SIMPLE RULES FOR ENSURING SAFE CARE AND AVOIDING MEDICO-LEGAL PITFALLS

HONG KONG

Presented by:

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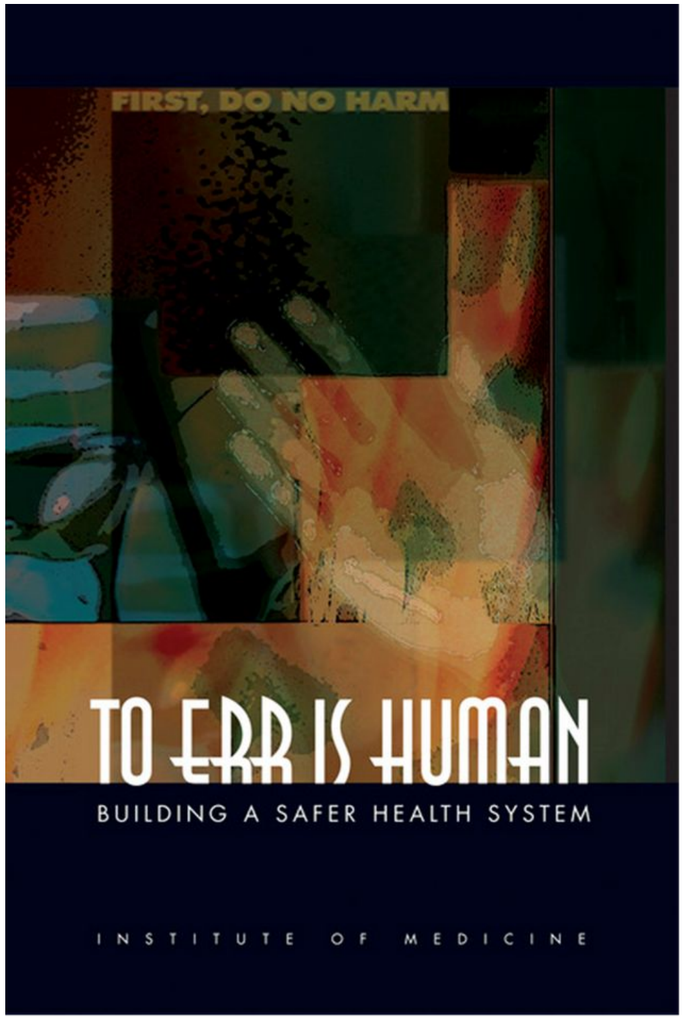
Learning Objectives

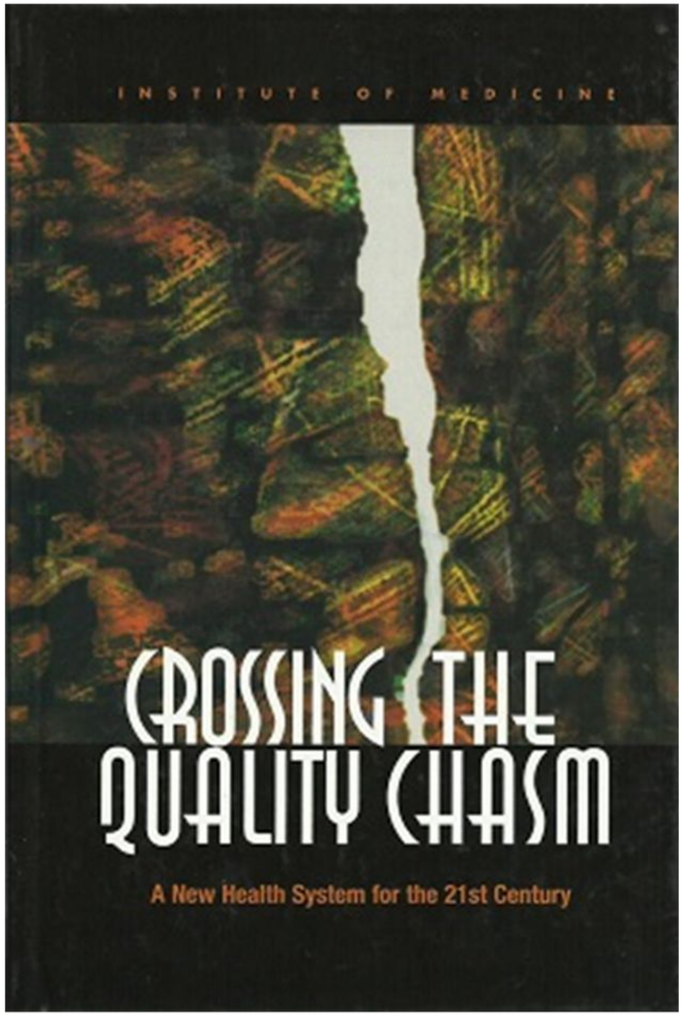
Medicine is a noble profession, but today's patient-doctor relationship has become more formal and structured.

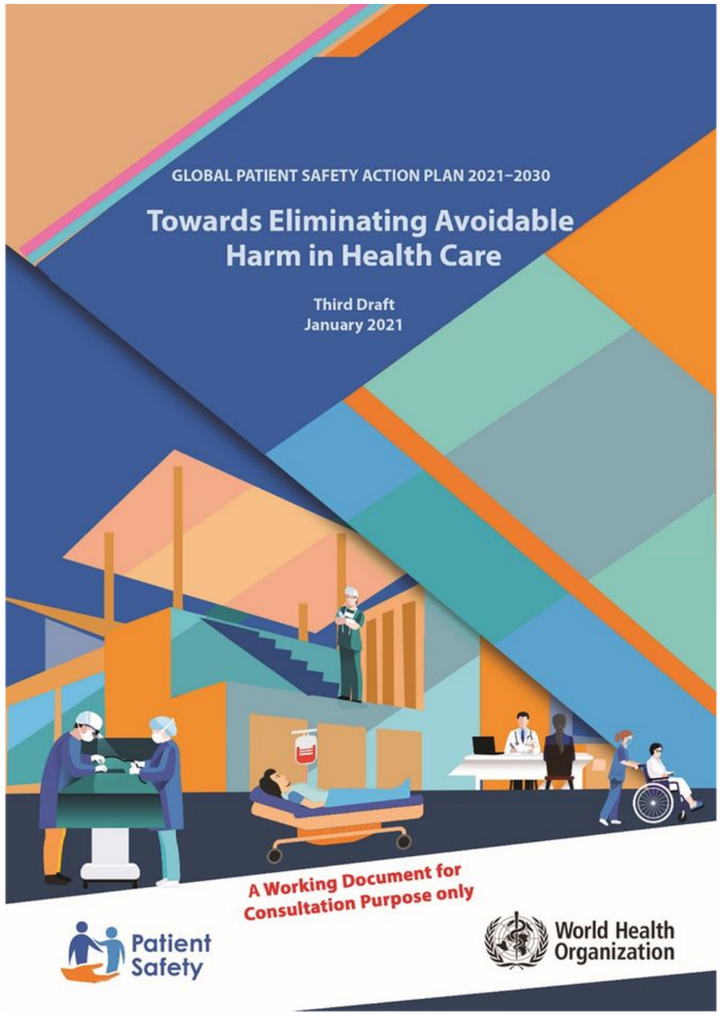
Doctors are not infallible and must take steps to avoid mistakes. Learning from mistakes is essential, and prevention is the best way to handle them.

This presentation offers measures to improve the quality of care while safeguarding clinicians and improving patient safety.

QUALITY AND PATIENT SAFETY







GLOBAL PATIENT SAFETY ACTION PLAN 2021-2030

Around 1 in every 10 patients is harmed in health care

WHO- 2023

In low-to-middle-income countries, as many as 4 in 100 people die from unsafe care.

About 50% of harm (1 in every 20 patients) is preventable; half of this harm is attributed to medications.

In primary and ambulatory settings, as many as 4 in 10 patients are harmed, while up to 80% (23.6–85%) of this harm can be avoided.

Patient harm potentially reduces global economic growth by 0.7% a year. On a global scale, the indirect cost of harm amounts to **trillions of US dollars each year**.

Investing in **reducing patient harm can lead to significant financial savings and better patient outcomes**. For example, patient engagement can reduce harm by up to 15%.

System Focus

“Incompetent people are, at most 1% of the problem. The other 99% are good people trying to do a good job who make very simple mistakes and it’s process that set them up to make these mistakes.”

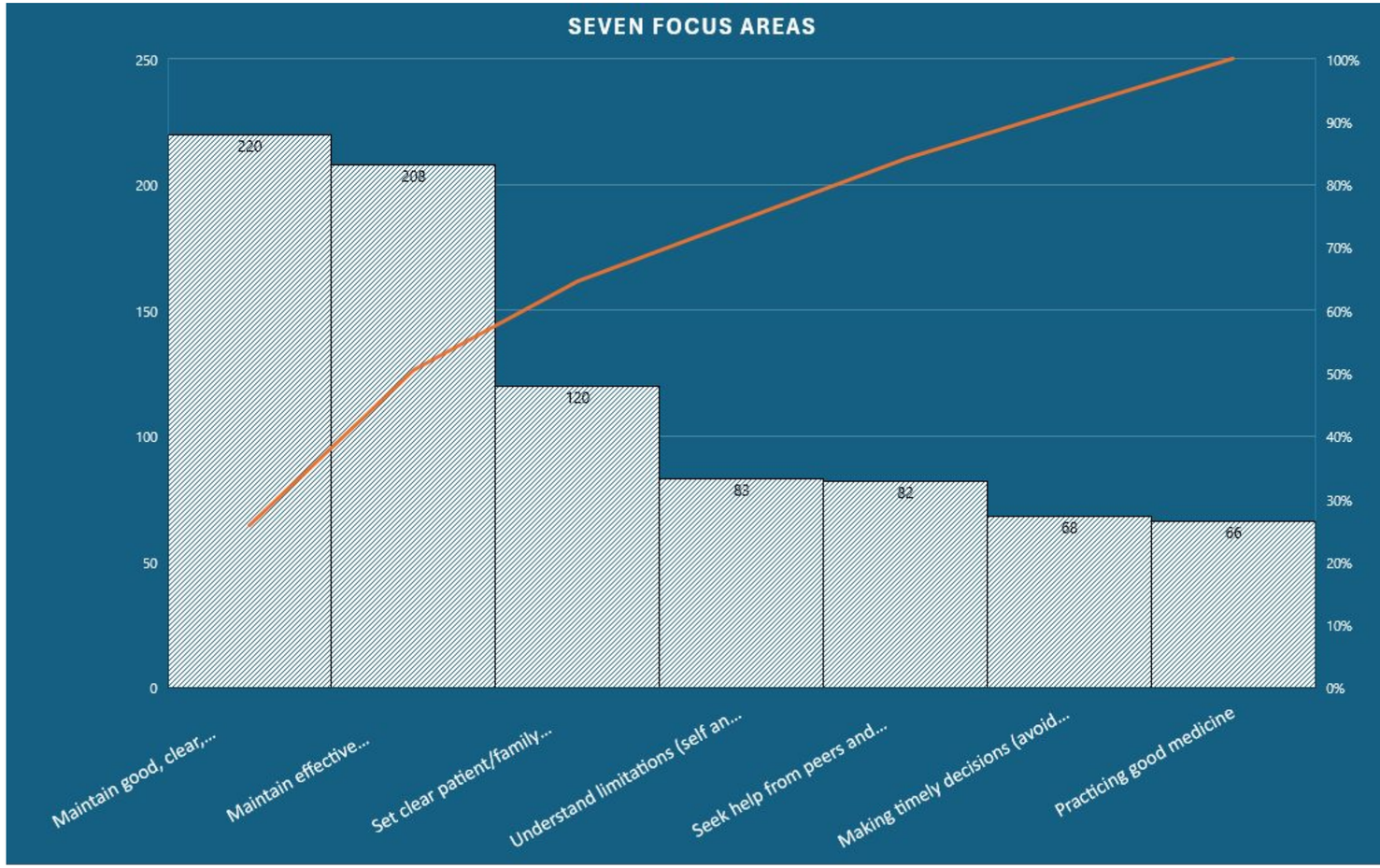
Dr. Lucian Leape, Harvard School of Public Health

We looked at both OFIs and good practices to broaden our understanding of what needs to be improved and what needs to be sustained.

How we started it?

Case Number	Practicing good medicine	Maintain effective communication	Set clear patient/family expectations	Maintain good, clear, contemporaneous documentation	Seek help from peers and colleagues immediately when needed (Escalation)	Making timely decisions (avoid delay)	Understand limitations (self and organizational limitations)
MN00001	1	1	0	1	0	1	0
MN00002	0	1	0	1	0	1	0

Focus Area	Number	%
Practicing good medicine	66	25.10
Seek help from peers and colleagues immediately when needed (Escalation)	82	31.18
Making timely decisions (avoid delay)	68	25.86
Understand limitations (self and organizational limitations)	83	31.56
Set clear patient/family expectations	120	45.63
Maintain good, clear, contemporaneous documentation	220	83.65
Maintain effective communication	208	79.09



Seven rules to improve Quality and Patient Safety - Lessons Learned

Practice Good medicine	• Evidence based and compassionate care delivered to the patient in a timely manner
Documentation	• Practice detailed, contemporaneous documentation
Setting Expectations	• Listen to your patients and set clear patient expectations
Communication	• Have a good communication with patient, family and teams involved.
Timely Escalation	• Timely Escalate, when needed.
Decision making	• Make timely decisions which are in the best interest of your patient
Understand limitations	• Understand limitations

7

Rule 1
Good Medicine

Good communication, Compassion, empathy

Patients must be able to trust doctors with their lives and health.

Treat the patient, not just their illness.

- Put your patient as your first concern.
- Provide a good standard of care.
- Keep your professional knowledge and skills up to date.
- Respect patients' right to dignity and confidentiality
- Listen to and respond to their concerns and preferences.
- Work with colleagues in the ways that best serve patients' interests.

Practicing Good Medicine- involves listening to patients

A study in the Journal of General Internal Medicine found that, on average, patients get about 11 seconds to explain the reasons for their visit before they are interrupted by their doctors (2018).

Our results suggest that we are far from achieving patient-centered care," said lead researcher Singh Ospina of the University of Florida, Gainesville.

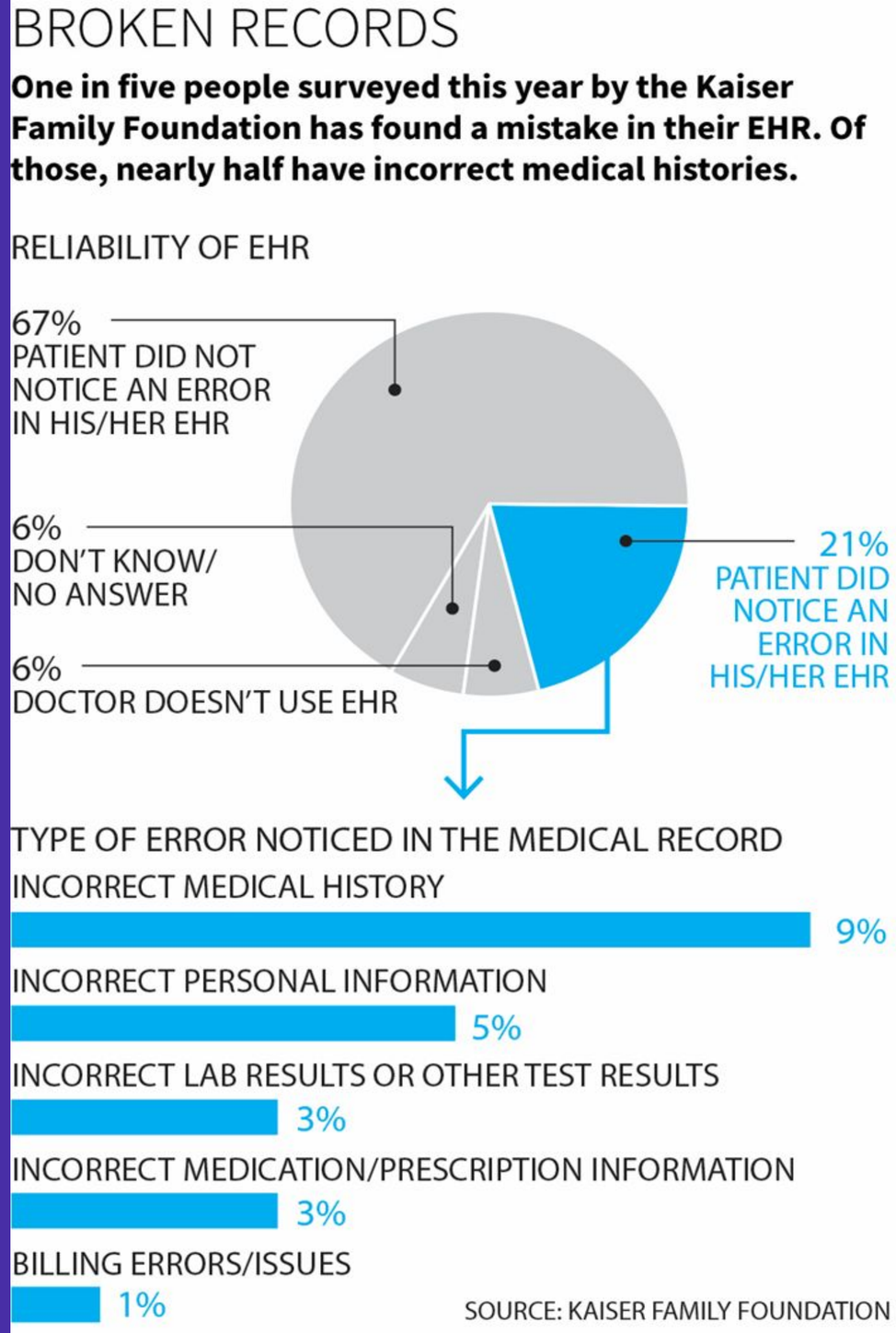
“The Doctor,” a painting by Samuel Luke Fildes that hangs in the Tate Museum in London

Rule 2
Good Documentation

Good documentation is essential for maintaining patient safety and ensuring quality care. In today's digital age, electronic health records (EHRs) have become the standard for documentation in healthcare.

Good documentation can also serve as evidence in legal cases.

There are several benefits of good documentation



Practice good, contemporaneous documentation

- Complete information to be recorded
- Comprehensive, contemporaneous
- Describes the facts, details of the procedures, consents, refusals
- Communication related information
- Treatment plan, progress notes, any deviations to the agreed plan and consents

Manufacture

↓

Medication choice

↓

Writing the prescription

↓

Dispensing the medication

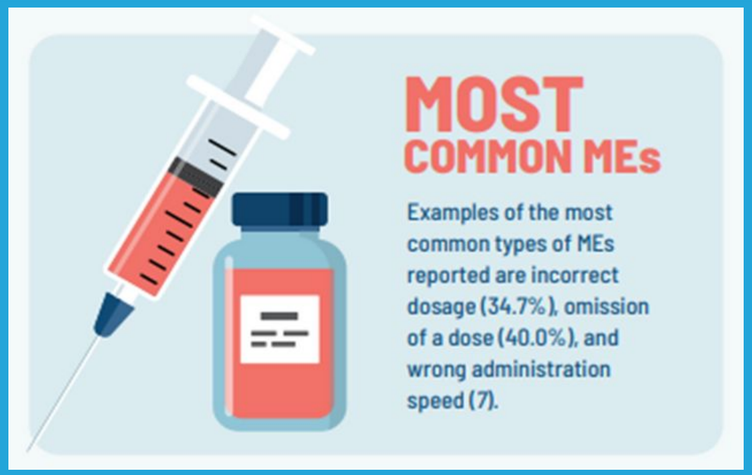
↓

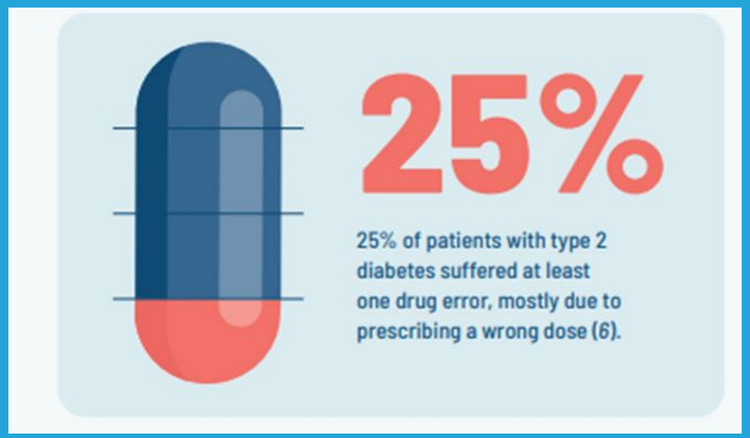
Medication administration

↓

Monitoring therapy

Generic name/Strength/Form	Dose/Cycle/Route	Duration	Qty.	Refill	Qty. Disp.
NOVAMED NEBULIZER MASK CHILD	1 Piece / Daily / NEBULIZER	7 days	7 PCS		
MULTIVITAMINS AND MINERALS / COMBINATION / ORAL LIQUID	7 ML / Daily / ORAL	60 days	3 Bottle		
PARACETAMOL / 250mg/5ml / Syrup	5 ML / Whenever it is required three times daily / ORAL	5 days	1 Bottle		
Comments: When: Fever					
IBUPROFEN / 100mg/5ml / Suspension	78 ML / Whenever it is required four times daily / ORAL	5 days	16 Bottle		
Comments: When: Fever					
CETIRIZINE / 1mg/ml / Syrup	5 ML / Bedtime / ORAL	7 days	1 Bottle		
HERBAL / ZECUF / Syrup	5 ML / TID (three times daily) / ORAL	7 days	2 Bottle		





Documentation- Medication errors

Medication errors are among the most common errors, harming at least 1.5 million people yearly. 98% of medication errors are prescription errors.

Prescription errors are documentation errors that happen due to improper selection of drugs (sometimes from drop-down lists), wrong dosage, route, or frequency documentation, and improper cross-checking of medication prescriptions before handing them over to the patient

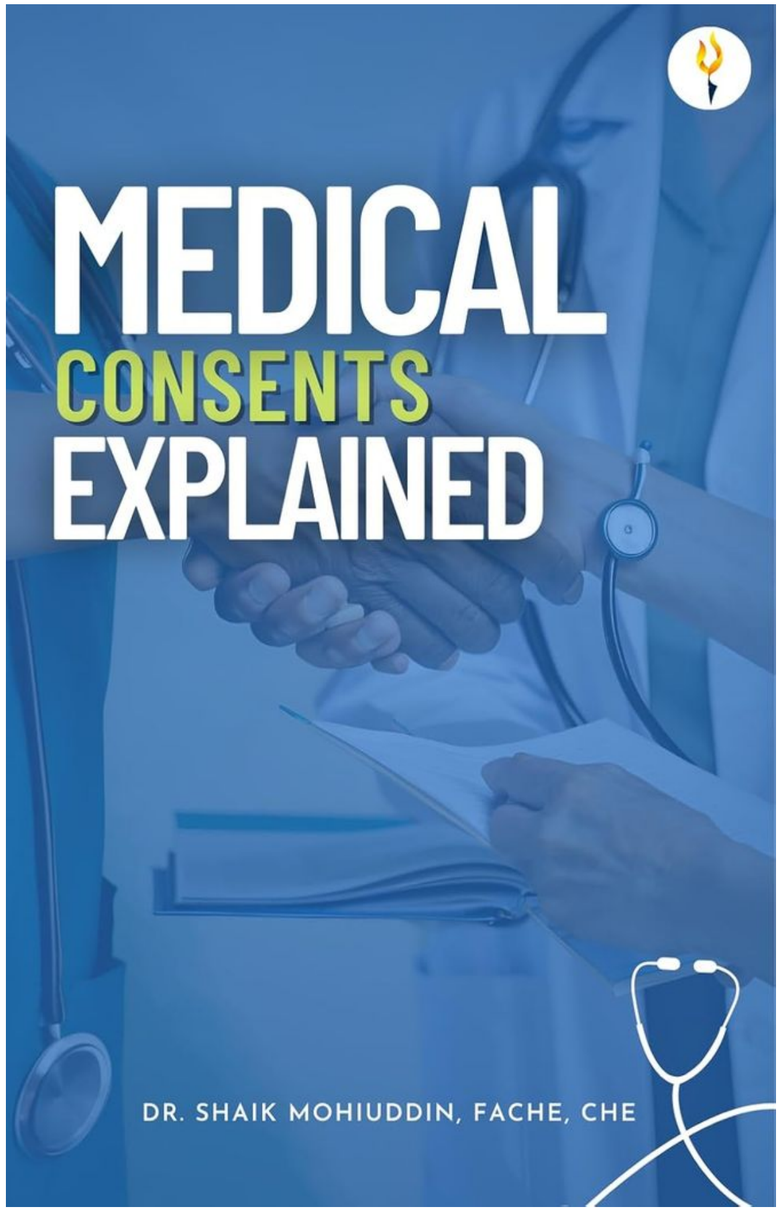
Practice Good Documentation- Consents

Surgical/Procedure consents: there are at least five essential elements that every consent should have.

Name of the patient, procedure, risks, advantages/benefits, alternatives, opportunity to ask questions, witness, signatures of both parties

OT records: write the procedure in detail as we did during our residencies.

Practice Good Documentation- Consents



Informed Consent Process:

The informed consent process is more than just signing a form. It involves:

Disclosure: The healthcare provider must explain the nature of the procedure, its risks, benefits, and alternatives in clear, understandable language.
Comprehension: The patient must understand the information provided.
Voluntariness: The patient must freely choose to undergo the procedure without coercion or undue influence.
Competence: The patient must be mentally capable of making the decision.

Legal Implications:

Failure to obtain proper consent can lead to charges of battery or negligence. Documenting the consent process is crucial for legal protection.

Ethical Considerations:

Informed consent is a cornerstone of medical ethics, respecting patient autonomy and dignity.

Rule 3- Set Right Expectations

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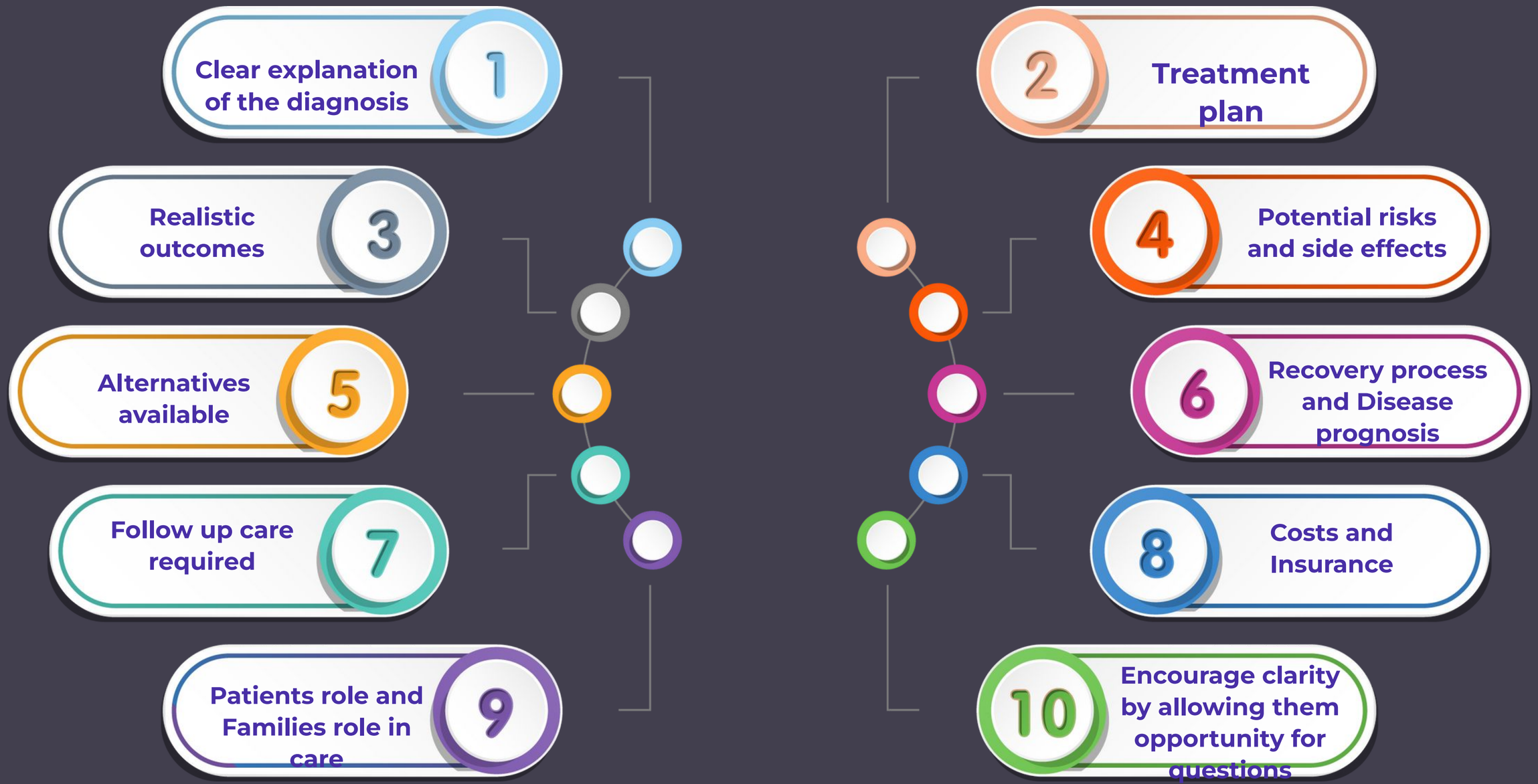
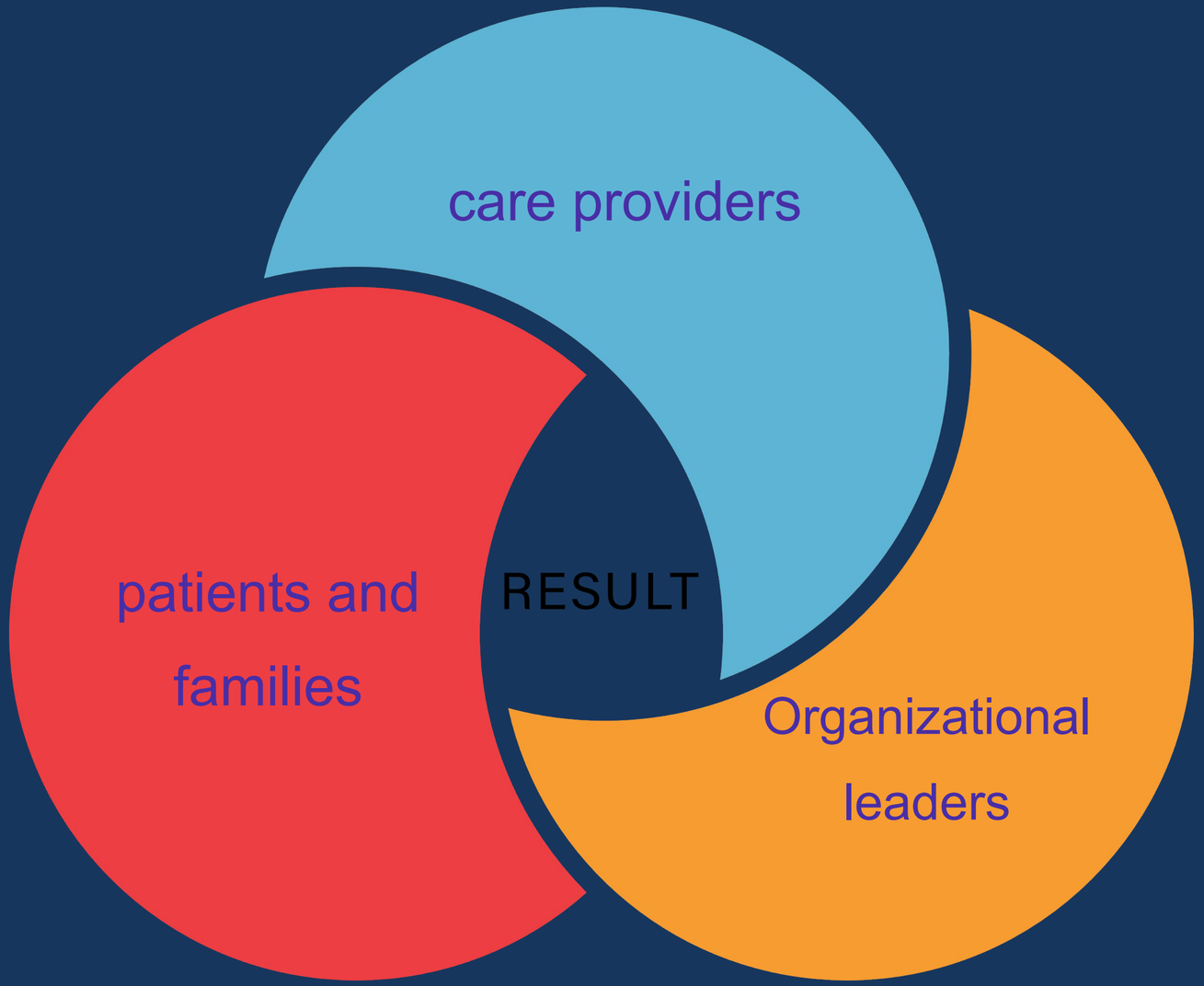


Rule 4- Good Communication

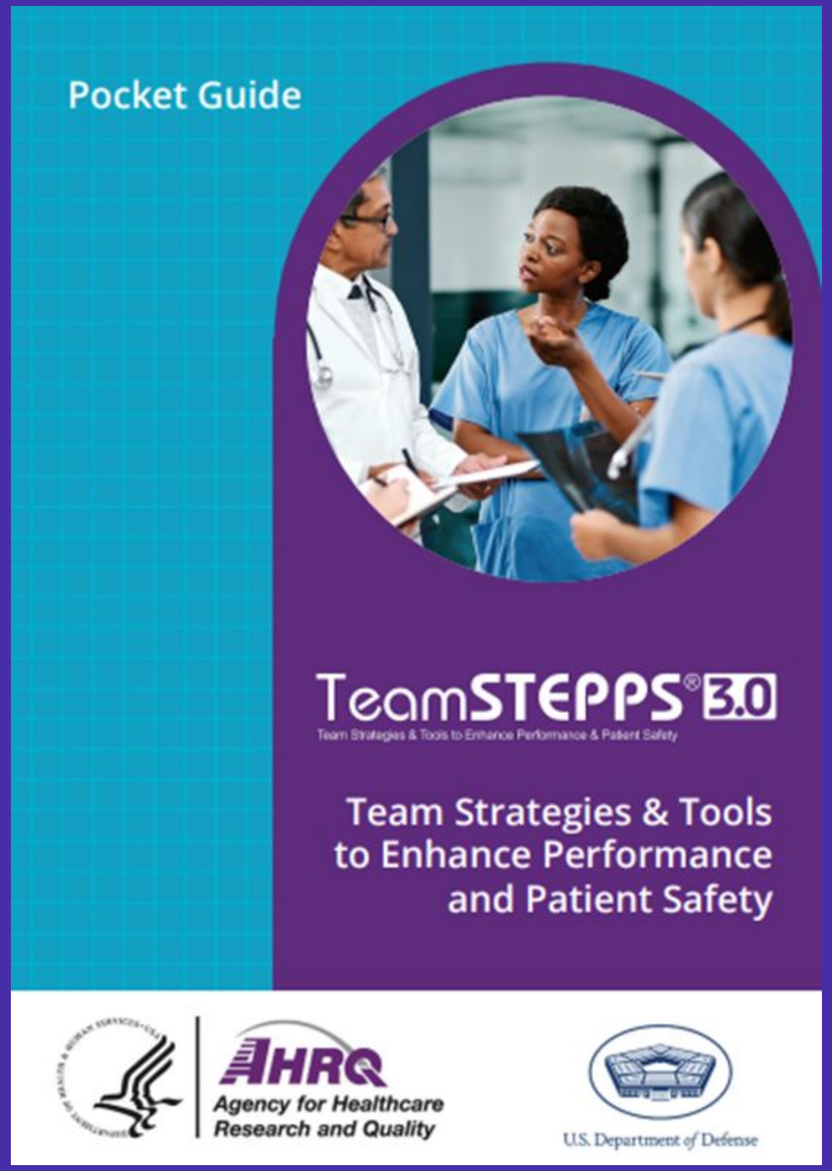


- Leadership:
  - Ensure leaders prioritize and model good communication.
  - Provide ongoing training on communication and safety. Include communication training in your annual plan.
  - Improve the use of technology, EHRs, and other tech tools to enhance communication.

- Patient involvement:
  - Encourage patients to speak up about safety concerns.
  - Educate- Educate-Educate
  - Communicate- Communicate- Communicate

- Care Providers:
  - Implement consistent procedures for high-risk situations- SBAR
  - Break down silos between different areas of healthcare.
  - Conduct periodic reviews of communication practices and safety measures.

Just culture: Foster an environment where people feel safe reporting errors.



World Patient Safety Day 2023 was observed on 17 September under the theme "Engaging patients for patient safety", in recognition of the crucial role patients, families and caregivers play in the safety of health care.

World Patient Safety Day 17 September 2023

Can we work like the Pit Stop Team?

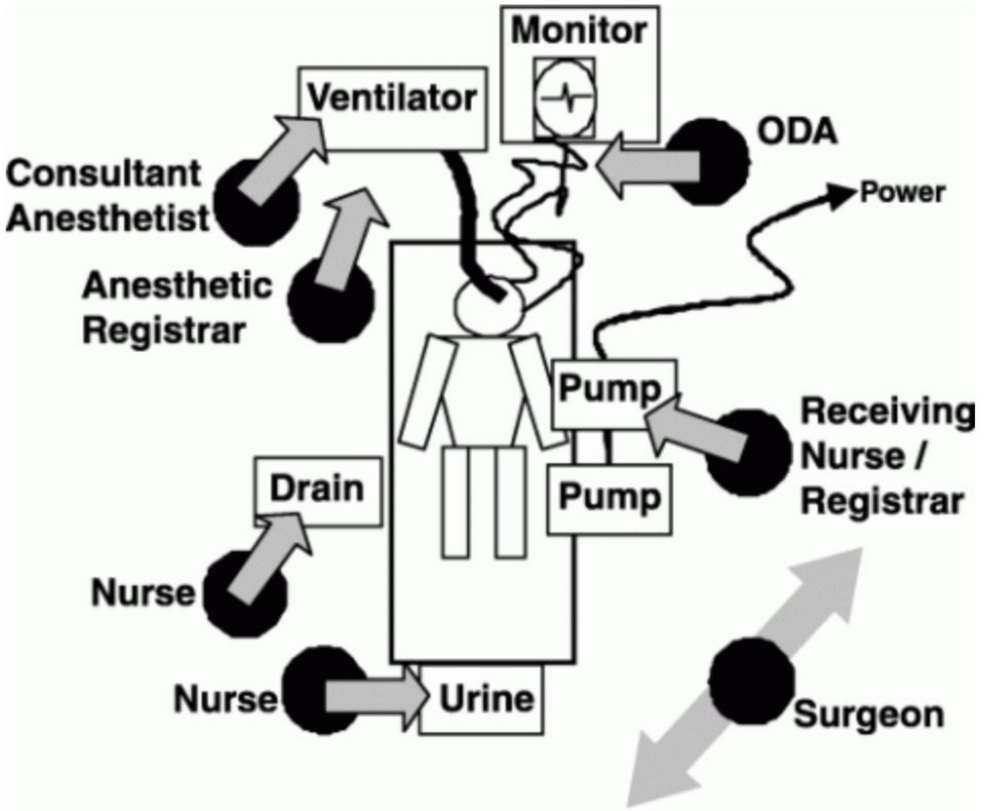
The sub-2-second pit stop was made possible only due to exceptional teamwork, which involves extensive practice, coordination and deep understanding by every person on the crew. Approximately 20 people on the pit crew need to work in a well-choreographed orchestration to make this possible.

Today's healthcare challenge

Today's challenge is " not how we will deliver care in teams, but how well we
deliver care in teams".

Reference: Marilyn September's 1990 paper Advancing the Social Sciences through the Interdisciplinary Enterprise.

Teamwork with one common goal



Pediatric Anesthesia, May 2007

Reference: Peter Van Manen, Ted Talks, Dalhousie University, 2016

Communicate with patients and encourage patients to speak

28th April 1988- Aloha Airlines Flight 243

Source: https://www.independent.co.uk/news/world/americas/aloha-airlines-flight-243-clarabelle-lansing-b2328174.html

Scholastic Medical Science

Review Article

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Embracing the Power of Teamwork with Patients to Propel Healthcare Organizations Towards Excellence in Quality and Safety: A Systematic Literature Review

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Abstract

Objective: The aims of this review are to analyze the various measures of teamwork in healthcare organizational contexts and healthcare services, to determine whether patients get involved in strategy planning for organizations, and to discuss teamwork's effects on quality strategy.

Materials and Methods: The search strategy involved combining terms relating to three sub-key concepts for 'Healthcare Organizations', 'Team Structuration' and objects of 'Quality' and/ or 'Strategy'. Additionally, the review utilized various combinations of keywords to search Google Scholar, focusing on quality strategy, hospital, teamwork, and healthcare services. A total of 1282 publications were reviewed.

Results: Teamwork also has potential to drive healthcare improvement and enhance organizational strategy. Communication and coordinated teamwork also impact healthcare collaboration. Overall, throughout the search, involvement of patients in quality strategies was missing.

Conclusion: Good evidence exists to demonstrate healthcare organizations see a critical need to improve teamwork to enhance patient safety. However, there is a need to shift in healthcare policy towards better involvement of patients in improvement strategies and move from a focus on individual clinical competence, towards an emphasis on improved group and team-based functioning that involves all stakeholders, including patients.

Keywords: Strategy, Patients, Teamwork, Improvement

Where is patient?

Case Communication Failure

Case of severe dehydration presented and fever to ED.

Multiple attempts were made to access the vein, but all in vain.

Communication made.

More than 12 hours without an IV cannula.

The patient landed up into severe health issue

Let’s follow the Follow-Ups

Instances when test results are not received by the ordering physician.

If you ordered a test, make sure you review the test results before discharge if that’s a critical test for your discharge decision.

It is essential that physicians and their staffs are able to track the status of these orders to make sure that none are overlooked or forgotten.

Another aspect of care needing better follow-up involves referrals to specialists.

Every step has to be documented not only for preventing medico-legal issues but also for good patient care as well.

Rule 5- Timely Escalation

Timely escalation of care in hospitals is crucial for ensuring patient safety and quality of care.

High-reliability organizations (HROs) in healthcare emphasize the importance of promptly identifying and responding to patient condition changes to prevent adverse outcomes.

Timely escalation of care involves recognizing signs of deterioration early, communicating effectively within the healthcare team, and activating appropriate interventions to address the patient's needs promptly.

Leveraging technology such as electronic health records (EHRs) and telemedicine can facilitate rapid communication and decision-making in escalating care for patients.

Telemedicine platforms offer remote consultation services that can support clinicians in managing complex cases and obtaining specialist input promptly.

Source: AHRQ- CUS (Concern-Uncomfortable-Safety Issue)

Rule 6- Timely Decision-Making

The role of timely decision-making in healthcare settings cannot be overstated, as it plays a pivotal role in preventing and mitigating clinical issues.

Timely decision-making enables appropriate and efficient resource allocation, emergency response, diagnostic accuracy, appropriate and timely medication administration, and good interdisciplinary collaboration.

Timely decisions also enable patient flow effectiveness, cost-effectiveness, and quality improvement.

Rule 7- Understanding Limitations

Facility limitations

Understanding scope limitations

Focus on a Culture of Safety to Achieve Zero Harm

CONTAIN

Deference to expertise

Decision-making migrates to the person or people with the most expertise with the problem at hand, regardless of authority or rank..

Commitment to resilience

Developing capabilities to cope with, contain, and bounce back from mishaps that have already occurred before they worsen and cause more serious harm..

ANTICIPATE

Sensitivity to operations

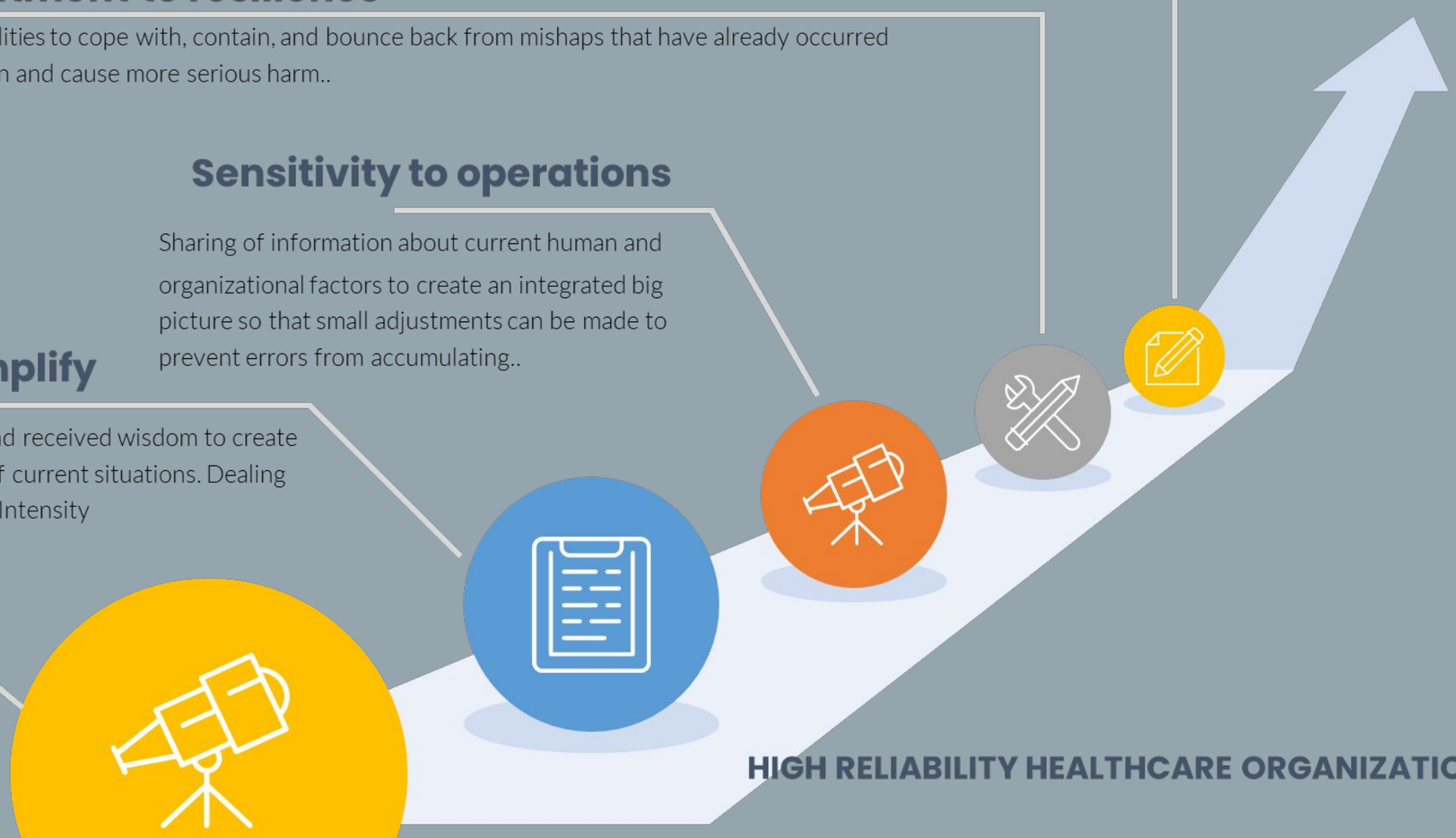
Sharing of information about current human and organizational factors to create an integrated big picture so that small adjustments can be made to prevent errors from accumulating..

Reluctance to simplify

Deliberately questioning assumptions and received wisdom to create a more complete and nuanced picture of current situations. Dealing with all incidents with the same level of Intensity

Preoccupation with Failure

Operating with a heightened awareness of potential risks and near misses that may jeopardize safety.



HIGH RELIABILITY HEALTHCARE ORGANIZATION

Focus on ZERO

- Zero falls
- Zero complications of care
- Zero infections
- Zero missed opportunities
- Zero overuse
- Zero lost revenues
- Zero harmful events of any kind to patients, staff, and visitors.


Make it safe; prove
it by saving

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