Research Paper Medical Science

Patient Safety and Risk Management

K.N.Dave Associate Professor,Department of Biochemistry,LokamnyaTilak Municipal Medical College,Mumbai.

Dr.Kapil.A.Das Associate Professor and Acting Head,Department of Ophthalmology,H.B.T Medical College, Mumbai-56.

KEYWORDS

This article has frequently referred to the need to have policies, procedures and training for the patient safety. These are important but they will achieve nothing unless they are part of a patient safety culture where every one ,from the most senior staff to most junior,understands the importance of patient safety and why it matters.

Training of staff should show how everything they learn affects the safety of patients. Senior staff should lead by example- junior will imitate what they do.Staff should understand why it is important that equipment is properly used,that infection control and hygiene are carried out properly; that instructions are clearly understood and followed correctly ;that prescriptions are written carefully and so on.

One way of helping staff to understand about safety and learn from mistakes is to have an adverse incident reporting system. When something goes wrong, the staff involved should be able to report what has happened without fear of undue blame and the events leading up to the incident or error should be reviewed to know what went wrong and to see if it can be prevented in the future.

Many useful lessons about safety have been learnt from similar incidents reported in different places. As a result ,the common causes have to be indentified and the knowledge to be shared.

It can be useful to have designated staff with responsibility for coordinating all the patient safety activities ;For instance, ensuring that policies are up to date and that staff receives training when they need to. But it is important that they are not seen as the person or team responsible for the patient safety. The people responsible for patient safety are members of the staff who have anything to do with that patient- whether as doctor or nurse, therapist or technician,cleaner or cook,engineer or purchase clerk paying for drugs.Anyone who has a job in a hospital makes patient safer when they do their job properly and work well as part of the hospital team.

Even as modern healthcare continues to achieve excellent results, all too often patients are put at risk either through errors or through failure to assess their needs properly, manage their care and recognize deterioration.

The 'right thing' might also mean having up-to-date knowledge and skills to allow clinicians to give their patients the best care. Much of the patient safety activity at the moment is focused on good patient management using proven methods, sophisticated instruments, quality control (internal and external)standard operating procedures (SOP).Perfect standardization of methods, reporting the reports in the time are the factors which counts the patients safety and allow the right treatment to give best prognosis.

A classic example is to restrict the use of antibiotics to patients with bacterial infections rather than viruses to reduce the spread of antibiotic resistance and opportunistic bowel infection. The need to do this has been recognized for decades but changing practices can be painfully slow. All healthcare organizations need to consider how much they can rely on individual clinician's judgement and to what extent they can intervene with directives or by taking action to force compliance with changes

The right patient:
This sounds painfully obvious ,but many error occurs because patient have similar names. Errors could have occur when the wrong patient is taken to X-Ray or a doctor picks up the wrong set of notes or specimens are mislabelled or even because in busy ward there is a new patient on bed. It should be routine for staff to check at each stage of care that they are dealing with the correct patient and if they have heard the patient's name correctly when they are asked to carry out an instruction.

The right method:
This includes for instance ,ensuring that diagnostic tests are performed and interpreted correctly. Similarly,many errors occur where drugs are given by the wrong route or in the wrong concentration . One very well known case in England involved a chemotherapy drug,Vincristine, being administered into the spine instead of vein. When this happens it is always fatal.

Obviously all invasive procedures must be carried out by competent staff or staff under competent supervision. It is important and advisable that training and written procedures (SOPs-Systemic Operating Procedures)are in place to ensure that 'right method 'is followed .It is also important that untrained ,unskilled, unexperienced staff know that (and abstain from)they should not perform certain procedures which carry significant risks. This risks may put patient's life in dangerous situation.

Ensuring the right method also means having systems in place to keep medical equipment clean and in good working order. Patients are safer when staff do not have to choose between similar pieces of equipment which work in different ways ,such as one hr and 24 hr infusion pumps ,it is not always easy to standardize equipment ,but when new equipment is chosen, ease of use and potential risk should be taken into account .For any new equipment, their maintainance, the quality control, theaccuracy, the precision, the follow up (half yearly or yearly)should be the usual procedure , which should be done by the concerned staff in the department.

The right time:
Again it seems obvious but this includes giving drugs as prescribed and not getting confused by 24 hour clock. More

subtle care management such as not giving a drug or treatment when there is a contraindication, checking the patient and recording observations as and when required, recognizing the need for pain relief or other symptoms control and acting properly if the patient's condition is deteriorating. Many hospitals have introduced 'early warning systems' design to alert staff about deteriorating patient and to guide and empower them to seek senior assistance.

Good Communication:

"In healthcare, information, especially the one related to the patient's health, is key to the care provided. Faulty treatments, in most cases, can be attributed to improper communication of critical data"The opening comment in the editorial of Asian hospital and Healthcare management issue 16,illustrates clearly why good communication about patient care is as important a component of safety as all the treatments that the patient receives.

Other article in that issue and recent editions talk about the need to communicate well with the patient and their family. It helps not only patients in understanding their condition but also healthcare providers in providing proper care to the patients .Listening to what patients have to say and respecting their wishes forms the basis to healthcare in 21stcentury. More over patients who feel involved and in control of their care tend to do better and more satisfied with the care they receive. A smooth 'Doctor- Patient,'relationship' may improve the healthcare . In communication between doctor and patient, there should be frankness reciprocating the fact about illness and their plan of treatment and prognosis which will create a faith, trust and confidence in both of them.

Patient records:

Many teams are involved in the care for patients in a modern hospital.This includes doctors ,nurses therapists, technicians, pharmacists etc. Their relationship with each other requires sharing of information and acting on instructions. The doctor or nurse on duty must know what was done to the patient the previous day and why. And in their shift they must record changes in patient's condition ,results of a tests, new plans for care and anything else that everyone carrying for the patient needs to know.

The vital information remains useless if it is not shared. It will not be shared if different professionals keep their own records. Hospitals should review their systems for storing patient information and sharing it through team reports, ward meetings or by any other means. Many errors occur when messages (through E-mail,sms,whatsapp)are not passed on or something is not written in the notes or when what has been written is not clear and can be misunderstood.

There should be policies and training to ensure that all records are kept properly .The details of when and who should write in the records should be clearly mentioned. They should also specify the means to ensure that all the information is filled correctly and new information is seen (such as test results)and dealt with appropriately.

Openness:

Good communication is important beyond the patient record-in how staff talks to patients and each other .Many industries have learnt that it is important for safety to have a culture where no one is above criticism(because any human being can make mistake) and where junior staff can put forward suggestions or concerns and have to treated with respect. Valid suggestions or criticism should be welcomed by superior or senior staff to improve the administrations and management which will put the whole system in good shape to improve the patient healthcare.