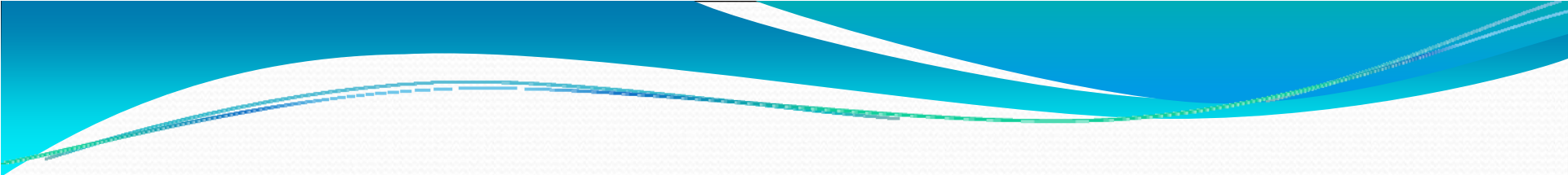


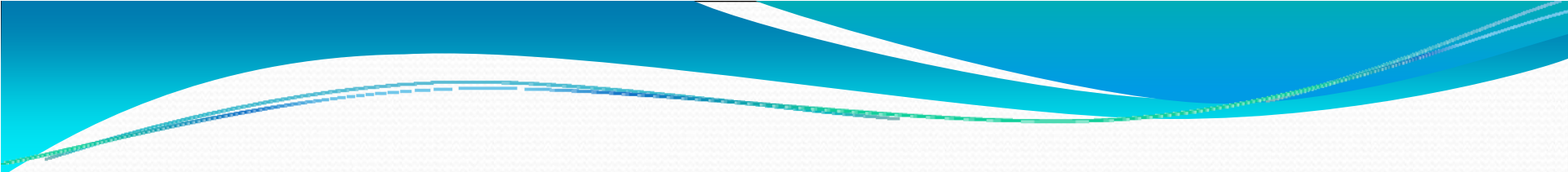
- In May 2006, Mrs O. G. the proprietress of a group of schools in Abuja went to the Hospital to complain of fever and headaches. A diagnosis of malaria was made and she was given Amalar (sulphonamide). The doctor did not check her drug allergy history which indicated that she had previously reacted to Fansidar. She developed the Steven-Johnson Syndrome and died 3 weeks later

- 
- In August 2005, Alhaji A. A was nervous for his wife, Z. A. In their home in the Lagos she was suffering excruciating headaches and high fevers.
 - Accompanying her to hospital, he was unable to get attention and answers as doctors handed over her case from one team to another without a definite diagnosis. Her diagnosis was changed five times over ten days, with a final diagnosis of meningitis. The delay was fatal and Mrs. Z.A, a young mother with a seven-month old child, died of her infection.

**PATIENT SAFETY-
OUR RESPONSIBILITY**

DR AJIBIKE OYEWUMI

FWACS, CPHQ

- 
- 4TH century Hippocratic oath – Pledge to “prescribe regimens for the good of my patients according to my ability and judgment and never do harm to anyone”
 - ***PRIMUM NON NOCERE*** – A central tenet of Medical practise

Winning isn't Everything... It is the ONLY thing!



Patient Safety isn't Everything... It is
the **ONLY** thing!

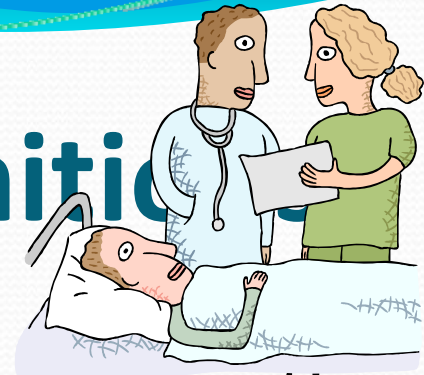


Is Health Care Unsafe?

On balance, our health care system does much more good than harm, but there are problems...

- Mrs O. G
- Alhaji A. A

IOM *To Err is Human* Definitions



Adverse Event(AE):

Injury caused by medical management rather than underlying disease/condition of patient

Error:

- 1) *Planning*: Use of a wrong plan to achieve desired aim
- 2) *Execution*: Failure of a planned action to be completed as intended.

Source: IOM Report

COUNTRY	ADVERSE EVENTS RATES(%)
worldwide	4 – 16 (Hospital Patients)
Australia	10.6
Denmark	9.0
South Africa	12 – 35 (ICU)
United Kingdom	11.7%
United States of America	3.8 – 5.4

Data/Studies



- 1 in 4 patients that experienced a patient-safe incident died.
- 44,000 - 98,000 deaths/year
- 6th leading cause of death, ahead of car crashes, Diabetes, breast cancer & AIDS (USA)
- United States - \$17 - 29 billion in lost income, disability and health care costs annually
- United Kingdom - £ 2 billion yearly in extra bed days

Error rate is equivalent to two 747's crashing every week

Data/Studies

- 5% to 10% of patients acquire one or more infections in health facilities, the risk being **two to 20 times** higher in developing countries, with patients undergoing surgery being the most affected.
- In 2004, 7% of countries in the African Region did not test all donated blood for HIV; 22% did not test for hepatitis B and 51% did not test for hepatitis C. The proportion of infections caused by syringes or needles reused without sterilization ranged from 1.5% to 69.4%

- Dr Luis Sambo, WHO Regional Director for Africa

Data/Studies

In developing countries:

- 77% of all reported cases of counterfeit and substandard drugs
- 50% of all medical equipment is unusable or only partially usable at any given time.

Source: WHO report on patient safety (2002)

Data/Studies

- Overall, WHO estimates that 1 in every 10 persons receiving healthcare will suffer harm

How dangerous is health care?

- Less than one death per 100 000 encounters
 - Nuclear power
 - European railroads
 - Scheduled airlines
- One death in less than 100 000 but more than 1000 encounters
 - Driving
 - Chemical manufacturing
- More than one death per 1000 encounters
 - Bungee jumping
 - Mountain climbing
 - Health care

What is Safe Care?

- Identifying what works – **effective practice**
- Ensuring that the patient gets it - **appropriate use**
- Delivering care flawlessly – **no errors**

Patient Safety Values, Goals & Aims

- No needless deaths
- No needless delays
- No waste
- No needless pain or suffering
- No helplessness

What are Health care Errors?

- Failure to diagnose / incorrect diagnosis
- Failure to provide adequate observation
- Failure to utilize or act on diagnostic test
- Use of inappropriate or outmoded diagnostic test or procedure
- Failure to provide follow-up
- Medication error / adverse drug event
- Wrong-site surgery; surgical error
- Transfusion error

JCI SENTINEL EVENTS DATABASE JAN '95 THROUGH DEC'06

- 531 events of wrong site surgery
- 520 inpatient suicide
- 488 operative/post op complications
- 385 events relating to medication errors
- 302 deaths related to delay in treatment
- 224 patient falls
- 153 deaths of patients in restraints
- 125 perinatal deaths/injury
- 94 transfusion related events
- 85 infection related events
- 67 anaesthesia related events
- 66 fires
- 51 retained foreign body

Why Errors Happen

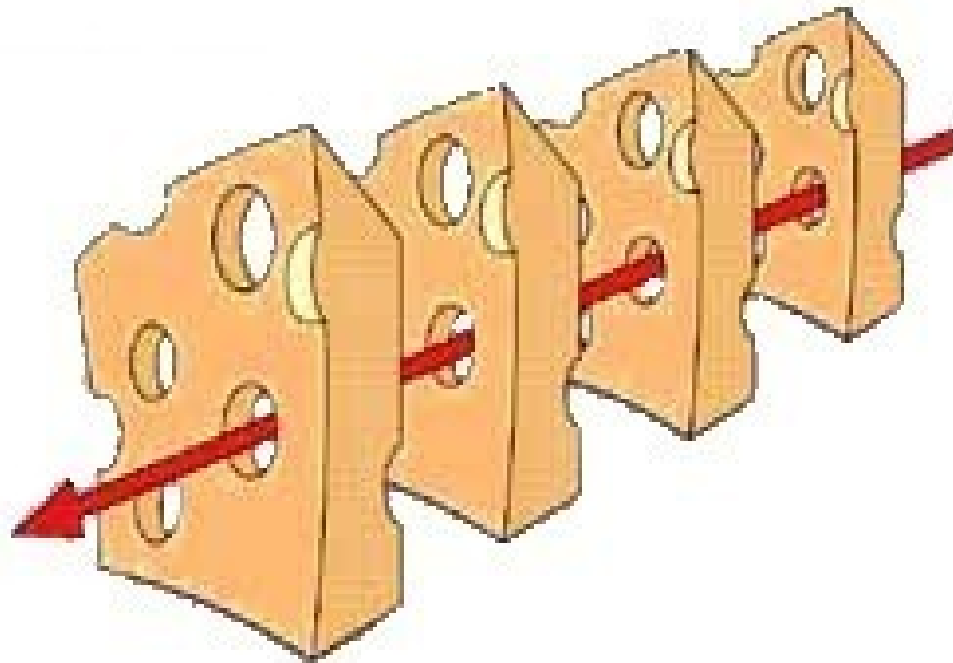
- Many and varied interactions with technology
- Many individuals involved in care; multiple hand-offs; poor communication among caregivers
- High acuity of illness or injury
- Ambient environment prone to distraction
- Need for rapid decisions; time pressures
- High volume, unpredictable patient flow
- Lethargy; short staffing

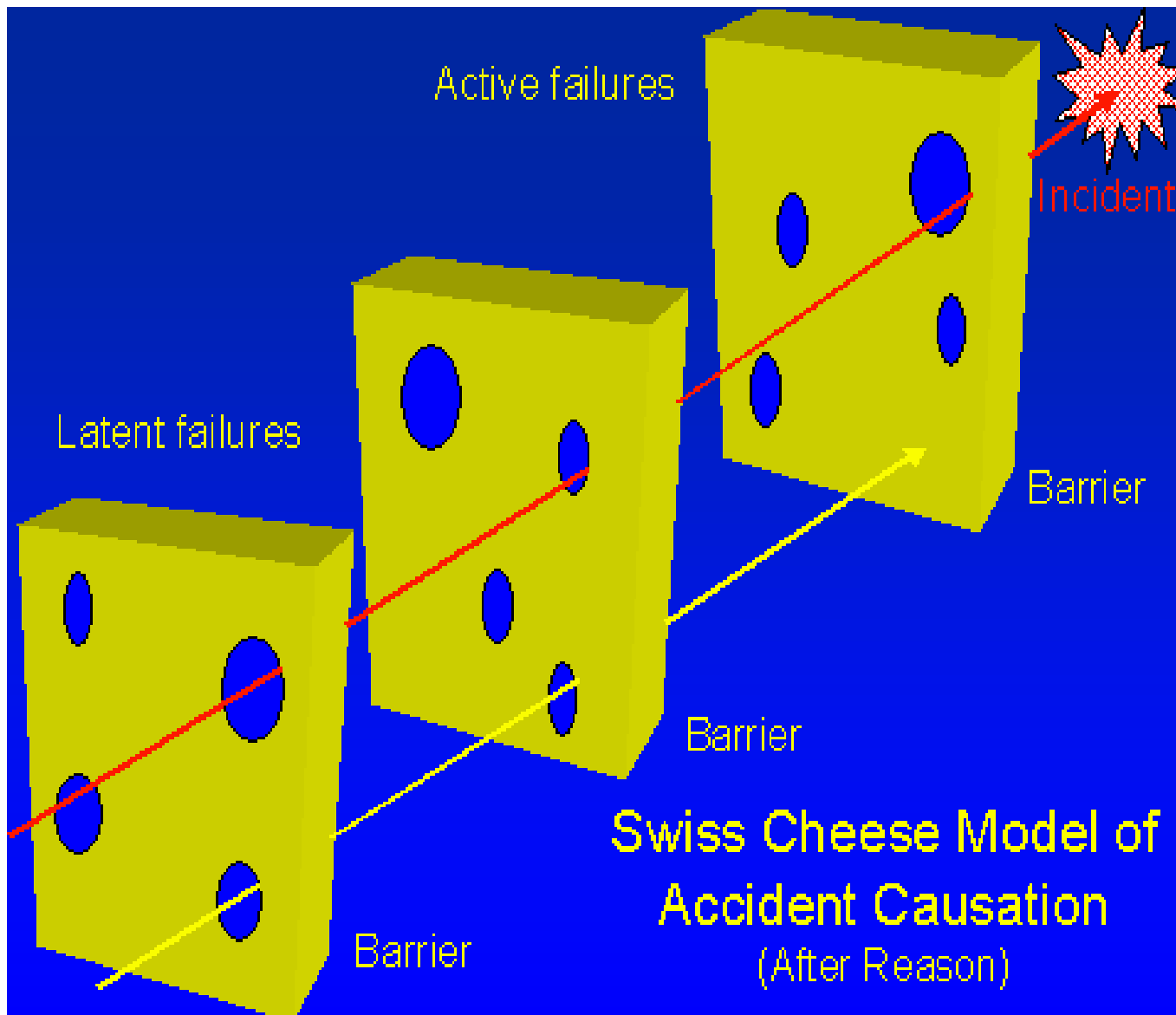
Why Errors Happen

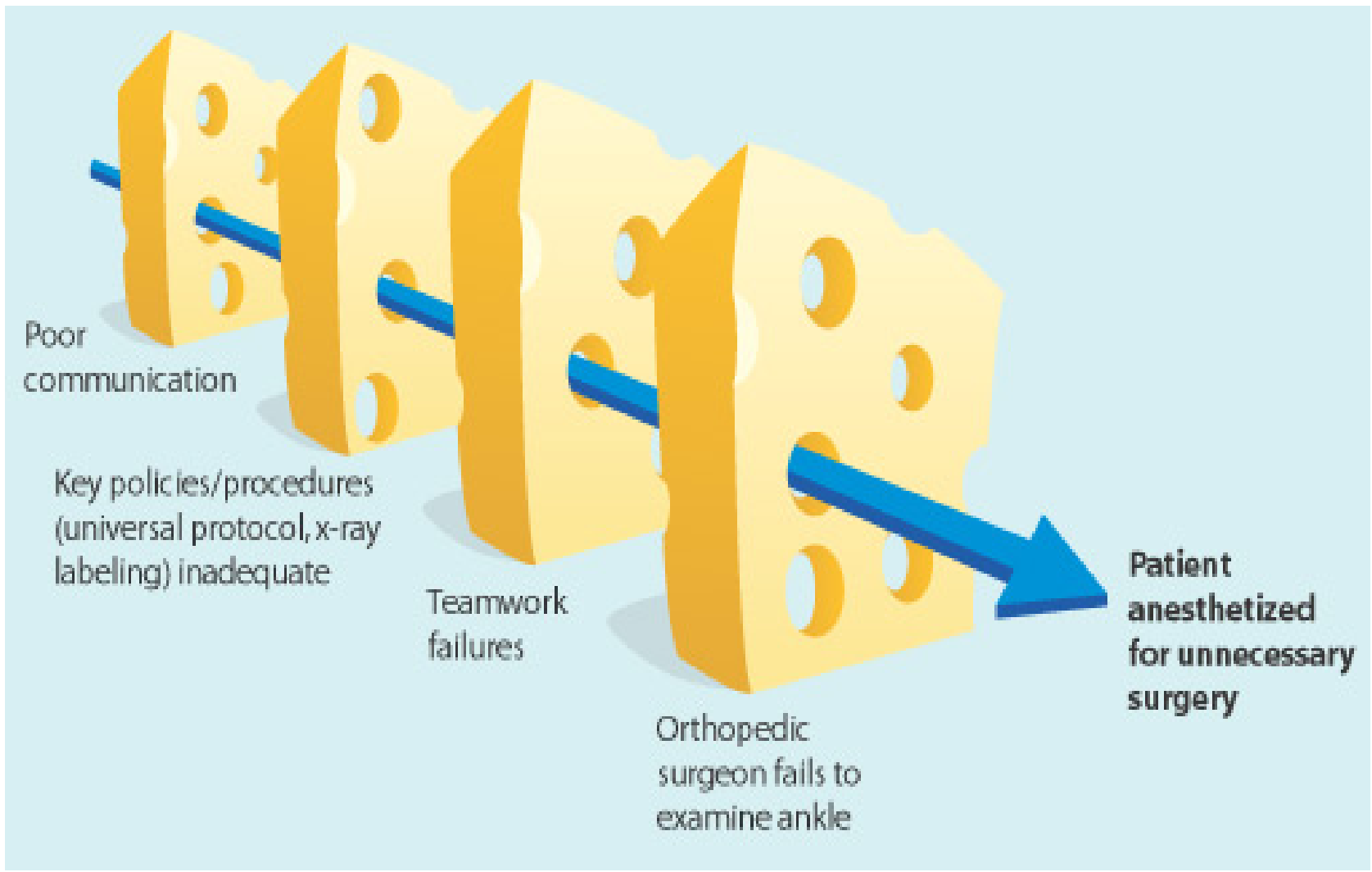
- Process of care delivery is inherently unsafe
 - Side-effects of drugs
 - Hazards posed by medical devices
 - Human shortcomings
- Prime responsibility - deficiencies in systems designs, organisation and operation.
- **NOT INDIVIDUALS!!!**

Reason's Swiss Cheese Model

multiple errors combine to create major adverse events
because of inadequate defenses, explains many adverse
patient events







Key Issues in Patient Safety

- Responsibility for leadership to create environment that:
 - encourages error identification and remedial steps to reduce risk of future recurrences, and
 - Minimizes individual blame or retribution for the involved staff and for the reporter
- Organizational engagement in proactive systems analysis as an error prevention strategy

Key Issues In Patient Safety

- Training at all levels that addresses teamwork and error identification, analysis and prevention;
- Importance of effective communication in the care delivery process;
- Use of knowledge-based information (Evidenced-Based Practice);
- Need to inform patient, and when appropriate, patient's family, of unanticipated outcomes of care.

Ten Actions Which Could Significantly Improve Patient

Safety In The African Region.

Dr Sambo - fifty-eighth session of the WHO Regional Committee for Africa which took place in Yaoundé, Cameroon, September 2008.

- Development of a national policy for patient safety;
- Raising awareness of all stakeholders on the importance of patient safety;
- ensuring safe surgical care;
- Minimizing healthcare-associated infections;
- ensuring adequate funding for patient safety activities.



Ten Actions Which Could Significantly Improve Patient Safety In The African Region.

- improving knowledge and learning in patient safety;
- re-orienting health systems to make patient safety an integral part of quality care;
- ensuring appropriate use, quality and safety of medicines;
- and strengthening surveillance and capacity for research.

Role of Hospital Accreditation In Ensuring Patient Safety

- Standards express a minimum acceptable criteria
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation was an effective intervention to drive efforts to reduce medical errors.
- Found to be the primary driver of safety efforts



Summary

- The issue of patient safety and adverse events is one of the most challenging in health care today. Despite medical breakthrough and an ever –expanding knowledge base, thousands of adverse events that have potentially dire consequences occur routinely in health care organisations around the globe



Conclusion

- Adverse events are very personal tragedies for patients and their families and have a profound negative impact on healthcare professionals, health care organisations and health care systems

***LET US DO OUR PART TO IMPROVE
PATIENT SAFETY***

*THANK YOU
FOR LISTENING*





**THANK YOU FOR
LISTENING**