

## WHAT DO PATIENTS EXPECT WHEN THINGS GO WRONG?

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The Joint Commission on Accreditation of Healthcare Organization (JCAHO) requires that patients be informed about adverse events.

“It is the right of patient to receive information about clinically relevant medical errors.”

“Disclose information regarding the errors to the patient on a prompt, clear and honest manner”.

How to do this tricky issue, the four step approach :-

Step 1 – Tell patient the truth – what happened in a plain language.

Step 2 – Accept responsibility on your own and on behalf of the institution.

Step 3 – Apologize

Step 4 – Describe the next steps – (i) for the patient what to do and

(ii) prevent these in future

List of serious reportable events

### 1.SURGICAL EVENTS :-

A. Surgery performed on the wrong body part

B. Surgery performed on the wrong patient

C. Wrong surgical procedure performed on a patient

D. Retention of a foreign object on a patient after surgery or other procedure

E. Intra-operative or immediately post – operative death in a ASA Class 1 patient.

### 2.PRODUCT OR DEVICE EVENTS

A. Patient death or serious disability associated with the use of contaminated drugs, devices or biologics provided by the health care facility.

B. Patient death or serious disability associated with the use or function of a device in a patient care, in which the device is used for functions other than as intended

C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility.

### 3.PATIENT PROTECTION EVENTS

A. Infant discharged to the wrong person

B. Patient death or serious disability associated with patient elopement (disappearance) for more than four hours.

C. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a health care facility

### 4.CARE MANAGEMENT EVENTS

A. Patient death or serious disability associated with a medication error (e.g. errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration.

B. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

C. Maternal death or serious disability associated with labour or delivery in a low-risk pregnancy while being cared for in a health care facility.

D. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility.

E. Death or serious disability associated with failure to identify and treat hyperbilirubinemia in neonates.

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- F. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility.
- G. Patient death or serious disability due to spinal manipulative therapy

## 5. ENVIRONMENTAL EVENTS

- A. Patient death or serious disability associated with an electric shock while being cared for in a health care facility.
- B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.
- C. Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility.
- D. Patient death associated with a fall while being cared for in a health care facility.
- E. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility.

## 6. CRIMINAL EVENTS

- A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
- B. Abduction of a patient of any age.
- C. Sexual assault on a patient within or on the grounds of the health care facility.
- D. Death or significant injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of the healthcare facility.

Event means a discrete, auditable and clearly defined occurrence.

Adverse describes a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

Adverse event range is -> extra day stay

-> Missing a dose of medicine

Unintended medical errors are a big threat to patient safety.

Health Care errors resulting in patient harm are a leading cause of morbidity and mortality although there is no national reporting of such occurrences.

WHO says – 1 in 10 hospitals has adverse event

- 1 in 300 admissions has death

In 1999, in USA,

44,000 to 98,000 per year die of medical errors.

Indian statistics shows only a few in –

AIIMS, New Delhi

Rajiv Gandhi Institute of Med. Sciences, Karnataka

CMC, Vellore

The Institute of Medicine (IOM) recommended that healthcare errors and adverse events be reported in a systematic manner. This systematic reporting to be shared with the other states and will be beneficial for the patient safety. These reports are generated electronically and issued quarterly and annually.

Also,

- Newsletters
- Video and Teleconferencing
- Regional and local conferences
- Individual exchange
- Patient Safety Net (PSN)
- Online system for analysis -  
Automation  
Intimation to concerned person  
Root cause analysis  
Lessons learned  
Lessons applied

On a similar basis, national institute of patient safety – by AIIMS was found a year ago.

- HOW

- WHEN
- WHERE Negligence happened
- WHY
- WHAT

- Mistake Call it what you want
- Mishap The sacred relationship
- Mischief Patient and Doctor crumbles

In GKNM Hospital, we have Sentinel Events 23 and Near Miss Events – 40. These methodologies put in safety rounds in the hospital. Administrative Rounds for patient safety and quality.

Finally,

- Patient Compensatory System
- Hallmark
- Prompt recognition of medical injury and payment opportunity to recognize and learn from mistakes

It is free from,

- Blame game
- Less defensive medicine
- Cost effective
- False security protection

‘Poka-Yoka’ is the Japanese term for mistake proofing to ensure mistake never happens again.

“Human errors in healthcare is defined as Medical errors”.

A medical error is a preventable adverse effect of care, whether or not it is evident or harmful to the patient.

How to improve the patient safety?

A new healthcare discipline emphasis the reporting, analysis and prevention of medical error leading to adverse healthcare events.

There is a critical need for Healthcare Organisations to be now accountable for the safety and well being of the patients.

#### Medical Error Reporting System [M E R S ]

Changes in organizational culture, the involvement of key leaders, the education of providers, the establishment of Patient Safety Committees, the development and adoption of safe protocols and procedures, and the use of technology are all essential elements in hospital and healthcare facilities’ efforts to reduce medical errors and improve patient safety. A broad range of approaches follows, with special focus on strategies selected by AHRQ grantees as having special promise for efficacy and ease of implementation.

These are called MERS Information

First, Quality of care in hospitals is a legitimate concern for those inheritances in improving patient safety.

Secondly, goals and aims of incident tracking and reporting is to provide a vehicle for hospitals to improve patient safety.

I would like to conclude that all Doctors take Hippocrates Oath that we shall do only good for the patients. Never do harm to anyone.

Hippocrates quoted [460 B.C.]

“Primum non nocere”

“First do no harm”