

Southwestern Surgical Congress: Claude H. Organ, Jr. Memorial Lecture

Patient safety: the what, how, and when



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Abstract Patient safety is a construct that implies behavior intended to minimize the risk of harm to patients through effectiveness and individual performance designed to avoid injuries to patients from the care that is intended to help them. The Accreditation Council for Graduate Medical Education has made patient safety a focused area in the new Clinical Learning Environment Review process. This lecture will focus on definitions of patient safety terminology; describe the culture of patient safety and a just culture; discuss what to report, who to report it too, and methods of conducting patient safety investigations.

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It is with great respect for Dr. Claude Organ Jr. and Dr. Ronny Stewart that I give this Dr. Claude Organ Jr. Memorial lecture. This is such an honor for me to be selected to give this lecture to the membership of the Southwest Surgical Congress. I have made great friends at the annual meeting. I have put into practice a numerous things that I have learned attending the scientific sessions. I have been updated on the priorities of the American College of Surgeons and the American Board of Surgery that affect my practice at the special sessions. I have encouraged prior trainees and junior faculty to join this association for these reasons.

I read the presidential address “You can make a difference” by Dr. Organ in 2003, and the statement resounded with me in my daily practice.¹ I try to follow his advice in academic practice and try to make a difference in the area

of this address, patient safety. I hope to assist those of you who are in attendance in understanding the terms of patient safety, reporting and investigating areas for improvement.

I want first to take a moment to publicly thank Dr. Ronny Stewart for his support of my career; opportunities to assist on committee work for this association and the opportunity to give this lecture. I hesitated when offered this most recent opportunity; however, when Ronny stated that I could talk about what I was passionate about my anxiety lessened, and I was hooked. My passion for the past 25 years, sometimes to my own detriment, has been the patients that I have the privilege of treating. Patients and their families do incredible things for physicians and the institution when they sense that those caring for them are concerned for their safety and passionate about what they do. We have had patients who have been injured in all terrain vehicle crashes now participate in public service announcements to promote all terrain vehicle safety. We have had patients and their families testify before the state legislature to help “save the trauma center” and the trauma system because of the high burden of uncompensated care. As I stated, patients and family will do incredible things when they feel that someone sincerely cares about them, their outcome, and their safety.

I have been involved in patient safety throughout my entire surgical career. Not at the level of Dr. Lucian Leape,

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Dr. Peter Pronovost, or Dr. Atul Gawande, but with similar passion at a small scale for the patients that I have the pleasure of providing care. The patients and families that are so appreciative of health care providers that care, pay attention to details, and coordinate their care when multiple professionals and disciplines are involved in their care. I do believe in this complex care of critical patients that checklists are important, appropriate handovers are required, and cohesive teams need to be formulated in care units. Attention to safety and communication will assist us in prevention of preventable deaths as outlined in the book *Josie's Story* by Sorrel King.² Josie King's preventable death was the inspiration for Peter Pronovost dedication to patient safety initiatives and the development of a simple checklist that has saved thousands of lives.³ Patients and families will repay us many times over with appreciation for making their care safe and providing honest communication on concerns.

Patient safety is a construct that implies behavior intended to minimize the risk of harm to patients through both system effectiveness and individual performance designed to avoid injuries to patients from the care that is intended to help them. In short, the World Health Organization defines patient safety as "freedom...from unnecessary harm or potential harm associated with health care."⁴ The Accreditation Council for Graduate Medical Education has made patient safety a focused area in the new Clinical Learning Environment Review (CLER) process. The intent of the CLER process is to review program and institutional attributes that have a salutary effect on quality and safety in settings where residents learn and on the quality of care rendered after graduation.⁵ CLER has 6 focus areas: supervision, transitions of care, professionalism, health care quality, duty hours and fatigue management and patient safety.⁶ The core recommendations are for faculty development for a shared common academic and clinical vision for patient safety, integration of quality, and patient safety concepts into meaningful learning experiences for residents and fellows and that this is supported at the college level with identification, development, and support of a critical mass of faculty experts in quality and safety. The CLER pathways to excellence in patient safety include education for reporting adverse events, close calls (near misses), appreciation of a culture of safety, and involving residents and fellows in patient safety investigations and follow-up. The first patient safety CLER pathway requires knowledge of the roles and responsibilities of residents in reporting, how to report, and knowledge of a central repository for reports at the institution. To meet these pathway requirements, residents will need to know the basic definitions for patient safety.

The first basic term is what is harm? Harm is an unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment, or hospitalization, or that result in death. Next, a sentinel event is an unexpected occurrence that resulted in death or psychological injury to a patient, such as a transfusion reaction, medication error, or abductions from

the facility. Sentinel events require immediate investigations and response, and each facility should have policies that define these events and the process of investigation. A "never event" or serious reportable event is preventable, serious, and unambiguous adverse events that should never occur. This includes death or serious harm to a patient that results from an error or lapse in a health care facility. Examples of surgical "never events" include wrong site surgery, procedure on the wrong patient, wrong procedure on a patient, unintended retention of a foreign objects after surgery or invasive procedure, and intraoperative or immediately postoperative and/or postprocedure death in an ASA Class I patient. An error is a failure of a planned action to be completed as intended. An error may not be serious but may be reportable. An error can result from a "slip" which is an observable error, such as a nurse grabbing the wrong medication or an oxygen tank gets hooked to the laparoscopic tower instead of CO₂ or you watch a resident introduce a right upper quadrant laparoscopic trocar into the liver. An error may result from a "lapse" that is not observable, the individual simply forgot. An example is forgetting to order a chest x-ray after line placement or to order antibiotics in a septic patient. If the patient in the first example decompensates later from a tension pneumothorax, that was a lapse which resulted in a treatment error. Errors such as slips or lapses may be the result of fatigue, anxiety, fear, anger, or illness that clouded judgment. Errors can also be violations which are deliberate deviation from an operating procedure, standard, or rule. Violations if observable should be stopped at the time of occurrence. All team members have the right to "stop the line" because of concern for a safety issue. This can be done gently by requesting clarity about the process from the individual involved or more assertive by using CUS—I am Concerned, I am Uncomfortable, and this is a Safety issue, please stop. These techniques may be used in operating room settings when there is failure to follow the time out checklist or in the intensive care unit during central line placement and failure to follow appropriate procedure checklists.

Lucian Leape, the father of safety, has been known to state that error is inevitable. "Physicians and nurses need to accept the notion that error is an inevitable accompaniment of human conditions, even among conscientious professionals with high standards. Errors must be accepted as evidence of system flaws not character flaws."⁷ We are human we are going to make errors but we need systems that will assist us in catching them and not harming patients. We need to intercept the errors before they cause harm. We need to find the hazard and the near misses and learn from them before there is a serious injury or fatality. Leape describes errors in 4 major categories.⁸ A diagnostic error is an error or delay in diagnosis, failure to use indicated tests or use of outmoded tests or failure to act on results of testing. Preventive error is to fail to provide prophylactic treatment, inadequate monitoring, or inadequate follow-up of treatment. Treatment errors are errors in the performance of an operation, administering treatment, wrong dose, delay

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