



Introduction to Patient Safety

Session 2



Learning Objectives

- At the end of this session, the participant should be able to:
 - Explain patient safety terminology and definitions
 - Describe harm caused by healthcare errors
 - Identify patient safety events and how they can be monitored
 - Explain how a culture of safety functions
 - List and describe the National Patient Safety Goals
 - Describe the role of Infection and Control practitioner in Patient Safety



What is Patient Safety?

“...the reduction and mitigation of unsafe acts within the healthcare **system**, as well as through the use of **best practices** shown to lead to **optimal patient outcomes**.”

The Canadian Patient Safety Dictionary, October 2003



Introduction

- Patient safety is fundamental to delivering quality essential health services.
- Quality health services across the world should be effective, safe and people-centred.
- To realize the benefits of quality health care, health services must be timely, equitable, integrated and efficient.



Introduction

- Patient safety is a framework of organized activities that creates
 - Cultures,
 - Processes,
 - Procedures,
 - Behaviours,
 - Technologies and
 - Environments

in health care that consistently and sustainably lower risks during health care delivery.

- Quality of care is defined as *“the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes.”*
- Considering patient safety and quality of care as separate entities would be a misunderstanding of their concepts entirely as they are intrinsically linked



Terminology and Definitions

Patient Safety:

Freedom from accidental or preventable injuries produced by medical care; activities to avoid, prevent or correct adverse outcomes which may result from the delivery of health care

Adverse events:

Are incidents in which harm resulted to a person receiving **health care**

Prevention and Mitigation:

Are measures taken or proposed to reduce the incidence and effects of adverse occurrences

Harm:

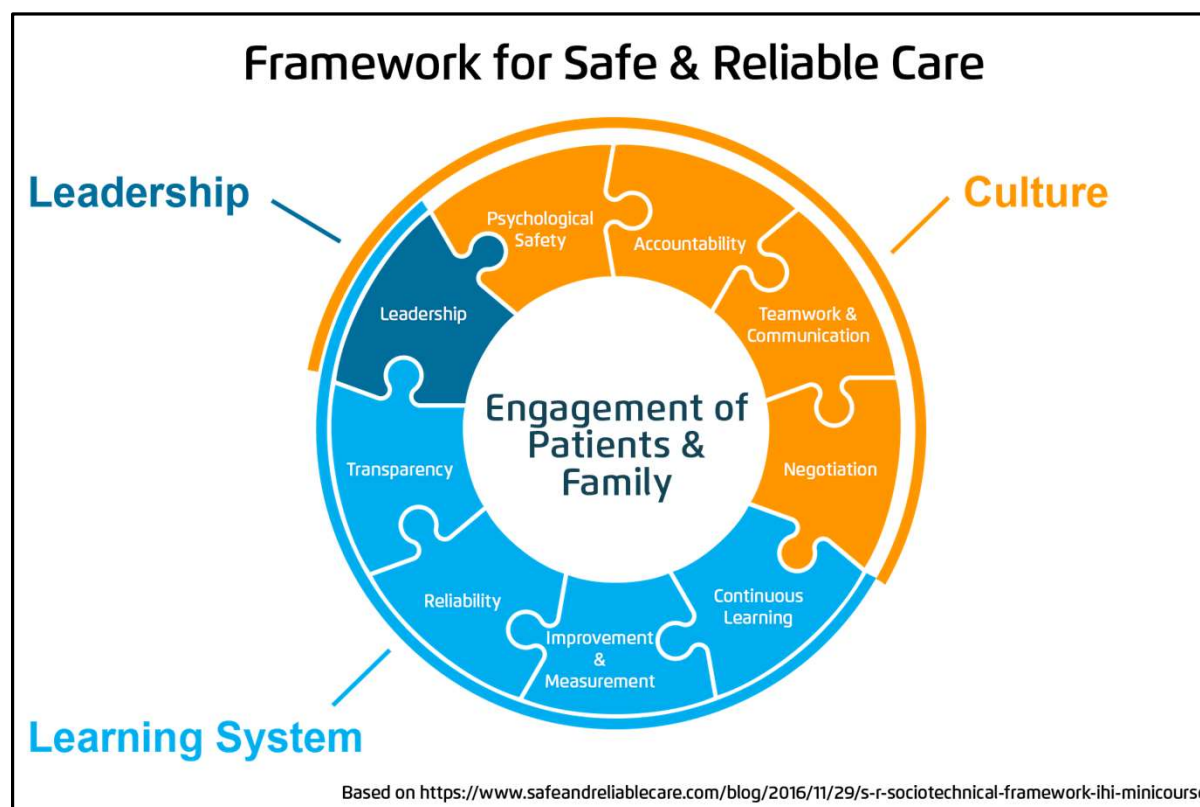
Outcomes or effects of the incident to the patient

Cause:

Factors and agents that lead to an incident



The Patient Safety Policy Framework





Facts on Patient Safety

- In 2002, WHO Member States agreed on a World Health Assembly on a patient safety resolution, recognizing that this is a serious global health issue.
- At any given time, 1.4 million people worldwide suffer from an healthcare associated infection (HAI)¹
 - In developed nations, as many as 1 in 10 inpatients are harmed while receiving hospital care¹
 - In developing countries, HAI is as much as ***20 times higher***
 - Hand hygiene is the most significant and simplest way in reducing HAIs and antimicrobial resistance



¹WHO (2007). Improved Hand Hygiene to Prevent Health Care-Associated Infections. Volume 1, Solution 9
Image credit: gea79on, unchanged, <https://www.flickr.com/photos/gea79on/7689043636>



Facts on Patient Safety (cont.)

- Annually, 1.3 million deaths are attributed to unsafe infection practices¹
 - This is primarily due to the transmission of blood-borne pathogens (e.g., hepatitis B, hepatitis C, and HIV)
- Poor patient safety has been shown to cost countries between US\$6 billion to US\$29 billion per year²
 - Due to additional hospitalizations, litigation costs, HAIs, prolonged need for medical services, lost income and disability

¹ <http://safeneedle.org/articles/safety-of-injections/>

² Chief Medical Officer. An organisation with a memory. Report of an expert group on learning from adverse events in the NHS. London: Department of Health. United Kingdom, 1999.



In the USA, deaths due to HAIs are equivalent to one fully loaded jumbo jet crashing daily.

Leape LL: Error in medicine. JAMA 1994, 272(23):1851–1857

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A Culture of Safety

	Pilots*	Medical*
Is there a negative impact of fatigue on your performance?	74%	30%
Do you reject advice from juniors?	3%	45%
Is error analysis system-wide?	100%	30%
Do you think you make mistakes?	100%	30%
Easy to discuss/report mistakes?	100%	56%

*Percent in agreement

Sexton JB, Thomas EJ, Helmreich RL, Error, stress and teamwork in medicine and aviation: cross sectional surveys. BrMedJour, 3-18-2000.

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Origin of Patient Safety Concept

- Hippocratic Oath
 - To prescribe a regimen that is for the good of my patients according to my ability and my judgment
 - Never do harm
- Improving patient safety means reducing patient harm
- Hospitals were founded to give care to those who need care and to keep patients safe is their moral right
- Collection, aggregation and analysis of patient safety data are essential to improve care systems for safety

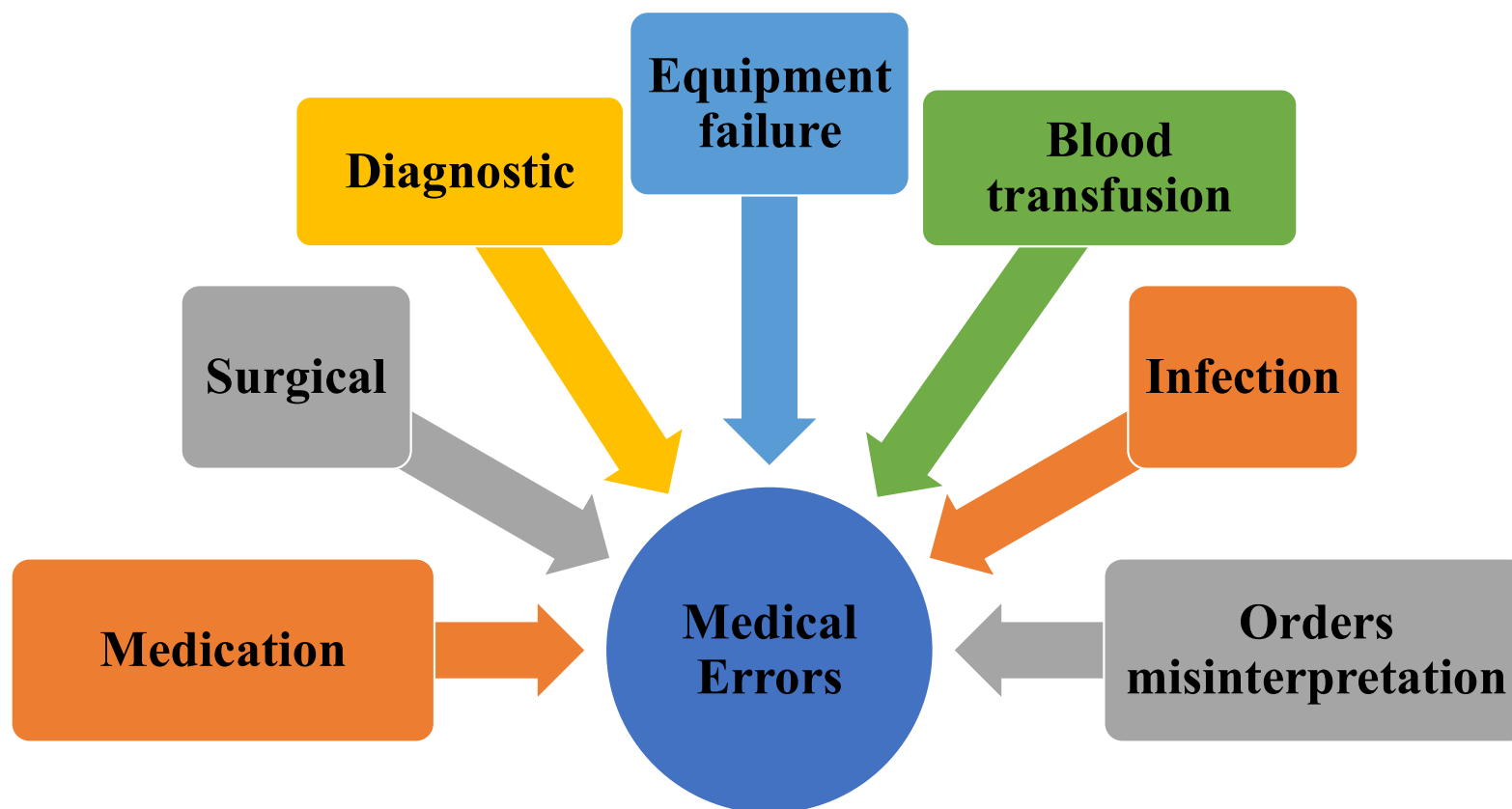


Why is Healthcare Prone to Error?

- Many individuals are involved in the care of a patient
- Multiple hand-offs/transfers of medical information
- High acuity of illnesses
- Work environment with many distractions
- Rapid, time-pressured decisions
- High volume of patients
- Patient care often contains multiple steps



Common Medical Errors





Factors Contributing to Medical Errors

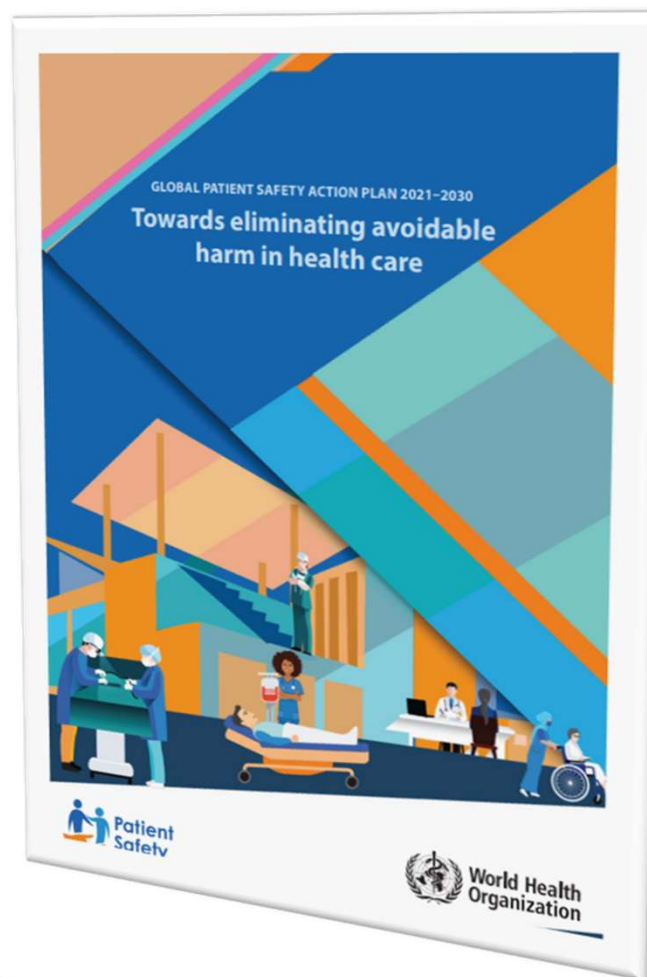
- Communication problems
- Inadequate information flow
- Human problem
- Patient-related issues

- Knowledge problems
- Staffing patterns/ workflow
- Technical failures
- Inadequate policies and procedures



Global Patient Safety Action Plan

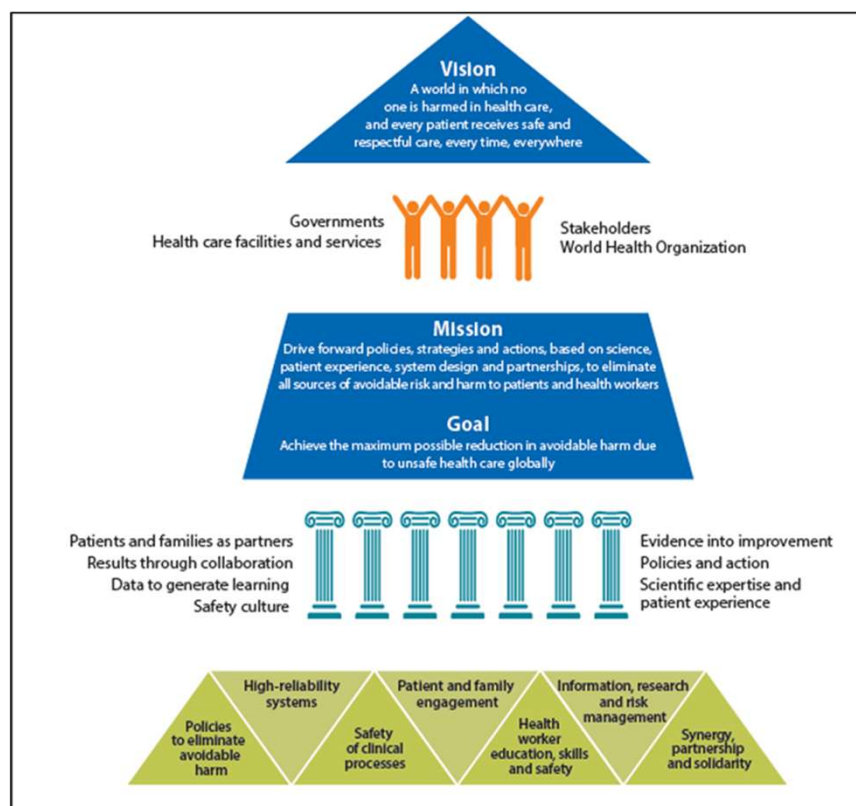
Provide guidance for enhancing a safe environment for patients and healthcare workers to ensure safety and quality of health care services is provided.





Guiding Principles in implementation of Patient Safety Initiatives

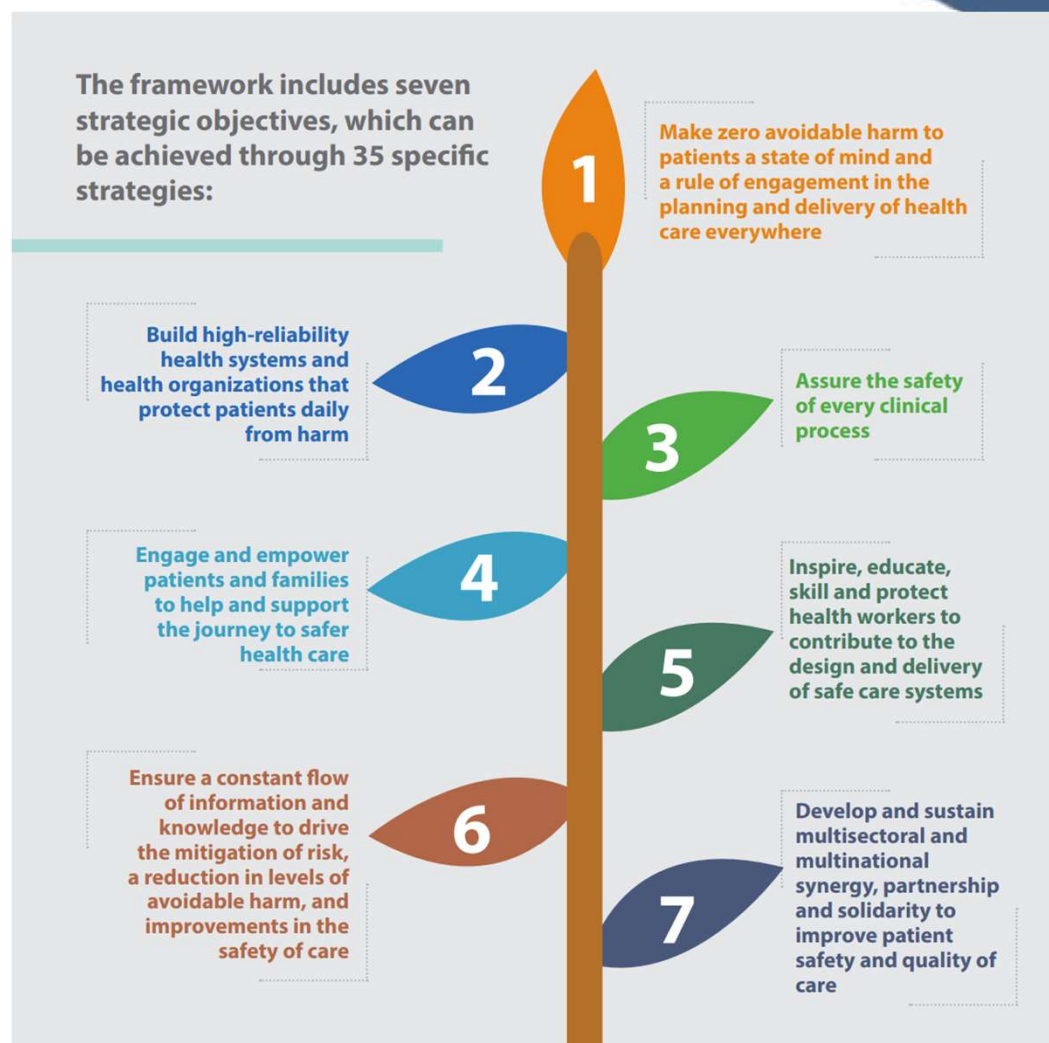
- Engage patients and families as partners in safe care
- Collaborative working
- Analyse and share data to generate learning
- Translate evidence into actionable and measurable improvement
- Base policies and action on scientific expertise and patient experience
- Instill a safety culture in the design and delivery of health care



Source: Global patient safety action plan 2021–2030: towards eliminating avoidable harm in health care. Geneva: World Health Organization; 2021



Global Patient Safety Framework for Action



Source: Global patient safety action plan 2021–2030: towards eliminating avoidable harm in health care. Geneva: World Health Organization; 2021

Fostering Regional Cooperation for Better Health



African Nations' 12 Patient Safety Action Areas

1. Patient safety and health services and systems development
2. National patient safety policy
3. Knowledge and learning in patient safety
4. Patient safety awareness raising
5. Healthcare associated infections
6. Healthcare worker protection
7. Healthcare waste management
8. Safe surgical care
9. Medication safety
10. Patient safety partnerships
11. Patient safety funding
12. Patient safety surveillance and research





Role of Infection Preventionist and the IPC Committee in Patient Safety

- Knowledgeable about healthcare associated infections (HAIs)
- Oversee infection prevention and control (IPC) program to ensure:
 - Identification of risk
 - Practice monitoring
 - Surveillance
 - Training
- Integrates evidence-based research into practice



Prevent Healthcare Associated Infections

- Follow the guidelines from the MOH, Centers for Disease Control and Prevention (CDC) and the World Health Organization
 - Increase adherence to hand hygiene
 - Prevention of Antimicrobial Resistance (AMR)
 - Prevention of blood stream infections from central lines
 - Prevention of infection after surgery
 - Prevention of urinary tract infections caused by catheters



Identify Patient Safety Risks

- Conduct an initial risk assessment on and re-assess periodically
 - Risk for falls, healthcare associated infections, suicide, developing pressure ulcers, etc.
- Address the patient's immediate safety needs and the most appropriate setting for treatment
- Ensure:
 - Increased awareness
 - Routine precautions are taken
 - Surveillance for additional warning signs or changes in patient condition



Steps to Improve Patient Safety in Hospitals

- Establish a patient safety committee
- Develop clear patient safety policies and protocols
- Regularly discuss patient safety initiatives with hospital staff
- Provide tools to help monitor patient safety
- Provide a hospital orientation and reorientation for hospital staff on patient safety



Steps to Improve Patient Safety (cont.)

- Encourage transparency in incident review
- Establish non-punitive incident reporting
- Allow each department to devise their own patient safety protocols
- Investigate each accident/incident reported and take remedial measures
- Review, monitor and evaluate safety procedures regularly and other patient care documents



Healthcare Worker's Responsibility in Patient Safety

- Do not undertake any procedure unless sure you are competent in performing the task
- Remind yourself daily that you should be safe first and brave afterwards
- Spend longer time with patients explaining and discussing the risks and benefits of treatment
- Be obsessive about hand hygiene
- Have enough humility to recognize when 'I am stepping beyond my depth and willing to ask for help'



Summary

- Medical errors or healthcare errors can lead to adverse consequences to patients.
- HAIs are the most common complications of hospital care and one of the top 10 causes of mortality worldwide.
- Patient safety reduces the risk for potential errors, injuries or infections.
- Infection Control Practitioners play a vital role in promoting IPC within Health facilities.
- With proper safeguards, errors can be corrected and prevented.



Thank You
Questions ?





References

- Global Patient Safety Action Plan 2022
- APIC Text of Infection Prevention and Control and epidemiology P. Grota et al, (2014), 4th Edition
- Joint Commission National Patient Goal, 2014
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- World Health Organization. (2010). Topic 1: What is patient safety?