QUALITY AND PATIENT SAFETY –MANDATORY OR BY CHOICE?

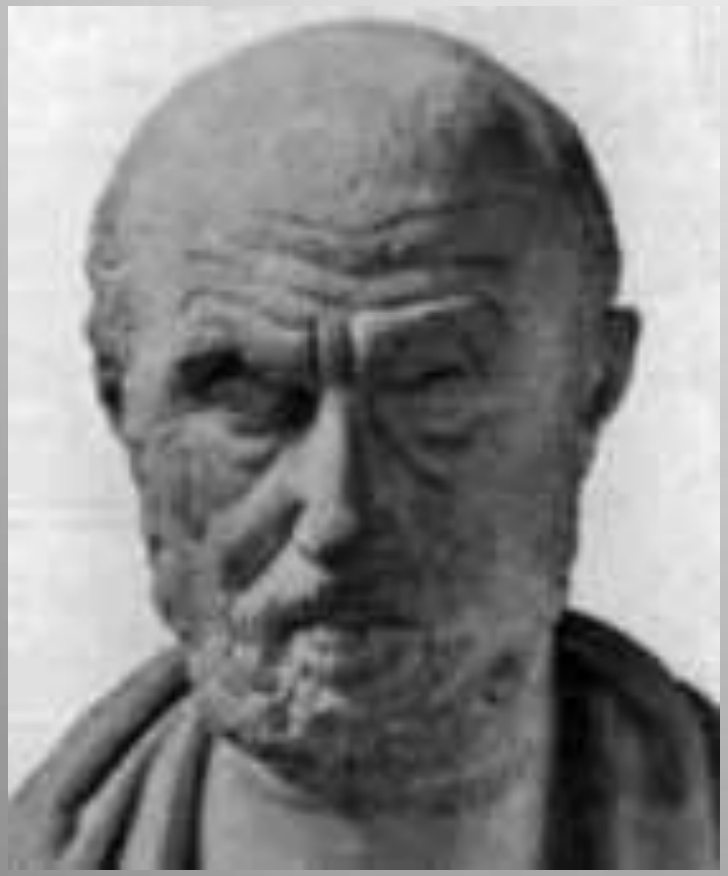
ECONOMICS OF PATIENT SAFETY CULTURE

DR.RAVINDRA KARANJEKAR
CORPORATE CEO
JUPITER HOSPITAL

Jupiter Hospital Thane

Jupiter Hospital

There's nothing new about this



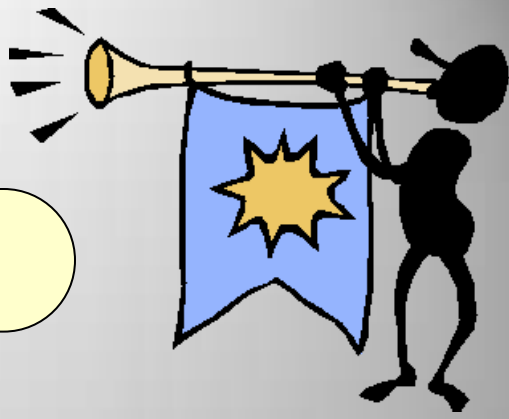
- "First, do no harm"

Essence

To Err is Human

Do No Harm

Words We Live By



"The customer is king"

"First impressions count"

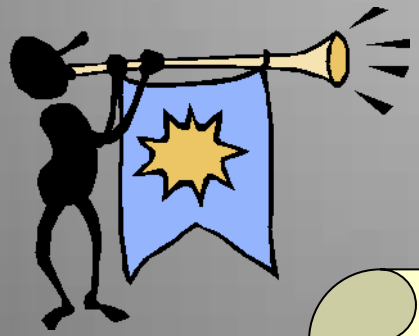
"Moments of truth"

"It's all about attitude"

"The excellence is in the details"

"Complaints are a gift"

"Bending the rules"



What is Patient Safety

- Freedom for a patient from unnecessary harm or potential harm associated with health care

- Adverse events
  - injuries caused by healthcare, rather than the patient's underlying condition, leading to disability (prolonged length of stay, morbidity at the time of discharge, or death)

Safety Culture

Safety culture is a complex phenomenon that is not clearly understood by hospital leaders, thus making it difficult to operationalize.

Senior leadership accountability is key to an organization-wide culture of safety

Hospital leaders are increasingly pressured by federal, state, regulatory, and consumer groups to demonstrate an organizational safety culture that assures patients are safe from medical error

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CLINICAL SCHOLARSHIP

What is Patient Safety Culture? A Review of the Literature

Christine E. Sammer, RN, PhD[1], Kristine Lykens, PhD[2], Karan P. Singh, PhD[3], Douglas A. Mains, DrPH[4], & Nuha A. Lackan, PhD[5]

Aspects of Patient Safety

- **public, professional, political, and scientific attention**
- **human burden associated with adverse events**
- **economic cost of patient safety**
- **economic impact of unsafe care**
- **Value of improvement strategies**

Seven subcultures of patient safety culture

a) **Leadership,**
b) **Teamwork,**
c) **Evidence-based,**
d) **Communication,**
e) **Learning,**
f) **Just**
g) **Patient-centered**

CHALLENGES TO QUALITY AND SAFETY

- Widespread lack of awareness
- Lack of methodological uniformity in identification and measurement
- Inadequate adverse event reporting
- Undue concerns over breaches in confidentiality of data,
- The fear of professional liability, and
- Weak information and communication systems

Patient Safety Indicators

Provider-level indicators

- Accidental Puncture or Laceration
- Birth Trauma – Injury to Neonate
- Complications of Anesthesia
- Death in Low-Mortality DRGs
- Decubitus Ulcer
- Failure to Rescue
- Foreign Body Left During Procedure
- Iatrogenic Pneumothorax
- Obstetric Trauma – Vaginal with Instrument
- Obstetric Trauma – Vaginal without Instrument
- Obstetric Trauma – Cesarean Delivery
- Postoperative Hip Fracture
- Postoperative Hemorrhage or Hematoma
- Postoperative Physiologic and Metabolic Derangements
- Postoperative Respiratory
- Postoperative Pulmonary Embolism or Deep Vein Thrombosis
- Postoperative Sepsis
- Postoperative Wound Dehiscence
- Selected Infections Due to Medical Care
- Transfusion Reaction

Area-level indicators

- Accidental Puncture or Laceration
- Foreign Body Left During Procedure
- Iatrogenic Pneumothorax
- Postoperative Hemorrhage or Hematoma
- Postoperative Wound Dehiscence
- Selected Infections Due to Medical Care
- Transfusion Reaction

U.S. Department of Health & Human Services

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

HOSPITAL SAFETY CULTURE

- Leadership priority
- Organisational commitment to patient safety (infrastructure and resources)
- Establish processes
- No-blame culture
- Training for risk reduction

The SIX Elements of Quality

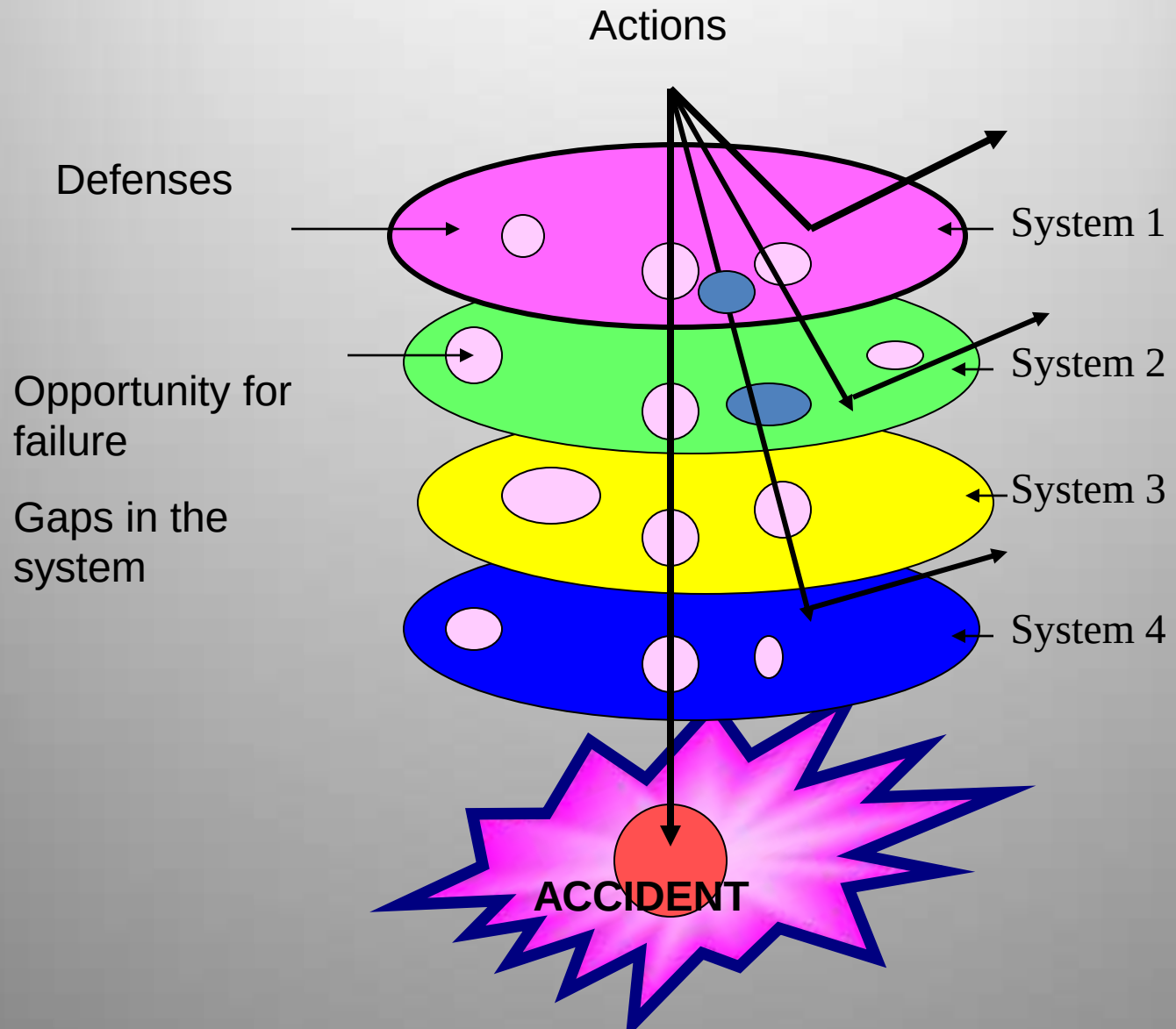
- *Patient safety*
- *Effectiveness*
- *Patient centeredness*
- *Timeliness*
- *Efficiency*
- *Equity*

*Source:*Institute of Medicine 2001.

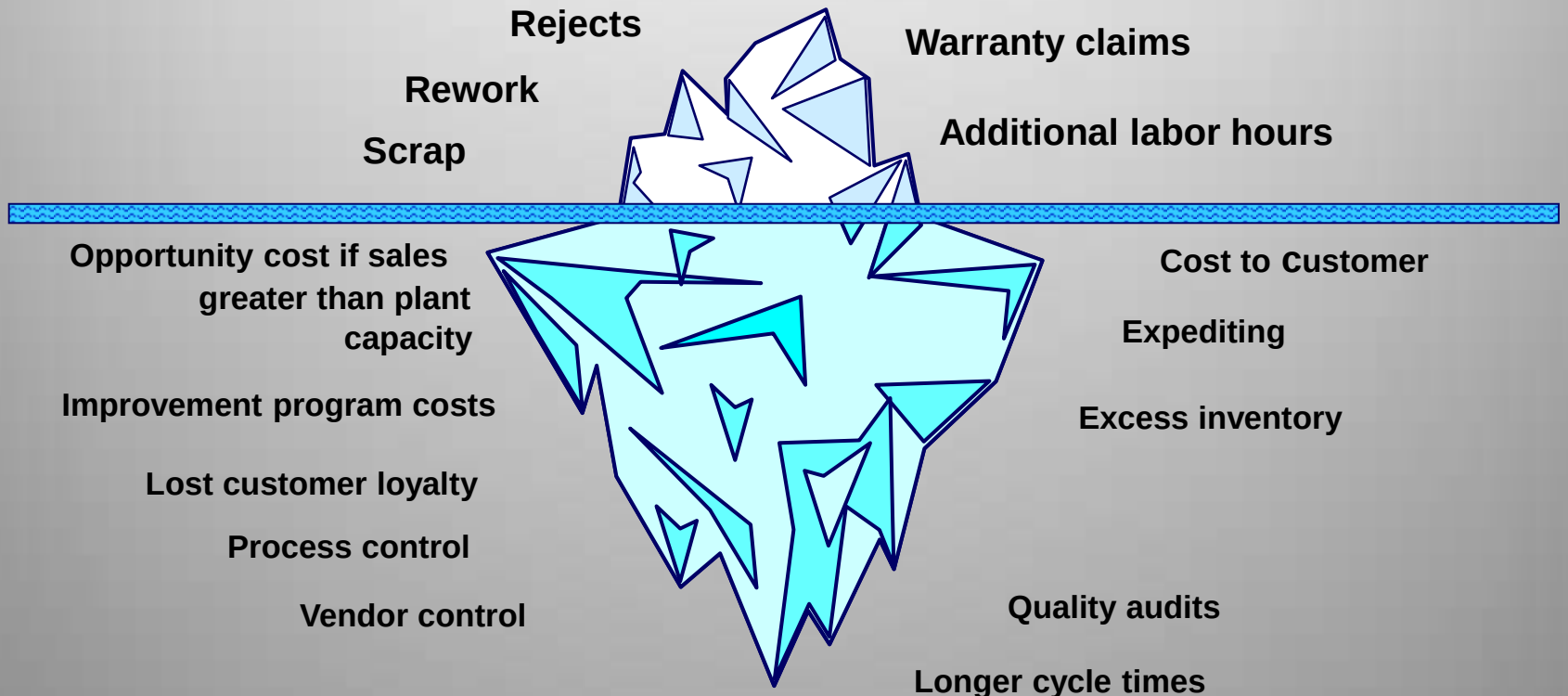
2016 National Patient Safety Goals

1. Ambulatory Health Care
2. Behavioral Health Care
3. Critical Access Hospital
4. Home Care
5. Hospital
6. Laboratory Services
7. Long Term Care (Medicare/Medicaid)
8. Nursing Care Center
9. Office-Based Surgery

Swiss Cheese Model



Cost of Poor Quality



How far do we look below the surface?

MEDICATION ERRORS MAINLY CLASSIFIED IN FIVE AREAS

1 OPERATIVE –35%
2 DRUG REALATED
3 DIAGNOSTICS RELATED
4 PROCEDURE RELATED
5 OTHER

ECONOMICS OF PATIENT SAFETY

HOW

BIG

IS THE PROBLEM?

EVERY YEAR

200000(TWO LAC) AMERICANS

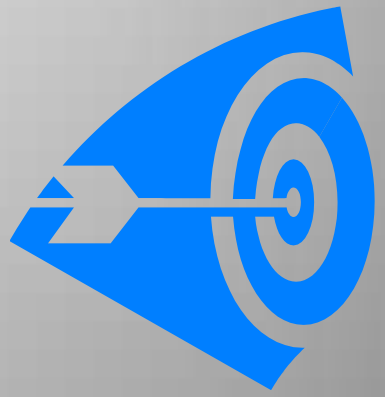
DIE OF PREVENTABLE MEDICAL ERRORS INCLUDING FACILITY AQUIRED CONDITIONS

EVERY YEAR MEDICAL ERRORS ARE 3rd LEADING CAUSE OF DEATH IN UNITED STATES

1.HEART 6.0LACS,

2.CANCER 5.7LACS

3.MEDICATION ERRORS 2LAC



4.CHR.RESP DISEASE 1.4LACS

5.STROKE 1.3LACS

6.ACCIDENTS 1.2LACS


BMJ
No 7257 18 March 2000
Reducing error
Improving safety

EVERY YEAR MEDICAL ERRORS COST UNITED STATES CUMMULATIVELY DEATHS MORE THAN

300 JUMBO JETS CRASH/YR

(OLD REPORT)

NOW IT IS MORE THAN THAT

EVERY YEAR MEDICAL ERRORS COST UNITED STATES **170000000000 USD** (17 BILLION USD) DIRECTLY

EVERY YEAR MEDICAL ERRORS
COST UNITED STATES
100000000 DAYS
(10 MILLION DAYS)
LOSS OF PRODUCTIVITY

EVERY YEAR MEDICAL ERRORS COST UNITED STATES CUMMULATIVELY

980 BILLION --1TRILLIAN USD

WHEN QALYS (QUALITY ADUJUSTED LIFE YEARS) ARE APPLIED

EVERY YEAR MEDICAL ERRORS COST UNITED STATES **14000000000 USD** (1.4 BILLION USD) DUE TO INCREASED MORTALITY

QUALITY CARE----
OPERATIONAL EXCELLENCE---
PATIENT SAFETY POLICIES

CAN CHANGE IT.

YOU ONLY CAN CHANGE IT

WHY?

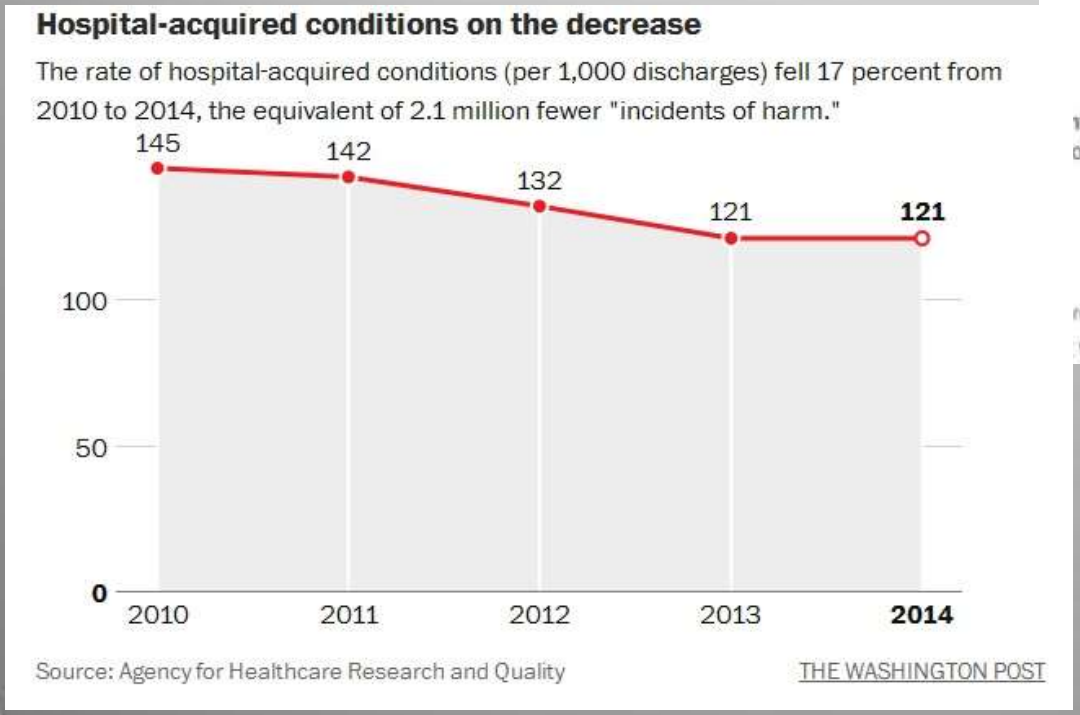
- An adverse outcome due to a medical error should be considered worse than an adverse outcome for some other reason

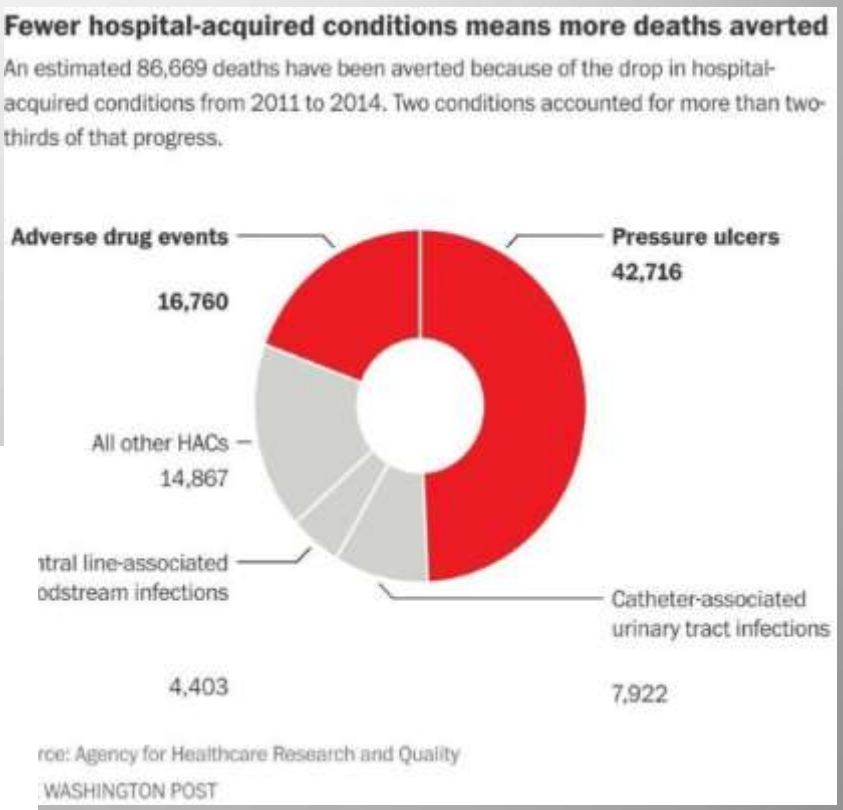
- Medical error is costly – 'Business - case' for patient safety . . .
  - Ensuring Patient Safety is not just reduced costs, or
  - reduced malpractice settlements, but
  - Increased demand for care that a provider experiences when they can offer patients care that is safer

- **HHS (health & Human services dept USA)says**

  patient safety efforts have saved 87,000 lives, $20 billion

- The rate of hospital-acquired conditions (per 1,000 discharges) fell 17 percent from 2010 to 2014, the equivalent of 2.1 million fewer "incidents of harm.“





HHS


The journey to 1000 miles begins with a single step

THANK YOU