

III International Conference on Patient Safety -- Patients for Patient Safety

Patient Safety Solutions

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WHO World Alliance for Patient Safety

**to address the problem of
patient safety worldwide**

World Alliance on Patient Safety Strands

- Global Patient Safety Challenge
- Patients for Patient Safety
- International Patient Safety Events Taxonomy
- Reporting Systems
- Research
- Dissemination of Patient Safety Solutions

Solutions for Patient Safety



10. august 2004

Beskyttelsesfiksering med blodtætte

Der kan være risiko for at patienter kan komme i klemme ved brug af bløde strømfætre. Dette er især skadeligt, hvis bæltet ikke kan tilpasses patienten på en hensigtsmæssig måde.

Hvorfor?

Beskyttelsesfiksering og brug af blodtætte har en positiv klinisk effekt. *Journal of Clinical Pharmacy and Therapeutics*, 2004

En util hændelse

En ældre der lever under de mest af dårligt beskyttelsesbånd blev anvendt ring indtil patienten sov

Ten tips for patients

- 1 Speak up if you have any questions or concerns. It is important that you understand your treatment, findings so far, and the reasons for your examination. Do not accept answers that you do not understand!
- 2 Let us know about your habits. Please let the staff if you are on medication, any alternative treatment, dietary supplements, natural health products, and if you are on a special diet. If you are allergic to medication, foods, or other...

...uring your stay. Your experience during your illness. In addition, it is usually to down your questions, so that you will remember to ask the staff.

When better

Bring a family member or a friend to the doctor on examinations and results. If more people hear what the doctor has to say, the risk of misunderstandings and

...omebody else handle your consultation for the energy for, if you are welcome to ask the staff and treatment with one of your family members.

...personal data and personal identification number with the staff. Initials, treatment, or administration of medication.

Your operation

If it is a good idea to go over the surgeon prior to the operation, find out if the surgeon to your body that needs surgery in the procedure.

Side effects

If you know your symptoms, don't appear in other places than the

Large from hospital

...about how the treatment is to continue and so yourself.

Medication you are taking

...in the name of the medication you are taking, its effect, when to take it. Keep a list of the medication you are taking to know the side effects, and ask the staff about any types of pills, which may reduce the effect of the treatment.



MEDICATION ALERT!

From the Medication Safety Taskforce of the Australian Council for Safety and Quality in Health Care

The purpose of this alert is to provide frontline health professionals and administrators with information on high risk medications that have the potential to cause serious or catastrophic harm to patients. The intention is to raise awareness of the potential harm and provide a strategy for local level response.

Alert 1, October 2003

POTASSIUM CHLORIDE can be fatal

Prepared appropriately

Chief Executive Officers of Services, Doctors, Nurses

...on immediately

...olated with the preparation and patients are at risk. Ampoules

...been identified routinely

...es are mistaken for ampoules (saline) when reconstituting in accidental overdose of potas

...mice (a diuretic), but a potassium. This type of cognitive error is seen in patients who are taking fr

...potassium chloride is prepared in

...non cause root cause—potassium only other patient care areas.

...ES OF POTASSIUM CHLORIDE WITH PREMIXED WITH INTRAVENOUS potassium chloride kept as a stock item in wards.

...concentrations and doses of potassium chloride ampoules and ready identification from prep

...ly to ampoules of potassium



Clean hands help to save lives

Healthcare associated infection leads to the death of 5,000 patients and costs the NHS £1 billion a year. International studies show that infection rates can be reduced by 50% when healthcare staff properly clean their hands.

...ch cause infection, but miss infect or wash their hands

...using their hands between a trust has indicated that at the point of care and and hygiene rises significantly

...overhaul: campaign later 10 lives and 140 million a lot nationally. For a trust of £400,000 a year, or a

...x the campaign, NHS acute

...nt of care across their

...already begun this work,

...to the near future. Use

...with the use and storage of

...Partnership and Safety Agency

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Safer practice notice



Notice

20 May 2004 Issue 1

Improving infusion device safety

Fifteen million infusions are performed in the NHS every year. The vast majority are delivered safely. However, at least 700 unsafe incidents are reported each year, of which 10 per cent are attributed to user error.

A National Patient Safety Agency (NPSA) pilot study has helped to confirm the root causes of those incidents where no fault with the equipment has been identified. These are:

- 1 trusts have a wider range of infusion device types than they need and too many with a higher specification than is necessary;
- 2 staff training is not a priority or competency-based;
- 3 devices of the same type have multiple configurations and react differently under the same circumstances;
- 4 investigate the benefits of a centralised equipment library.

Action for the NHS

To reduce the risk of patient safety incidents involving infusion devices, NHS acute trusts in England and Wales are advised to take the following steps within the NHS financial year 2004/5:

- 1 review how purchasing decisions are made;
- 2 evaluate the necessity for an infusion device before it is purchased;
- 3 reduce the range of infusion device types in use, and within each type, have agreed default configurations;
- 4 investigate the benefits of a centralised equipment library.

The NPSA has developed a toolkit to help trusts review their existing device management systems, as well as assess the potential for significant cost benefits and improved patient safety.

For response by: NHS acute trusts in England and Wales for advice by: Safety Alert Broadcast Systems Nation officers (England and Wales) governance leads (Wales) - to distribute to: Heads of pharmaceutical engineering departments

We recommend you also inform: Trustee director Board member with responsibility for device management

A summary of this safer practice notice is on the NPSA website and can be used for briefing NHS staff and patients.



National Patient Safety Agency

TrygFonden

BankTalker - Bank for Patients



Definition

A Patient Safety Solution is any system design or intervention that has demonstrated the ability to prevent or mitigate patient harm stemming from the processes of health care.

WHO Collaborating Center on Patient Safety Solutions

- Identify Current Regional Safety Problems and Solutions Available
- Understand Regional Barriers to Solutions
- Assess Risk of Solutions
- Adapt Solutions to Local/Regional Needs
- Develop Disseminate Solutions

Solutions Development Process

- Literature Search – March-April 2007
- International Steering Committee - April
- Complete Draft Solutions – Apr-Aug
- Review by Advisory Groups – Aug-Nov
- International Field Review – Dec-Feb
- Approval by International Steering Committee - April 2008

International Collaborative Network

- Advisory Structure & Network
 - International Steering Committee
 - Regional Advisory Councils
 - National Patient Safety Agencies
 - National Accrediting Bodies
 - NGOs & Others (IHF, WMA, NPSF, etc.)

Utilize Global Regional Advisory Councils

Assure appropriateness of solutions to unique health care systems in countries

- Asia-Pacific
- Middle East and Northern Africa
- Europe
- Africa
- Americas

2007 Solutions – inaugural set

- **Look-Alike, Sound-Alike Medication Names**
- **Patient Identification**
- **Communication During Patient Hand-Overs**
- **Performance of Correct Procedure at Correct Body Site**
- **Control of Concentrated Electrolyte Solutions**
- **Assuring Medication Accuracy at Transitions in Care**
- **Avoiding Catheter and Tubing Mis-connections**
- **Single Use of Injection Devices**
- **Improved Hand Hygiene to Prevent Health Care Associated Infections**

Template for Solutions

- Statement of Problem and Impact
- Associated Issues
- Suggested Actions
- Looking Forward
- Strength of Evidence
- Applicability
- Engaging Patients and Families
- Potential Barriers
- Risks for <unintended Consequences
- Selected References and Resources

Communication During Patient Hand-Over

Patient Safety Solutions
| volume 1, solution 3 | May 2007



Gaps in hand-over (or hand-off) communication between patient care units, and between and among care teams, can cause serious breakdowns in the continuity of care, inappropriate treatment, and potential harm for the patient. The recommendations for improving patient hand-overs include using protocols for communicating critical information; providing opportunities for practitioners to ask and resolve questions during the hand-over; and involving patients and families in the hand-over process.

Engaging Patients and Families

- Provide information to patients about their medical conditions and treatment care plan in a way that is understandable to the patient.
- Make patients aware of their prescribed medications, doses, and required time between medications.
- Inform patients who the responsible provider of care is during each shift and who to contact if they have a concern about the safety or quality of care.
- Provide patients with the opportunity to read their own medical record as a patient safety strategy.

Engaging Patients and Families

- - Create opportunities for patients and family members to address any medical care questions or concerns with their health care providers.
 - Inform patients and family members of the next steps in their care, so they can be available to communicate this to the care provider on the next shift, and so they are prepared to be transferred from one setting to the next, or to their home.
 - Involve patients and family members in decisions about their care at the level of involvement that they choose.

2008 Solutions

1. Preventing Pressure Ulcers
2. Responding to the Deteriorating Patient
3. Communicating Critical Test Results
4. Preventing Central Line Infections
5. Preventing Patient Falls in Health Care Organizations

Action on Patient Safety – High 5s

- To achieve significant, sustained, and measurable reduction in the occurrence of 5 patient safety problems over 5 years in at least 7 countries and
- To build an international, collaborative learning network that fosters the sharing of knowledge and experience in implementing innovative, standardized, safety operating protocols.

High 5s Solution Topics

- Communication During Patient Hand-overs
- Performance of Correct Procedure at Correct Body Site
- Medication Reconciliation
- Control of Concentrated Electrolyte Solutions
- Hand Hygiene

High 5s Participating Countries

- Australia
- Canada
- Germany
- Netherlands
- New Zealand
- United Kingdom
- United States

Phases of High 5s Initiative

- Phase One – Launch and Development of Standardized Protocols
- Phase Two – Learning
- Phase Three – Evaluation and Spread

National Patient Safety Goals

- Annual selection of topics
- Patient Safety experts prioritize topics
- National Field Review of draft NPSGs
- Requirement of Accreditation

2008 National Patient Safety Goals

1. Patient identification
2. Communication among caregivers
3. Medication safety
7. Health care-associated infections
8. Medication reconciliation
9. Patient falls
10. Flu & pneumonia immunization
11. Surgical fires
13. Patient involvement
14. Pressure ulcers
15. Focused risk assessment (suicide; home fires)
16. Rapid response to changes in patient condition
- Universal Protocol for Preventing WSS

NPSG #13

Goal 13: Encourage the active involvement of patient and their families in the patients own care as a patient safety strategy

Requirement: Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.

Speak UP

HELP PREVENT
ERRORS IN
YOUR CARE

Everyone has a role in making health care safe — physicians, health care executives, nurses and technicians. Health care organizations across the country are working to make health care safety a priority. You, as the patient, can also play a vital role in making your care safe by becoming an active, involved and informed member of your health care team.

An Institute of Medicine (IOM) report has identified the occurrence of medical errors as a serious problem in the health care system. The IOM recommends, among other things, that a concerted effort be made to improve the public's awareness of the problem.

The "Speak Up" program, sponsored by the Joint Commission on Accreditation of Healthcare Organizations, urges patients to get involved in their care. Such efforts to increase consumer awareness and involvement are supported by the Centers for Medicare and Medicaid Services. This initiative provides simple advice on how you, as the patient, can make your care a positive experience. After all, research shows that patients who take part in decisions about their health care are more likely to have better outcomes.

**To prevent
health care errors,
patients are
urged to ...**

Speak UP™



Joint Commission
on Accreditation of Healthcare Organizations
www.jcaho.org



Organizations can order campaign buttons that can be worn by staff.

Brochures can be printed that have a blank panel to allow for information about the organization, its commitment to patient safety, and the organization logo.

Speak Up

To help prevent health care errors, patients are urged to:

Speak up if you have questions or concerns, and if you don't understand, ask again. It's your body and you have a right to know.

Pay attention to the care you are receiving. Make sure you're getting the right treatments and medications by the right health care professionals. Don't assume anything.

Educate yourself about your diagnosis, the medical tests you are undergoing, and your treatment plan.

Ask a trusted family member or friend to be your advocate.

Know what medications you take and why you take them. Medication errors are the most common health care mistakes.

Use a hospital, clinic, surgery center, or other type of health care organization that has undergone a rigorous on-site evaluation against established, state-of-the-art quality and safety standards, such as that provided by the Joint Commission.

Participate in all decisions about your treatment. You are the center of the health care team.

For more information:

The Joint Commission International Web Site

www.jcrinc.com

The Joint Commission Web Site

www.jointcommission.org

Joint Commission International Center for Patient Safety

www.jcipatientsafety.org

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