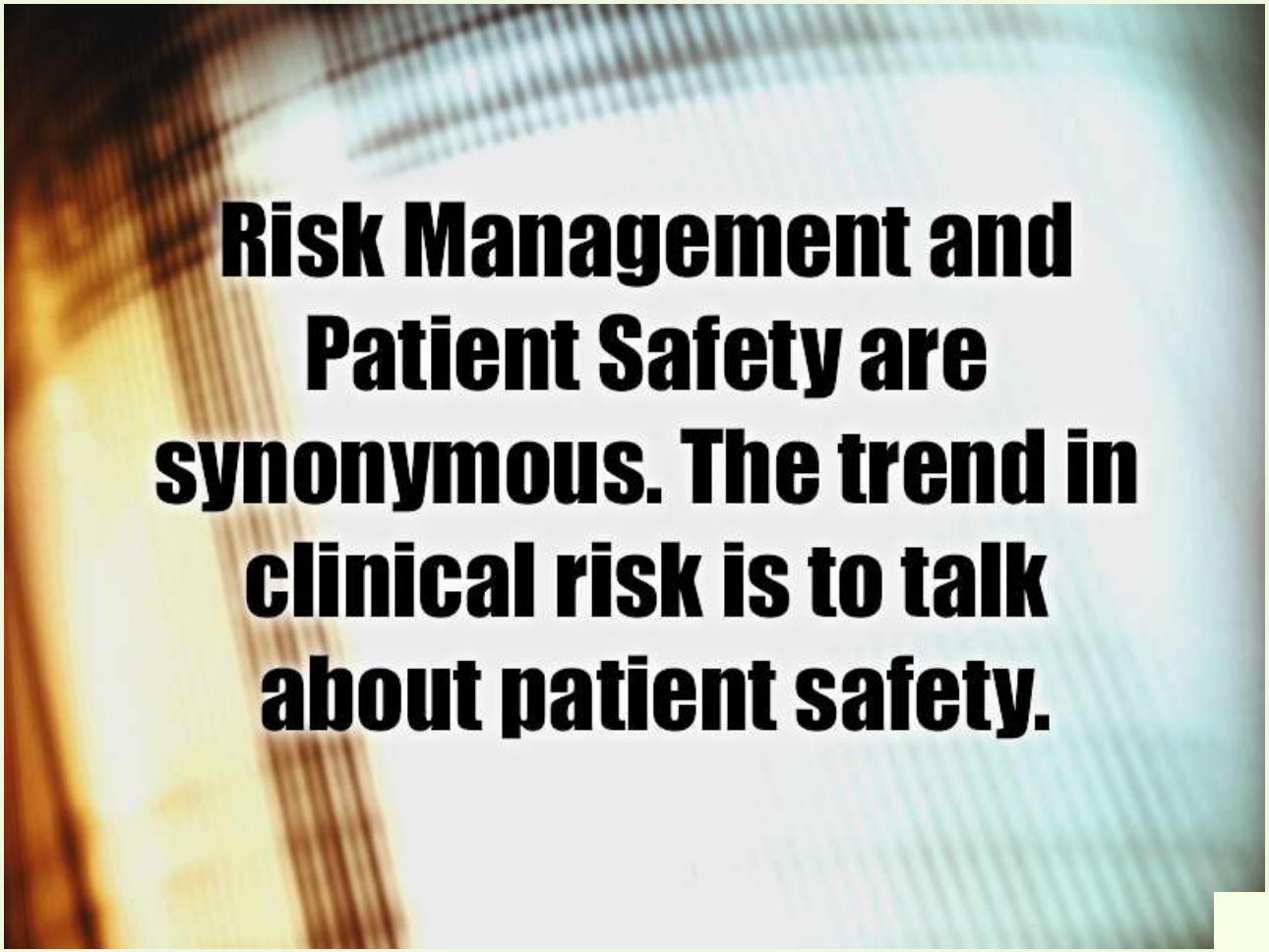
九十五年度中區醫療區域輔導暨醫療資源整合計劃

「醫療事故風險管理研習會」

醫療風險管理及病人安全最新趨勢

財團法人仁愛醫院

總院長　詹廖明義


Risk Management and
Patient Safety are
synonymous. The trend in
clinical risk is to talk
about patient safety.

Presentation Outline

1. ***How to build and maintain a hospitalwide culture of safety***
2. ***Principles & practice***
3. ***Why so important***
4. ***Ideals vs Realities***
5. ***Recent topics and trend***

Presentation Objectives

1.Define "culture of safety"

2.Identify steps to build a culture of safety

3.Discuss methods to improve patient safety

4.Keep abreast of what's new


Patient-Centeredness
first and foremost,
it means SAFETY.

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Risk Management
(ASHRM)
1. crisis management
2. claims management
3. risk financing
4. patient safety

Categories of Risk

- ***Patient care-related risks***
- ***Medical staff-related risks***
- ***Employee-related risks***
- ***Property-related risks***
- ***Financial risks***
- ***Other risks(infrastructure, reputation, marketplace etc.)***

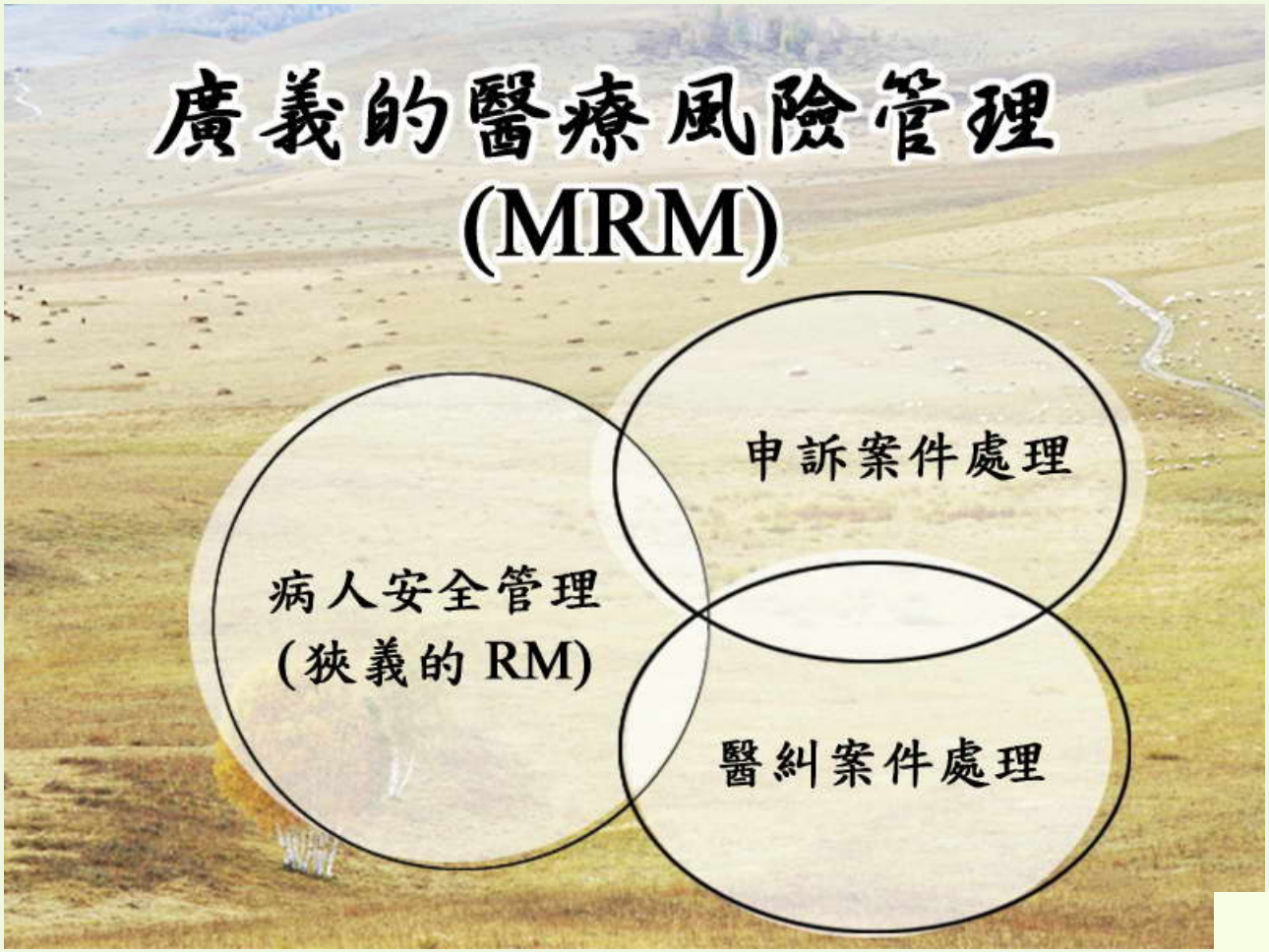
MRM的目標

1.Medical QA

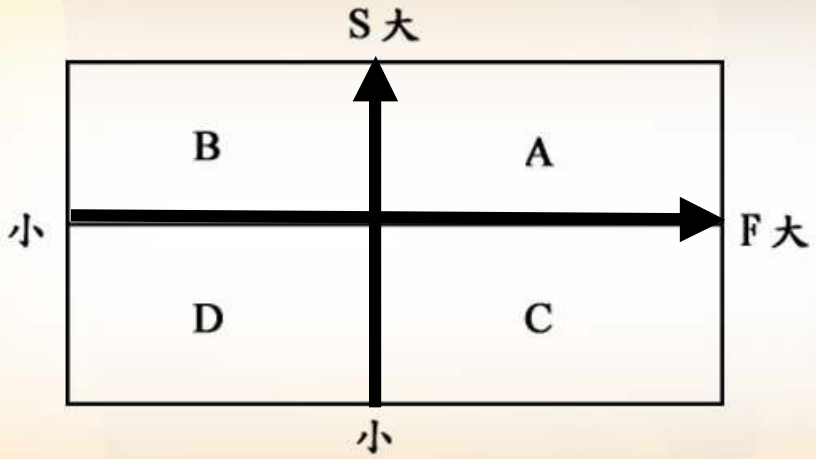
2.Patient Safety

3.Loss prevention + Mitigation

4.Litigation prevention


廣義的醫療風險管理
(MRM)
病人安全管理
(狹義的 RM)
申訴案件處理
醫糾案件處理

Risk Control



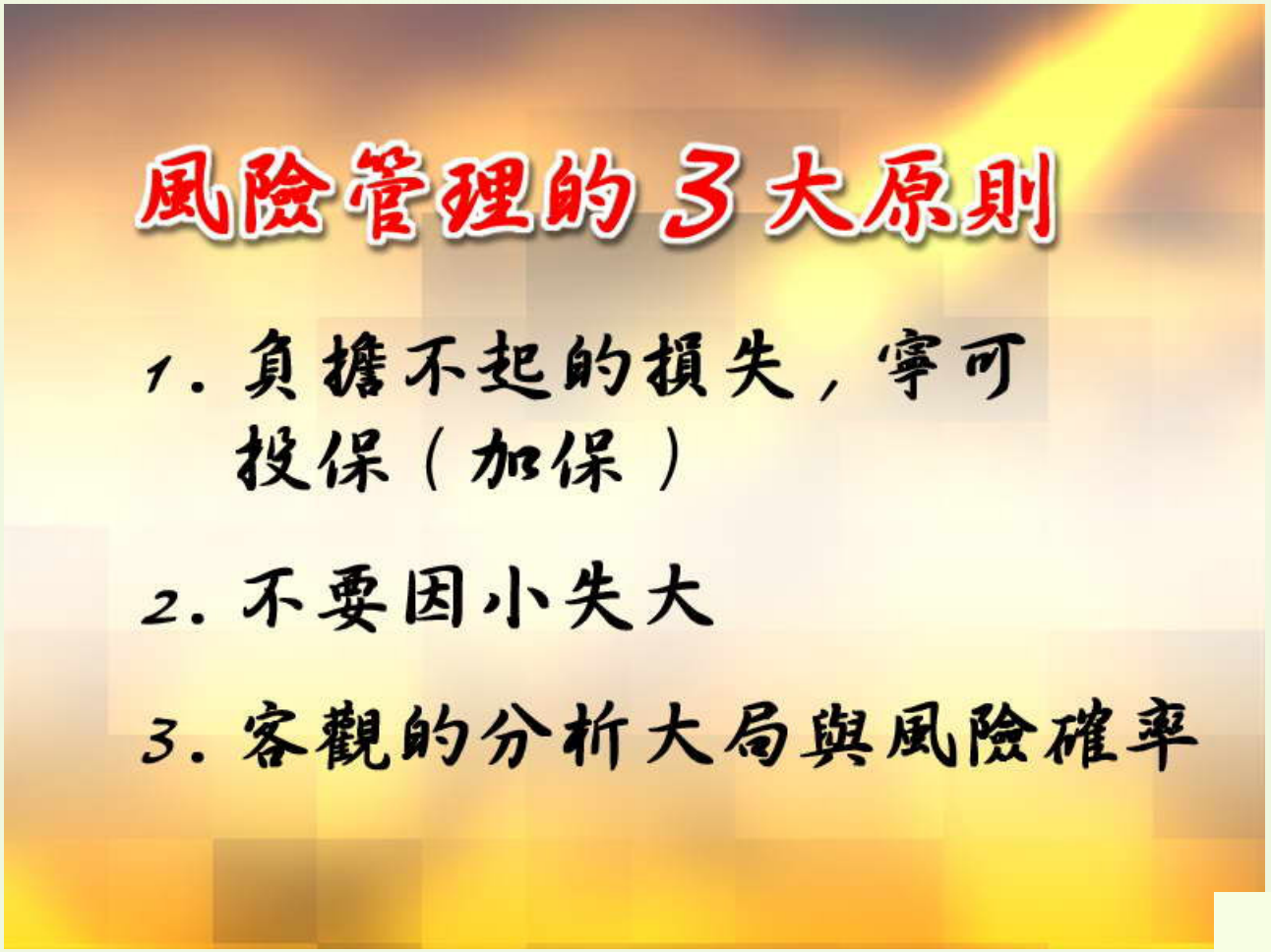
S： Severity

F： Frequency

A ： 建議完全迴避

B,C ： 建議投保

D ： 審慎，提高警覺


風險管理的3大原則
1. 負擔不起的損失，寧可投保（加保）
2. 不要因小失大
3. 客觀的分析大局與風險確率


Pyramid of Adverse Events
Major injury (x)
= Sentinel Events
Minor injury (10-30x)
Reported incident,
no injury (300-600x)
= Near miss

Famous American Organizations for PS

1. JCAHO
2. VA Hospital Group
3. NQF (National Quality Forum)
4. AHRQ (National Center for PS)
5. Leapfrog Group
6. MHA (Maryland Hospital Association)
7. IOM (Institute of Medicine)

我們的病人安全目標

1.Safe culture
2.Safe care
3.Safe staff
4.Safe patients
5.Safe place
6.Safe support systems

2006 International PS Goals(JCI)

1. *Identify patients correctly*
2. *Improve effective communication*
3. *Improve the safety of High-Alert medications*
4. *Eliminate wrong-site, wrong patient, wrong procedure surgery*
5. *Redue the risk of healthcare-associated infections*
6. *Reduce the risk of patient resulting from falls*

2007 NPSG
Eight new proposals

- *Goal 3E —Reducing the likelihood of patient harm associated with the use of anticoagulants*
- *Goal 15A — Reducing the risk of patient harm from falls*
- *Goal 15B — Preventing healthcare-associated pressure ulcers*
- *Goal 15E — Identifying patients at risk for suicide*
- *Goal 16 — Discouraging disruptive behavior within the organization*
- *Goal 17 — Providing orientation to temporary or agency workers*
- *Goal 18 — Using teams to respond to changes in a patient's condition*
- *Goal 19 — Preventing patient harm associated with healthcare worker fatigue*

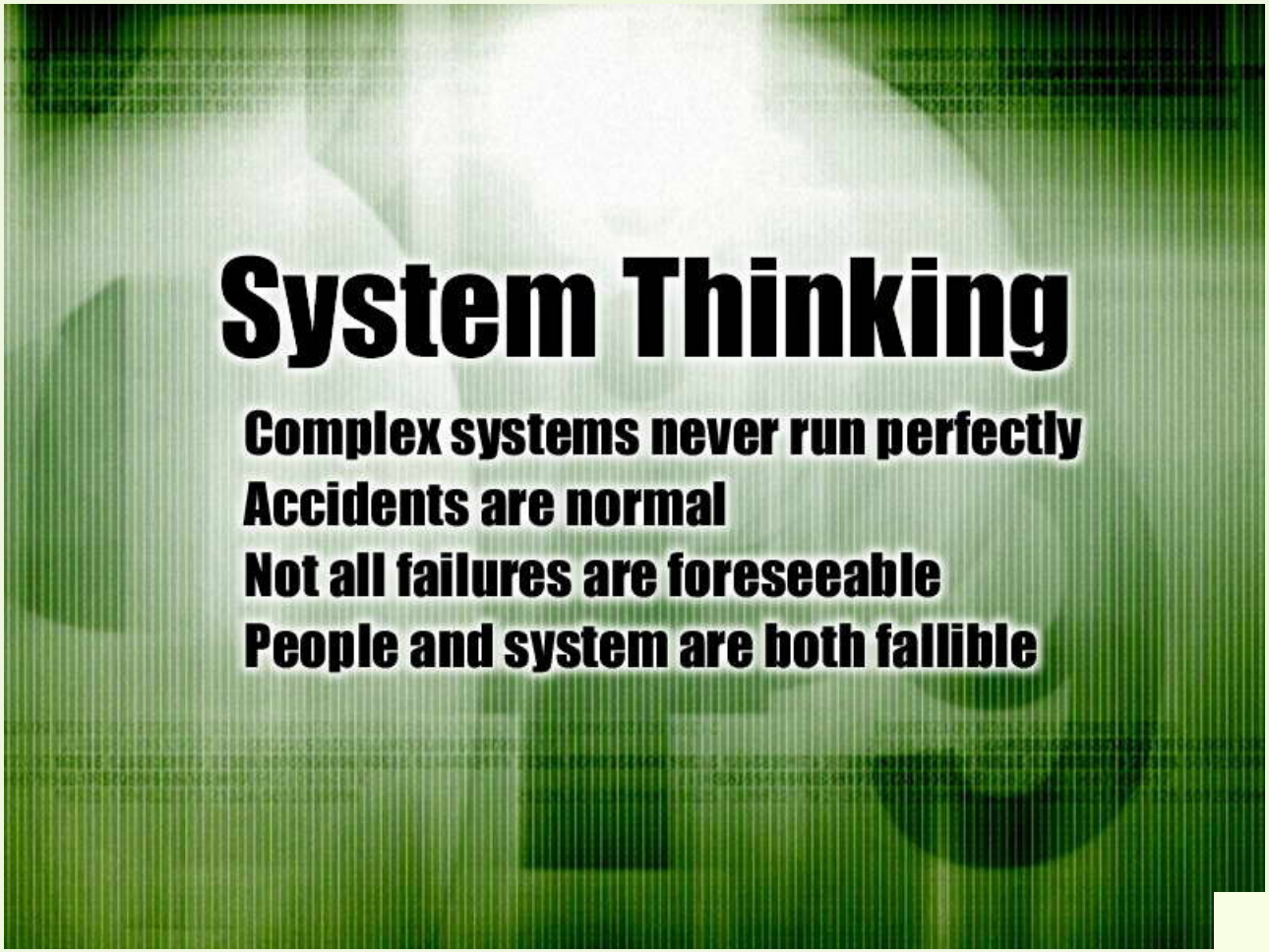

Patient Safety Culture Revolution
It takes time ! (3 ~ 5 years)
(Brown-Spath & Associates)

Modern PS Movements emphasize certain values:

1. *Transparency*
2. *Non-punitive environment*
3. *Systems thinking*
4. *Learning from errors*
5. *Flexible culture*
6. *Open communication*
7. *Effective teamwork*

Healthcare Transparency

1. *Measure, keep score and publicize*
2. *Open and honest disclosure(truth-telling)*
3. *Patients and their families are in the game*
4. *Learn from the failures*
5. *Patients have their voices heard*
6. *Tell how much we spend for PS*


System Thinking
Complex systems never run perfectly
Accidents are normal
Not all failures are foreseeable
People and system are both fallible

JCAHO PS STANDARDS

1.Leadership and commitment

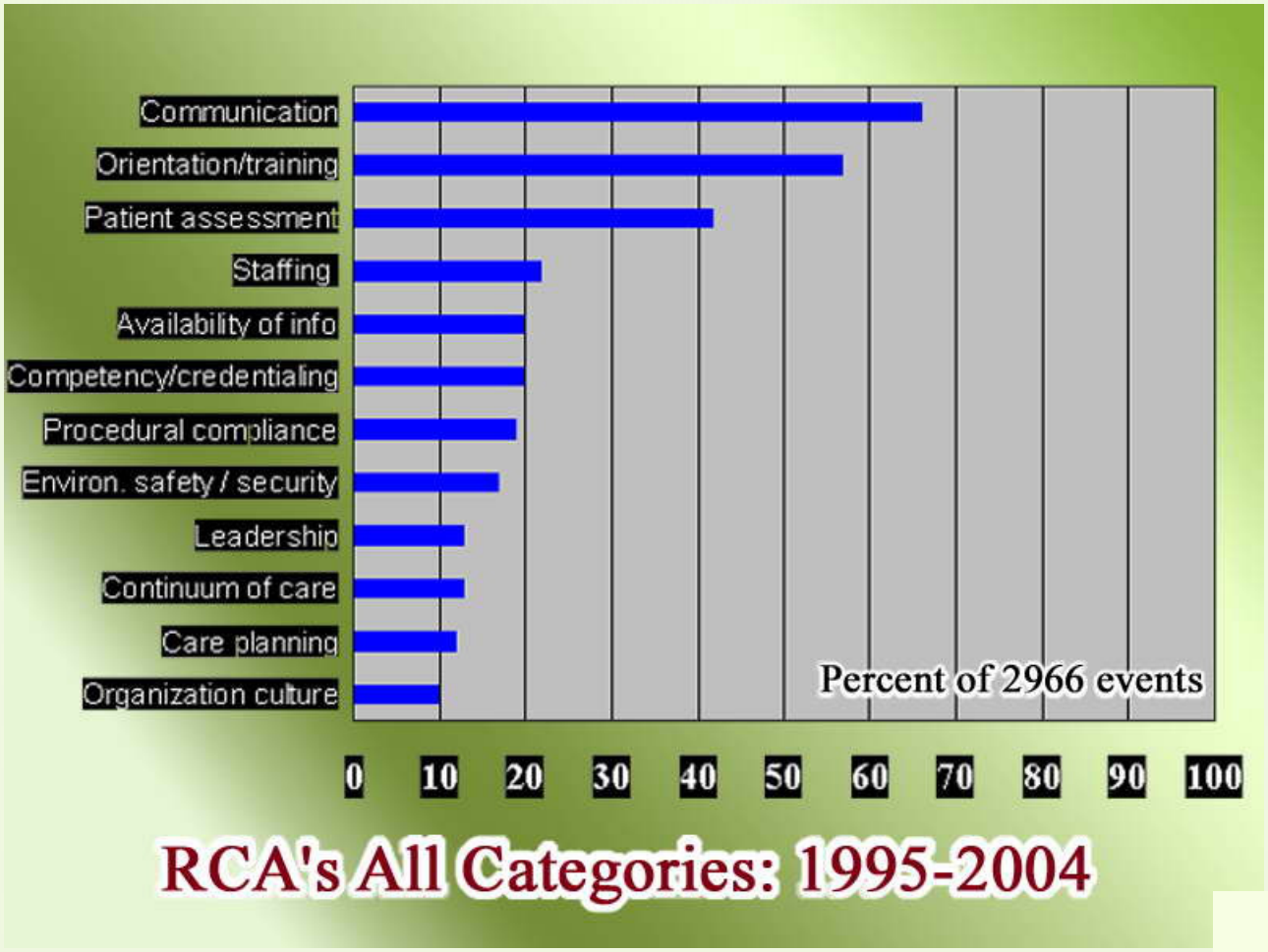
2.IT management

3.Human resource management

4.Patients' rights

5.Performance improvement

6.Patient & Family education


Communication
Orientation/training
Patient assessment
Staffing
Availability of info
Competency/credentialing
Procedural compliance
Environ. safety / security
Leadership
Continuum of care
Care planning
Organization culture
Percent of 2966 events
0
10
20
30
40
50
60
70
80
90
100
RCA's All Categories: 1995-2004


Communication is the
mainstay of safety

2966 sentinel events reviewed by the Joint Commission, January 1995 through December 2004:

415 inpatient suicides
370 events of surgery at the wrong site
365 operative/post op complications
326 events relating to medication errors
221 deaths related to delay in treatment
144 patient falls
124 deaths of patients in restraints
107 assault/rape/homicide
85 transfusion-related events
84 perinatal death/injury
57 infection-related events
57 deaths following elopement
51 fires
49 anesthesia-related events
511 “other”

NQF
27 Never Events

www.qualityforum.org

我們常用的工具 (Tools) 與策略 (Strategies)

- Checklists
- Newsletter
- 院訊專刊
- 海報
- 標語
- 衛教單
- 異常事件通報系統
- 每週巡查 (walkrounds)
- 品管圈 (QCC)
- 重症暨死亡病例討論
- Chart review
- Informed Consent
- 醫療安全手冊
- RCA

Tools for Medical Risk Management

1. Checklists

2. Patient safety rounds

3. Incident data analysis(RCA, FMEA)

RCA

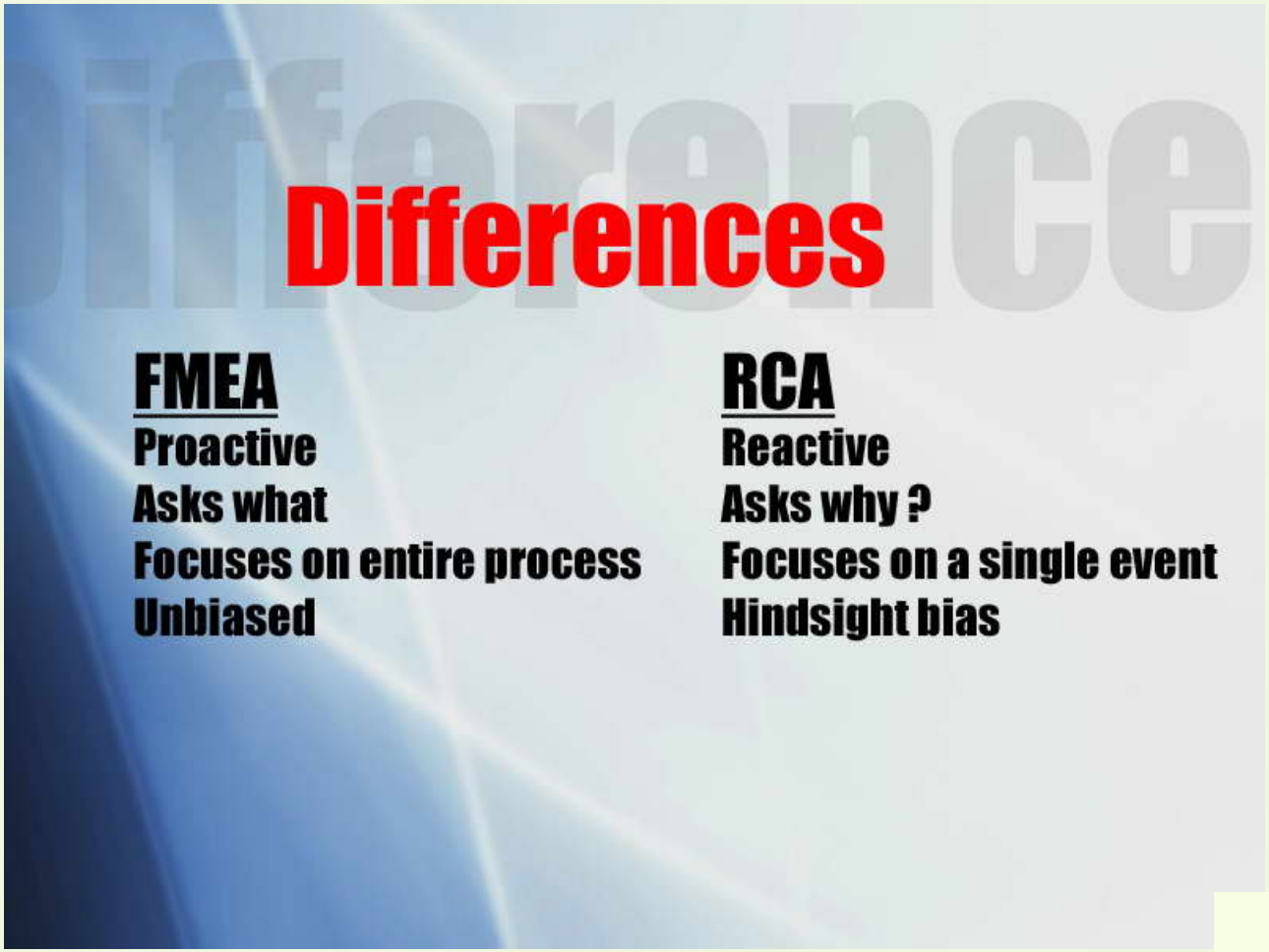
- **5W1H**

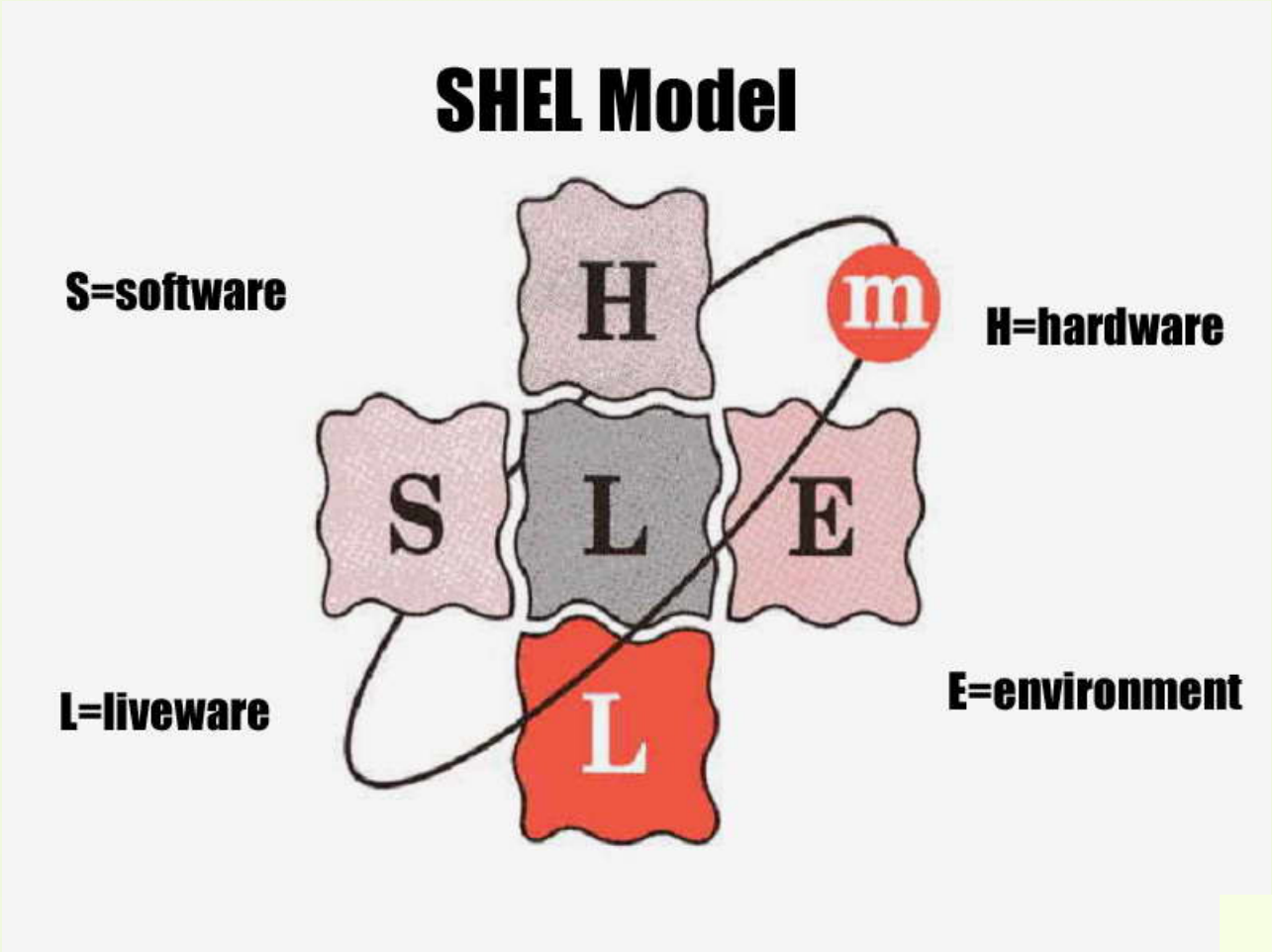
(what, when, who, where, why, how)

↓

- **7W2H2E**

(what, when, who, whom, which, where, why, how much, how to, evidence, evaluation)


Difference
Differences
FMEA
Proactive
Asks what
Focuses on entire process
Unbiased
RCA
Reactive
Asks why ?
Focuses on a single event
Hindsight bias


SHEL Model
S=software
H=hardware
L=liveware
E=environment
H
m
S
L
E
L

PS/RM Strategies

1. Informed consent

2. Documentation

3. Incident reporting

4. Standardize & simplify the process

(SOP, guidelines, protocols, standard manual, ISO 9001,Clinical paths)

5. *Education/training*
6. *Peer review/EBM*
7. *Back-up systems*
8. *IT with information sharing*
9. *Medical simulation*
10. *Liability insurance*
11. *KYT (危險預知測驗)*
12. *Others (5S, 6 Sigma)*

Internal Surveillance

※ *Electronic medical records*

※ *Executive safety rounds*

External Surveillance

Evaluate against PS Indicators (AHRQ)

Unannounced visits by accreditation surveyors

How to measure Patient Safety

1. Customer satisfaction

2. Incident reporting system

3. Competency of healthcare provider

4. Results of accreditation survey

5. Patient safety indicators

6. Litigation case number

7. Number of adverse events

8. Self – Assessment Questionnaire

Hospital Ratings Available to the Public

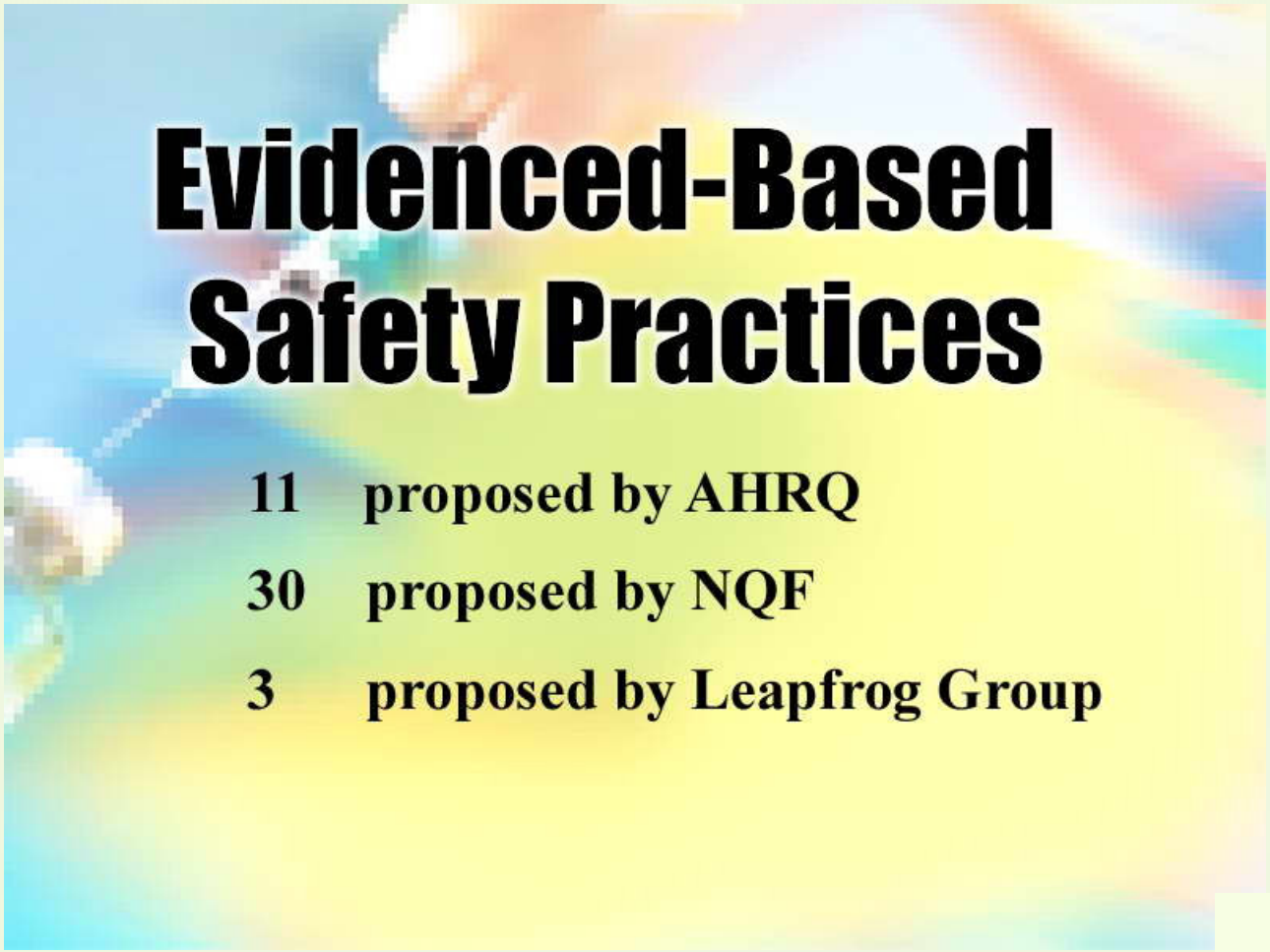
- *www.usnews.com (Best 50)*
- *www.healthgrades.com (5-star rating)*
- *www.solucient com (100 Top Hospitals)*

Impact of hospital performance?

PS Is Largely Dependent On 2 Elements of Healthcare System:

1. Design → re-design → health reform

2. Performance → Improvement → CQI


Evidenced-Based
Safety Practices
11 proposed by AHRQ
30 proposed by NQF
3 proposed by Leapfrog Group

Leapfrog Group PS Standards

Using intensivists to manage the ICU

Computerized Physician Order Entry

Evidenced referral

根據EBM可積極推展的病安措施(11/79)

No.	病安問題	建議策略
1	Venous Thromboembolism 靜脈血栓症(VTE)	VTE預防措施
2	接受非心臟手術病患於周術期發生心臟血管合併症	周術期使用乙型阻斷劑
3	與CVP相關的血流感染	插入導管時充分使用無菌
4	手術部位感染(SSI)	使用預防性抗生素
5	忘記取得病人知情同意，說明不詳盡或病人有理解困難	回想IC過程中說明內容並重覆說明
6	與CVP有關的血流感染	使用抗菌性導管

No.	病安問題	建議策略
7	VAP	聲門下分泌物持續抽吸CASS
8	褥瘡性潰瘍 Pressure Ulcers	使用可緩和壓力的床墊
9	術後重症病人的營養	各種營養補給(Nutritional Support)
10	中央靜脈導管起因的合併症(CVP)	插入導管時使用超音波導引
11	長期使用Warfarin	居家使用Monitor並自我測量

Basic Measures to Save Up to 100,000 Lives Per Year

1.Prevent ventilator pneumonia(VAP)

2.Prevent IV catheter infections

3.Stop surgical site infection(SSI)

4.Respond rapidly to early warning signs
by formation of a rapid response team

5.Make heart attack care absolutely reliable
by use of aspirin, beta-blocker, stent and clot buster.

6.Medication reconciliation

(IHI 2004)

National PS Web-based Reporting System

1. *U.K.*
2. *Japan*
3. *Taiwan*

Uniform Consent Forms (surgery & anesthesia)

- *Taiwan's National Action Plan*
- *First-of-its-kind in the world ?*
- *Pros and cons*

Apology Laws

-honesty is the best policy

-passed at least in 19 states

-allow doctors to say sorry without it being used against them in malpractice suits

-a win-win situation

Informed Consent

- *A national consensus standards (AHRQ)*
- *JCAHO does not list what procedures required IC*
- *Issues of low health literacy*
- *Complication rate greater than 1/1000 to be explained (Tokyo University)*
- *Ethically "Gray areas"???*

Some Topics of Interest

- ***HIPAA compliance in IT security and privacy protection***
- ***Budgeting for PS and cost justification***
- ***Legislating staffing standards***
- ***Impact of hospital performance, ranking and public disclosure***
- ***"RAID" model of clinical governance***


The Price of Safety
醫療安全與安心要花多少錢
• 人事費用的
1.4 %
醫療安全
3.5 %
風險管理
(ASTD 2001)

Theme of ICN for the year 2006

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病人安全策略要素分析
(SWOT)

優勢 (Strengths)

- Leadership & Commitment
- 經費 .資源比較充沛
- Teamwork 默契良好
- 多數員工已有概念

弱勢 (Weaknesses)

- 醫師參與度不夠
- 專責人員處理病人安全問題經驗不足
- IT 系統功能不盡理想
- 通報案例仍未達目標值

MANAGING DOCTORS IS AS DIFFICULT AS HERDING CATS

威脅 (Threats)

- 健保政策使經營(風險管理)難度增加
- 各單位的本位主義不易掛除
- 金字塔式的等級制度(Hierarchy)
- 消費者意識抬頭，病人無理要求不罕見
- 護理人員流動率大，資淺新人佔比高

機會 (Opportunities)

- 醫療疏失無法完全避免 ,風險管理絕對有其必要
- 新制醫院評鑑標準近半與安全相關
- 醫糾近年有增無減

Benefits of Risk Management in Health Care

- happier patients
- improved patient outcomes
- improved service standards
- better patient education
- improved professional and personal reputation of our doctors
- better time management for doctor
- better documentation
- better financial status
- better hospital reputation and status

CONCLUSION

We strive to improve patient outcomes
by providing:
the Right Patient with
the Right Treatment at
the Right Timing in
the Right Setting by
the Right Provider utilizing
the Right Resources.

Thank You

www.medicalsafety.org.tw