Patient Safety

What is patient Safety?

BUILDING A SAFER HEALTH SYSTEM

Patient Safety

To err is human, and expecting flawless performance from human beings working in **complex**, **high-stress environments** is **unrealistic!**

Patient Safety

- Patient Safety is a health care discipline that emerged with the evolving complexity in health care systems and the resulting rise of patient harm in health care facilities.

- It **aims** to prevent and reduce risks, errors and harm that occur to patients during provision of health care.
- A cornerstone of the discipline is continuous improvement based on **learning from errors and adverse events.**

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- Patient safety is fundamental to delivering quality essential health services.

- Indeed, there is a clear consensus that **quality health services** across the world should be:

➢ Effective

➢ Safe

➢ People-centered

Key facts

- The occurrence of adverse events due to unsafe care is likely one of the 10 leading causes of death and disability in the world .
- In high-income countries, it is estimated that one in every 10 patients is harmed while receiving hospital care.
- The harm can be caused by a range of adverse events, with nearly 50% of them being preventable.

Key facts

- Each year, 134 million adverse events occur in hospitals in low- and middle-income countries (LMICs), due to unsafe care, resulting in 2.6 million deaths.
- Another study has estimated that around two-thirds of all adverse events resulting from unsafe care, and the years lost to disability and death (known as disability adjusted life years, or DALYs) occur in LMICs.
- Globally, as many as 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 OECD countries, 15% of total hospital activity and expenditure is a direct result of adverse events.

Why does patient harm occur?

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- A mature health system takes into account the increasing complexity in health care settings that make humans more prone to mistakes.

- For example, a patient in hospital might receive a wrong medication because of a mix-up that occurs due to similar packaging.

Who is to blame?????

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- In this case, the prescription passes through different levels of care starting with the doctor in the ward, then to the pharmacy for dispensing and finally to the nurse who administers the wrong medication to the patient.

- Had there been safe guarding processes in place at the different levels, this error could have been quickly identified and corrected.

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Underlying factors :

- Lack of standard procedures for storage of medications that **look alike**
- Poor communication between the different providers
- Lack of verification before medication administration
- Lack of involvement of patients

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- Traditionally, the individual provider who actively made the mistake (**active error**) would take the blame for such an incident occurring and might also be punished as a result.
- Unfortunately, this does not consider the factors in **the system** previously described that led to the occurrence of error (**latent errors**).
- **It is when multiple latent errors align that an active error reaches the patient.**

Types of Error

- **Medication errors** are a 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 and 10 out of every 100 hospitalized patients in high-income countries and low- and middle-income countries respectively.

- **Unsafe surgical care** procedures cause complications in up to 25% of patients. Almost 7 million surgical patients suffer significant complications annually, 1 million of whom die during or immediately following surgery.

Types of Error

- **Unsafe injections practices** in health care settings can transmit infections, including HIV and hepatitis B and C, and pose direct danger to patients and health care workers; they account for a burden of harm estimated at 9.2 million years of life lost to disability and death worldwide (known as Disability Adjusted Life Years (DALYs)) .
- **Diagnostic errors** occur in about 5% of adults in outpatient care settings, more than half of which have the potential to cause severe harm. Most people will suffer a diagnostic error in their lifetime.
- **Unsafe transfusion practices** expose patients to the risk of adverse transfusion reactions and the transmission of infections. Data on adverse transfusion reactions from a group of 21 countries show an average incidence of 8.7 serious reactions per 100 000 distributed blood components.

Types of Error

- **Radiation errors** involve overexposure to radiation and cases of wrong-patient and wrong-site identification. A review of 30 years of published data on safety in radiotherapy estimates that the overall incidence of errors is around 15 per 10 000 treatment courses .
- **Sepsis** is frequently not diagnosed early enough to save a patient's life. Because these infections are often resistant to antibiotics, they can rapidly lead to deteriorating clinical conditions, affecting an estimated 31 million people worldwide and causing over 5 million deaths per year.
- **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.

Key strategic action areas

- providing global leadership and fostering collaboration between Member States and relevant stakeholders
- setting global priorities for action
- developing guidelines and tools
- providing technical support and building capacity of Member States
- engaging patients and families for safer health care
- monitoring improvements in patient safety
- conducting research in the area

Thank you!