Patients safety organizations

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Introduction

Occurrence of adverse events due to unsafe care:

one of the 10 leading causes of death and disability

in the world

Introduction (Cont…)

- **Globally:**
  - 4 in 10 patients are harmed in primary and outpatient health care
  - Up to 80% of harm is preventable
  - The most detrimental errors are related to diagnosis, prescription and the use of medicines

- **In high-income countries**
  - one in every 10 patients is harmed while receiving hospital care
  - nearly 50% of them being preventable.

- **In low- and middle-income countries:**
  - Each year, 134 million adverse events occur in hospitals
  - unsafe care: resulting in 2.6 million deaths
  - two-thirds of all adverse events resulting from unsafe care

Investment in reducing patient harm lead to:

significant financial savings

better patient outcomes

Patient safety

- Patient safety: fundamental to delivering quality essential health services
- Aim: prevent and reduce risks, errors and harm that occur to patients during provision of health care

situations cause concern about patient safety

- **Medication errors:**
  - leading cause of injury and avoidable harm in health care systems
  - globally, the cost associated with medication errors has been estimated at US$ 42 billion annually
- **Health care-associated infections**
  - occur in 7 out of every 100 hospitalized patients in high-income countries
  - occur in 10 out of every 100 hospitalized patients in middle-income countries
- **Unsafe surgical care procedures**
  - cause complications in up to 25% of patients
- **Unsafe injections practices**
  - can transmit infections, including HIV and hepatitis B and C, and pose direct danger to patients and health care workers;

situations cause concern about patient safety

- **Diagnostic errors**
  - occur in about 5% of adults in outpatient care settings, more than half of which have the potential to cause severe harm.
- **Unsafe transfusion practices**
  - expose patients to the risk of adverse transfusion reactions and the transmission of infections
- **Radiation errors**
  - involve overexposure to radiation and cases of wrong-patient and wrong-site identification
  - overall incidence of errors is around 15 per 10 000 treatment courses
- **Venous thromboembolism (blood clots)**
  - is one of the most common and preventable causes of patient harm
  - contributing to one third of the complications attributed to hospitalization
  - Annually, there are an estimated 3.9 million cases in high-income countries and 6 million cases in low- and middle-income countries

General Strategies to Improve Patient Safety

- **Work with a Patient Safety Organization (PSO)**

- **Use real-time alerts and reporting tools**
  - providing healthcare organizations with technologies that alert doctors and nurses to major changes in vital signs or to potential patient emergencies.

- **Improve data transparency.**
  - By reporting and compiling data, clinicians can identify some of their vulnerabilities and put safeguards in place

- **Revise handover processes**
  - In a handover, one provider transfers patient responsibility to another, and a new "attending" physician makes decisions about care. Ensuring the right processes are in place for distributing accurate patient information is essential for high-quality care

Patient safety organizations (PSO)

- Health care organizations cannot judge the safety of the care without data and information related to patient safety
- PSOs conduct activities to improve the safety and quality of patient care
- PSOs create a legally secure environment where clinicians and health care organizations can voluntarily report, aggregate, and analyze data, with the goal of reducing the risks and hazards associated with patient care
- The Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act) authorized the creation of PSOs and the development of Common Formats for uniform reporting of patient safety events

PSOs functions

- Collect data on the prevalence and individual details of errors
- Analyze sources of error Propose and disseminate methods for error prevention
- Design and conduct pilot projects to study safety initiatives, including monitoring of results
- Raise awareness and inform the public, health professionals, providers, purchasers, and employers
- Conduct fundraising and provide funding for research and safety projects
- Advocate for regulatory and legislative changes

3 types of patient safety events that can be reported to a PSO

- incidents
  - events, accidents, or errors that actually reached the patient even if there was no harm (eg, wrong dose of drug given but no side effects or harm).
- near-misses
  - events, accidents, or errors that did not reach the patient (eg, wrong dose of drug drawn up or pulled but caught before administration)
- unsafe conditions
  - situations that could potentially result in a patient safety event (eg, drug labels or packaging of 2 very different drugs are noted to be remarkably alike and therefore could be mistakenly administered).

All of these events, once reported, can result in the identification of system errors and the anticipation of potential safety issues, hopefully resulting in the development of solutions and preventive practices.

Benefits of PSOs

Over half of hospitals surveyed work with a PSO and nearly all of them say **PSOs are valuable**

Eight of every 10 hospitals that work with a PSO say the feedback has helped them **prevent future patient safety events**

Nearly two-thirds of hospitals that work with PSOs say the PSO's analysis resulted in **measurable improvements in patient safety**

Active PSOs Worldwide

PSOs

- **World Alliance for Patient Safety**:
  - WHO launched the World Alliance for Patient Safety in October 2004
  - The goal was to develop standards for patient safety and assist UN member states to improve the safety of health care

- **Patients for Patient Safety (PfPS)**
  - it is part of the World Alliance for Patient Safety
  - PFPS works with a global network of patients, consumers, caregivers, and consumer organizations to support patient involvement in patient safety programmes, both within countries and in the global programmes of the World Alliance for Patient Safety

PSOs in United Kingdom & USA

UK:

- National Patient Safety Agency
- National Institute for Health and Clinical Excellence
- US:
- The Agency for Healthcare Research and Quality
- Food and Drug Administration

PSOs in Australia and New Zealand

- **Therapeutic Goods Administration and Adverse Drug Reactions Advisory Committee**
- **Australian Commission on Safety and Quality in Health Care**
- **New Zealand Health Quality & Safety Commission**

The Agency for Healthcare Research and Quality (AHRQ)

- **The lead federal agency for health care safety**
- **From 2010–2013, it**
  - **prevented 1.3 million errors,**
  - **saved 50,000 lives,**
  - **avoided $12 billion in wasteful spending**

Patient safety, Iran

- The Ministry of Health and Medical Education implemented the Patient Safety Friendly Hospital Initiatives in 2010
- It was initially piloted in 10 hospitals
- The hospitals have been internally and externally assessed and by 2015 the Initiative will be expanded to a further 50 hospitals.

main objective of Patient Safety Friendly Hospital program

- Achieve implementation of a critical standard
- To ensure better implementation of standards in pilot hospitals:
  - a team composing a physician, a nurse and hospital manager was established in each hospital

Patient Safety Friendly Hospital domains

- PSFH in Iran include 140 standrds in 5 following domains:

- Domain A: Leadership and management
- Domain B: Patient and public involvement
- Domain C: Safe evidence-based clinical practices
- Domain D: Safe environment standards
- Domain E: Lifelong learning standards

Conclusion

- Health care delivery organizations have a unique opportunity to advance efforts to improve patient safety through participation in PSOs.
- PSO programs provide a forum for understanding, collaboration, and translation of evidence into practice at a faster pace than traditional methods of scientific review and deliberation.
- PSO programs help to promote a culture of safety in support of medicine's primary view to "first, do no harm"

Thank you
for your attention