

THEME

Applying Best Practices in Healthcare Delivery

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PATIENT SAFETY

Part of the vocabulary of our graduates?

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Disclosure of interests


- Elected Member, Malaysian Medical Council 1995 - 2010
- Member, Malaysian Council of Healthcare Standards 2001 - date
- Member, National Patient Safety Council 2003 - date
- Director, Medical Defence Malaysia 2004 - date
- Committee Member, MSQH 2009 - 2010



Primum non cere
First do no harm

“The physician must...have two special objects in view with regard to disease, namely, **to do good or to do no harm...** I will follow that system of **regimen** which, according to my ability and judgment, I consider for the **benefit of my patients**, and **abstain from whatever is deleterious and mischievous.**”

Hippocrates 400 BC



“When you do not know the nature of the malady, leave it to nature; do not strive to hasten matters. For either nature will bring about the cure or it will itself reveal clearly what the malady really is.”

Avicenna 980 - 1037

Patient safety

- The **freedom from accidental injury** due to medical care or from medical error
Institute of Medicine 2000
- The **avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of health care.** These events include “errors,” “deviations,” and “accidents.” Safety emerges from the interaction of the components of the system; it does not reside in a person, device, or department. Improving safety depends on learning how safety emerges from the interactions of the components. Patient safety is a subset of health care quality.
Cooper JB, Gaba DM, Liang B, Woods D, Blum LN. The National Patient Safety Foundation Agenda for Research and Development in Patient Safety. MedGenMed. 2(3):E38, 2000.85

Patient safety

- **Freedom from accidental injuries** during the course of medical care; activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care.

The identification, analysis and management of patient-related risks and incidents, in order to make patient care safer and minimize harm to patients.

Committee of Experts on Management of Safety and Quality in Health Care, Glossary of terms related to patient and medication safety – approved terms. Council of Europe. 2005

- The **prevention and mitigation of harm** to patients.

National Quality Forum. Standardizing a Patient Safety Taxonomy – A Consensus Report. Washington, DC: National Quality Forum, 2006

Patient safety

- **Major priority** for all healthcare providers
- Reasonable **expectation** that all undergraduate medical students should have the necessary **competence** to **ensure** that **harm** to patients is **minimized** in their future career as a doctor

Questions

- Current state
- What should be learned
- When should it be taught
- How should it be taught
- Barriers
- Summary

House of Commons Health Committee Report - Patient Safety 3 July 2009

- 195. There are **serious deficiencies** in the **undergraduate medical curriculum**, which are **detrimental to patient safety**, in respect of training in: clinical pharmacology and therapeutics; diagnostic skills; non-technical skills; and root-cause analysis. These must be addressed in the next edition of *Tomorrow's Doctors*. The **DH and GMC must monitor** the quality of new medical graduates' use of the skills listed above. Elements of patient safety are **taught, but** this tends to be done **implicitly rather than explicitly**; this should also be addressed in the curriculum, which must make clear that **patient safety** is the **first priority** of medical practice. Patient safety must also be **fully integrated** into **postgraduate** medical education and training as a **core element**, not an optional extra.

House of Commons Health Committee Report - Patient Safety 3 July 2009

- 196. Patient safety, including Human Factors, has **yet to be fully and explicitly integrated** into the education and training curricula of **healthcare workers** in general. This training should include the **recognition** that **errors** will **inevitably** occur in **certain circumstances**. There are convincing arguments for **interdisciplinary training** to foster good teamwork skills across professional boundaries: those who work together should train together.

Malaysia

- Except for one medical school, **elements** of patient safety are **taught implicitly**, not explicitly
- MMC monitoring housemen at end of first 4 months since 2009.
No results published yet

Challenges

- Ensure that patient safety is regarded as an **essential aspect** of the undergraduate medical **curriculum**
- **Dilemma** of how it can be included in an already crowded curriculum
- Wide variety of statements on **what should be learned**

Recommendations for patient safety education in undergraduates

Sanders et al Medical Teacher 2007; 29: 60

- Increase **knowledge** of patient safety, including the causes and frequency
- Develop **willingness** to take responsibility
- Develop **self-awareness** of the situations when patient safety is compromised
- Develop **communication** skills, especially inter-personal
- Develop **team-working** skills

Recommendations for patient safety education in undergraduates

Sanders et al Medical Teacher 2007; 29: 60

- Develop **skills** in **root-cause analysis**
- Develop **skills** in **safe prescribing** and **procedures**
- Develop **skills** to **empower patients** to have involvement in patient safety
- Develop **skills** in **dealing with the aftermath** of errors, in both doctors and patients

WHO Patient Safety Curriculum 2009

Aims

- **Prepare** medical students for **safe practice** in the workplace
- **Inform** medical schools of the **key topics** in patient safety
- Enhance patient safety as a **theme throughout** the medical curriculum
- Provide a **comprehensive curriculum** to assist teaching and integrating patient safety learning
- Further **develop capacity** for patient safety educators in medical schools
- Promote a **safe and supportive environment** for teaching students about patient safety
- **Introduce or strengthen** patient safety **education** in medical schools worldwide
- **Raise** the international **profile** of patient safety teaching and learning
- **Foster** international collaboration on patient safety education **research** in the higher education sector

WHO Patient Safety Curriculum 2009

Underlying Principles

- **Capacity-building** is integral to curriculum change
- A **flexible** curriculum to meet individual needs
- **Easily understood** language for a targeted yet global audience
- A curriculum guide for all countries, cultures and contexts
- A curriculum guide that is based on learning in a safe and supportive environment

WHO Patient Safety Curriculum 2009

Topics

- What is **patient safety**?
- What is **human factors** and why is it important to patient safety?
- **Understanding systems** and the impact of complexity on patient care
- Being an effective **team player**.
- Understanding and **learning from errors**.
- Understanding and **managing clinical risk**.
- Introduction to **quality improvement** methods.
- **Engaging** with **patients** and carers.
- **Minimizing infection** through improved infection control.
- Patient safety and **invasive procedures**.
- Improving **medication safety**.

Curriculum Structure for Patient Safety and Risk Management

- Developed in October 2007 by Malaysian Medical Association, Ministry of Health and Human Resource Development Fund
- Targeted at health care workers with managerial, team leader and/or advanced clinical responsibilities for implementing Patient Safety and Risk Management

When

- Throughout **all phases** of the undergraduate course including the first few years
- Greater **emphasis** in the **later years**

How

- **Integrated** with the overall undergraduate curriculum
- **Specific** awareness-raising sessions
- Importance of **inter-professional** education
- Develop **individual self-awareness** and **responsibility** as an essential attribute
- Develop **collective responsibility**

How

- Consider the effects of medical errors on a doctor
- How these effects can be managed
- Develop skills in how to communicate medical errors to patients and relatives

How

- Problem-based teaching (facilitated group learning)
- Simulated-based learning (role plays and games)
- Lecture-based teaching (interactive/didactic)
- Mentoring and coaching (role models).

Foundation Programme UK

- Academy of Medical Royal Colleges, Foundation Programme Committee, in co-operation with Modernising Medical Careers in the Department of Health (2005), “Curriculum for the foundation years in postgraduate education and training”

www.dh.gov.uk/assetRoot/04/10/76/96/04107696.pdf

Competencies

Understands the importance of good teamworking for patient safety - F1

- Enters **discussions** with colleagues and patients (carers) about treatment options including relative risks and benefits.
- Demonstrates **good handover** practice and ensures continuity of care when going off duty.
- Meticulously **cross checks** instruction and actions with colleagues (e.g. medicines to be injected). Seeks and welcomes feedback from patients and colleagues on the quality of care and safety of care being delivered.
- **Communicates** effectively with all team members to ensure shared understanding of patient problems and to foster continuity of care.

Competencies

Understands the importance of good teamworking for patient safety - F2

- **Comments** on implications for patient safety in clinical meetings.
- Always **speaks up** if concerned about patient safety.
- Is **not deterred** by deference to a colleague's seniority or standing from drawing attention of a risk, or potential risk to patients where appropriate.
- Works effectively with other professional colleagues and management to **create a culture** where quality and safety improvement are part of routine practice

Competencies

Understands the needs of patients who have been subject to medical harm or errors & their families - F1

- **Demonstrates evidence of knowledge of**
 - Common reaction of patients/carers and staff to error and harm
 - Principles of error disclosure
 - The need for explanation and apology

Competencies

Understands the needs of patients who have been subject to medical harm or errors & their families - F2

- **Demonstrates evidence of knowledge of**
 - The principles and skills of effective apology
 - The long-term effects of medical error
 - Local and other stages of complaints procedures
 - The role of the health service ombudsman

Malaysian Housemen Assessment criteria

- **Academic**
 - a. Core Knowledge
 - b. Case Presentation/ Communication Skills
 - c. Clinical Appraisal Skills
 - d. Medical problem solving
 - e. Management of patients
- **Basic Procedural Skills**
 - a. Taking Blood
 - b. Setting IV Line
 - c. Measuring of BP
 - d. Urinalysis (urine dipstick)
 - e. Funduscopy
 - f. ECG – taking and interpreting
 - g. Blood Sugar Measurement (Glucometer)
 - h. Basic Life Support including Cardio-Pulmonary Resuscitation
 - i. Catheterisation

Malaysian Housemen

Assessment criteria

- **Interpersonal Skills** - Relationship with:
 - a. Colleagues
 - b. Other health professionals
 - c. Patients
 - d. Patients' relatives/family/carers
- **Appropriate Personality/Attitudes**
 - a. Appropriate dress code
 - b. Respect for patients' rights, privacy
 - c. Awareness of legal and ethical issues
 - d. Safe handling of hazards including the practice of universal precaution
 - e. Obtaining consent appropriately
 - f. Practice professional work attitude e.g.
 - Know own limitations;
 - Refer when appropriate; and
 - Teamwork

Malaysian Housemen

Assessment criteria

- **Discipline**
 - a. Readily available at place of work at appointed time
 - b. Easily contactable
 - c. Speedy response
- Continuing Professional Development (**CPD**)
 - a. Participates actively in CPD programs e.g.CPCs, departmental audits, etc.
- **Initiativeness/Leadership** Qualities
 - a. Readiness to take steps/offer ideas to improve delivery of health care
 - b. Readiness to mentor juniors/other health professionals

Code of Professional Conduct Malaysian Medical Council 1987

- Responsibility for Standards of Medical Care to Patients
The public is entitled to expect that a registered medical practitioner will provide and maintain a good standard of medical care.
This includes:-
 - a. **conscientious assessment** of the history, symptoms and signs of a patient's condition;
 - b. **sufficiently thorough** professional attention, examination and where necessary, diagnostic investigation;
 - c. **competent** and **considerate** professional **management**;
 - d. **appropriate** and **prompt action** upon evidence suggesting the existence of condition requiring urgent medical intervention; and
 - e. **readiness**, where the circumstances so warrant, **to consult** appropriate professional colleagues.

Good Medical Practice

Malaysian Medical Council 2001

- The doctor is at all times expected to practise good medicine, exhibit the norms of good clinical practice and present himself as follows:
 - Be attentive and a good listener
 - Avoid criticising or admonishing the patient
 - Be gentle and concerned
 - Be clear and discreet

Good Medical Practice

Malaysian Medical Council 2001

- Give the relevant options when discussing treatment, and the limitations and possible complications
 - Be patient and compassionate
 - Avoid criticising colleagues
 - Be gentle
 - Cultivate a friendly and amicable relationship
 - Avoid being business-like
 - **Avoid presenting yourself as the embodiment of noble perfection and giving the impression that the patient has finally reached the ultimate healer**
 - Avoid patronising your patients

Barriers

- **Professional culture** of doctors has sustained the idea of **infallibility**, maintaining that “good” doctors do not make mistakes
- Senior doctors and nurses **unable to adapt** to new health care challenges or who are able but actively discourage any change
- They can change a student from a patient safety advocate to a passive learner of textbook medicine
- Maintenance of own cultures by other health care professionals who continue to **work in silos**
- **Lack of concern** of some hospital owners and managers

Summary

- Much has been done
- Much more needs to be done by
 - regulators
 - universities
 - medical profession
 - other health care professions
 - owners and managers of hospitals
 - patients
 - civil society

Summary

- Professionals must always strive for excellence
- They have in their hands the most valued things people have: life and health, and their duty is to do the best for them

Aristotle

Nicomachean Ethics I 1: 1094 a 18–26)

- *“There is some end of the things we pursue in our actions which we wish for because of itself, and because of which we wish for the other things; [...] clearly this end will be the good, i.e. the best. Then surely knowledge of this good is also of great importance for the conduct of our lives, and if, like archers, we have a target to aim at, we are more likely to hit the right mark”*



Thank you