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SPECIAL SUPPLEMENT

Top Killers

Medical errors: is prevention possible?

How the Patient Safety Movement is striving for zero preventable deaths by 2020

A patient death is distressing enough, but when the cause is a lack of hospital safety culture and it could have been prevented, healthcare needs to act. Now.

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A health crisis across the globe is claiming over 4.8 million lives every year. It's devastating countless families and clinicians in every country and across every continent. But because we only hear of an incident happening once in a while in the news, many people believe it's a rare occurrence. The fact is that it happens 500 times a day in the United States alone. Preventable hospital deaths are the third-leading cause of death in the United States and the 14th across the globe. This situation has become so dire that it has caught the attention of the World Health Organization's Director-General, who spoke at the 6th Annual World Patient Safety, Science and Technology Summit earlier this year.

Dr Tedros Ghebreyesus said no one should be harmed seeking care, while acknowledging the reality that, every year, millions of patients die or are injured because of unsafe and poor-quality healthcare. Ghebreyesus stressed that most of these deaths and injuries were totally avoidable and went on to say that adverse events are now estimated to be the 14th leading cause of death and injury globally. He detailed figures of 421 million hospitalisations in the world every year, and how, on average, 1 in 10 of those results in adverse events. Even more disturbing are his words that that at least half of adverse events can be prevented.

This last insight should be both troubling yet encouraging because we can put processes in place in our hospitals to avoid preventable harm.

Leading causes of preventable deaths

Since I launched the Patient Safety Movement Foundation in 2012, we have teamed up with some of the world's leading medical experts, hospital administrators and patient safety advocates to identify and develop evidence-based solutions addressing the primary causes of preventable patient deaths. Close to 5,000 hospitals across 44 countries have implemented these Actionable Patient Safety Solutions (APSS) or their own novel solutions to reduce preventable mortality. Last year, they reported saving between 81,533 and 200,000 lives as a result of their continuous improvement efforts.

So, what are the leading causes of preventable patient deaths? We've identified at least 16, which include healthcare-associated infections, medication errors, etc. However, the main cause for preventable patient deaths is when hospitals lack a culture of safety. Studies report that hospital departments where staff have more positive patient safety culture perceptions have fewer adverse events (Najjar et al. 2015).

What is a safety of culture?

What does a culture of safety look like? A strong safety culture promotes the identification and reduction of risk as well as the prevention of harm. A poorly defined and implemented culture of safety may often result in concealing errors and therefore a failure to learn from them. According to the Institute of Medicine, "the biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm" (Committee on Quality of Health Care in America, Institute of Medicine 2001). Hospitals like Florida's Parrish Medical Center have experienced dramatic improvements by implementing a culture of safety. For example, they've achieved zero ventilator-related pneumonia in 12 years, one catheter-related UTI in 10 years and one central line-associated bloodstream

Joe Kiani: Zero is possible today and it doesn't require limitless resources.

infection (CLABSI) in the past 10 years (Patient Safety Movement 2018). At Parrish, a culture of safety means tracking and monitoring data, continuously using that data to improve their processes so they can achieve their vision of zero harm.

> "PREVENTABLE HOSPITAL DEATHS ARE THE THIRD-LEADING CAUSE OF DEATH IN THE UNITED STATES AND THE 14TH ACROSS THE GLOBE"

Edwin Loftin, Chief Nursing Officer at Parrish Medical Center says when an organisation really commits to a culture of safety and measures relentlessly, then they will know where they need to make changes and they will know how. In other words, it won't be guesswork or based on anecdotal evidence.

Monitoring and reporting preventable harm is critical for hospitals to understand where they can improve. Spain's SENSAR, a nonprofit organisation made up of 108 partner hospitals in Spain and Chile, has leveraged their national reporting tool, the first of its kind in Spain, to help create widespread learning and system improvement following critical incidents. The incident reporting tool is anonymous and focuses on corrective measures, and lessons learned instead of blame. This innovative reporting tool and their accompanying commitment to education has saved 6,772 lives since their commitment began in October 2016.

What needs to happen to reach zero preventable patient deaths?

- Every person in the healthcare ecosystem needs to commit and lead his or her institution to make safety the number one priority.
- Hospitals need to implement proven processes that address every identified challenge and create a policy of zero tolerance toward continued practices that are proven to be inadequate.
- Hospitals need to be transparent. Every 3 months, each hospital should report the number and type of preventable patient harms and deaths that have occurred in the institution.
- Hospitals need to implement the Communication and Optimal Resolution (CANDOR) Programme, which is available as a free online toolkit (Agency for Healthcare Research and Quality 2016). CANDOR provides healthcare organisations with a framework for communicating accurately and openly with patients and their families in the event of a medical error, and promotes a culture of safety that focuses on organisational accountability and learning from every mistake.


Dr Tedros Ghebreyesus: at least half of adverse health events can be prevented.

Which hospitals are demonstrating success?

Hospitals are proving that zero is possible. We're already seeing hospitals getting to zero deaths in certain areas such as hospital-acquired infections. For example, Tri-City Medical Center in San Diego, California, recently celebrated 7 years of zero CLABSI in its neonatal ICU. Intermountain Healthcare System based in Salt Lake City, Utah, hasn't seen a single catheter-associated urinary tract infection in its 160-bed LDS in 6 months. The common thread that these and other hospitals achieving remarkable patient safety outcomes share is that they're putting systems in place to deter anyone from violating patient safety processes while creating a culture focused on what's best for the patient. Participation is mandatory, not optional.

What life in a hospital with zero looks like

Zero is possible today and it doesn't require limitless resources. In fact, processes that avoid preventable deaths reduce costs. We've seen success in both large hospitals and small ones. It does require fostering a culture of safety from top to bottom and bottom to top. It also requires diligently implementing new proven processes. Once you implement the APSS and start reducing preventable patient deaths in the areas most hospitals find challenging, it will spread to every clinician and unit.

Spreading success will inspire more hospitals to participate in this movement. The best part is that your team will function with the confidence and peace of mind of knowing they're doing everything in their power to protect their patients' wellbeing. Clinicians, pharmacists, administrators, patients and families will benefit from open lines of communication, and any mishaps will be addressed quickly, effectively, and with full transparency. With a goal of zero, every incident of harm will be analysed for a root cause. Hospitals will experience fewer medical liability claims and improved patient satisfaction scores by engaging patients and families throughout the process. Zero is possible. ■

KEY POINTS

- ✓ 4.8 million people die each year because of a lack of healthcare safety culture
- ✓ Strong safety culture identifies and reduces risk as well as harm prevention
- ✓ Hospitals need to put the CANDOR programme into place for zero preventable deaths
- ✓ The processes that prevent deaths are not costly and, in fact, reduce the bottom line
- ✓ Zero preventable deaths is possible

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