PATIENT SAFETY

Sebuah konsep dan pendekatan sistematik mutu pelayanan kesehatan

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CNN.com

Nursing mistakes cause thousands of deaths, probe finds

September 10, 2000
Web posted at: 7:43 p.m. EDT (2343 GMT)
In this story:

Errors rise as pressure increases

Pleas for help went unnoticed

RELATED STORIES, SITES

the University of Illinois at Chicago Medical Center

.....selain itu juga ditemukan bahwa paling tidak terdapat 119 orang pasien yang meninggal setelah ditangani oleh perawat yang tidak berlisensi, tidak terdaftar, yang penghasilannya sekitar $9 per jam .

Setiap perawat wajib overtime dan bekerja 16-jam, akibatnya sangat sedikit yang berminat bekerja di the University of Illinois at Chicago Medical Center, kata registered nurse Kathy Cloninger, yang telah bekerja di tempat tersebut selama 7 tahun.

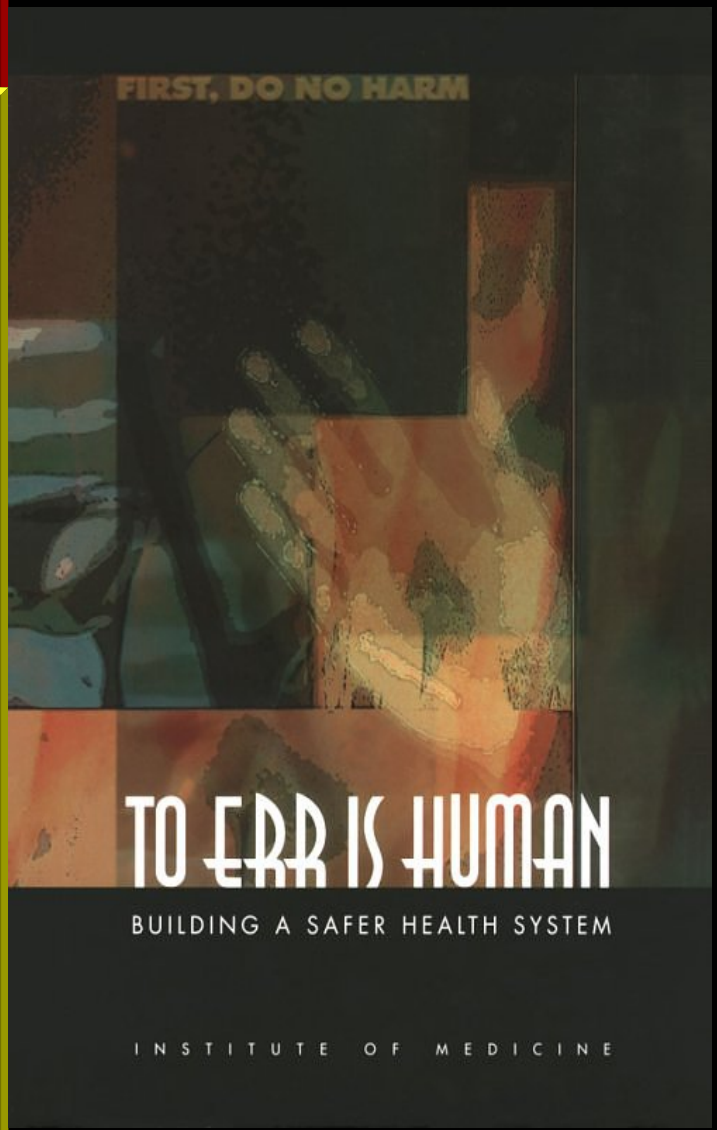
"I wake up every day and hope I don't kill someone today," Cloninger told the Tribune. "Every day I pray: God protect me. Let me make it out of there with my patients alive

Kasus tuntutan hukum akibat nursing care

Shirley Keck, 61-tahun suatu pagi mengalami sesak nafas hebat tanpa diketahui oleh perawat di Wesley Medical Center, Wichita, Kansas.

Salah satu anaknya, Becky Hartman, mencoba menghubungi perawat di counter perawat beberapa kali tetapi tidak menemukan satupun perawat di sana. Akhirnya Mrs Keck mengalami kerusakan otak permanent setelah kejadian itu, tanpa seorangpun petugas mengetahuinya.

Atas kejadian tersebut, pengadilan menjatuhkan denda sebesar US$ 2,7 juta (25,650 M) atas terjadinya kematian Mrs. Keck



TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM

Institute of Medicine

Committee on Quality of Health Care in America

(Classen et al., 1997).

Adverse drug events pada pasien rawat inap

extra biaya

Memperpanjang LOS

mortalitas

$8.4 juta/tahun untuk RS Pendidikan dengan 700-bed

1983-1993: naik 2 x lipat (7.391 kematian 1993)

(Bates et al., 1997).

(Phillips, Christenfeld, and McGlynn, 1998)

Brennan et al., 1991

acute care hospitals di New York State

adverse events: 3.7%

27,6% akibat kelalaian

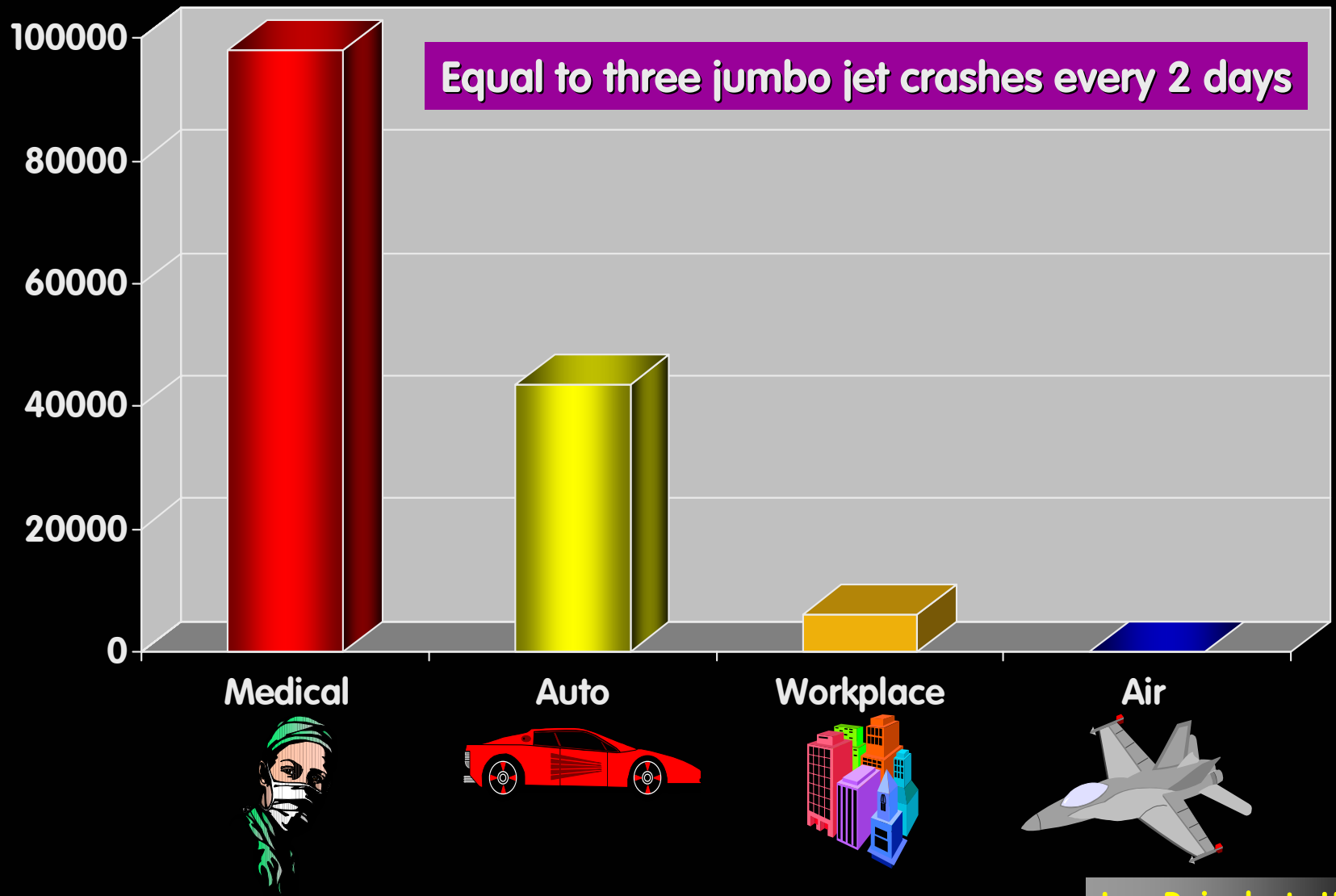
Gopher et al., 1989

intensive care unit

1.7 errors/hari/ pasien

29 % berpotensi untuk terjadinya injury yang serius & fatal

Annual Accidental Deaths (IOM, 1999)



Iwan Dwiprahasto, UGM

the NHS Litigation Authority

850 000 adverse events a year

> 33 000 complaints berkaitan dengan pelayanan di rumahsakit

6797 klaim klinis baru dilaporkan ke otoritas litigasi NHS pd tahun 2002-3

MEDICAL ERROR IS AN ICEBERG PHENOMENON

Guide to patient safety indicator

adverse event.

"An injury caused by medical management rather than by the underlying disease or condition of the patient."4 In general, adverse events prolong the hospitalization, produce a disability at the time of discharge, or both.

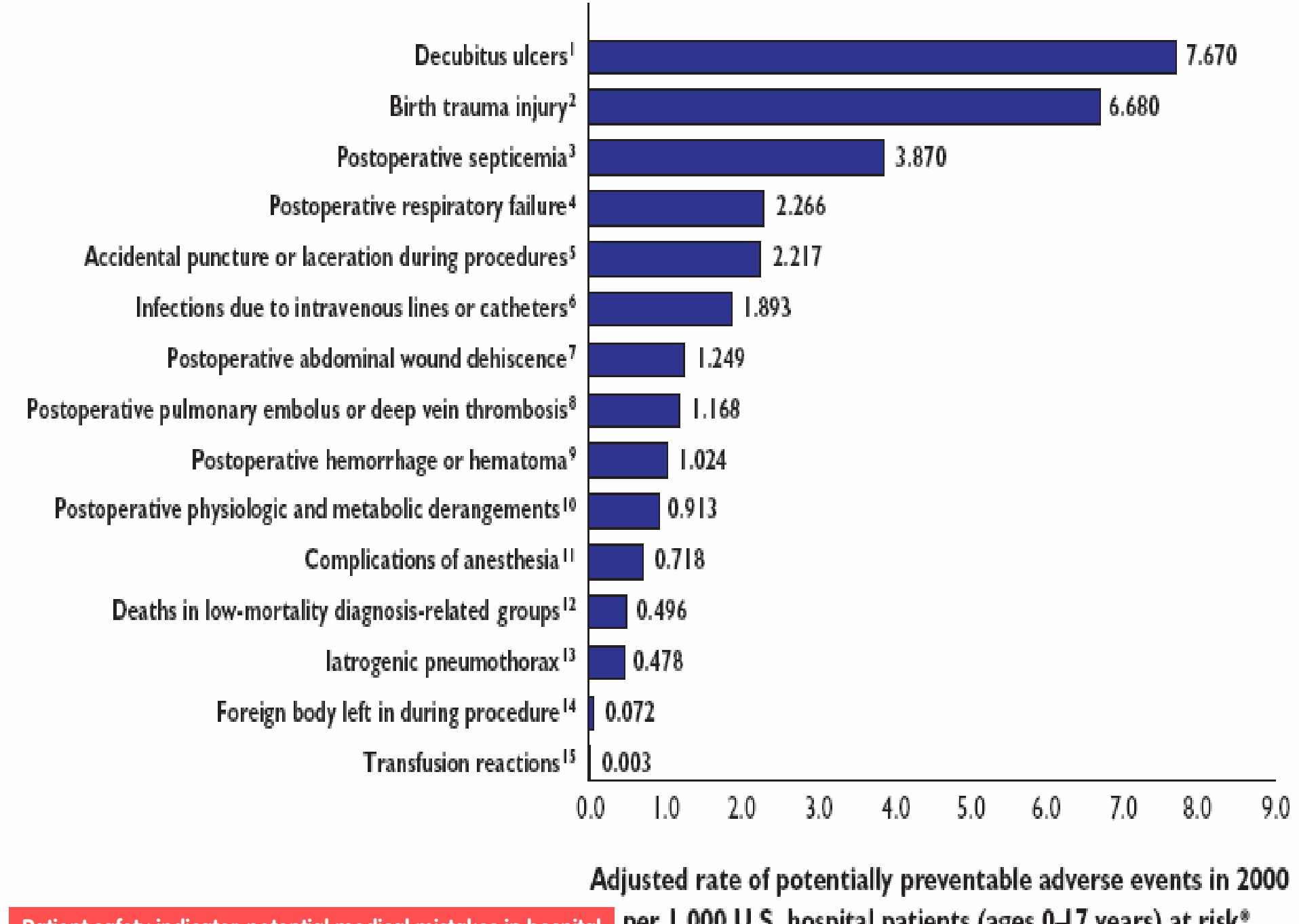
Medical error

"The failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning)."

Patient safety

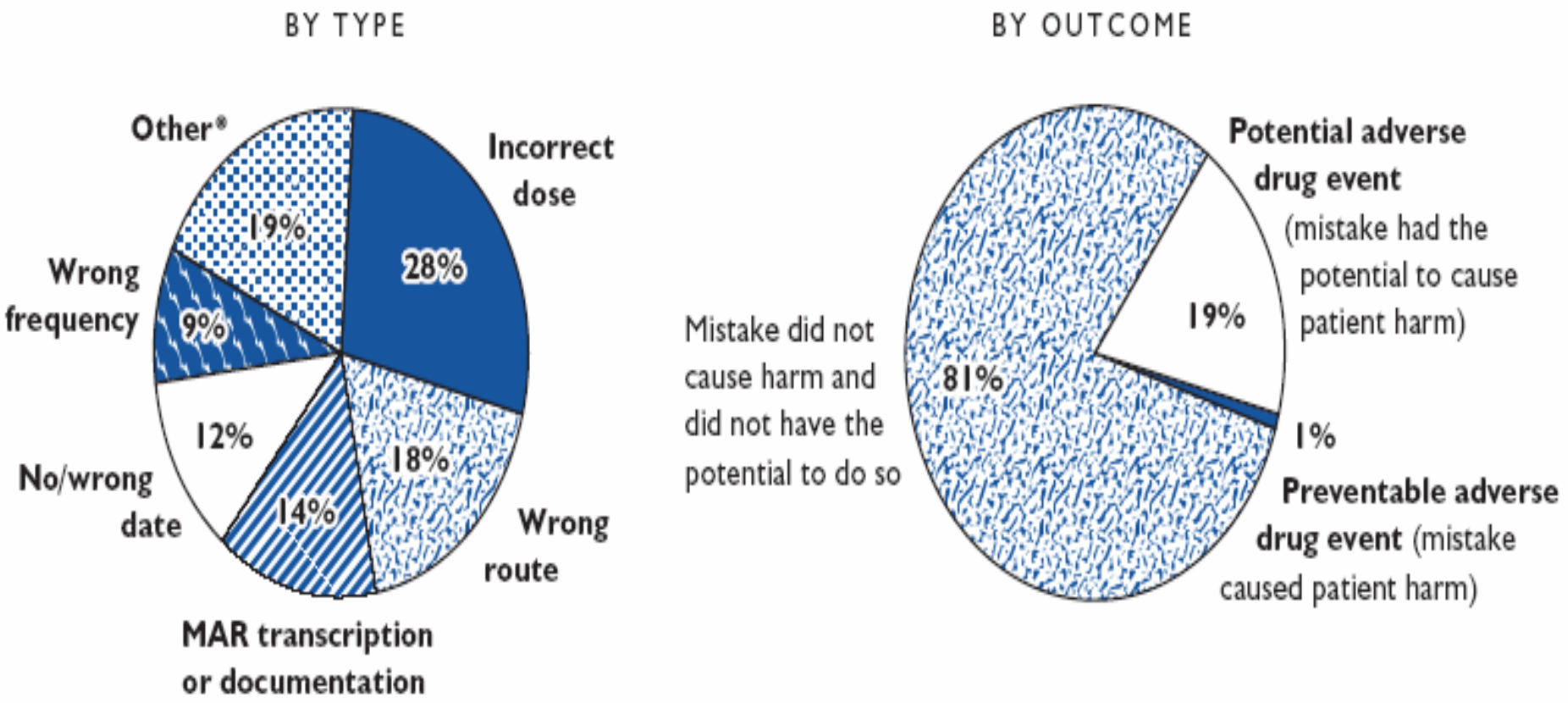
Freedom from accidental injury

avoiding injuries or harm to patients from care that is intended to help them

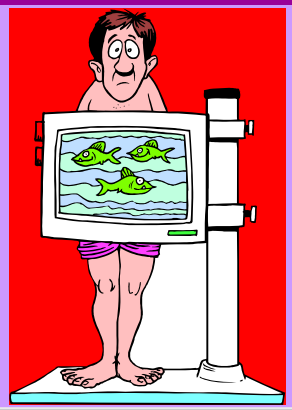


Patient safety indicator-potential medical mistakes in hospital

Pediatric Medication Mistakes Detected at Two Hospitals During Six Weeks in 1999



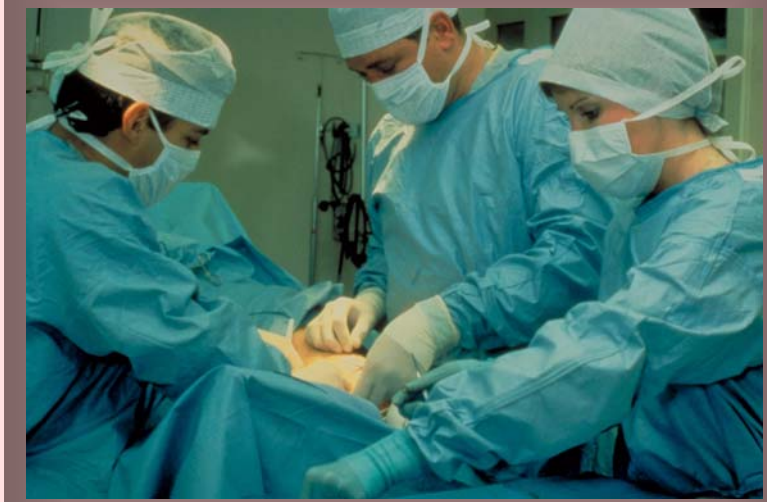
“near miss”



Suatu kejadian atau situasi yang sebenarnya dapat menimbulkan kecelakaan, trauma, atau penyakit, tetapi belum terjadi karena secara kebetulan diketahui atau upaya pencegahan segera dilakukan.

Clinical Negligence (kelalaian klinik)

care that fell below the standard expected of physicians in their community
(a relative standard not a "gold" standard)



Jury Awards $38 Million To San Jose Family In Malpractice Suit

01/01/02 - A San Jose family has won a 38 million dollar (342 Milyar) malpractice award after a jury agreed that delayed care for a newborn baby led to serious brain damage.

The Santa Clara County Superior Court jury ruled against the San Jose Medical Group, Doctor Ilene Newman and Regional Medical Center of San Jose. Brandon Nunez is now three years old and lives at home with his parents, Carmelo and Sonia Nunez.

Sonia Nunez was two weeks overdue when she went into labor on September 27th, 1999. Her labor didn't progress normally and experts testified that an immediate Caesarean section was called for. A C-section was finally performed, but Fagel says that by that time the baby had already suffered brain damage.

The Culture of Blame

- Denial, distancing, displacement
- Dishonesty with patients
- Cover-up, non-reporting
- Unwillingness to take responsibility for peer misconduct

The common reaction when an error occurs is to find and blame someone. However, even apparently single events or errors are due most often to the convergence of multiple contributing factors. Blaming an individual does not change these factors and the same error is likely to recur….. The problem is not a bad people. The problem is that the system needs to be made safer.

Institute of Medicine: To Err is Human

SLIP is observable anda LAPSE is not

Keliru memutar knob pada suatu alat medik → SLIP

Tidak ingat/lupa melakukan upaya medik → LAPSE

Tindakan sesuai dengan rencana, tetapi outcome tidak seperti yang diharapkan, karena prosedur yang dilakukan keliru → MISTAKE

TABLE 1. Recommended Definitions*

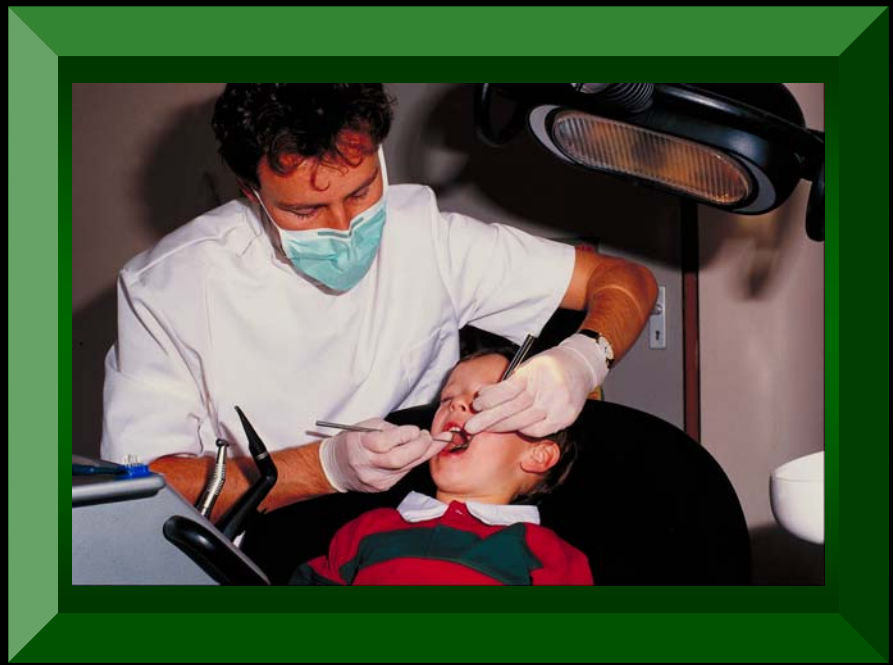
Active error: An error that occurs at the level of the frontline operator and whose effects are felt almost immediately.

TABLE 1. Recommended Definitions*

Latent error: Errors in the design organization, training, or maintenance that lead to operator errors and whose effects typically lie dormant in the system for lengthy periods of time

TABLE 1. Recommended Definitions*

Accident: An event that involves damage to a defined system that disrupts the ongoing or future output of the system



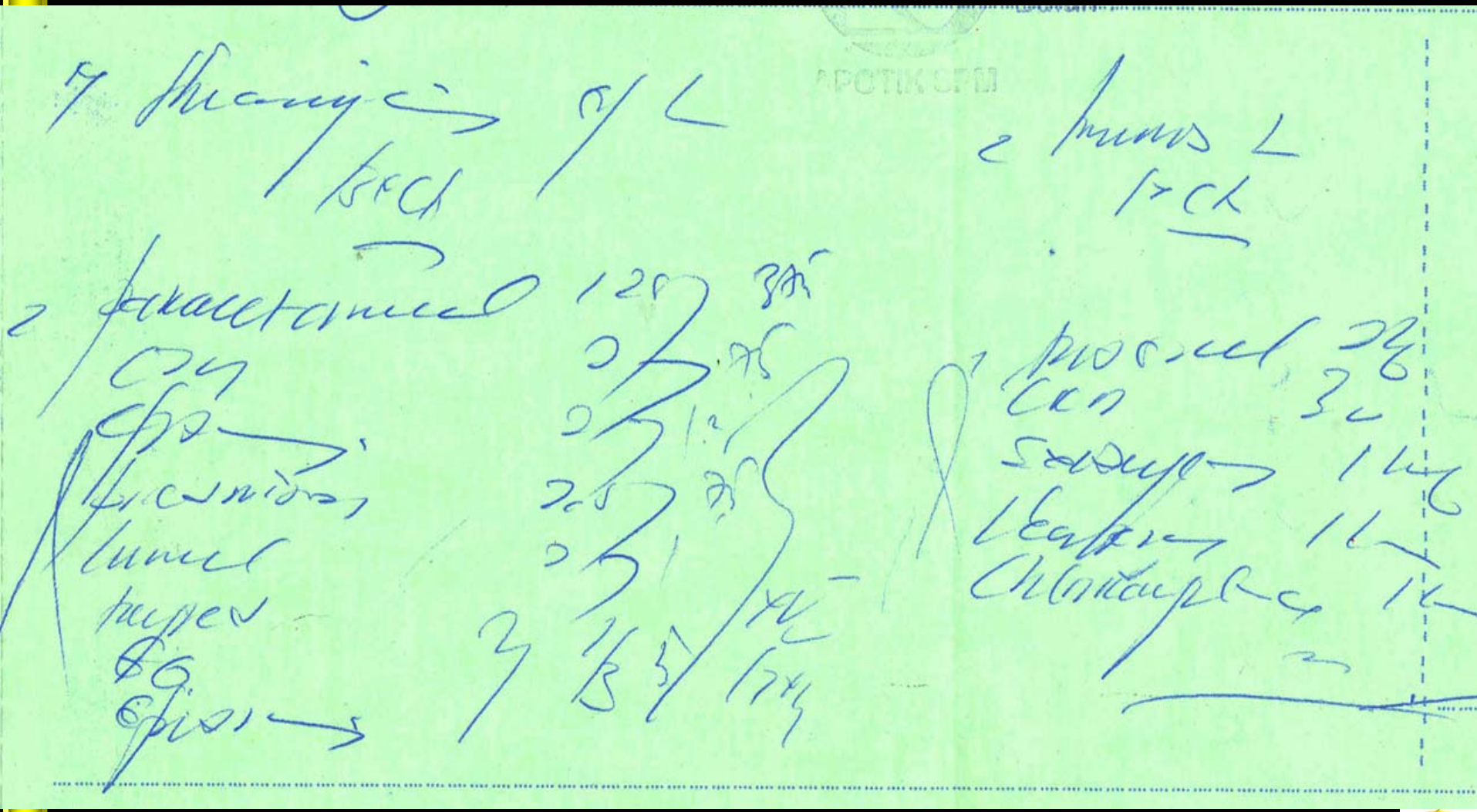
mala praxis (malpractice),

"Injuries . . . by the neglect or unskilful [sic] management of [a person's] physician, surgeon, or apothecary . . . because it breaks the trust which the party had placed in his physician, and tends to the patient's destruction."

Sir William Blackstone, 1768

MENGAPA TERJADI MEDICAL ERROR?

Handwriting



Dr/Drg.

Drugs with similar names

Losec (omeprazole)	**Lasix** (furosemide)
Coumadin (anticoagulant)	**Kemadrin** (antiparkinson)
Taxol (paclitaxel, anticancer)	**Paxil** (paroxetine, antidepressant)
Zebeta (beta blocker)	**Diabeta** (sulfonamide)
Seldane (terfenadine)	**Feldene** (NSAIDs)
Norvir (Ritonavir-protease inhibitor)	**Retrovir** (zidovudine)

Faktor yang potensial mencetuskan ERROR

Terlambat/terlalu cepat memberikan obat periode berikutnya	Omission Error
Perawat memberi obat di luar instruksi dokter	Unauthorized Drug Error
Cara pemberian keliru	Wrong Route Error
Kecepatan tetesan obat infus kurang atau berlebih	Wrong Rate Error

Faktor yang potensial mencetuskan ERROR

Interval pemberian obat keliru	Wrong Time Error
• Suspensi tidak dikocok, • sediaan slow release dijadikan puyer, • incompatible, • inadequate product packaging	Wrong Drug Preparation Error
• Injeksi tanpa metode steril, • menggerus obat secara keliru	Wrong Administration Technique Error
Obat rusak, kadaluarsa, obat tidak disimpan di lemari es	Deteriorated Drug Error

Table 3. Risk Factors for Retention of a Foreign Body after Surgery.*

Characteristic	Risk Ratio (95% CI)	P Value
Operation performed on an emergency basis	8.8 (2.4–31.9)	<0.001
Unexpected change in operation	4.1 (1.4–12.4)	0.01
>1 Surgical team involved	3.4 (0.8–14.1)	0.10
Change in nursing staff during procedure	1.9 (0.7–5.4)	0.24
Body-mass index (per 1-unit increment)	1.1 (1.0–1.2)	0.01
Estimated volume of blood lost (per 100-ml increment)	1.0 (1.0–1.0)	0.19
Counts of sponges and instruments performed	0.6 (0.03–13.9)	0.76
Female sex	0.4 (0.1–1.3)	0.13

Risk Factors for Retained Instruments and Sponges after Surgery. N Engl J Med 2003;348:229-35.

The 20 most frequent principal natural categories (PNCs)

PNC
Catheter related urinary tract infection
Wound infection following abdominal/retroperitoneal/pelvic procedure
No, delay, inadequate investigations ischaemic heart disease
Pressure sore/decubitus ulcer
Wound infection following peripheral procedure
Incisional hernia: post-procedural
Inadequate reduction of a fracture/poor alignment
Ongoing pain/restricted movement following back surgery
Pulmonary embolism postoperatively
GI bleed secondary to NSAID
Postoperative bowel obstruction/adhesions
Wound infection after lower segment Caesarean section
Recurrent incisional hernia
Postoperative nausea and vomiting
Injury due to fall in nursing home
Failed/blocked/ruptured/ aneurysm, vascular grafts
Acute pain postoperative/procedure
Problems following radiation therapy
Injury due to fall in hospital
Postoperative atelectasis/nosocomial pneumonia

MENGAPA TERJADI ERROR?

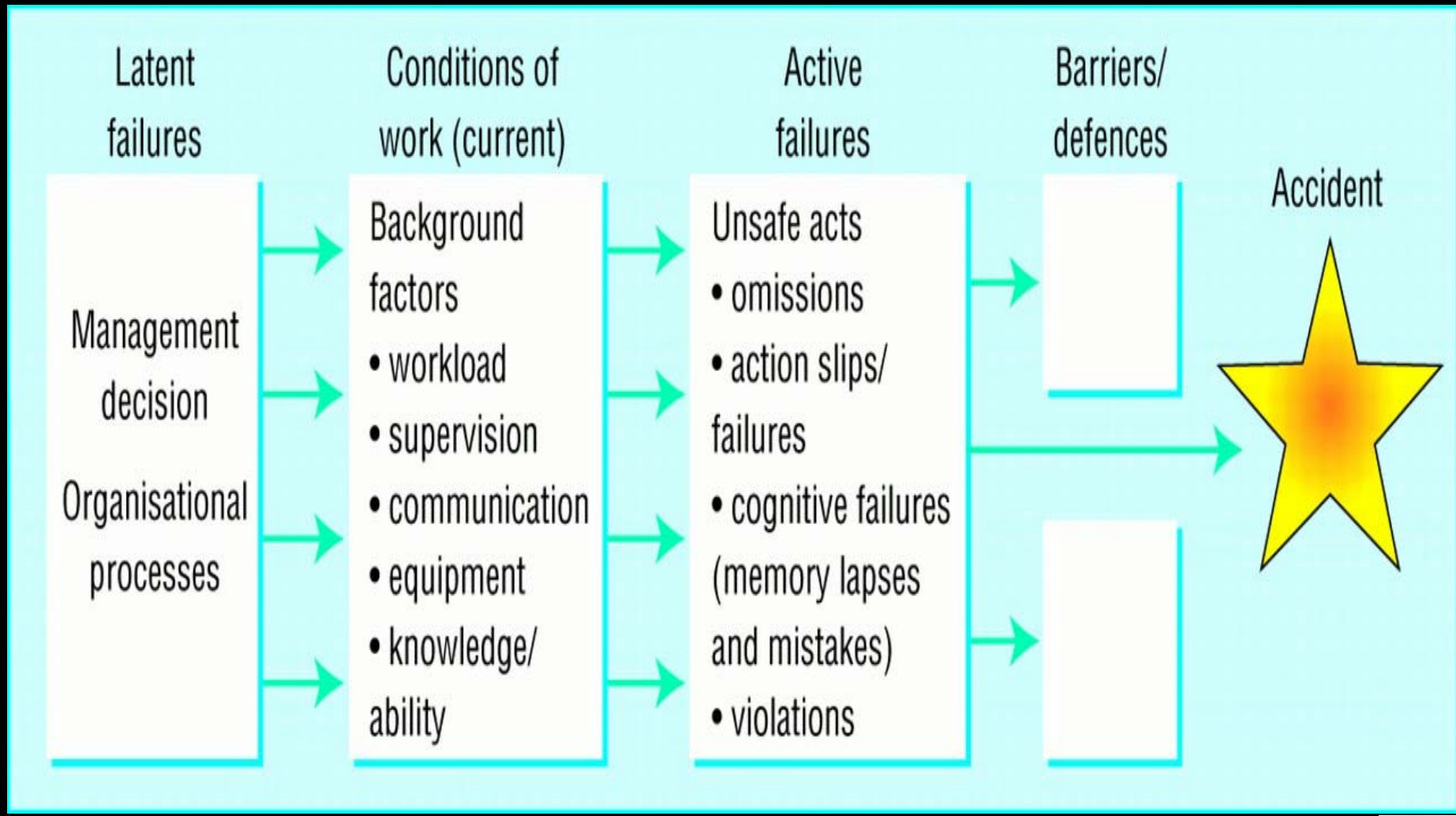
- Menggunakan prasat medik yang sudah obsolete/ abandoned
- Tidak merasa/menyadari bahwa ada masalah
- Kebudayaan tradisional mengenai tanggungjawab petugas kesehatan
- Lemahnya sistem pengamanan hukum bagi konsumen
- Status sistem informasi kesehatan yang primitif
- Alokasi sumberdaya yang buruk
- Kurangnya pengetahuan petugas ttg kejadian error,

KONDISI-KONDISI PENYEBAB TERJADINYA ERROR

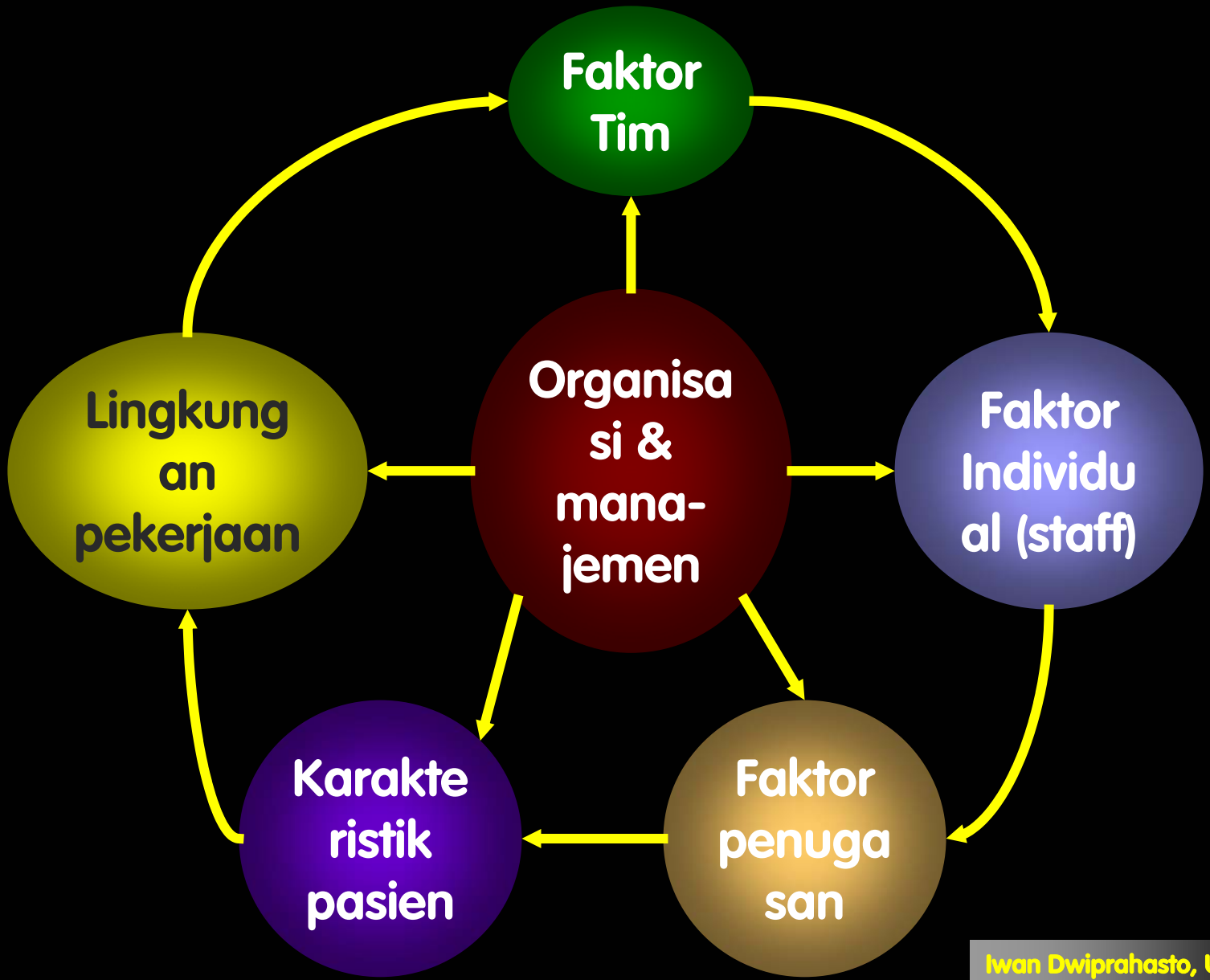
Kondisi	Faktor Risiko
Penugasan tidak jelas	x 17
Waktu terbatas	x 11
Poor signal: noise ratio	x 10
HAM yang buruk	x 8
Designer user mismatch	x 8
Irreversibility of error	x 8
Terlalu banyak informasi	x 6
Negative transfer between task	x 5
Mispersepsi thd risiko	x 4
Tidak ada feedback dari sistem	x 4
Kurang pengalaman	x 3
Prosedur/instruksi yang buruk	x 3
Checking tidak adekuat	x 3
Education mismatch of person with task	x 2
Disturbed sleep paterns	x 1.6

Williams, 1988

Proses terjadinya Risiko

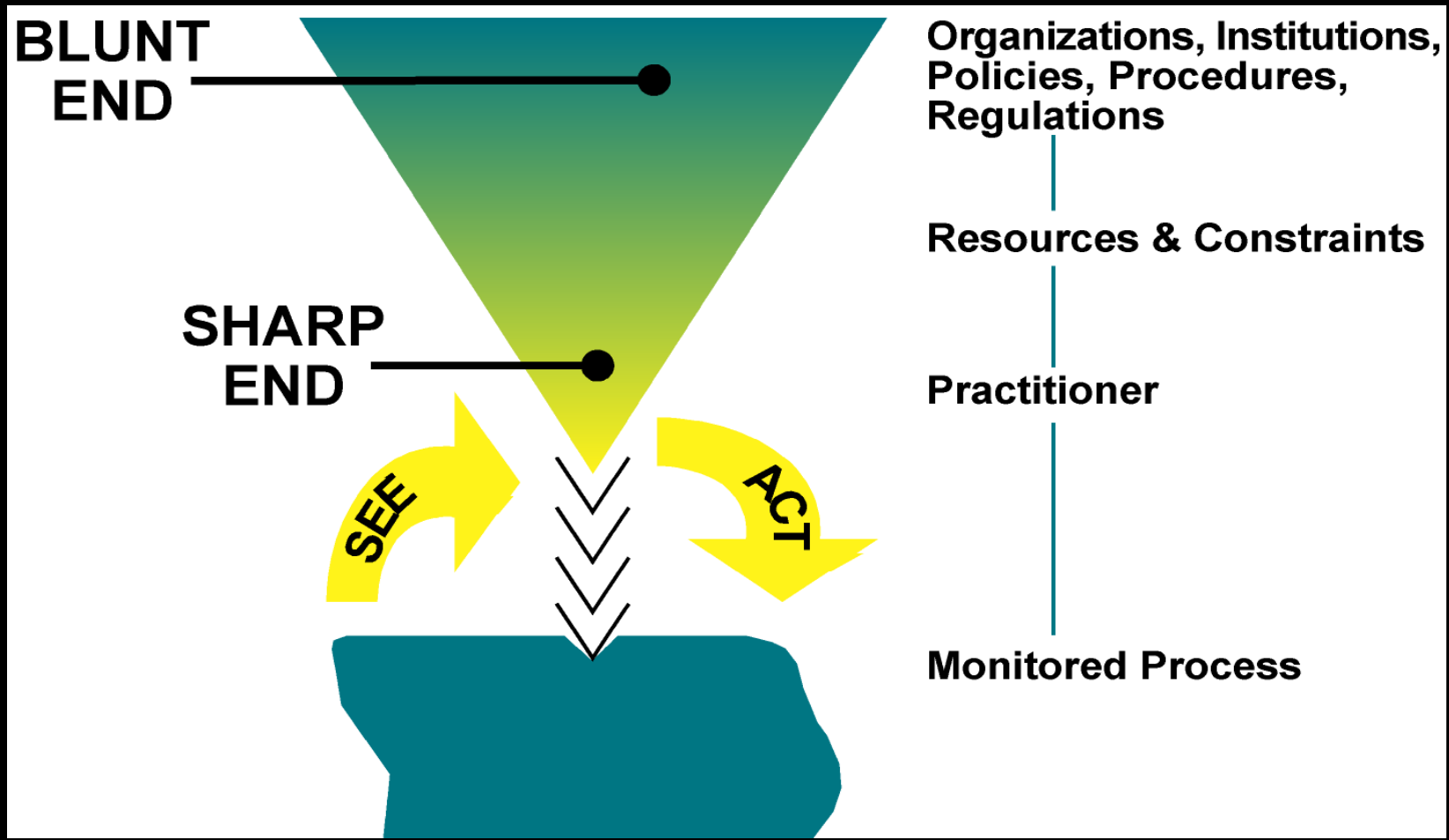


Faktor yang berpengaruh terhadap terjadinya Risiko



Blunt & Sharp

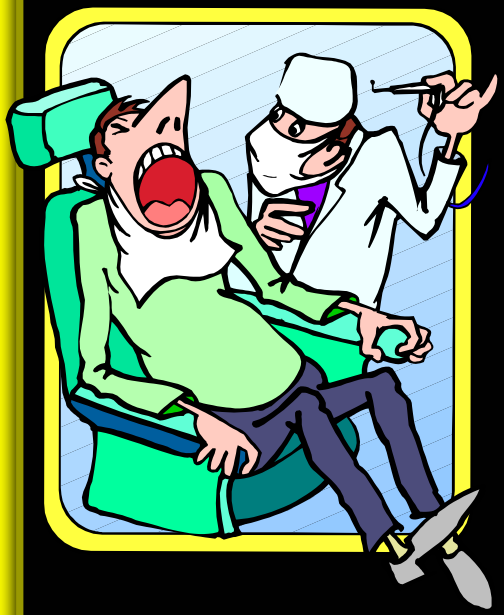
Modified from Woods, 1991. Cook RI 1999



Strategi untuk meminimalkan errors dan adverse events

- Memperbaiki ketepatan pencatatan identitas pasien
- Meningkatkan efektivitas komunikasi antar petugas
- Meningkatkan safety thd high alert medications
- Mengeliminasi kesalahan prosedur operasi, operasi pada pasien yang salah, sisi yang keliru
- Meningkatkan safety pada penggunaan infusion pumps
- Meningkatkan efektivitas sistem alarm klinis

Strategi untuk meminimalkan errors dan adverse events



- Mengurangi kompleksitas
- Optimalisasi proses informasi
- Otomatisasi secara bijak
- Menggunakan constraints yang ada
- Aware terhadap adverse event untuk berubah

System changes to improve patient safety (NOLAN, BMJ)

Apa yang harus dilakukan?

Menciptakan budaya Safety

Mengembangkan program-2 untuk patient safety

Membiasakan mencatat setiap kejadian yang berpotensi untuk error

Budaya Safety (continued)

Root Cause Analysis

1. Analisis masalah error secara intensif
2. Meredesign sistem yang ada
3. Menguji design yang baru
4. Diseminasi ke seluruh staf
5. Follow-up

Safety Survey

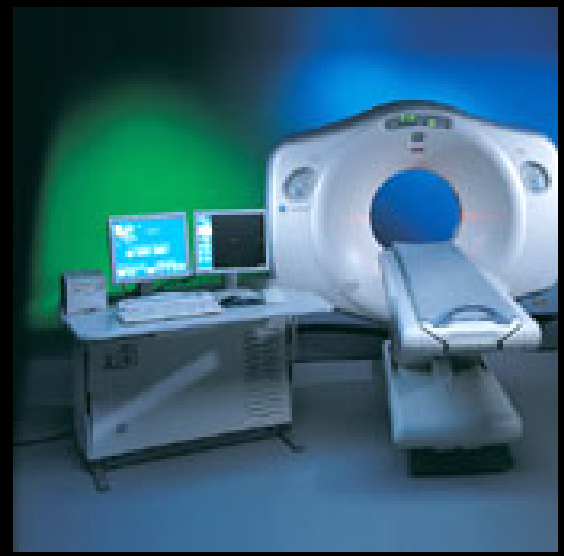
Petugas

Pekerja

Pasien

Teknologi berfokus pada Safety

- Menilai kebutuhan
- Aksesibilitas
- Ketepatan
- Links dgn internal equipment
- Links dg. external resources

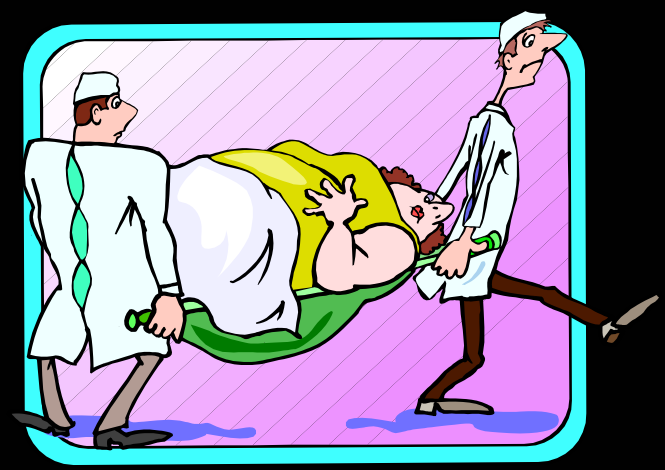


Pelayanan berfokus pada pasien (patient centered care)

- ✓ Menilai faktor potensial risiko (mis. pasien jatuh dari bed)
- ✓ Inkorporasikan hasil penilaian dengan rencana pelayanan
- ✓ Lakukan pendidikan tentang safety pada pasien dan keluarga

Mencegah Errors

Alokasi resources secara adekuat



- ✓ Human
- Information
- Physical
- Financial

Jelaskan outcome yang unanticipated

- ✓ Berikan penjelasan bahwa outcome yang terjadi memang di luar yang diharapkan
- ✓ Bahwa risiko memang tidak selalu terjadi tetapi sering tidak dapat dihindari

James Reason's bottom line

Fallibility is part of the human condition

We can't change the human condition

We can change the conditions under which people work