# Strengthening IPC for Effective Epidemic Preparedness

**FOCAL PERSONS IPC TRAINING**

## Topic: Introduction to Patient Safety

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# Outline

- Introduction
- 10 facts about patient safety
- Patient practices
- Types and causes of harmful practices
- General patient safety guidelines

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# Introduction

- **Patient safety is a serious global public health issue. Estimates show that in developed countries as many as one in 10 patients is harmed while receiving hospital care.**

- **Of every hundred 100 hospitalized patients at any given time, 7 in developed and 10 in developing countries will acquire health care-associated infections. Hundreds of millions of patients are affected by this worldwide each year.**

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# Cont.

- Adverse events may result from problems in practice, products, procedures or systems. Patient safety improvements demand a complex system-wide effort, involving a wide range of actions in performance improvement, environmental safety and risk management, including infection control, safe use of medicines, equipment safety, safe clinical practice and safe environment of care.

- In recent years, countries have increasingly recognized the importance of improving patient safety. In 2002, WHO Member States agreed on a World Health Assembly resolution on patient safety.

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# 10 Facts about patient safety -WHO

1. Patient safety is a serious global public health issue:
2. One in 10 patients may be harmed while in hospital:
3. Hospital infections affect 14 out of every 100 patients admitted
4. Most people lack access to appropriate medical devices
5. Unsafe injections decreased by 88% from 2000 to 2010
6. Delivery of safe surgery requires a teamwork approach
7. About 20%–40% of all health spending is wasted due to poor-quality care
8. A poor safety record for health care
9. Patient and community engagement and empowerment are key
10. Hospital partnerships can play a critical role

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# Patient safety defination

- **Patient Safety:** "Patient safety is a fundamental principle of health care. Every point in the process of care-giving contains a certain degree of inherent unsafely"

- "Patient safety is the avoidance, prevention and amelioration of adverse outcomes/injuries stemming from the process of care"

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# Cont.

- Patient safety was defined by the Institute of Medicine (IOM) as “the prevention of harm to patients.” Emphasis is placed on the system of care delivery that

(1) prevents errors;

(2) learns from the errors that do occur; and

(3) is built on a culture of safety that involves health care professionals, organizations, and patients.

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# Safety tip

**S** – Sense the Error

**A** – Act to prevent it

**F** – Follow safety guidelines

**E** – Enquire into accident/deaths

**T** – Take appropriate remedial measure

**Y** – Your responsibility

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# Quality care

- **Quality Care:** The Institute of Medicine (IOM) defined quality as the “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

- **Patient safety practices:** “Patient safety practices have been defined as “those that reduce the risk of adverse events related to exposure to medical care across a range of diagnoses or conditions”

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# Patient safety practices

- Appropriate use of prophylaxis to prevent venous thromboembolism in patients at risk
- Use of perioperative beta-blockers in appropriate patients to prevent perioperative morbidity and mortality
- Use of maximum sterile barriers while placing central intravenous catheters to prevent infections
- Appropriate use of antibiotic prophylaxis in surgical patients to prevent postoperative infections
- Asking that patients recall and restate what they have been told during the informed-consent process to verify their understanding

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- ➢Continuous aspiration of subglottic secretions to prevent ventilator-associated pneumonia
- ➢Use of pressure-relieving bedding materials to prevent pressure ulcers
- ➢Use of real-time ultrasound guidance during central line insertion to prevent complications
- ➢Patient self-management for warfarin (Coumadin) to achieve appropriate outpatient anticoagulation and prevent complications
- ➢Appropriate provision of nutrition, with a particular emphasis on early enteral nutrition in critically ill and surgical patients, to prevent complications

# Cont.

- Use of antibiotic-impregnated central venous catheters to prevent catheter-related infections

- Use of simulators, bar coding, computerized physician order entry, and crew resource management, have been considered as possible strategies to avoid patient safety errors and improve health care processes;

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# Categories of errors and harmful Events

- **The types of error and harm are further classified regarding domain, or where they occurred across the spectrum of health care providers and settings.**

**Such events may be related to;**

- **Professional practice**
- **Health care products**
- **Procedures and systems including prescribing; order communication; product labeling; packaging; compounding; dispensing; distribution; administration; monitoring and use.**

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# Types and causes of harmful events

- **Sentinal event:** Unexpected incident involving dead or serious physical or psychological injury or the risk thereof;

The fundamental of sentinel event reporting is corrective in nature and identification of appropriate actions to prevent recurrence

- **Near miss or "Close call":** An event or situation that could have resulted in an accident injury or illness, but did not either by chance or timely intervention.

It is a serious error or mishap that has the potential to cause an adverse event but fails to do so because of chance or it is intercepted.

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- **Latent failure:** An error that precipitated as a consequence of management and organization processes that poses the greatest danger to complex systems.

Latent failures cannot be foreseen but, if detected, they can be corrected before they contribute to mishaps.

This involves removal from the practitioner and involving decisions that affect the organizational policies, procedures, allocation of resources

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# Cont.

- **Risk**: Any exposure to harmful event. It is directly related to hazards and vulnerability and inversely to capacity.
- **Adverse drug reaction**: Any undesirable or unexpected medication related event that requires discontinuing a medication or modifying the dose, or requires prolong hospitalization, results in disability, requires supportive treatment, is life threatening or results in dead, results in congenital abnormalities or occurs following vaccination

# Cont.

- **Medication Error:** Any preventable event that may cause or lead to inappropriate use or patient harm while the medication in control of the health care professional, patient or consumer.

- **Unexpected event:** Any situation that is not consistent with the routine operation of the safety a patient. All events identified should be reported following the patient incident report policy utilizing patient incident report.

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# General patient safety guidelines

- Better lighting and work clutter in work areas where medications are prepared, keeping distractions to a minimum, and keeping noise levels down
- Drug companies and healthcare facilities should also standardize medication labels and packaging.
- Medications that are having a particular dangerous effect are marked as “high alert”.
- Hospitals should embark on technology to minimize errors such as computerized prescription system, machines that dispense medications for just one patient at a time.

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- Patients are given identification bracelets showing their names and allergies
- All medical personnel are required to wear name tags showing their level of training
- Unacceptable abbreviations are not used in documentations and medical records
- Two identifiers are checked prior to procedures and medication administration
- Physician’s verbal and telephone orders are read back to the physician
- Medication is labeled appropriately

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# Cont.

- Hand washing guidelines are utilized
- Medications are reconciled by the physician on discharge
- Fall prevention
- Encourage patient involvement in their own care
- Pressure ulcer prevention
- Time out procedures prior to procedures requiring anesthesia or conscious sedation.
- Blood components checked by two registered nurses at the bedside of the patient.

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# Thank You!

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