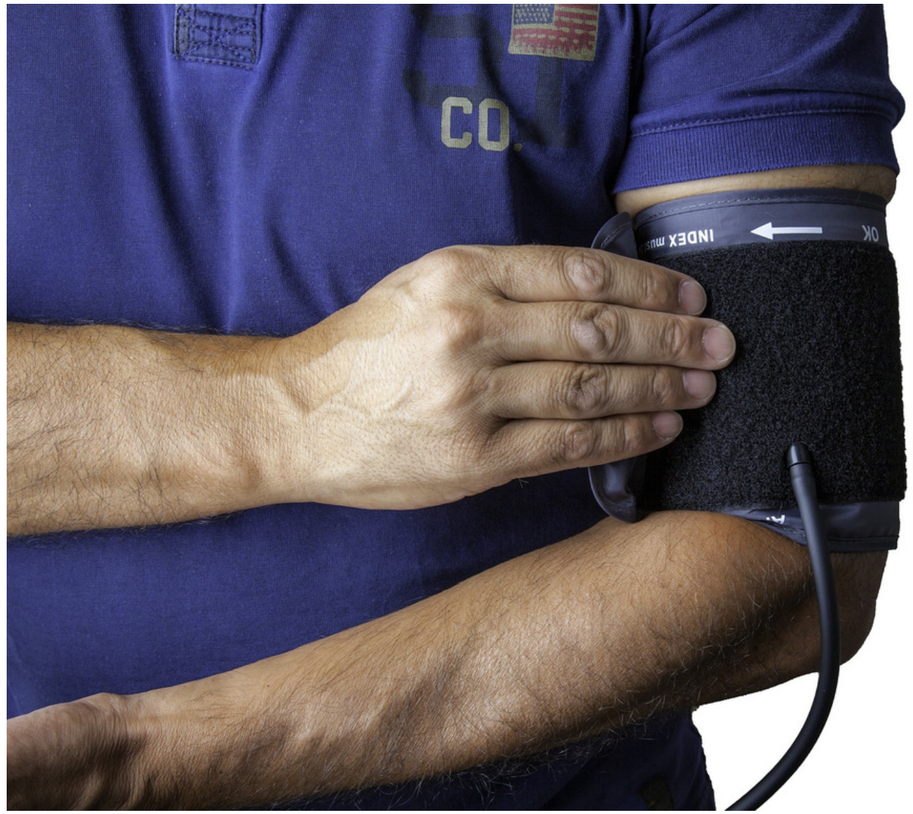
Patient Safety Events

Patient Safety Events



- **Patient Safety Event**

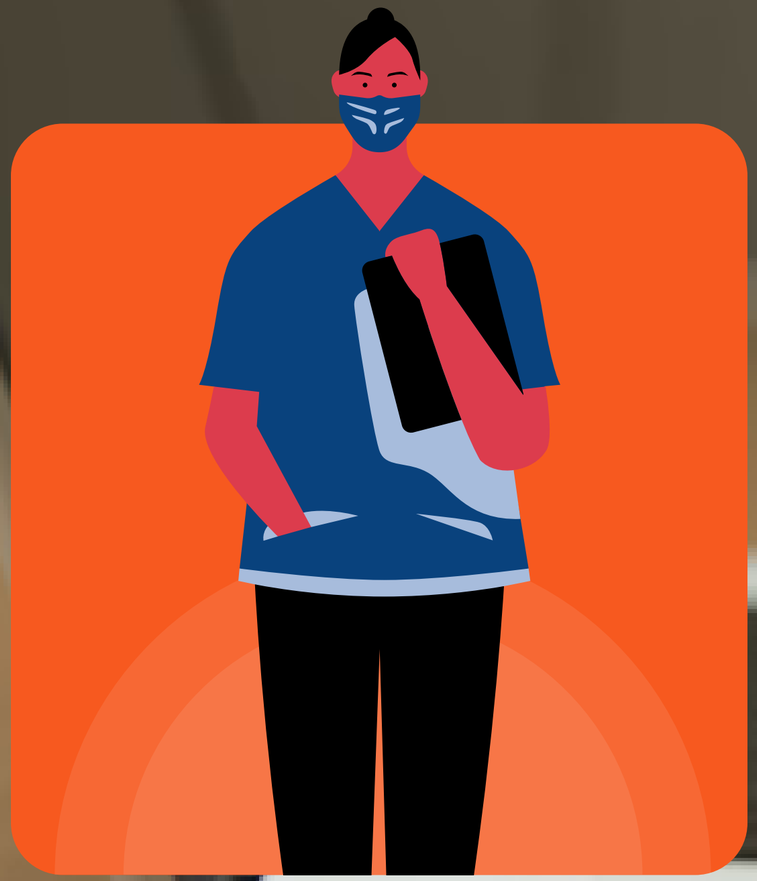
An event, incident or condition that could have resulted or did result in harm to a patient and may or may not be necessarily a result of a defective system or process design, a system breakdown, equipment failure or human error

- **Near miss event (or “great catch”)**

A patient safety event that did not reach the patient

- **No Harm**

A patient safety event that reaches the patient but does not cause harm



- **Adverse Event**

A patient safety event that resulted in harm to a patient.

- **Sentinel Event**

A patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that reaches a patient and results in any of the following

1. Death
2. Disability
3. Enduring loss of function > 15 days

- # Never Events

Serious events as defined by the National Quality forum that should never occur in a hospital

- Wrong patient, site, wrong surgery
- FB retention

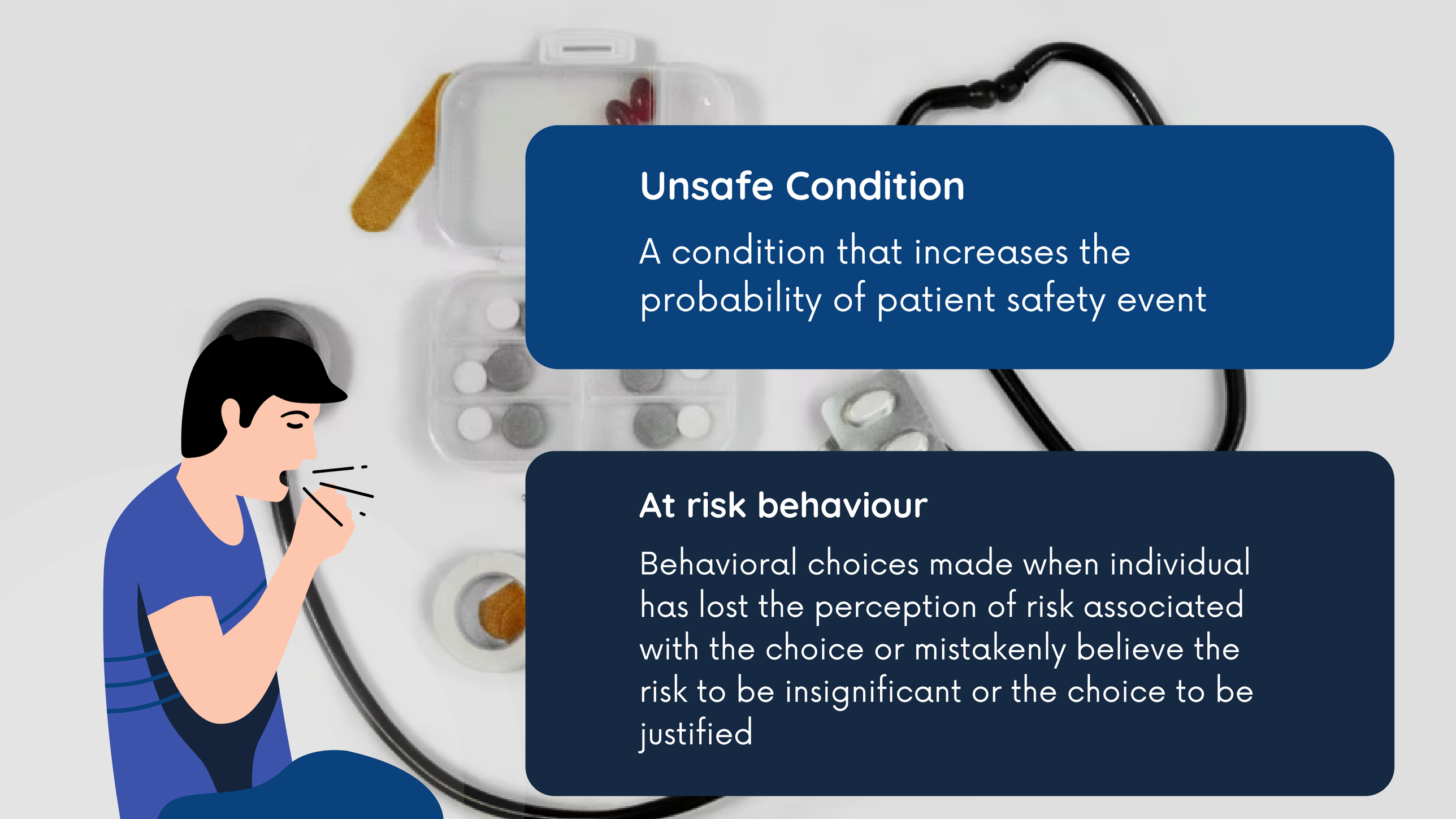
- # Disclosure

Disclosure is the sharing of a patient’s health information to individuals, or representatives; Govt; Law-enforcement agencies

Root Cause Analysis (RCA)

Identifying basic or casual factor(s) underlying variation in performance, including the occurrence or possible occurrence of a sentinel event. Includes

- Assessment of the problem
- Identification of an opportunity for improvement
- Planning and implementation of improvement strategies
- Long-term effectiveness evaluation for sustained improvement

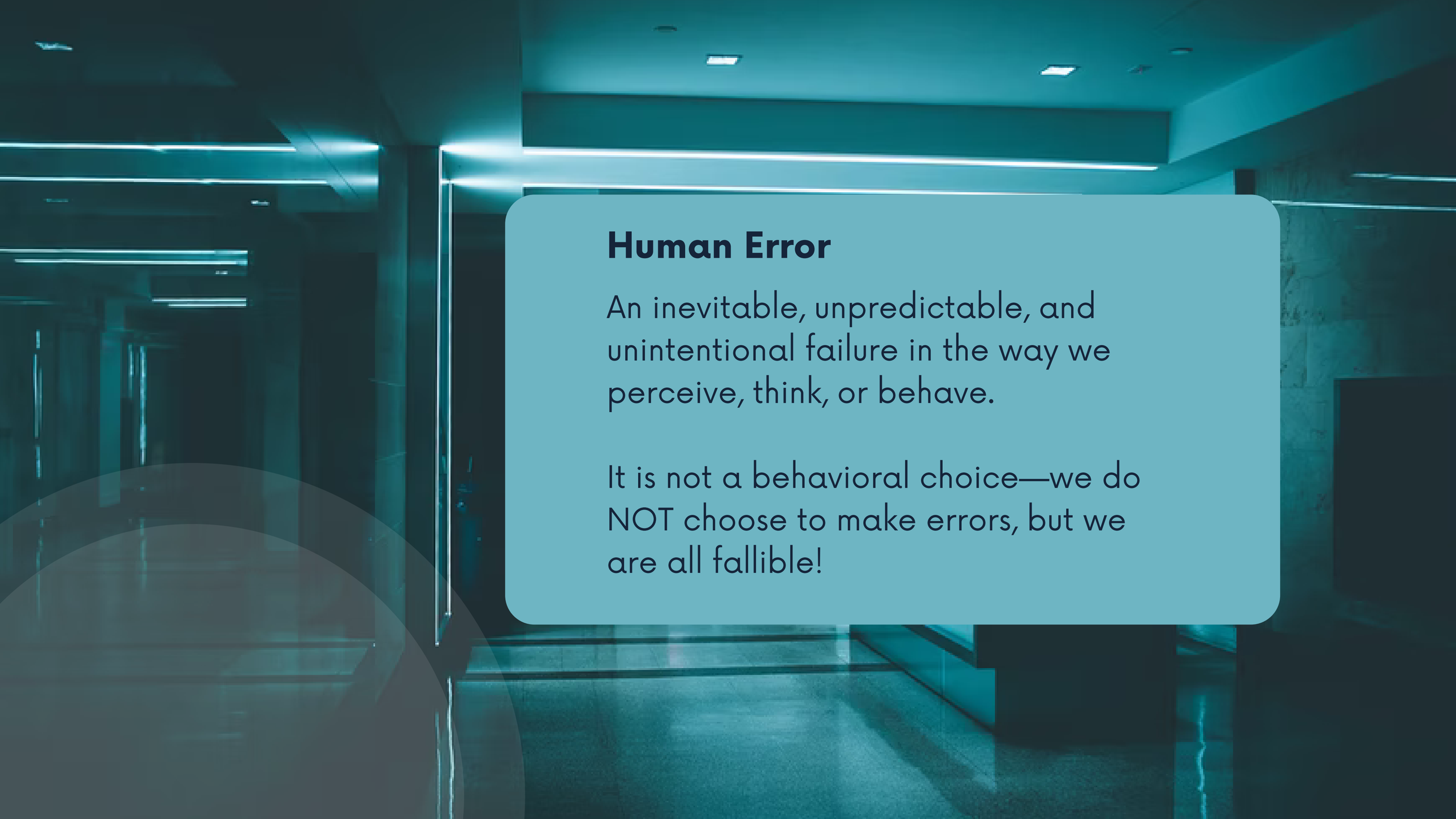


Unsafe Condition

A condition that increases the probability of patient safety event

At risk behaviour

Behavioral choices made when individual has lost the perception of risk associated with the choice or mistakenly believe the risk to be insignificant or the choice to be justified



Human Error

An inevitable, unpredictable, and unintentional failure in the way we perceive, think, or behave.

It is not a behavioral choice—we do NOT choose to make errors, but we are all fallible!

Reckless behavior

Conscious disregard of a substantial and unjustifiable risk

Individuals know the risk they are taking and understand that it is substantial

Behave intentionally and are unable to justify the behavior (i.e., do not mistakenly believe the risk is justified)

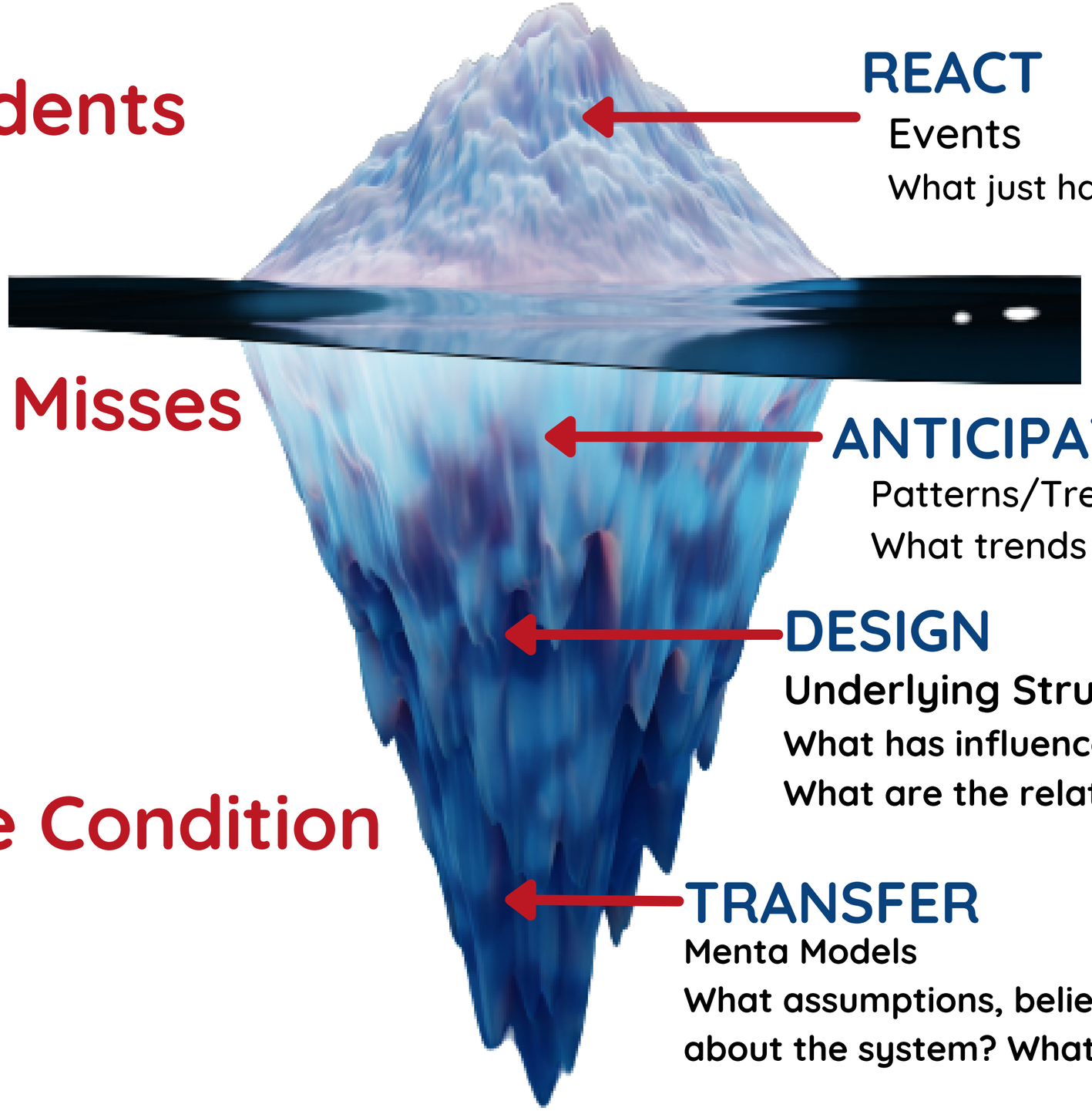
They know others are not engaging in the behavior (i.e., it is not the norm)

The Iceberg Model

Incidents

Near Misses

Unsafe Condition



REACT

Events

What just happened?

ANTICIPATE

Patterns/Trends

What trends have there been over time?

DESIGN

Underlying Structures

What has influenced the patterns?

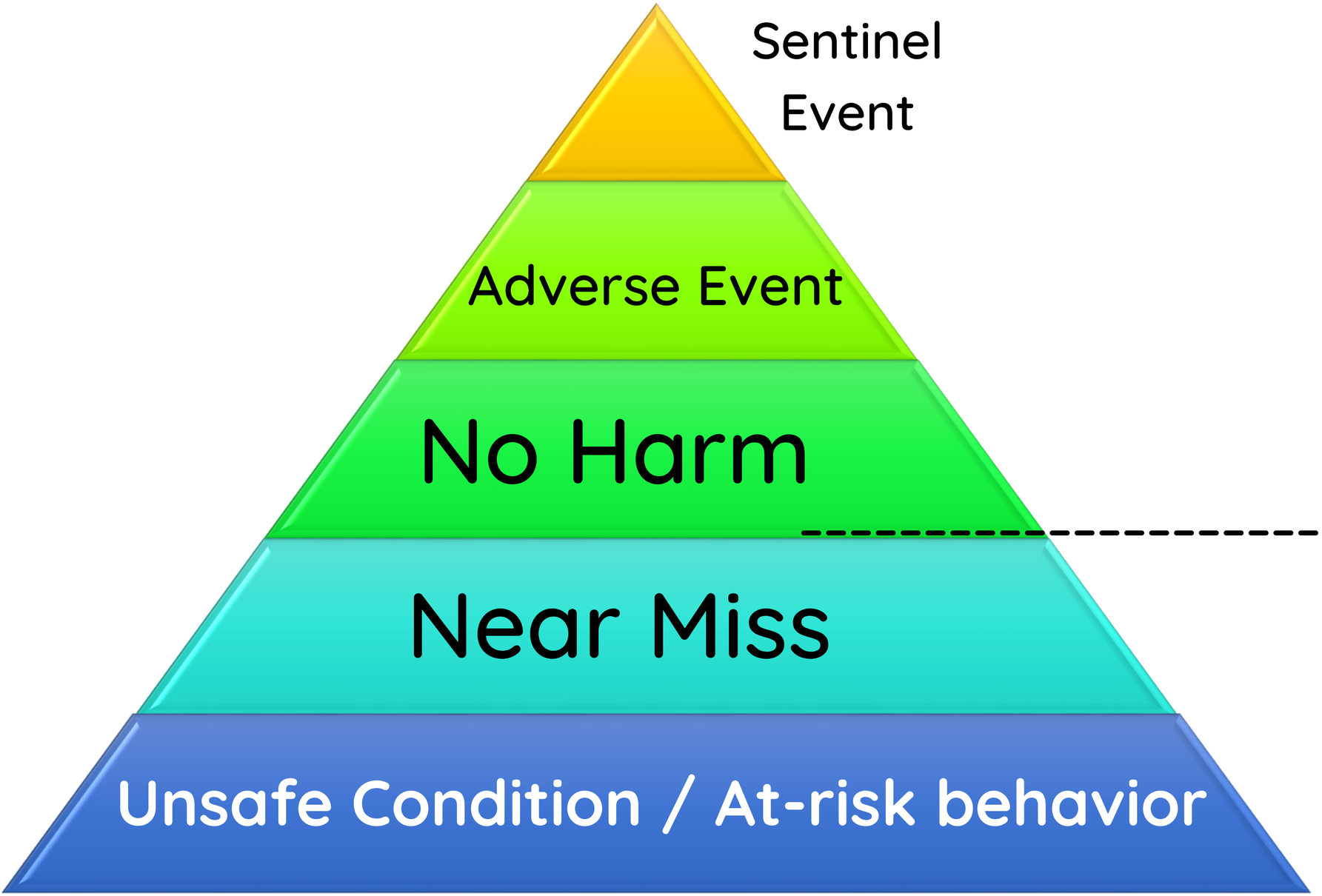
What are the relationship betweem the parts?

TRANSFER

Menta Models

What assumptions, beliefs, and values do people hold about the system? What beliefs keep the system in place?

Harm Hierarchy!



Always visible
Can't hide it anymore!

May or may not be visible depending upon the Hospital's organizational Culture, Safety Culture, Engagement Levels of Staff and Physicians and Communications channels

Processes Required

- Detection & Reporting
- Recording & Analysis
- Discussion & Decision

DETECTION & REPORTING

- Staff education to be able to detect
- Reporting systems – Forms, procedures, accountability,
- acknowledgment
- Non-punitive approach
- Physician & Staff engagement

Recording & Analysis

- Nodal person for recording all reports e.g. quality dept / person
- Summarizing & analysis

  Analytical tools – RCA, Pareto's analysis, Run chart, Control chart, Flow chart etc

- Identifying OFIs

Discussion & Decision

Discuss in appropriate forum – Quality committee, Apex committee
or HICC depending upon the issue

Analyse possible options for improvement

Select an option

Discussion & Decision

Designate person responsible for implementation of selected option

Decide for re-analysis after appropriate period of time

THANK YOU