

Quality And Safety Management To Avoid Medical Errors And Risk In The Healthcare Field

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Triumphant amelioration of medical errors is a foremost crisis in the health industry. Consumers and third parties have been increasing pressure on healthcare centres, which has led to a rise in the cost and demand for healthcare services. Consequently, there is a necessity for a proper understanding of the factors that cause medical errors and risks in the healthcare field to avoid cases of wrong diagnostics, treatment of the wrong patient, and lack of proper files for the patients (McFadden, 2015). Medical errors have been reported to amount to cause between 44000 and 98000 deaths annually. The cost of medical errors has also been estimated to range from about \$ 38 billion annually. Therefore, hospitals are urged to report hospital-acquired infections to reduce the risk of death (Pronovost, 2004).

According to the case scenario of ACME Medical Center, there was an error in the hospitalization and communication process, mainly in the Medication Use Process. The patient was admitted, and an initial TPN recipe was completed by a dietician, but there was a failure in the assignment of the first line, and that order had not been filled. The following day, the patient's calcium had dropped, and hence, the paediatrician changed the order to supply more of that component without the backing of the dietician.

There was an issue in the area of documentation and confirmation. The pharmacist who had entered the order had not acknowledged the error at first. The IV pharmacist who double-checked the order failed to recognize the mistake. The preparing pharmacist of the TPN had also failed to acknowledge an existing issue. This shows that there is no effective computerization of the health centre information on the patient during admission, transfer, and finally during discharge.

The Errors Had Occurred Due To:

Medical team handoffs: this is the process of transferring a patient from one individual or team to another individual in a physical or mental process. Errors could occur during the handover process due to factors such as information loss, miscommunication, and order omission, as happened in the case of ACME Medical Center. Failure to conduct a successful handoff could lead to the new care provider being unprepared for the effects of the preceding events and unable to anticipate the prospective tasks to embark on. Handoffs are also associated with a lot of vagueness and difficulty in medical care. There is confusion as to who is accountable for what aspect.

Diagnosis And Treatment:

The patient in ACME Medical Center was diagnosed with non-specific colitis several years before the occurrence of the event. The patient was admitted for a week and then discharged. The patient was later readmitted due to severe pain. During treatment, the clogged line was found to have been plugged with particulate matter, and this was dangerous to the patient. There is a risk of readmission since it results in increased costs for the healthcare providers, and the patient may end up acquiring hospital-acquired infections.

The Main Recommendations For ACME Medical Care In Promoting Quality And Safety Are:

ACME should ensure that it creates a culture of safety and quality. There should be shared norms, values, rituals, and traditions that guide the admission and hospitalization procedures of the patient. The culture should encourage clear communications to ensure the sharing is complete and accurate and there is no omission of orders by the providers. This will ensure that any mistake that occurs concerning the patient is detected and corrected.

During the admission and hospitalization process, the patient's information should be computerised, and teamwork should be encouraged. There should be a continuous flow of information from the date when the patient is admitted, transferred and discharged. The computerization will ensure accountability and responsibility among the providers and reduce the omission of orders from the system. Teamwork will ensure that there are feedback and communication about any errors or omissions about the patient will be positively communicated. Teamwork will create a chance for transfer of responsibility during any changes in shifts and passage of information.

To ensure effective handoffs of the patient through the physical or mental process, the procedure should be confidentially approved and carried out in a private room. The procedure should occur in a quiet, face-to-face setting to avoid instances of information loss or miscommunication. There should be no noise from television and radio. There should be minimal interruptions to ensure effective communication (Fletcher, 2014)

Policies, protocols, and electronic support tools should also be developed during the handoff. The procedure should be standardized to ensure it is strictly followed by the medical staff. There should be a type of measure taken against any reckless employees who do not adhere to the procedures. This will lead to the avoidance of causes of omission to report errors, as in the case of ACME Medical Center (Gaba, 2003).

The employees in ACME Medical Center have the following roles in ensuring quality and safety: Employees should communicate with their superiors and co-workers on issues concerning patient

safety. The employees should conduct safety management of the patient using the safety statement provided by ACME Medical Center. The safety statement sets out the action programme for safeguarding the patients as well as employees in the workplace. It also provides the employees with the rules, regulations, and code of conduct that are to be used during work time. The employees should ensure that the orders are computerized sufficiently in their system. The patient's record should then be continually updated to match the needs during admission, transfer, and discharge. This will help ensure that no vital information is left out that could, later on, lead to misdiagnoses.

ACME Medical Center employees should look out for any instances that may lead to medical errors. They should also regulate the behaviour and actions of their fellow employee, as an accident caused by an employee could quickly impact the other employee. The employee should report any case of reckless behaviour portrayed by their co-workers to their employer. There should be a reward and punishment system to regulate the expression of the employees in their conduct. The employees should comply with the relevant laws relating to the protection and safety of the patients. They should engage with other employees to participate in training programs offered by the medical centre. They should adhere to laws set out by the quality and regulation bodies, such as proper medication of patients, adequate filling of patient information, and correct usage of tools during the operation proceeds to avoid instances like that in ACME Medical Center where the line had a substance matter.

ACME Medical Center can create a culture of quality and safety to reduce medical errors. The healthcare centre should foster a critical thinking approach during the decision-making process on significant issues to reduce and prevent errors by creating a system of accountability for the patient's safety. The culture is to be created to ensure there is a focus on the identification and addressing of unsafe behaviours in the profession. There should be set rules, protocols, procedures, and policies to be applied uniformly in the health centre to avoid any information loss or miscommunication. The set procedure will ensure that there is a standard way of carrying out activities in the organization.

ACME can create a healthy culture by acknowledging the high-risk nature of the organization and determining how to achieve safe operations. It should also ensure there is a blame-free environment in the centre so that individuals can freely report errors without fear of punishment. The centre should encourage collaboration across all ranks and disciplines to ensure patient safety.

The centre should allocate its resources towards safety measures. Equipment should be readily available in a clean and hygienic manner during any operation. Resources should be set to ensure there is accurate data entry and complete safeguard of the patient information.

Health care should ensure it creates an environment that accommodates the change in attitude and behaviours and that priorities are set towards the identification and management of medical errors.

The quality, risk and performance analysis can be illustrated using the fishbone diagram. The fish-one picture is widely used as a patient safety tool as it helps in the facilitation of a cause analysis discussion. It describes the contributions of both the system and the individual cognitive errors (James, 2014). In our case, it can be represented as follows:

- Availability bias confirmation treatment
- Omitted order dangerous particulate matter
- The illness invoked ignored
- Cognitive factors
- System factors
- Multiple handoffs of
- Information no follow-up order cannot navigate the system
- Teamwork process Patient factors

The main factor that led to the medical error was the wrong diagnosis of the patient, which was carried out several years before the occurrence of the event. There was no proper confirmation of the order that had been placed, and therefore, some information was omitted. The patient was also subjected to the insertion of a line that had some matter. The lack of proper confirmation was due to a lack of teamwork; the patient could not navigate the system of the patient, and there was no follow-up procedure.

There Are Commentary Cases That Relate To The Above Example:

Medical handoffs: Lack of communication transfer during this process is a significant source of errors. This can lead to mistakes in task work. Poor communication and incomplete information can also lead to a delay in the acquisition or arrival of the equipment required during the procedure. The hierarchy of the organization also poses a significant risk in hand-off due to the power distance, which leads to errors going unchecked and necessary information not being transferred (Young, 2016).

There is also a lack of a formalization procedure for the handoff. Nurses often advocate for standardized formalization procedures, while physicians mainly advocate for unspoken procedures. Both teams have to communicate and work in harmony for effective handoffs. The superiors should set a good example by being committed to ensuring that healthcare safety is prioritized in every medical emergency (Fletcher, 2014).

Hospitalization Of Children:

Most of the reported cases showed that errors were experienced during the hospitalization of their children. Most of the errors were a result of wrong reviews carried out by physicians. There were also errors that were parent-reported, and these were mainly documented in the patient's medical record.

The differences between the parents' and the physician's errors can relate differently regarding priorities, definitions, and medical knowledge. This often leads to errors in the diagnostic and treatment methods of the children (Braithwaite, 2015). Hospitals should thus consider involving

families in the surveillance process. Family members can be of importance in reporting health care risks and the maintenance of safety among the health centres. This is because parents are in daily contact with their children and are actively involved in their children's healthcare both inside and outside the hospital. Parents, therefore, have a responsibility to report any malpractices in the health care providers such as nurses. If they, for example, spot a nurse who is administering excess medication during treatment, they should report the matter to the committee in charge of the healthcare.

Adverse drug effects: this mainly occurs in hospitalized patients. The errors are a result of the wrong prescription and admission of the medication. The study has shown that around 20% of the hospitalized patients are as a result of medication errors. High-alert medication such as insulin, narcotics, and sedatives may lead to serious complications even when correctly administered. Care should be taken, and a correct diagnosis should be carried out.

For effective medication, an assessment should be carried out on the capacity and readiness of the implemented systems to reduce adverse drug effects. There should also be awareness creation of high-alert medication in the healthcare centres. There should be set standards to guide pharmacists and physicians in medication administration.

The role played by regulation and quality to prevent the occurrence of medical errors is accomplished both professionally and through accrediting bodies. These bodies work in unison to ensure that high standards of health safety are maintained and healthcare risks are minimal. These bodies include:

The National Quality Forum:

It promotes education by carrying out outreach activities that are intended to ensure safety and health compliance. It also provides that entities place priorities on the goals of performance improvement, which can only be achieved through proper service delivery. The body endorses the national standards set out to ensure that there are performance appraisals and measurements to reduce risks and errors in healthcare centres. This body has established vital projects that are aimed at the reduction of medical errors. This includes the timely initiation of care and the transfusion reactions.

The Jcnps Goals:

The body aims to reduce any transfusion errors during patient diagnosis and treatment. It advocates for verbal or face-to-face communication of orders to minimize any omissions or loss of vital information. It regulates the occurrence of hospital-acquired conditions, which could occur through the treatment of the wrong patient or the wrong diagnosis. This is achieved through advocating for proper diagnosis of the patient.

The most important role played by this body is to ensure that there is a reconciliation of the patient information on admission, during transfer, and finally, during discharge. In this case, the instances of readmission are kept to a minimum. The body ensures that it has developed a database of serious medical errors and the results of organizational analysis of these errors.

The body has also required that all accredited organizations open a reporting channel for the occurrence of any unexpected situation. It also encourages the in-depth analysis of the reported issues, implementation of the recommended improvements, and the assessment of the recommended improvements on the internal systems and operations of the organization.

Institute for Safe Medication Practice: this is a non-profit organisation that solely prevents medical errors regarding medication, and it encourages the safe use of medication. It advocates for a clear distinction of the actual illness to avoid the use of look-alike medication in the treatment of patients with a misdiagnosed illness. The institution educates all medical practitioners through the issuing of educational newsletters that describe proper medication and the cause of action to be taken. (Institute of Safe Medication Practices, 2013)

The Centres For Medicare And Medical Services:

This body has stipulated the errors that should never occur in the field of healthcare. The errors include wrong diagnosis, wrong medication, and improper insertion of operating objects. It encourages for effective computerization of the ordering system and the continued involvement of pharmacists. These are errors that could potentially lead to the death of patients.

Institute For Healthcare Improvement:

It is also a non-profit institution whose main aim is to improve healthcare facilities across the world. It is recognized worldwide for its expertise and quality of work. Its main role is to educate and enhance leadership in healthcare services.

In conclusion, it is imperative for every healthcare premise to understand the needs that might arise and use all the available measures to solve risks to ensure growth within the premise. That is possible once the management realizes the roles that should be executed. On particular occasions, the administration might lack a sense of direction, forcing them to operate in the dark. Healthcare is such a demanding field that requires proper planning as well as the execution of the task in the best way possible. Ideally, that is the case since any case of negligence might result in deaths. Healthcare professionals must adhere to the existing rules within the premise to ensure success on most occasions. In contemporary society, the level of competition is stiff, forcing organizations to employ the most useful tools in management. Private hospitals have facilities that can make them scale operations. In that pursuit, it is imperative to ensure success while addressing every challenge as it arises from the premise.

References

- Braithwaite, J. E. (2015). International Journal for Quality in Health Care. *Resilient health care: Turning patient safety on its head*, 418-420.
- Fletcher, K. B. (2014). Current and future directions: Proceedings of the Human Factors and Ergonomics Society 58th meeting. *Medical team handoffs*.
- Gaba, d. S. (2003). Human factors. *Differences in climate between hospital personnel and navel aviators*, 173-185.
- Institute of Safe Medication Practices. (2013). Retrieved from <http://www.ismp.org/NAN/default.asp>.
- James B. Reilly, J. S. (2014). Diagnosis. *Use of a novel, modified fishbone diagram to analyze diagnostic errors*, 167-171.
- McFadden, .. G. (2015). Health Care Management Review. *Leadership, safety climate, and continuous quality improvement: Impact on the process quality and patient safety*, 24-34.
- Pronovost, P. G. (2004). Lancet. *How can clinicians measure safety and quality in acute care?*
- Young, S. L. (2016). Journal of PeriAnesthesia Nursing, Volume 31. *Alarm management: Decreasing alarm fatigue and noise levels in a pediatric PACU*, 34-35.