

# 永無止盡的病人安全

## Patient Safety

### A Never-Ending Journey

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## RM業務範圍8大主軸

1. 醫院營運與醫療安全整體相關活動
2. 確立病人安全體制
3. 病人安全教育與訓練
4. 組織安全文化之現況分析
5. 醫療不良事件通報作業含分析檢討與改善
6. 作業流程標準化
7. 對外之病人安全活動
8. 病安訊息之提供作業

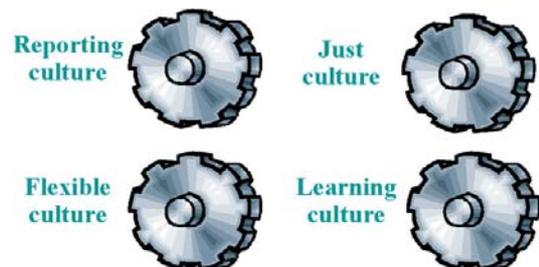
How do we achieve PS at JAH  
3 Major accomplishments as  
perceived by the risk managers

## Plethora of Patient Safety Literature & Impact of "To Err Is Human"

## PATIENT SAFETY is about

1. *culture*
2. *error management*
3. *teaching*

A safe culture = an informed culture  
consisting of many interlocking elements



## What changes are needed to create a culture of safety?

### From:

Focus on Individual  
Authoritarian culture  
Fear, defensiveness  
Secrecy, silence  
Shame and blame  
Humiliation

### To:

Focus on Team  
Communitarian culture  
Openness and support  
Transparency, apology  
Systems and support  
Mutual Respect

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## Making the Safety Journey

### Mission and Goals

- Safety is priority one
- System goals (e.g., medication)
- Annual specific goals (e.g., reconciliation)

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## Making the Safety Journey

### Policies

- Non-punitive approach to errors and reporting
- Mutual respect
- Accountability - for implementing safe practices, and for following them
- Transparency and honesty with patients

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## Making the Safety Journey

### Training

- Implementing safe practices
- Investigating adverse events(RCA)
- Designing systems changes using H F
- Implementing systems changes
- Communicating with injured patients
- Supporting colleagues

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## Making the Safety Journey

### Support (\$ and expertise)

- Implementation of safe practices
- Reporting
- Investigation
- Changing systems
- Training

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# Making the Safety Journey

## Accountability

- National: goals, standards, practices, measures, resources
- Institutional: goals, measures, transparency
- Individual: compliance, responsibility

# 病人參與醫療的類型(分類)

- 一、參與第一線的治療
  - 例1.注意點滴的速度
  - 2.志工活動
  - 3.ACLS(CPR)
- 二、社會啟發型
  - 例1.住院或遇到醫療不良事件之經驗分享
  - 2.全國性病友會
  - 3.抗病/關病的經驗
- 三、經與經營
  - 1.醫院獨立成立的病友會或支持團體
  - 2.病人代表受邀參與醫院營運狀況的審議

# Tools for Medical Risk Management

- Communication
- Teamwork
- Patient safety leadership rounds
- Checklists
- Root Cause Analysis(RCA)
- Failure Mode and Effects Analysis(FMEA)
- Liability insurance
- Safety culture assessment (e.g. SAQ)

# Safety Attitudes Questionnaire (SAQ)

Pronovost, Sexton. Qual Saf Health Care. 2005;14(4):231-3.

# 病人安全文化現況調查 (2006年8月)

Hospital Survey on Patient Safety Culture(AHRQ 版本)

發出 905 份問卷，問卷回收率 79%

統計結果證實病人安全已成為仁愛醫院文化



# RM Strategy for Promoting Patient Safety

- Informed Consent
- Documentation
- Data collection system(incident reporting)
- Consumer feedback
- Standardize and simplify the process
- SOPs, Guidelines, Protocols
- Clinical pathways
- Back-up system
- PDSA cycle of CQI
- EBM(evidence-based safe practices)
- IT with information sharing
- Education/Human Factors Training
- Medical simulation

## 我們常用的工具 (Tools) 與策略 (Strategies)

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

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## JCAHO PS STANDARDS

1. Leadership and commitment
2. IT management
3. Human resource management
4. Patients' rights
5. Performance improvement
6. Patient & Family education

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## 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. Reduce the risk of healthcare-associated infections
6. Reduce the risk of patient resulting from falls

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## Patient Safety Standards

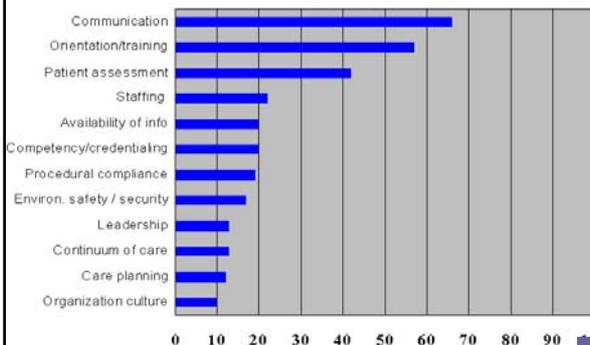
- Leadership's role in creating a culture of safety
- Proactive system design
- Training/Orientation
- Communication

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## Root Causes of Sentinel Events

(All categories; 1995-2005)



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## RN-MD Relationships



?

OR



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## The SBAR Checklist for Patient Handoffs

## S - B - A - R

- Situation
- Background
- Assessment
- Recommendation

## Situational briefing model

### Situation-current situation

- *What is the situation?*
- *Identify self, unit, patient, room number*
- *Briefly state the problem, what is it, when it happened or started, and how severe it is.*

### Background- quick history

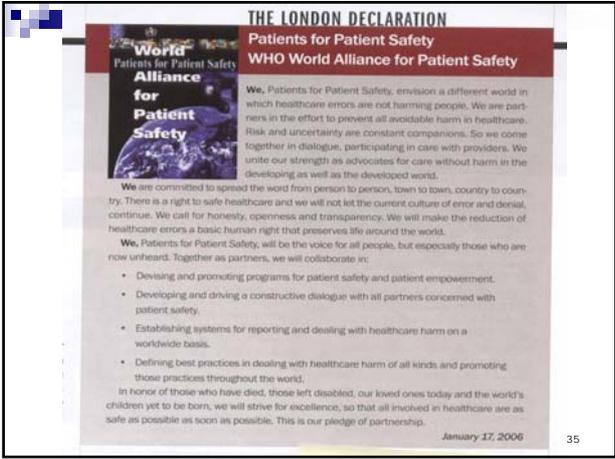
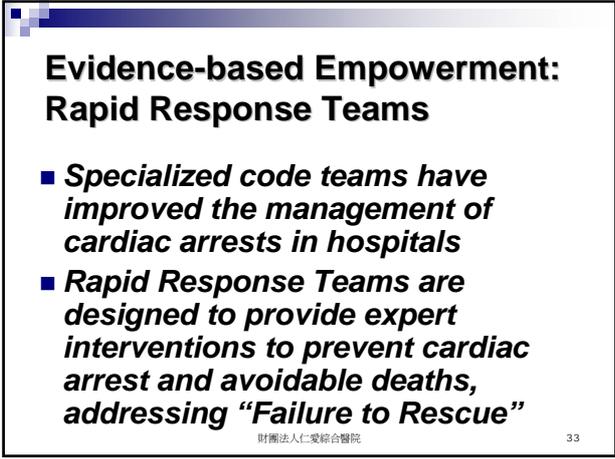
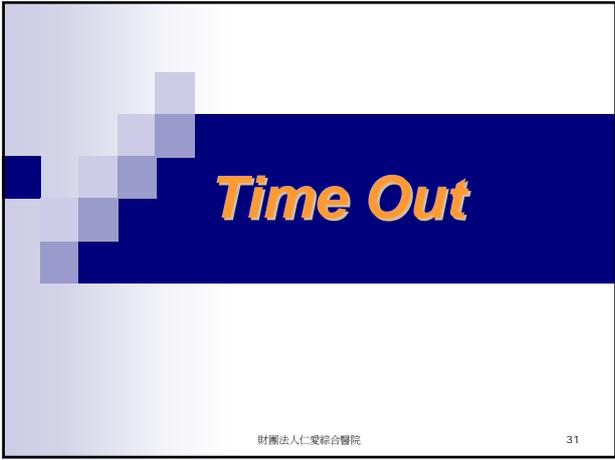
- *The admitting diagnosis and date of admission*
- *List of current medications*
- *Most recent vital signs*
- *Lab results*
- *Other clinical information*
- *Code status*

### Assessment - situation evaluation

- *What is the nurse's assessment of the situation*

### Recommendation - remedies

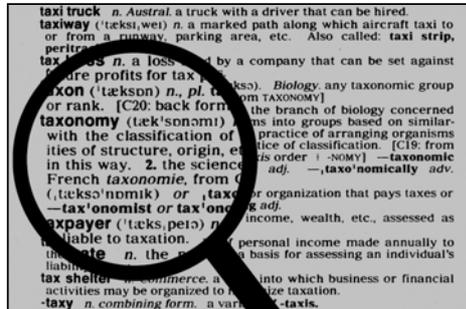
- *What does the nurse want?*
- *Examples could be recommending that the patient be seen immediately or that orders be changed.*
- *“SBAR Technique for Communication: A Situational Briefing Model. (IHI)*



## World Health Assembly Resolution 55.18

- *Develop global norms and guidance*
- *Promote evidence-based policies*
- *Encourage patient safety research*
- *Share best practices*
- *Promote cultures of safety in health care organizations*

## Taxonomy for patient safety



## 病人參與病安活動的基本概念

1. 在實施IC的條件下進行的醫療行為才是正當行為
2. 醫病之間的遊戲規則：互相承諾，確保安全
3. 醫院即是社會的縮小版圖

公共場所犯罪行為難免發生，  
醫病皆需同心協力確保安全

## 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

## Needlestick Injuries

- *Two million annually worldwide*
- *Nurses have the highest rate of injuries*
- *Most commonly associated with*
  - *Blood collection*
  - *Intravenous line insertion*
  - *Handling or disposing of used needles*
  - *Injections*

## Reducing Needlestick Injuries

- *Provide appropriate sharps containers close to point of use*
- *Purchase safer needle devices and provide training in their use*
  - *Studies suggest 23-100% of injuries are prevented by this change*



## Violence in the Workplace

95% of hospital nurses reported verbal aggression & 80% physical over prior year	O'Connell et al, 2000
UK ICU nurses reported high rates of verbal & physical abuse from patients and relatives	Lynch et al, 2003
Australian nurses exposed to more violence than other hospital workers, most often verbal	Alexander & Fraser, 2004
88% of Turkish Emergency Department nurses reported verbal & 49% physical violence over 1 year	Boz et al, 2006

## 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

## Leadership's Steps Towards Improving Patient Safety

- Establish standards focused on safety
- Encourage error reporting
- Shared lessons learned
- Proactive risk reduction
- Engage patients in safety
- Establish annual safety goals
- Convene, collaborate, educate



**Are your physicians driving PS or putting the brakes on?**

## 4 major barriers to physician participation in PS efforts

1. Fear of losing autonomy
2. Time constraints
3. Lack of motivation to change
4. Skepticism



## 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

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## Fact or Fallacy

*Managing doctors is  
as difficult as  
herding cats*

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## 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

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## 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

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## SLOGANS FOR PATIENT SAFETY

- *SpeakUP*
- *Stand up for PS*
- *Ask, listen & learn*
- *Safety first*
- *Better late than never*
- *Safe & Save*
- *Our patients – Our partners One team, One goal*

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## Quality Culture and Safety Culture Interface

**Medical quality is a natural extension of  
Patient Safety and vice versa**

**Quality in healthcare means Patient Safety  
Patient Safety in healthcare means Quality**

**RM=PS=QI ? Are they at odds?  
Similar philosophy and methodology**

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## 未來展望

- 1、每年舉辦一次全院同仁病人安全文化與認知調查
- 2、提高安全教育普及率導入 e-Learning，加強醫師繼續教育
- 3、推廣病人安全成為全民運動
- 4、落實資訊安全措施，控管病歷檔案之儲存以維護病人隱私
- 5、運用電腦虛擬“假人” SimMan<sup>®</sup> 強化病人安全教學訓練
- 6、東海大學醫管碩士學分班於本院開課

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## 結語

推動病人安全，大家一起來  
台中縣衛生局 仁愛綜合醫院關心您的健康

1. 我們堅持的理念：PS=QI=RM
2. 病安與品質改善是每個(病)人的權利與義務，但這不是只有風險管理部門或品質保證部門的工作。
3. 為達此目標，在醫院環境中，建置病人安全文化尤其重要。
4. 更重要的是有專責單位負責並整合全院，才算成功。

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# Thank you

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