Improving the Safety of Health Care

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Unsafe Care
where patients sustain injury from their care rather than their disease
• some injury may be preventable
• some injury may be the result of omission rather than commission
• some injury may not be known by patients, or even most members of the health care team

Six Domains of Quality

- Safe
- Appropriate
- Effective
- Accessible
- Efficient
- Patient’s view

Acceptable
54.9% of participants received recommended care

Failure to adhere to recommended processes of care pose a major threat to patients
Newspaper and television stories of catastrophic injuries occurring at the hands of clinicians spotlight the problem of medical error but provide little insight into its nature or magnitude. Clinicians, patients, and policy-makers may underestimate the magnitude of risk and the extent of harm.

How Hazardous Is Health Care? (Leape)

<table>
<thead>
<tr>
<th>DANGEROUS (&gt;/1000)</th>
<th>REGULATED</th>
<th>ULTRA-SAFE (&lt;/1/100K)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthCare</td>
<td>Driving</td>
<td>Scheduled Airlines</td>
</tr>
<tr>
<td>Mountain Climbing</td>
<td>Chemical</td>
<td>European Railroads</td>
</tr>
<tr>
<td>Bungee Jumping</td>
<td>Manufacturing</td>
<td>Nuclear Power</td>
</tr>
<tr>
<td></td>
<td>Chartered Flights</td>
<td></td>
</tr>
</tbody>
</table>

Describe an adverse event that you or a family or professional colleague have sustained
- What happened
- What was then done
- What were you/they told about the event
- What changes occurred as a result of the event
Consumers View
Australia 1999

- Annual incidence of reported AEs is 6.5%
- {Kaiser/AHRQ 6%}
- females > males
- young > seniors
- ↑hospitalisation ⇒ ↑AEs
- better informed ⇒ ↓AEs
- “the system is moderately safe, but getting worse”

Medication Errors

<table>
<thead>
<tr>
<th>In the past two years:</th>
<th>AUS</th>
<th>CAN</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given the wrong medication or wrong dose by a doctor, hospital or pharmacist</td>
<td>11</td>
<td>11</td>
<td>13</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Believed a medical mistake was made in your treatment or care</td>
<td>19</td>
<td>20</td>
<td>18</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>Medication error or believed an error was made</td>
<td>23</td>
<td>25</td>
<td>23</td>
<td>18</td>
<td>28</td>
</tr>
</tbody>
</table>

2002 Commonwealth Fund International Health Policy Survey
Adults with health problems.

Percent Reporting Medication Error or Medical Mistake in past 2 years

- Saw 1-2 doctors in the past 2 years
- Saw 3 or more doctors in the past 2 years
Safety in General Practice

*Med J Aust 1998; 169: 73-76*

- voluntary, anonymous reporting of incidents in general practice. 324 GPs reported 805 incidents in 20 months
- 76% preventable
- 27% had potential for severe harm
- 4% resulted in death of the patient, while 7% would result in the future death of the patient

Measurement of Safety

- Medical record review
- Incident monitoring
- Indicators/large data sets
- ICD coding of medical records
- Observational methods
- other

Sources of Patient Harm Data

- Retrospective Record Review
- Large data sets
- Reporting Systems
- Observation/Interview
Incident Reporting

Physician knowledge, attitudes, and behavior related to reporting adverse drug events.
Arch Int Med 1988; 148(7): 1596-1600

• 418/1121 had detected an ADE in the last 12 months
• 21/418 actually reported it

Incident Monitoring - ADE

Identifying adverse drug events: development of a computer-based monitor and comparison with chart review and stimulated voluntary report
J Am Med Inform Assoc 1998; 5(3):305-314

• chart review found 398 ADEs
• computer found 275 (from 2620 alerts)
• voluntary reporting found 23
• only 76 were detected by computer and chart review

Adverse events and near miss reporting in the NHS
R. Shaw, F. Drever, H. Hughes, S. Gibbon and S. Williams
1 National Patient Safety Agency, London, UK
2 Hammersmith Hospitals NHS Trust, London, UK

Results: A total of 28,998 incidents were reported including:
• 11,766 (41%) slips, trips and falls,
• 2514 (9%) medication management incidents,
• 2429 (8%) resource issues, and 2164 (7%) treatment issues.
• 138 catastrophic and 260 major adverse outcomes were reported.
• Slips, trips and falls (n = 11,766) were the most common type of incident
The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada


Table 3: Procedures or events in which AEs were related to service received or responsible in delivery of care at time of AE

<table>
<thead>
<tr>
<th>Type of procedure or event</th>
<th>Medical</th>
<th>Surgical</th>
<th>Obstetrical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical</td>
<td>135</td>
<td>111</td>
<td>110</td>
</tr>
<tr>
<td>Drug-related event</td>
<td>17</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>Other clinician management</td>
<td>11</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>12</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Medical</td>
<td>9</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Obstetrical</td>
<td>3</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td>Aphasia-related event</td>
<td>1</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Information-related event</td>
<td>1</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>N/A</td>
<td>152</td>
<td>145</td>
<td>119</td>
</tr>
</tbody>
</table>

Surgery 34.0%
Drug/fluid 23.6%
Clinical Mx 11.9%
Diagnostic 10.5%
Medical 7.2%

ICD coding of adverse events

O’Hara et al Med J Aust 1997;166

- E code rate of ~5% for Victoria - ICD9CM
- QAHCS shows that E codes detect fewer than 30% of adverse events
- ICD 10 may be better?
- Is it the codes or the coding?

Common Issues with Hospital Care

- Adequacy of preoperative assessment and decision making
- Poor communication, written or verbal, in handover of information or care
- Health care acquired infection
- Management of anticoagulation
- Follow up of test results
- Inpatient care of patients who cannot fend for themselves — paediatric, mental health, elderly, NES etc
Every system is perfectly designed to achieve the results that it achieves

*Berwick: central law of improvement, BMJ 1996 312:619-622*

reframes performance from a matter of effort to a matter of design

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**Observational Study**

*An alternative strategy for studying adverse events in medical care. Andrew LB, Lancet 1997; 349:309-313*

- observational study in 3 clinical units is tertiary referral hospital
- 17.7% of patients had at least one serious AE leading to longer hospital stays
- AE risk increased by 6% for each day in hospital
- 38% of AEs caused by "an individual", 10% by administrative decisions.

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**Medical Record Review - QAHCS**

- 73% of medical records were able to give complete data for MO review
- in only 24 records an AE was suspected but the record was inadequate to confirm
- agreement between MOs on the presence of an AE was 80% (κ 0.55)
- agreement between MOs on preventability of AE was 58% (κ 0.33)
What data sources do you have available for study?

**Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I**


- 3.7% of admissions had an adverse event
- 27.6% of these due to negligence
- 13.6% of AEs led to patient death

Adverse Events seriously harm patients and drain NHS resources

BMJ 2001;322:517–9
Interpretation: The overall incidence rate of AEs of 7.5% in our study suggests that, of the almost 2.5 million annual hospital admissions in Canada similar to the type studied, about 185 000 are associated with an AE and close to 70 000 of these are potentially preventable.

QUALITY IN AUSTRALIAN HEALTH CARE STUDY

- to estimate the prevalence of INJURY to patients caused by their HEALTH CARE
- by measuring ADVERSE EVENTS
- judging PREVENTABILITY of these events
- assessing DISABILITY from these events


Adverse Event Definition

- Injury or Complication
- Disability
- Caused by health care, rather than disease process

all three characteristics of an event must be satisfied for it to be included in the study
Inadequate documentation 21
No AE 3,852
ADVERSE EVENTS 2,353 (16.5%)

Charts screened positive 6,210 (43.3%)
Charts screened negative 7,979
Charts not screened 445 (see text)

Medical review 6,205
Missing 5

Sampled 14,655

The Medical Journal of Australia

16.6% of hospitalisations associated with AE
50% of AEs were preventable
18.6% caused permanent disability/death

The Quality in Australian Health Care Study

Patient Flow Chart

Patient Enters Healthcare System

Patient Assessed
Management Plan
Plan Implemented
Follow up
### QAHCS Summary of Results

- 16.6% of hospital admissions were associated with an adverse event
  - 470,000 admissions/year
- 51% of AEs were judged to be preventable
  - 240,000 admissions/year ~ 1,700,000 bed days
- 46.6% of AEs resulted in minimal disability
- 13.7% of AEs resulted in permanent disability
  - 50,000 cases/year
- 4.9% of AEs resulted in death
  - 18,000/year ~ 50% preventable

### QAHCS - Age and Harm

#### AE rate & Permanent Disability rate

<table>
<thead>
<tr>
<th>Age</th>
<th>AE rate</th>
<th>Permanent Disability rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Category

<table>
<thead>
<tr>
<th>Clinical category</th>
<th>Adverse events</th>
<th>Permanent disability</th>
<th>Death</th>
<th>High preventability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operations</td>
<td>115 (50.3%)</td>
<td>17%</td>
<td>2%</td>
<td>44%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>714 (31.5%)</td>
<td>32%</td>
<td>13%</td>
<td>1%</td>
</tr>
<tr>
<td>Therapy</td>
<td>376 (12.0%)</td>
<td>26%</td>
<td>15%</td>
<td>72%</td>
</tr>
<tr>
<td>Drug</td>
<td>216 (9.0%)</td>
<td>17%</td>
<td>5%</td>
<td>33%</td>
</tr>
<tr>
<td>Medical</td>
<td>120 (4.0%)</td>
<td>16%</td>
<td>3%</td>
<td>40%</td>
</tr>
<tr>
<td>Racute</td>
<td>135 (5.7%)</td>
<td>16%</td>
<td>2%</td>
<td>50%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>12 (5.0%)</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Exit</td>
<td>66 (2.7%)</td>
<td>21%</td>
<td>0%</td>
<td>62%</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>51 (2.1%)</td>
<td>8%</td>
<td>6%</td>
<td>1%</td>
</tr>
<tr>
<td>Nucareal</td>
<td>38 (1.5%)</td>
<td>20%</td>
<td>3%</td>
<td>50%</td>
</tr>
<tr>
<td>System</td>
<td>251 (10.8%)</td>
<td>26%</td>
<td>11%</td>
<td>74%</td>
</tr>
<tr>
<td>Total</td>
<td>2452</td>
<td>20%</td>
<td>6%</td>
<td>58%</td>
</tr>
</tbody>
</table>

1 These categories are not mutually exclusive and hence the total is more than 100%
**Harvard Medical Practice Study**

**Table 7: Adverse events by specialty of attribution, proportions with permanent disability (including death), deaths and high probability**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Adverse events</th>
<th>Permanent disability</th>
<th>Deaths*</th>
<th>High probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>351 (19.9%)</td>
<td>15%</td>
<td>3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>386 (17.8%)</td>
<td>19%</td>
<td>1%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>150 (5.0%)</td>
<td>41%</td>
<td>20%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Family practice</td>
<td>147 (6.9%)</td>
<td>16%</td>
<td>5%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>146 (6.2%)</td>
<td>6%</td>
<td>0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Gynecology</td>
<td>136 (5.8%)</td>
<td>6%</td>
<td>0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>118 (5.1%)</td>
<td>25%</td>
<td>4%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Urology</td>
<td>86 (5.3%)</td>
<td>12%</td>
<td>1%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>86 (4.3%)</td>
<td>12%</td>
<td>1%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Thoracic surgery</td>
<td>77 (3.7%)</td>
<td>14%</td>
<td>0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>71 (3.1%)</td>
<td>12%</td>
<td>0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>50 (2.6%)</td>
<td>12%</td>
<td>0%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>57 (2.7%)</td>
<td>23%</td>
<td>2%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Thoracic endovascular surgery</td>
<td>50 (2.2%)</td>
<td>23%</td>
<td>4%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

**Table 4: Rates of adverse events and negligence among clinical specialty groups**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Rate of adverse events</th>
<th>Rate of negligence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedics</td>
<td>4.2 (0.8)</td>
<td>12.4 (2.6)</td>
</tr>
<tr>
<td>Urology</td>
<td>4.9 (0.8)</td>
<td>17.4 (2.5)</td>
</tr>
<tr>
<td>Cardiology</td>
<td>9.9 (0.8)</td>
<td>32.6 (2.9)</td>
</tr>
<tr>
<td>Thoracic surgery</td>
<td>10.4 (0.8)</td>
<td>32.0 (2.9)</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>10.9 (0.8)</td>
<td>32.0 (2.9)</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>13.0 (0.8)</td>
<td>16.4 (2.5)</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>15.0 (0.8)</td>
<td>16.4 (2.5)</td>
</tr>
<tr>
<td>General surgery</td>
<td>20.0 (0.8)</td>
<td>16.4 (2.5)</td>
</tr>
<tr>
<td>General medicine</td>
<td>21.0 (0.8)</td>
<td>16.4 (2.5)</td>
</tr>
<tr>
<td>Other</td>
<td>23.0 (0.8)</td>
<td>16.4 (2.5)</td>
</tr>
</tbody>
</table>

*Values differ from the means of those reported above because of sampling error. The distribution of rates of events.
Every system is perfectly designed to achieve the results that it achieves

*Berwick: central law of improvement*  
*BMJ*  
1996 312:619-622

reframes performance from a matter of effort to a matter of design
• How would you use information about adverse events in your country?

It is possible to improve!

Harm Frequency Studies
% of hospitalisations sustaining an adverse event

- Harvard Medical Practice Study
- Utah Colorado Study
- Australia
- New Zealand
- UK
- Denmark
- Canada
- France*
- Japan
- Singapore

Preventability ~ 50%

Negligence
AE Rate ~ 10% (7.5-16.6)
Broad based published studies

- Strong (larger) hospital focus
- Obstetric and mental health care often excluded
- necessarily under-estimate the size of the problem
- divide into "negligence" studies with AE rates ~ 3-4%; and "improvement studies" with AE rates around ~10% +
- have reasonable reliability on AE causation, but less on preventability
- The harder you look the more you find

Fundamental Concepts

- Preventable patient harm is unacceptable at any time
- Where it has been measured, the level of harm is very high
  - Poor clinical outcomes
  - Waste of valuable resources
  - Can be viewed as an human rights issue
  - Can be viewed as a public health problem
- But, we need more knowledge!

Very Complex System

[Diagram of a very complex system with layers: Patient Care, Clinicians, Clinical Teams, Organisation, Financial/Political & Governance Environ]
Preventable in-hospital medical injury under the “no fault” system in New Zealand

P Duvin, E Egan, T Brintz, A Scott

System Factors

- Inadequate reporting or communication: 24%
- Inadequate training or supervision: 21.7%
- Delay in provision of services: 15%
- No protocol/failure to implement plan: 11.4%
- Other/can’t tell: 15.4%

QAHCS

System errors

<table>
<thead>
<tr>
<th>System error</th>
<th>Adverse events</th>
<th>Permanent disability</th>
<th>High preventability</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>180 (52%)</td>
<td>24%</td>
<td>91%</td>
</tr>
<tr>
<td>Inadequate reporting</td>
<td>62 (17%)</td>
<td>39%</td>
<td>94%</td>
</tr>
<tr>
<td>Inadequate training or supervision of staff</td>
<td>44 (12%)</td>
<td>32%</td>
<td>72%</td>
</tr>
<tr>
<td>Inadequate function of equipment</td>
<td>26 (7%)</td>
<td>27%</td>
<td>81%</td>
</tr>
<tr>
<td>Inadequate function of medication</td>
<td>16 (5%)</td>
<td>19%</td>
<td>93%</td>
</tr>
<tr>
<td>Inadequate function of equipment</td>
<td>5 (1%)</td>
<td>0</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Insufficient staffing</td>
<td>5 (1%)</td>
<td>30%</td>
<td>83%</td>
</tr>
<tr>
<td>Equipment not available</td>
<td>1 (1%)</td>
<td>0</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>No protocol</td>
<td>9 (3%)</td>
<td>23%</td>
<td>97%</td>
</tr>
<tr>
<td>Total</td>
<td>366 (100%)</td>
<td>25%</td>
<td>79%</td>
</tr>
</tbody>
</table>

* System errors accounted for 81% of all adverse events (AEs).

Why do people sue doctors?

- An injury in >70%
- Insensitive handling and poor communication after the event (<15% of explanations were considered satisfactory)

227 patients/relatives taking action through plaintive medical negligence solicitors

Reasons for litigation

• Concern with standards of care - “prevent it happening to someone else”
• The need for an explanation - “what happened and why”
• Compensation - actual losses, pain and suffering, future care needs
• Accountability - a sense that the staff or organisation should account for their actions

Do we learn from mistakes?

Wu AW, Folkman S, McPhee SJ, Lo B
JAMA 1991 July 24-31;266(4):512-3

• Survey 254 house officers; 45% returned a form describing their most significant mistake and their response to it
• Diagnosis 33%, prescribing 29%, evaluation 21%, communication 5%
• Patients had serious outcomes in 90% of cases (31% died)
• 54% discussed the mistake with their consultants and 24% told patients or families

Case summary 1.1

The patient A was a 42-year-old Chinese female. She was admitted for intermittent fever for 3 months. On examination, the patient was febrile (39.6°C) and jaundiced. Blood tests showed deranged liver function with coagulopathy and her condition continued to worsen.

Day 2, ultrasound showed an oedematous gallbladder containing sludge. Bilateral pleural effusions and some ascites were also reported.

Day 3 CXR showed an acute development of a moderate right pleural effusion.

Day 4, the decision was made to perform a pleural tap on the next day. Day 5, morning blood coagulation profile was deranged. Two units of FFP (approximately 500 ml) were transfused prior to performing the pleural tap. The procedure was performed immediately upon completion of the FFP transfusion on the 5th day, without further testing PT and PTT.
Case summary 1.2

The pleural tap was performed by a medical officer, Dr A. Both Dr A and Dr B (the registrar in that ward) selected the site of entry, after which Dr B attended to other patients in the ward. According to Dr B, manpower was not an issue at that time but he believed that Dr A should be able to handle the procedure. After obtaining straw-coloured pleural fluid with a 21G hypodermic needle, Dr A then made 2 attempts to drain the pleural fluid with an 18G intravenous cannula. According to Dr A, almost the entire cannula was inserted. This time however, the fluid obtained was, at first lightly, then heavily blood-stained. Dr A then removed the cannula and attempted once more but she was unable to obtain anything. Dr B, who was in the ward seeing some patients, was then called to assist Dr A. He made a single attempt that drew blood. The procedure was then abandoned.

Case summary 1.3

About 2 hours after the failed pleural tap, the patient had severe abdominal pain radiating to the back. Another 45 minutes later, the patient was very pale and her abdomen was distended and tense. The patient was intubated and transferred to the SICU for ventilatory support and further resuscitation.

The patient died in the morning of the 6th day, autopsy revealing a lacerated liver and hemoperitoneum

- List the clinical processes that failed here
- Provide recommendation(s) to prevent any one of these failed processes
SUMMARY OF CASE

• This 48 year-old male was a T5/6 paraplegic who was electively admitted for debridement and flap repair of a right ischial pressure sore and closure of a jejunostomy. The patient suffered a cardiac arrest one day following admission and died 7 days later.

• 27/03 The patient arrived on a medical ward at 1400 hours and was medically admitted at 2330 hours. During the day the patient had undergone a contrast study via jejunostomy using barium which revealed no evidence of obstruction.

• 28/03 The patient was fasted from midnight on 27/03. At 0800 hours on 28/03 a pre-operative ECG was performed. The ECG report documents an abnormal ECG. There is no documentary evidence that this was noted.
• 28/03/ Blood was taken for EUC’s, coagulation studies and FBC at 0834 hours on 28/03/. The nursing notes of 1010 hours document the sodium as 119 mmol/L, potassium as 8.5 mmol/L, chloride 88 mmol/L, bicarbonate as 22 mmol/L, anion gap as 18 mmol/L, urea as 28.9 mmol/L and creatinine as 0.11 mmol/L. The last blood tests performed 2 years earlier had been normal except for a sodium level of 131 mmol/L. The RMO was notified of the blood test results. No instructions were given and the Registrar was also contacted who ordered an immediate repeat of the blood tests.

• 28/03/ At 1030 hours the patient suffered a ventricular fibrillation and asystolic arrest. CPR was commenced immediately and the patient intubated at 1040 hours. Blood taken at this time revealed a potassium level of 8.9 mmol/L along with abnormal sodium, chloride, bicarbonate, urea and creatinine levels.

• 28/03/2000 The patient was transferred to the Intensive Care Unit where he was commenced on an adrenaline and insulin infusion and was rehydrated. The patient was extubated on 2/4/2000 but required reintubation one day later for increasing respiratory distress. The patient was seen by a Neurologist on 3/4/2000 who documented significant cerebral anoxia with a poor prognosis. An EEG revealed appearances consistent with anoxic encephalopathy. Following discussion with the family active treatment was withdrawn.

• 04/04/ The patient died at 1300 hours.
• What is the key clinical process(es) that failed here?
• What are your recommendations to the CEO on any one of these processes

Learning from adverse events

Fix urgent hazard

- Review case records
- Frame the problem
- Interview staff
- What happened?
- Why did it happen?
- How should we prevent it from recurring?
- Organisational learning

CEO

Risk Register

Recommendations implemented

Open Disclosure

What is it about?

- Encouraging open and effective communication with patients
- Acknowledging that adverse events occur
- Saying sorry to the patient for any harm suffered during their care
- Finding out the cause of the problem
- Supporting staff if something goes wrong
- Changing the culture of organisations from blame to improvement
- Making the health system safer
Solutions can be simple – dressing protocol

Gary Larson, Far Side, as reproduced in Chase & Stewart, Mistake-Proofing: Designing Errors Out, 1995

Essential Elements for QI

Leadership System

key features

- Building WILL for change
- VISION for change
  - Generating IDEAS for an improved system
    - innovation
  - Resources and permission for change
- EXECUTING changes to the system
Surgery patient's ID wasn't checked, inquiry told

The Bundaberg Base Hospital inquiry in Queensland has heard a patient underwent the wrong procedure in May last year because no-one checked his identity.

Jennifer White was the nurse unit manager of the operating theatre, and is giving evidence to the inquiry investigating malpractice allegations against Dr Jayant Patel.

She has told the inquiry a nurse called out a patient’s first name but another patient with the same name answered.

Ms White said Dr Patel performed the “investigative procedure”.

She told the inquiry four staff made mistakes by not checking the patient’s full name.

Commissioner Tony Morris suggested it may have been a matter of “shared responsibility”.

Dr Patel was the head of surgery at Bundaberg Base Hospital (ABC)


22/06/2005. ABC News Online
Patient Safety as a Public Health Risk

In New Zealand, adverse in-hospital health care is number 11 of the top 20 risk factors that account for 75% of all deaths annually,

- ahead of air pollution, alcohol and drugs, violence and road traffic injury, etc
- one third the size of tobacco related death

Patient Safety as an Human Right

- Informed consent about risk
- open disclosure “when things go wrong”
- compensation, timely and independent of the tort system
- Organisational Learning from adverse events