Reducing Harm from Medical Errors

A Health Watch USA℠

Healthcare Transparency &

Patient Safety: Integrity of Research & the Setting of Strong Quality Standards

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Medical Errors Are Significant Problems in US Hospitals

Definition of Medical Error

Medical errors are preventable events which either cause

- **patient harm (an adverse event) or**
- **could have led to harm (a near-miss).**

Medical errors may involve:

- Medical treatment
- Surgery
- Diagnosis
- Pharmacy
- Equipment
- Lab reports
- Other

Medical errors can occur anywhere in the healthcare system:

- Hospitals
- Clinics
- Surgery Centers
- Nursing homes
- Dialysis centers
- Pharmacies
- Patient homes

An adverse event occurs when patient receives medical care that causes harm to the patient.

- **Adverse Events**
  - **Preventable (Medical Errors)**
  - **Non-preventable**

Conference Topics

- Preventable Adverse Events (AEs)
- Med Devices & Healthcare Infections
- Culture of Safety
- Research Integrity & Health Policy
- Stories of Patient Advocates
- Full Disclosure of Adverse Events
- Overuse of Health Care

Deaths by Medical Errors

- To Err Is Human – 98K deaths /year
- Others report 200 – 400K based on pt estimates
- Point estimate for data is 0.71% of all hospital admissions die.

Incidents of deaths by medical errors equivalent to a Boeing 747 crashing every day with no survivors.

Medical Errors cost Billions of $ each year in the US

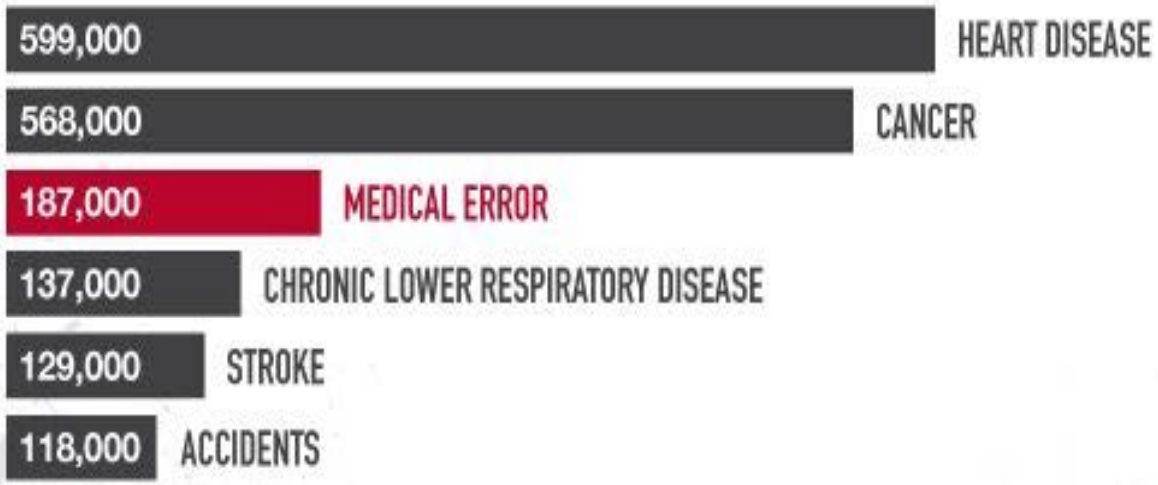
Medical Errors in US Hospital Admissions

- 35,416,420 admissions based on pt estimates
- 0.71% of all hospital admissions die.
- 10% of all US deaths due to/associated with medical errors.

Healthcare IT News. Erin McCann. “Deaths by Medical Mistakes Hit Records.” July 18, 2014. http://www.healthcareitnews.com/news/deaths-by-medical-mistakes-hit-recordshttp://www.healthcareitnews.com/news/deaths-by-medical-mistakes-hit-records, accessed on July 18, 2016.

MEDICAL ERROR

would be the 3rd leading killer in the U.S. per year



ESCAPEFIREMOVIE.COM

source: cdc.gov; Health Affairs

Patient Safety

The aim is to increase patient safety in American hospitals, and to get to “0” harm.

To prevent harm and to have a safety culture, we must have:

- Culture of open reporting
- Just culture
- Learning culture
- Informed culture

Keys to Safety

- **The keys to safety are:**
  - **Collaboration**
  - **Transparency**
  - **Consistency**

Transparency

In order to be transparent, we must:

- **Have early learning**
- **Steal good ideas and share them**
- **Work as partners**
- **Mentor**
- **All be teachers**
- **All be learners**

Safety Behaviors

- **Have early prevention training.**
- **High reliability**
- **Accept human errors & medical errors.**
- **Respond quickly.**
- **Timely**
- **Standardized**
- **Quick response**
- **Be optimistic.**
- **Focus on safety.**

If we do not change our direction,

we are likely to end up where we are headed.

Ancient Chinese Proverb