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Chapter 1 : Learning from patient safety incidents | NHS Improvement

Keywords: clinical audit, clinical risk management, incident reporting, medication error, patient safety Medication errors and drug-related adverse events have important implications - from increased length of hospitalization and costs to undue discomfort and disability or increased mortality [1, 2].

Writing in about how rural hospitals are "doing more with less," a hospital risk manager and quality improvement professional described how risk management and quality assurance, as the functions was previously called, were using a collaborative approach to share data to enhance patient care. ASHRM "Different" In the past, a typical organizational chart might have had risk management reporting to a chief operating officer or a legal department and the quality and patient safety activities reporting to a chief medical officer. The organization hierarchy did not allow for any coordination of risk and quality functions, nor did it allow for sharing of data. The following hypothetical scenario illustrates how separate reporting structures and segregated activities for risk and quality can limit their success. Risk management could be examining a particular issue—“an increase in emergency department ED claims, for example”—without knowing that quality has begun a process to improve the discharge process. Some physicians may even be writing their own instructions, increasing the variability in discharge instructions provided to patients. The problems cannot be fully solved without input from everyone involved in the discharge process. Risk management did not emerge as a distinct profession in healthcare, primarily in the hospital environment, until the mids, when the number of malpractice claims against physicians and hospitals increased dramatically and settlements and judgments skyrocketed. The result was a lack of affordable malpractice and hospital liability insurance. In response, healthcare organizations created risk-pooling programs, such as hospital-owned captive insurance companies. Many of the new risk financing programs offered reduced premiums to hospitals that had a risk management program because the practice was expected to reduce claims. In , the American Hospital Association also encouraged hospitals to implement risk management programs as a solution to malpractice problems, calling risk management the "science for the identification, evaluation, and treatment of the risk of financial loss" Dankmyer and Groves; Holloway and Sax. Rather than focusing on the underlying system design faults that contributed to the error, the risk manager would focus on defense of the claim or the lawsuit that might follow. The risk manager accomplished this by documenting the event, meeting with staff involved to learn about the event, and counseling those involved in the incident to refrain from discussing the information with others. Discussions with patients involved in an adverse event were often "too brief and vague" Kuhn and Youngberg. Building a Safer Health System "changed the conversation" about medical errors by saying that bad systems, not bad people, lead to the majority of errors and injuries in healthcare Leape and Berwick. The report called for better analysis of errors and near misses in order to design changes into healthcare delivery to prevent errors. The patient safety movement encouraged risk management professionals to expand their focus to include a proactive, preventive approach and to use a systems approach to understanding errors. Rather than limiting their focus to managing the aftermath of an event, "risk management must be integrated into the system and processes of healthcare work" Youngberg "Meeting". The standards helped to bring attention to the need for creating a culture of safety that promotes transparency and a willingness to learn from mistakes in order to enhance patient safety and prevent similar mistakes from recurring. Starting in edition, the Joint Commission devotes a chapter of its accreditation manual to patient safety systems. While the chapter does not establish new requirements for patient safety, it describes how facilities can use existing accreditation standards to improve patient safety Joint Commission "Patient". Risk manager of today. An earlier survey conducted in did not even list patient safety as a possible risk management function. Now, healthcare risk managers seeking designation from the American Hospital Association AHA as a certified professional in healthcare risk management must demonstrate an understanding of the combined topics of patient safety and clinical risk management in addition to four other areas. Top Activities for Risk Managers for a list of the

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principal activities identified by survey respondents as either their primary responsibility or one in which they have significant involvement. In addition to the traditional areas of risk familiar to healthcare risk managers i. For example, the organization must consider the risks of new business ventures, ranging from the acquisition of a physician practice to the decision to provide an emerging technology. For many risk managers, their involvement in patient safety and quality is a portion of their workload in an enterprise-wide approach to risk. Better coordination of their safety and quality activities with their colleagues who are also involved in these areas can help both achieve better results, as well as enable the risk manager to devote time to address other priorities. Hospital committees comprising medical staff leaders and nursing supervisory personnel dealt with quality-of-care, physician, or nursing problems on an individual, ad hoc basis. To meet legal requirements for due process, hospitals began to impose structural requirements on both medical and nursing staff review committees. By , the Joint Commission established quality assurance standards as a formal, systematic program to measure the care rendered to patients against established criteria Martin and Federico. Since then, the Joint Commission has incrementally revised the standards on quality, leading hospitals in the direction of integrated and coordinated hospitalwide efforts to continuously improve performance. In the late s, NCQA worked with corporate purchasers of healthcare services to develop standards to measure quality across health plans. The Joint Commission and the Centers for Medicare and Medicaid Services followed with requirements for healthcare facilities to collect and report performance data. NAHQ "Certified" Several of the activities, such as identifying opportunities for improvement, promoting proactive approaches, and identifying root causes of problems, overlap with those of the risk manager. Just as coordinating these overlapping activities helps the risk manager, so too does the quality manager benefit in achieving better results by bringing the two disciplines together and also in freeing time to complete their many other responsibilities. Many of the principles and frameworks for quality improvement used in healthcare today were originally laid out by quality experts in manufacturing. Edwards Deming to establish quality control measures for manufacturing Dlugacz et al. Other models for continuous quality improvement are similar to the one used by risk managers to guide decision making, further underscoring the shared aspects of the two disciplines refer to the discussion Streamline Activities for a description of those models. Concepts currently popular in healthcare quality initiatives, such as Lean management i. Quality professional of today. The study describes the role of the quality professional of today as very involved with nationally prominent quality activities, including several that promote public reporting of hospital-specific quality measures. These initiatives include the following: Patient Safety Healthcare organizations struggle with where in the organizational structure patient safety activities should fall. Are they the responsibility of risk or quality? Or should they be housed in their own department devoted to patient safety? ECRI Institute views patient safety as one of several intersecting activities of the risk and quality functions. Patient safety enables risk and quality programs to proactively examine care processes and risks and apply patient safety principles e. While the risk and quality functions may vary in organizations, a suggested delineation of their activities is depicted in Figure. Note that many of their overlapping activities promote patient safety. Both quality and risk are involved in the response. While each program may separately address matters related to the event, they also share responsibilities and a common goal for the organization to provide safe, high-quality care. Both may need to review the medical record, although for different purposes. The risk manager looks at the record to determine whether the organization may be responsible or liable for an injury; the quality professional reviews the record to get more information about the event and how it occurred. The risk manager assists with the disclosure of the event to the patient and family and, if appropriate, alerts the insurance carrier to a potentially compensable event.

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Chapter 2 : Patient Safety, Risk, and Quality

FDA collaborates with external stakeholders, regulators, patient safety organizations such as the Institute for Safe Medication Practices (ISMP), standard-setting organizations such as the U.S.

It is also one of the most complex, with delivery of each dose of medicine involving as many as 30 steps and almost as many people. Because they are so commonly used, medicines are associated with a higher incidence of errors and adverse events than other healthcare interventions. In NSW, medication and intravenous fluid related incidents are the second most frequently reported incident type, with a significant number of these incidents resulting in patient harm [3].

Overview The Medication Safety and Quality unit supports the safe and quality use of medicines by identifying and addressing emerging medication safety risks. The Continuity of Medication Management program provides tools and resources to support medication reconciliation - the process of ensuring that patients receive all intended medicines and that accurate, current and comprehensive medicine information follows them at all transfers of care. The High-Risk Medicines program aims to heighten awareness of the harm that can be caused and provide action-oriented information that will assist in improvements to the management of high-risk medicines in hospitals in NSW. The Medication Safety Self Assessment MSSA and associated tools were designed to facilitate evaluation of systems and processes related to medicines use and highlight opportunities for improvement. The CEC has adapted these for Australian hospitals. The VTE Prevention program assists health care facilities and clinical teams to implement robust processes for the prevention of hospital-associated venous thromboembolism VTE. It provides clinicians and health professionals with the tools and resources required to address this patient safety issue. For further information on this program please contact the Medication Safety team. Each program provides tools and resources to make medicine use safer and to assist health services meet the requirements of the National Safety and Quality Health Service Standard 4 - Medication Safety. Pharmacy Barcode Scanning - barcode scanning has been shown to reduce the rate of pharmacy dispensing errors. Tall Man Lettering - uses a combination of lower and upper case letters to highlight the differences between look-alike medicine names, helping to make them more easily distinguishable. This project highlights recent revisions to the chart.

References [1] Roughead, E. Medication safety in acute care in Australia: Australia and New Zealand Health Policy. Adverse drug events and medication errors in Australia. International Journal for Quality in Health Care.

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Chapter 3 : Safety and quality

Safety and risk management in â€¢ Incidents involving medication are reported most frequently. safety and risk management (SRM). Patient safety has.

Some states also have reporting requirement for certain types of adverse events. You wanted to track incidents to enable you to better understand a potential event that could end up in a claim. That report was called To Err is Human. The emphasis changedâ€”instead of looking at an incident, you were really looking at how do you identify patient harm, either potential patient harmâ€”something that could happen to a patientâ€”or actual harm. My company, Clarity Group, focuses on risk, quality, and safety management. These should be integrated patient safety management tools. That becomes a really important aspect of the change that we see happening, and our product responds to that change. Even the name of our product is called the Healthcare Safety Zone Portal. Now we have to broaden that definition to all healthcare settings because as the landscape of healthcare delivery changes and becomes much more outpatient focused than it ever has been, you have to follow potential harm wherever the patient is being treated. We do a lot of education with our clients. We do onsite work, including proactive risk modification so people can get established. The portal is web-based; readily accessible on our internal intranet by all colleagues and medical staff; easy to use with drop-down screens; integrates with our electronic health record to download demographic, coding, and diagnosis-related information; gives us real-time notifications; and provides enhancements based on needs as decided by the users. We are able to collect and analyze events in real time for more efficient and effective decision making. It enables us to communicate quicker and oftentimes resolve patient issues while the patients are still with us. What you have to do after that is use very robust investigation and analytical processes. The whole point of reporting is to create internal transparency, so that you know what is going on and you can correct problems. They may have behavioral facilities, or ambulatory care units, or physician practices. A lot of the facilities are part of groups, so it has become a much more diverse set of entities that have to be managed, where the data has to be managed at a group level to trend corporate-wide as well as at the individual facility level for specific trends. The RiskQual incident reporting system allows us to improve processes and techniques to avoid complacency and placing blame. And the program has the ability to have different modules incident, quality, claims link data across the interface so that all information is organized and easily accessible. The system needs to be able to track and trend the common formats and be able to modify them as needed. Keeping up with all of these regulations and new trends is important to making the system adapt as changes occur. With RiskQual, we have automation of processes, data consolidation, and reporting improvements and auditability capabilities. The reporting module is easy to use and reports generated are extremely helpful as we address patient safety issues. Customer service has been great in being available to assist us as needed. The staff needs to understand what follow-up is being done and what improvements are being made, so that some of these events can be prevented in the future. How can the staff be assisted by management in analyzing the events to help them to prevent these events from happening? As more hospitals move to fully computerized forms and point-of-service data entry, training and education will help smooth the transition. Medical Interactive Community LLC, a two-year-old company in Metairie, Louisiana, is a provider of online risk management resources that can help. Using a laptop or notebook computer enabled with MiCapture, risk managers can complete the entire assessment process on-site. Managers can track the quantity and quality of assessments by region or by specialty. While the MiCapture software does not include an incident-reporting feature, adding that function is one of the goals of Medical Interactive Community for They currently do have educational programs that address issues related to incident reporting. Poorly documented incidents can pose significant costs to a facility during a malpractice claim. With proper documentation, risk managers will be able to collect the data needed to address patient safety issues and provide protection in the event of a malpractice claim. Medical Interactive sells to hospitals and other healthcare facilities and, since their

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educational materials are available on their website, many doctors and medical professionals obtain them directly. With more parts of the ACA being implemented, increased awareness of event reporting in the profession has led Medical Interactive to create a template within their software to address incident reporting. Because of its litigation and insurance experience, Medical Interactive understands that poorly documented incidents can create significant risk for individual providers, hospitals, or other healthcare facilities. That is why their programs focus on how to properly document incidents to address patient safety issues and provide protection in the event of a claim. This is a very important shift in the way leadership is looking at incident reporting and the impact that adverse event reporting can have on patient outcomes in a proactive environment. Instead, I would lean towards clarity of legislation. Again, I think that reporting for the sake of reporting benefits no one. Reporting potential risks and adverse events should lead to change, which would improve patient outcomes and at the same time, lower the cost of care. Focusing on quality of care improves patient outcomes and can drive costs down, which is something positive that we can all stand behind. Proactive surveillance products that trigger potential risks and enable teams to take action before an adverse event happens would improve this. RL has proactive surveillance in our RL6: RL has also been evolving our customizable, schedulable reports, as reporting is a critical component of adverse event management. The interventions, improvements and trends can then all be reported graphically in dashboards. By partnering with our clients and legislative bodies, RL is able to provide software solutions to all of the different vectors of an adverse event. This will help our healthcare teams make data-driven decisions and subsequently improve patient safety. Clinicians are able to capture and share patient safety knowledge in seconds. The system provides a tool for PSOs, hospitals, and other organizations seeking to comply with federal recommendations about patient safety reports. With the help of Purple Button technology, hospitals and healthcare organizations have a secure method of generating and analyzing patient safety event reports. The Purple Button enables clinicians to record and submit patient safety events or unsafe conditions via Direct Project secure messaging. In 60 to 90 seconds, you can take preventive action and alert people as to something that needs to be fixed, using common formats. It produces reports for whatever organizations are involved. We do all the management, alerting, tracking, and tracing, and we know if the alert has been opened. This is a critical step because it means that no recalls can ever be lost. One of the many unique things is that every hospital gets a representative, a liaison at our office, in case they have any questions or problems. This is a tool that will help people engage in prevention and reduce medical errors and costs. This is certainly true in Britain and Canada. In , a law firm in London that specialized in defending National Health Service NHS hospitals against medical malpractice claims founded patient safety software company Datix from the concept that the best way to protect hospitals from lawsuits being brought by patients is to stop harming patients in the first place. The company is also expanding in the USA, Canada, and other parts of the world. This is something I believe in absolutely and passionately. People need to feel encouraged to report incidents rather than live in fear of raising genuine concerns. Some of the best lessons can be learned from the reporter simply telling the story. The CEO needs to believe in the message and to make sure it is being effectively heard and acted on by managers throughout the organization. Everyone has to understand and believe in a just, risk-aware culture where learning is the key. The message has to come from the top and be transmitted throughout the organization. Facilities will need to be part of a PSO, a patient safety organization. Some of the regulations within the PSO are going to drive standardization in terms of how incident data is captured. The challenge is getting these folks comfortable with the technology. There is a big opportunity for safety incident reporting, especially with companies like Quantros and some of our competitors, to make the systems very fast and easy to access. There are many different methodologies out there for analysis. We try to create the framework more than prescribe specific protocols hospitals should follow. They also need to understand where they are with respect to other facilities. Through safety incident capture and reporting, we can get inside the patient experience and figure out ways to connect with a patient who experiences something that they feel is a mistake or causes harm. Being able to give that back to the hospitals is a big opportunity for safety incident reporting

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and management.

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Chapter 4 : Clinical Excellence Commission - Medication Safety and Quality

Why clinical risk is relevant to patient safety Risk management is routine in most industries and has traditionally been associated with limiting litigation costs.

A medication error is an error of commission or omission at any step along the pathway that begins when a clinician prescribes a medication and ends when the patient actually receives the medication. An adverse drug event ADE is defined as harm experienced by a patient as a result of exposure to a medication. As with the more general term adverse event, the occurrence of an ADE does not necessarily indicate an error or poor quality care. Preventable adverse drug events result from a medication error that reaches the patient and causes any degree of harm. It is generally estimated that about half of ADEs are preventable. Medication errors that do not cause any harm—either because they are intercepted before reaching the patient or because of luck—are often called potential ADEs. An ameliorable ADE is one in which the patient experienced harm from a medication that, while not completely preventable, could have been mitigated. Finally, a certain percentage of patients will experience ADEs even when medications are prescribed and administered appropriately; these are considered adverse drug reactions or nonpreventable ADEs and are popularly known as side effects. For example, the intravenous anticoagulant heparin is considered one of the highest-risk medications used in the inpatient setting. If a clinician prescribes an incorrect dose of heparin, that would be considered a medication error even if a pharmacist detected the mistake before the dose was dispensed. If the incorrect dose was dispensed and administered but the patient experienced no clinical consequences, that would be a potential ADE. If an excessively large dose was administered, the overdose was detected by abnormal lab results, but the patient experienced a bleeding complication due to clinicians failing to respond appropriately, that would be considered an ameliorable ADE that is, earlier detection could have reduced the level of harm the patient experienced. Adverse drug events are one of the most common preventable adverse events in all settings of care, mostly because of the widespread use of prescription and nonprescription medications. Clinicians have access to an armamentarium of more than 10,000 prescription medications, and nearly one-third of adults in the United States take 5 or more medications. Each year, ADEs account for nearly 10 million emergency department visits and 1 million hospitalizations. Ambulatory patients may experience ADEs at even higher rates, as illustrated by the dramatic increase in deaths due to opioid medications, which has largely taken place outside the hospital. Transitions in care are also a well-documented source of preventable harm related to medications. Polypharmacy—taking more medications than clinically necessary—is likely the strongest risk factor for ADEs. Elderly patients, who take more medications and are more vulnerable to specific medication adverse effects than younger patients, are particularly vulnerable to ADEs. Pediatric patients are also at heightened risk, especially when hospitalized, since many medications for children must be dosed according to their weight. Other well-documented patient-specific risk factors include limited health literacy and numeracy the ability to use arithmetic operations for daily tasks. It is important to note that in ambulatory care, patient-level risk factors are probably an underrecognized source of ADEs. Studies have shown that both caregivers including parents of sick children and patients themselves commit medication administration errors at surprisingly high rates. The Institute for Safe Medication Practices maintains a list of high-alert medications—medications that can cause significant patient harm if used in error. These include medications that have dangerous adverse effects, but also include look-alike and sound-alike medications: The Beers criteria, which define certain classes of medications as potentially inappropriate for geriatric patients, have traditionally been used to assess medication safety. Though there are specific types of medications for which the harm generally outweighs the benefits, such as benzodiazepine sedatives in elderly patients, it is now clear that most ADEs are caused by commonly used medications that have risks, but offer significant benefits if used properly. These medications include antidiabetic agents e. Focusing on improving prescribing safety for these useful but higher-risk medications may reduce the burden of ADEs in elderly patients more

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than focusing on use of potentially inappropriate classes of medications. The opioid epidemic¹ which was declared a public health emergency in 2017² has also brought to light the role of clinician-specific and health system factors in medication errors. Opioid prescribing has increased dramatically over the past 15 years, and recent research questions the benefit of this practice. For example, opioid prescribing after dental procedures and low-risk surgical procedures increased sharply between 2000 and 2010, despite lack of evidence for the benefit of opioids in these situations. Another study found wide variation in opioid prescribing practices between physicians in the same specialty. In hospitals or long-term care settings, this is generally the responsibility of nurses or other trained staff; in ambulatory care the responsibility falls to patients or caregivers. The widespread use of electronic health records has helped avert errors at the ordering and transcribing stages, but these errors still persist, and studies have found a high rate of medication administration errors in both the inpatient and outpatient settings. Preventing medication errors requires specific steps to ensure safety at each stage of the pathway Table.

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Chapter 5 : Fall prevention: Simple tips to prevent falls - Mayo Clinic

Patient Fall Prevention and Management Protocol with Toileting Program. Patient Safety and the Just Culture: A Presentation by David Marx, J.D. Patient Safety Primer: Medication Errors.

The committee recommends ways to make more effective handovers and error reporting an integral part of resident learning experiences to help achieve these goals. Teamwork coordination and clinical information technology can also foster increased learning, productivity, and patient safety. A transformation in the medical environment is needed so that a system-wide culture of safety develops and a system of blame is replaced with one of shared responsibility. The committee further recognized that redesigning hospital practices or system processes may be necessary to facilitate redesign of graduate medical education or implementation of the proposed recommendations. The strategies discussed in this chapter and the recommendations of the committee are aimed at systems that not only improve resident work and learning, but also improve the delivery of care in teaching institutions by all staff. In order to implement such changes, an organization-wide approach is necessary to create an environment that involves all hospital workers in achieving the desired results of maximum safety and the provision of quality care. Adjustments that would assist in transforming the resident work environment, and the environment for all health workers, include improving communications skills among hospital staff, implementing team strategies to complete work more efficiently, and developing a safety culture that extends across hospital settings. Therefore, this chapter discusses organizational and systems strategies that can help to 1 establish a culture of safety, 2 improve handover processes, 3 use adverse event and error-reporting systems for resident learning, and 4 develop a team culture to improve communication and task performance among residents. The committee builds on those earlier reports, focusing attention on adopting strategies for teamwork development and error reporting to better serve the educational needs of residents while fostering safe patient care. Culture of Safety and High Reliability Definitions of the concept of a culture of safety vary, but organizations that establish a safety culture generally demonstrate the following characteristics Singer et al. Safety is considered the highest priority of the organization. There are strongly shared values and behavioral norms throughout the organization that are centered around safety. Resources and incentives are available for the organization to pursue and implement a safety commitment. There is non-hierarchical and open communication among workers—particularly in safety-related scenarios. There are rare occurrences of errors, but open recognition and reporting of them is accomplished without blame for individuals. Organizational learning is highly valued. High-reliability organizations HROs build on culture of safety elements to go beyond the norm and approach their goals of zero errors and avoidance of potential disasters, such as multiple deaths Weick and Sutcliffe, Businesses in particularly risky industries that could have a catastrophic impact on the public, such as military operations, commercial airlines, and nuclear power generation, were among the first to adopt the continual processes needed to achieve high-reliability operations while producing minimal errors. Although recognition of a safety culture and high-reliability components and practices e. Reasons for slow adoption by some institutions include resistance to organizational change Carroll and Quijada, and insufficient resources to support safety culture practices Patterson, , although some experts note that a major investment of resources is not necessary Hines et al. Tension can exist between the goals of a safety culture and individual residents, program directors, or departments, which is why leadership—at both the clinician and the executive levels—is a critical component in overcoming any resistance and establishing the importance of high reliability throughout an organization Roberts et al. Leaders in healthcare settings accomplish this by aligning incentives and encouraging the ideas that drive a culture of safety, promoting the continued progression of system redesign and eventually sustaining the developments made Roberts and Perryman, Suggesting that they be more active in establishing patient safety standards for clinical performance and that such practices become part of medical training is in line with recommendations from the IOM report To Err Is Human IOM, In an effort to take a

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lead in promoting a culture of safety for healthcare settings, the Agency for Healthcare Research and Quality AHRQ now encourages hospitals to adapt the concepts of high reliability to their organizations, along with the previously mentioned elements of safety culture Hines et al. The introduction of high-reliability practices is still relatively new in the medical field, and the exact impact of the culture of safety on specific improvements in healthcare organizations has yet to be documented on a broad scale Shojania, However, it is known that error rates in hospital care tend to be far greater than those associated with HROs in other industries e. The 44., estimated deaths in the United States related to medical errors are just one component of risks to patients. Many more nonfatal preventable events also harm patients, with impacts such as extended hospital stays, pain and suffering due to hospital acquired infections, or an adverse drug event. The frequency of such errors certainly indicates a need for improvement and is discussed in Chapter 6. In this chapter the focus is on organizational attitudes and culture: To prevent such occurrences, hospital environments that promote communications by all levels and professions of workers should be supported. This does not apply only to medical residents, but focusing attention on them may be a good place to introduce the culture change required for this shift to team mentality or shared responsibility and accountability in healthcare settings. However, to achieve stronger patient-physician relationships and serve its educational purpose, continuity of care relies heavily on the continuity of information itself. A service that must be available 24 hours daily, such as health care, requires transferring this information and responsibility of tasks from one team member to another at some point or points during the day. In a hospital setting, for example, where teams of physicians, nurses, and residents are all responsible for a single patient, continuity of care involves a comprehensive handover of patient information from one provider or team to another so that clinical care can be maintained successfully among a healthcare team. Handovers take place among teams of nurses, teams of physicians, and teams of residents, as well as between those teams and between integrated care teams consisting of various types of clinicians. Handovers occur between emergency departments, different inpatient settings from surgical to postoperative care, and different hospitals, not to mention transitions out of hospitals to nursing homes or home care settings Patterson et al. The act of transferring responsibility for patient care is not inherently a negative practice. However with each additional handover per patient, there is more opportunity for dilution or omission of information, which can lead to inaccuracies that affect patient care and outcomes Arora et al. Such communication breakdowns result in information gaps that intensify discontinuity of patient care and the potential for errors. These factors make them pivotal moments in the care continuum and an important aspect of preventing medical errors and ensuring patient safety Saultz, For residents, these exchanges are also opportunities for professional interaction, learning how to assess patient care situations, and problem solving. The next several sections discuss the role handovers play in the continuity of patient care, the impact they have on patient safety and resident education, how they are affected by the regulation of duty hours, and suggestions for redesigning handover processes to optimize patient safety and resident education. Consequences of Transfers and Communication Failure for Patient Safety Several studies, not specific to residents, highlight observed patient cases that point out the errorsâ€”at times fatalâ€”caused by poor communication during handovers Beach et al. An evaluation by the Joint Commission in of more than 3, root-cause analyses of reported error data revealed that nearly 70 percent of sentinel events in accredited healthcare entities result from communication failures Joint Commission International Center for Patient Safety, The Joint Commission further stated that there is evidence that at least half of such communication failures occur during handovers. In a study by Gandhi and colleagues, poorly executed handovers contributed to 20 percent 36 of of malpractice claims that resulted in serious harm or death to patients Gandhi et al. Additionally, poor handover and follow-up practices at discharge are particularly likely to increase safety risks for patients Forster et al. Poor discharge practices have been associated with higher readmittance rates or avoidable readmission of discharged patients Halasyamani et al. Because this evidence is not specific to residents, it demonstrates the extent to which poor communication permeates the health system, posing safety risks to patients. Among residents, however, communication failures are among the most common factors

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contributing to adverse patient events Sutcliffe et al. In a study by Singh , 19 percent 46 of cases with errors made by residents including interns and fellows that resulted in malpractice claims and led to medical injury of patients were attributed to poor handoffs. Another study by Arora et al. Variability of Handovers A likely contribution to errors during handovers is the variability of the handover process across settings without specification of the information that needs to be provided. Handover procedures and type of information transferred can vary from hospital to hospital and program to program within hospitals, and often are not structured or uniform between or among provider teams. Some use fax systems, others written tools, and others electronic tools, allowing handovers to take place either face-to-face, in written form only, in verbal form only, or in multiple formsâ€”amplifying the variability of the process and information that gets transmitted across teams and care units. Solet and colleagues illustrate such variations in a single internal medicine residency program that provides medical training across four different hospitals that each used different methods to transfer patient information. Three different computerized systems were utilized among the four institutions, and only two of the four used a computerized system for handovers. Other studies describe additional variations in handover processes and their differing degrees of effectiveness in communicating necessary patient information Borowitz et al. Impact of Duty Hour Regulations on Handovers and Continuity of Care Although fewer duty hours or appropriately placed rest periods may help to reduce fatigue in residents, they raise serious concerns for continuity of care. Practice has shown that the number of hours worked and the number of handovers among patients are inversely related, meaning that the fewer hours residents spend in the hospital, the more often patient care has to be handed over to other residents Horwitz et al. Therefore, shorter shifts to comply with the duty hour regulations and periods of sleep within extended duty periods, as this committee recommends, can result in an increase of handovers. In light of the error rates associated with handovers Arora and Farnan, ; Fletcher et al. In the United Kingdom, this same trend of increased handovers because of adherence to the European Working Time Directive has led its Department of Health to emphasize the effectiveness of handovers as an area of improvement for patient safety Sabir et al. Here in the United States, the Joint Commission has recently established a National Patient Safety Goal specific to improving handover practices which apply to all healthcare professionals, not only to residents as part of its accreditation process Joint Commission, Experts in the field suggest that many errors stemming from poor handovers are preventable or can be made less severe if hospitals take steps to improve communication and coordination of care Kripalani, , create better opportunities for interaction, and provide better guidance for the process. Examinations of hospital systems and resident programs have shown that structured and supervised handover procedures can dramatically decrease the rates of errors associated with them Catchpole et al. It has also been observed that implementing such processes is possible within current spending levels and without having to pass new legislation Coleman and Berenson, , thus building a case for improving quality of care through improved handovers. Instead of merely viewing more frequent handovers as an increased opportunity for error, they can be viewed as another opportunity for resident learning. Handovers are particularly crucial for all clinical staff to learn to navigate, and it is important that residents be familiar with effective strategies in order to apply them successfully in any setting. Suggestions for possible interventions and training follow in the next section. It is generally believed that providing some structure for handover procedures is the appropriate solution for improving outcomes. Other industries in high-risk or high-reliability environments have already identified aspects of handover processes, and several of their lessons or techniques are applicable to hospital settings Patterson et al. Examples from such industries were indeed drawn upon to help formulate the Joint Commission requirements for these procedures. Improve the Effectiveness of Communication Among Caregivers. Improving handovers provides an opportunity to restructure the way residents learn, possibly leading them to greater collaboration with peers and supervisors and helping them to build new skills that promote quality care. One-size-fits-all interventions or complete standardization of the process across all settings, however, is not feasible in a highly variable and complex system such as health care; therefore flexibility in adopting any suggested handover method would be crucial

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to its success Patterson, Application of core components should be evaluated for each setting and care scenario to ensure that they are not used superfluously and do not hinder existing effective transfer methods Patterson, ; Perry et al. It is expected that handover practices would be tailored somewhat to accommodate the differing needs of intensive care units compared to emergency rooms, surgical and internal medicine disciplines Arora and Johnson, , or outpatient and inpatient settings, but that core components would be instituted within a basic framework with consistent principles. Therefore, the basic elements that may help improve current medical handover processes presented in the following section are general suggestions. Limited data are available on the implementation of handover guidelines or their effectiveness, but the existing evidence suggests that following a somewhat structured protocol does improve resident communication Chung and Ahmed, and patient outcomes Catchpole et al. General Guidance for Improving Handovers One of the factors most consistently found in the research to help ensure successful handovers for residents is face-to-face interaction Horwitz et al. Most residency programs do solely written sign-outs, and there are times when physicians can be available only via phone or e-mail to exchange crucial information. However, direct face-to-face communication enhances the comprehension of written orders and allows for greater expression of what points need emphasizing and those that are less urgent Solet et al. This approach also allows residents to ask questions and clarify instructions, interactions that are helpful for learning and avoiding errors. Face-to-face communication also creates clearer transitions of responsibility and authority on a case, which some believe is equally important to recognize during the handover process Behara et al. Because of the benefits of face-to-face interactions, finding locations in which they can occur with limited distractions or interruptions may be helpful Perry et al. Building in overlap time between shift schedules also helps set aside the time for this type of interaction, improving handover processes and increasing their educational value by providing the opportunity to ask questions and clarify treatment plans or other pertinent information Afessa et al. Each of these actions is very team oriented and often requires training because they are not easily instituted by written standards alone. The literature further suggests that structuring the content of what is exchanged during handovers and using uniform language or terminology to communicate information assist in preventing omission of necessary information and help reduce confusion about what tasks are to be completed Arora et al. These checklists outline specific information to exchange during handovers such as patient name, diagnosis, pending tests, allergies to medications, and so forth. Ideally, they would be as concise as possible without omitting relevant information. More advanced tools that achieve this same goal are electronic sign-out systems. Electronic systems can improve handover content by providing structured, easy-to-access databases of patient information and creating formatted checklists of tasks that need to be considered for patient treatment. When residents record information electronically, they reduce paperwork and duplication. Electronic systems can also enhance the uniformity of terminology and procedures if multiple departments or an entire hospital uses the same electronic program, much like the Department of Veterans Affairs VA does with the system it recently adopted Carpenter, The VA system combines sign-out strategies by importing patient data electronically but also includes a free-text entry segment that allows users to personally add treatment plans or anticipated tasks Solet et al. Together, these factors can increase handover efficiency, reduce instances of content omission, and help resident and integrated teams have consistent and up-to-date information about their patients and care schedules. Although electronic systems have demonstrated improved resident performance and patient outcomes by reducing rates of adverse events and allowing residents more time to spend on direct patient care Petersen et al.

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Chapter 6 : Incident Reporting Systems - Patient Safety & Quality Healthcare

The WA Health system is based on a culture that values safety and quality in health care and focusses on system improvement. The Office of Patient Safety and Clinical Quality, Led by Dr Audrey Koay provide strategic direction to, and oversight of, the safety and quality of the WA public health service providers.

Sign up now Fall prevention: Simple tips to prevent falls Falls put you at risk of serious injury. Prevent falls with these simple fall-prevention measures, from reviewing your medications to hazard-proofing your home. As you get older, physical changes and health conditions “ and sometimes the medications used to treat those conditions “ make falls more likely. In fact, falls are a leading cause of injury among older adults. Instead, consider six simple fall-prevention strategies. Make an appointment with your doctor Begin your fall-prevention plan by making an appointment with your doctor. Be prepared to answer questions such as: What medications are you taking? Make a list of your prescription and over-the-counter medications and supplements, or bring them with you to the appointment. Your doctor can review your medications for side effects and interactions that may increase your risk of falling. To help with fall prevention, your doctor may consider weaning you off medications that make you tired or affect your thinking, such as sedatives and some types of antidepressants. Have you fallen before? Write down the details, including when, where and how you fell. Be prepared to discuss instances when you almost fell but were caught by someone or managed to grab hold of something just in time. Details such as these may help your doctor identify specific fall-prevention strategies. Could your health conditions cause a fall? Certain eye and ear disorders may increase your risk of falls. Be prepared to discuss your health conditions and how comfortable you are when you walk “ for example, do you feel any dizziness, joint pain, shortness of breath, or numbness in your feet and legs when you walk? Your doctor may evaluate your muscle strength, balance and walking style gait as well. Keep moving Physical activity can go a long way toward fall prevention. Such activities reduce the risk of falls by improving strength, balance, coordination and flexibility. He or she may recommend carefully monitored exercise programs or refer you to a physical therapist. The physical therapist can create a custom exercise program aimed at improving your balance, flexibility, muscle strength and gait. Wear sensible shoes Consider changing your footwear as part of your fall-prevention plan. High heels, floppy slippers and shoes with slick soles can make you slip, stumble and fall. So can walking in your stocking feet. Instead, wear properly fitting, sturdy shoes with nonskid soles. Sensible shoes may also reduce joint pain. Remove home hazards Take a look around your home. Your living room, kitchen, bedroom, bathroom, hallways and stairways may be filled with hazards. To make your home safer: Remove boxes, newspapers, electrical cords and phone cords from walkways. Move coffee tables, magazine racks and plant stands from high-traffic areas. Secure loose rugs with double-faced tape, tacks or a slip-resistant backing “ or remove loose rugs from your home. Repair loose, wooden floorboards and carpeting right away. Store clothing, dishes, food and other necessities within easy reach. Immediately clean spilled liquids, grease or food. Use nonslip mats in your bathtub or shower. Use a bath seat, which allows you to sit while showering. Light up your living space Keep your home brightly lit to avoid tripping on objects that are hard to see. Place night lights in your bedroom, bathroom and hallways. Place a lamp within reach of your bed for middle-of-the-night needs. Consider trading traditional switches for glow-in-the-dark or illuminated switches. Turn on the lights before going up or down stairs. Store flashlights in easy-to-find places in case of power outages. Use assistive devices Your doctor might recommend using a cane or walker to keep you steady. Other assistive devices can help, too. Hand rails for both sides of stairways Nonslip treads for bare-wood steps A raised toilet seat or one with armrests Grab bars for the shower or tub A sturdy plastic seat for the shower or tub “ plus a hand-held shower nozzle for bathing while sitting down If necessary, ask your doctor for a referral to an occupational therapist. He or she can help you brainstorm other fall-prevention strategies. Some solutions are easily installed and relatively inexpensive. Others may require professional help or a larger investment.

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Chapter 7 : Accidents and their Prevention. Accident prevention info. Patient | Patient

In Virginia Mason chose to integrate the risk management function into the patient safety department and since then have utilized the Virginia Mason Production System (VMPS) management methods, to continuously improve the patient safety system by enhancing transparency in reporting, disclosing, mitigating risk, and improving patient safety.

Medication Errors and Risk Management in Hospitals Medication errors are a serious threat to patient safety in both hospitals and in the community. Risk managers are taking a more proactive approach to preventing medication incidents in hospitals. This has been exemplified during my recent contacts with hospitals in the metropolitan Toronto area. There is evidently support for a change in culture in organizations, from a suppressive and closed error reporting culture to a more open and non-punitive culture. Most importantly, there is commitment to implementing quality improvement initiatives to ensure safer medication use systems in our hospitals. Although medication error reduction and prevention efforts need to be made by all health care disciplines, at all levels of the hospital, risk managers have a unique and important role to play: Facilitate the creation of an open and non-punitive culture in the organization to encourage error reporting, to ensure learning from error occurs, and ensure improvement needs are identified. Encourage reporting of "near-misses" to identify areas for improvement before an incident occurs. Coordinate educational sessions for staff to discuss errors and their prevention strategies. Focus efforts on specific high alert drugs and error-prone situations. References are available which identify these areas. Be involved in the review and "root-cause" analysis of medication errors. Participate and provide input into the development of quality improvement initiatives. Share error reduction and prevention strategies and other patient safety information with the other facilities In this article I would like to highlight two very important strategies for health care administration, risk managers and practitioners. It is unfortunate that many healthcare facilities still believe that their "error rate" is a measure of patient safety. The true incidence of medication errors will vary, depending very much on the vigor with which errors are identified and reported. Although many hospitals have a relatively standardized method to define a medication incident a medication error that reaches a patient , the manner in which they are detected and the efforts to report them differ widely. Simply comparing "numbers" of medication errors lacks validity, and more importantly can dangerously undermine efforts for full reporting. A high error rate could suggest unsafe medication practices or it could reflect an organizational culture which promotes error reporting. Likewise, low error rates may suggest a successful error prevention program or may be the result of an inherent punitive approach which inhibits individuals from reporting errors and analyzing causes of errors. Hospitals which focus their attention on maintaining a "low error rate", will inadvertently promote an unproductive cycle of underreporting of errors, and allow unrecognized weaknesses in the medication use system to continue. Low error rates can result in a false sense of security and an implicit acceptance of preventable errors. A focus on error rates derived from spontaneous reporting systems often places pressure on practitioners to report fewer errors. According to Michael Cohen, co-founder and president of ISMP US , analyzing the causes of actual incidents and potential incidents and implementing changes to address these causes, and measuring outcomes of the change is an effective and more meaningful way to gauge error prevention efforts. The self assessment tool is currently being adapted for Canadian Hospital use. The second important issue is the extraordinary similarities existing between infection control management and medication error prevention. In both scenarios, one must distinguish between the preventable and non-preventable events and, with rare exceptions, there are no "silver bullets" to eliminate problems identified. Both areas of prevention strategies require evaluating and searching through multiple systems and possible causes. Risk Managers and all disciplines committed to preventing errors can benefit from the vast body of knowledge, research, and experience that has been gained through the many infection control efforts made. Today, regulatory, accrediting, and other infection control advisory bodies recommend that hospitals employ specifically trained, dedicated practitioners to identify the presence of nosocomial infections AND coordinate

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an effective infection control plan". Typically, infection control surveillance is focused on high priority areas with increased risk of serious infections, such as intensive care units, and surgical patients etc. The CDC no longer recommends the use of an overall nosocomial infection rate from hospital-wide surveillance for hospital comparisons. Such broad determinations are left to researchers and focused research. Trained infection control practitioners collect data on nosocomial infections in a uniform manner from multiple sources, rather than relying only on information that may be readily available through self-reports or medical records abstractors. Extensive time is devoted to analysis of the data, implementation of infection control strategies, evaluation of their effectiveness, education and dissemination of the information. There is no doubt we can learn to do better by learning from another setting. There is a great deal of reference material available to risk managers, which discusses documented reported actual and potential medication errors and also suggests recommendations to prevent errors in healthcare organizations. One excellent source of information is the Medication Safety Alert! This newsletter is a subscription service provided by ISMP to over hospitals, other healthcare organizations and practitioners in the US. Should you like to have a complimentary copy of the newsletter, please send your request via email to info@ismp-canada.com. ISMP Canada is an independent nonprofit organization established for the collection and analysis of medication error reports and the development of recommendations for the enhancement of patient safety. ISMP Canada also intends to serve as a national resource for promoting safe medication practices throughout the health care community in Canada. For additional information, please visit our web site: