Materi Patient Safety dalam Pendidikan & Training Tenaga Dokter di Indonesia

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Bahasan:

1. Patient safety – apa, mengapa dan seberapa besar problemnya
2. Taxonomy Patient safety
3. Penyebab umum dari medical error
4. Patient safety: Education & Training
5. Materi Patient Safety untuk pendidikan dokter, training untuk dokter RS dan Manager RS

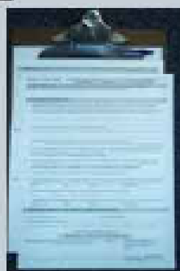
Ensuring Correct Surgery in the Veterans Health Administration

Days to hours before surgery

Step 1: Consent Form

The consent form must include:

- patient's full name
- procedure site and side
- name of procedure
- reason for procedure



Step 2: Mark Site

The operative site must be marked by a physician or other privileged provider who is a member of the operating team

Do **NOT** mark non-operative sites

Just before entering OR

Step 3: Patient Identification

OR staff shall ask the patient to state (NOT confirm):

- their full name
- full SSN or date of birth
- site for the procedure

Check responses against the marked site, ID band, consent form and other documents

Immediately prior to surgery

Step 4: "Time Out"

Within the OR when the patient is present and prior to beginning the procedure, OR staff must verbally confirm through a "time out":

- presence of the correct patient
- *patient properly positioned*
- marking of the correct site and side
- procedure to be performed
- availability of the correct implant

Step 5: Imaging Data

If imaging data is used to confirm the surgical site, two members of the OR team must confirm the images are correct and properly labeled

For more information see the Veterans Health Administrative Directive 2004-028 and your Patient Safety Manager

NCPS

* Indicates new items for Directive 2004-028 (http://www.patientsafety.gov/CorrectSurgDir.pdf or http://www.ncps.med.va.gov/CorrectSurgDir.pdf)

Revised August 2004

(*Patient safety:* What)
Keselamatan Pasien

Suatu sistem dimana rumah sakit membuat asuhan pasien lebih aman.
Hal ini termasuk:

- **asesmen risiko,**
- **identifikasi dan pengelolaan hal yang berhubungan dengan risiko pasien,**
- **pelaporan dan analisis insiden,**
- **kemampuan belajar dari insiden dan tindak lanjutnya serta**
- **implementasi solusi untuk meminimalkan timbulnya risiko.**

Sistem ini mencegah terjadinya cedera yang disebabkan oleh kesalahan akibat melaksanakan suatu tindakan atau tidak mengambil tindakan yang seharusnya diambil. *(KKP-RS)*

(*Patient safety:* Why)

Berbagai Upaya RS untuk meningkatkan mutu pelayanannya dengan berbagai cara: Quality Assurance. Total Quality Management, Continous Quality Improvement, Akreditasi RS, ISO, Malcom Baldrigde Award, Benchmarking, Good Clinical Governance etc

Tetapi : masih terjadi terus Medical Error

(*Patient safety:* Who Big is the Problem)

- IOM (Institute of Medicine) di Amerika Serikat Tahun 2000 membuat laporan berjudul : To ERR IS HUMAN yang berhasil merebut perhatian dunia kedokteran : Extrapolasi kematian karena medical error per tahun mencapai 44.000-98.000 orang pertahun jauh lebih besar daripada kematian karena Kec lalulintas (43.458) Cancer (42.297) AIDS(16.516)

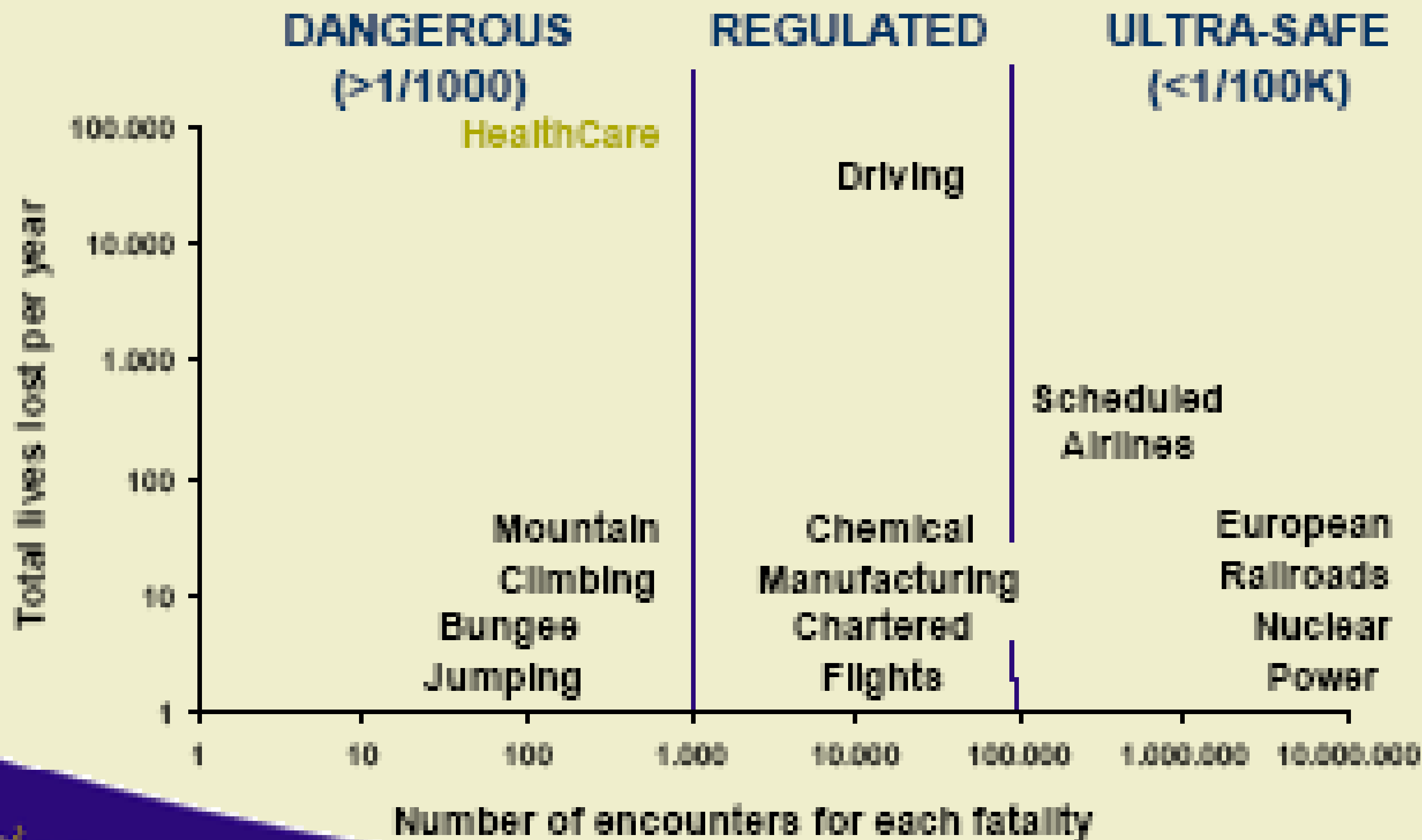
(WHO : World Alliance for Patient Safety, Forward Programme, 2004)

Table 1. Data on Adverse Events in health care from several countries

Study	Study focus (date of admissions)	No of Hosp Ad-mission	No of Adv Event	Adv Event Rate (%)
1.USA(NewYork State) (Harvard Medical Practice Study) (1,2)	1.Acute care Hosp ('84)	30 195	1133	3.8
2.USA (Utah-Colorado Study (UTCOS)) (10)	2.Acute c.Hosp('92)	14 565	475	3.2
3.USA (UTCOS)1 (10)	3.Acute c.Hosp('92)	14 565	787	5.4
4.Australia (Quality in Australian Health Care Study (QAHCS)(3)	4.Acute c.Hosp('92)	14 179	2353	16.6
5.Australia (QAHCS)2(10)	5.Acute c.Hosp('92)	14 179	1499	10.6
6.UK (4)	6Ac c.Hosp('99-'00)	1 014	119	11.7
7.Denmark (12)	7.Acute c.Hosp('98)	1 097	176	9.0
8.New Zealand (6,7)	8.Acute care ('98)	6 579	849	12.9
9.Canada (8)	9.Ac&Com.Hosp('01)	3 720	279	7.5

(Schellekens, W : Patient Safety Conference,
European Union Presidency Luxembourg, 4 – 5 April 2005)

How dangerous is our healthcare?



Taxonomi Patient Safety

KNC / Near Miss

Kejadian Nyaris Cedera =
1. **Dpt obat "c.i.", tdk timbul (chance)**
2. **Plan, diket, dibatalkan (prevention)**
3. **Dpt obat "c.i.", diket, beri anti-nya (mitigation)**

KTD / Adverse Event

Kejadian Tidak Diharapkan = Suatu kejadian yg mengakibatkan cedera yg tdk diharapkan pada pasien karena suatu tindakan ("commission") atau krn tdk bertindak ("omission"), ketimbang krn "underlying disease" atau kondisi pasien. *(KKP-RS)*

Pasien tidak cedera

Pasien cedera

Medical Error

(Preventable)

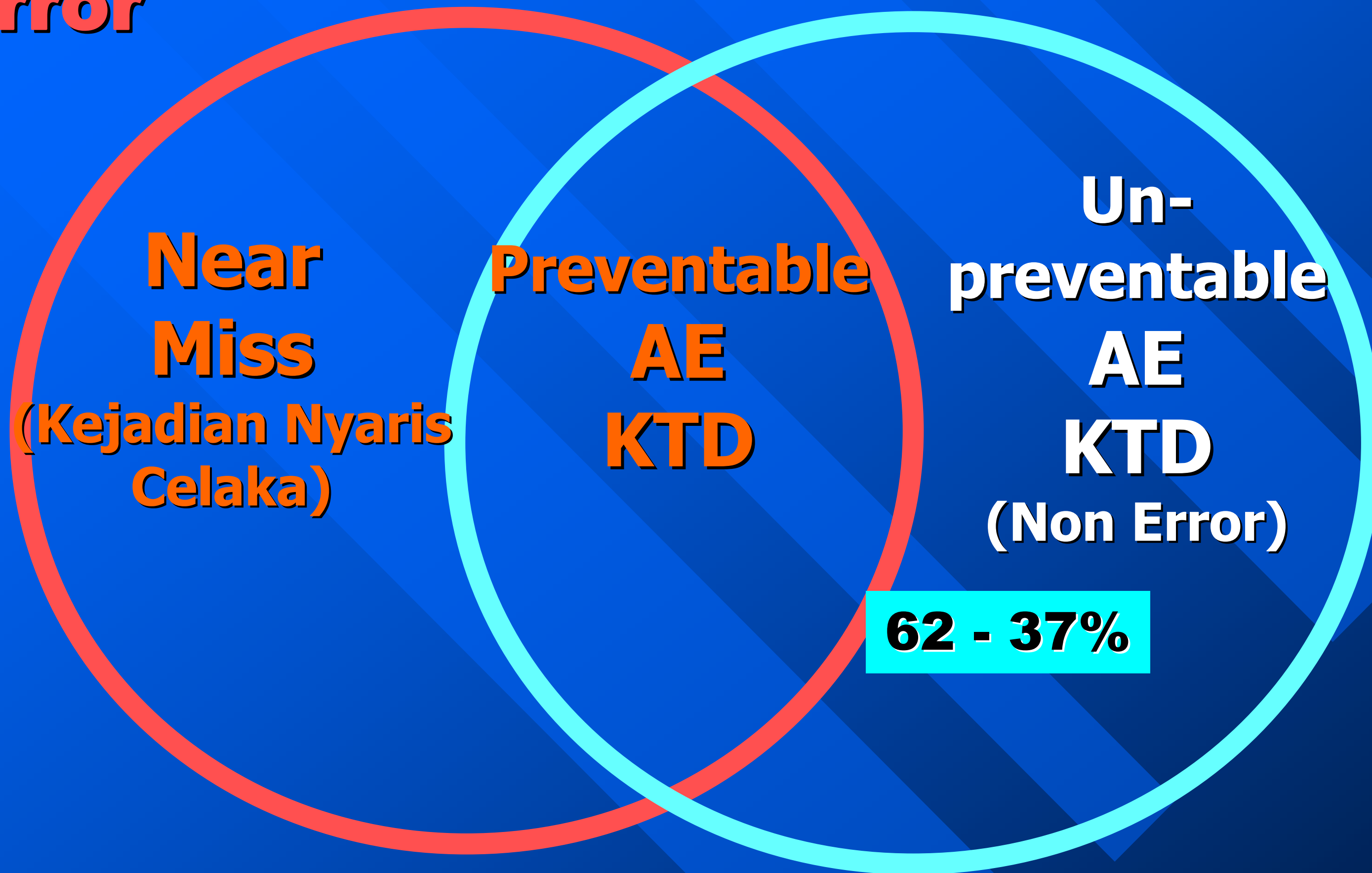
- **Kesalahan proses**
- **Dpt dicegah**
- **Pelaks Plan action tdk komplit**
- **Pakai Plan action yg salah**
- **Krn berbuat : commission**
- **Krn tdk berbuat: omission**

(Unpreventable)

Proses of Care (Non Error)

Medical Error

Adverse Event AE / KTD



1. Stuart Emslie :International Perspectives on Patient Safety,National Audit Office, England, 2005
2. Studdert DM, Mello MM, Gawande AA, Gandhi TK, Kachalia A, Yoon C, Puopolo AL, & Brennan TA. Claims. Errors, and Compensation Payments in Medical Malpractice Litigation. N Engl J Med 354;19 www.nejm.org May 11, 2006

Most Common Root Causes of Medical Errors

(AHRQ Publication No. 04-RG005, December 2003.)

-Agency for Healthcare Research and Quality-

1. Communication problems
2. Inadequate information flow
3. Human problems
4. Patient-related issues
5. Organizational transfer of knowledge
6. Staffing patterns/work flow
7. Technical failures
8. Inadequate policies and procedures

Dimana kesalahan dibuat ? (Type of Errors)

- **Diagnostic**
  1. Kesalahan atau keterlambatan Diagnosis
  2. Tidak menerapkan Tes yg sebenarnya diindikasi
  3. Mengunakan Tes / Terapi yg sdh tdk dipakai
  4. Tidak bertindak atas hasil monitoring atau hasil tes
- **Treatment**
  1. Kesalahan pada Operasi, Prosedur atau Tes
  2. Kesalahan pada pelaksanaan Terapi
  3. Kesalahan metode pengunaan suatu obat
  4. Keterlambatan dlm pengobatan atau merespon thd hasil tes yg
  5. abnormal
  6. Asuhan yg tidak layak / diindikasi
- **Preventive**
  1. Tidak memberikan terapi profilaktik
  2. Monitoring atau follow up yg tidak adekuat pd suatu pengobatan
- **Other**
  1. Gagal melakukan komunikasi
  2. Kegagalan Alat
  3. Kegagalan sistem lain

(Leape, Lucian; Lawthers, Ann G.; Brennan, Troyen A., et al. Preventing Medical Injury. Qual Rev Bull. 19(5):144-149, 1993.)

Patient Safety Education and Training

Patient Safety Education for Medical Students: Report of 3 Years of a Curriculum at New York Medical College

Presenters: Joseph L. Halbach, M.D., M.P.H.
Institution: Department of Family Medicine; New York Medical College, Valhalla, New York
Co-Author: Laurie Sullivan, Ph.D., C.S.W.

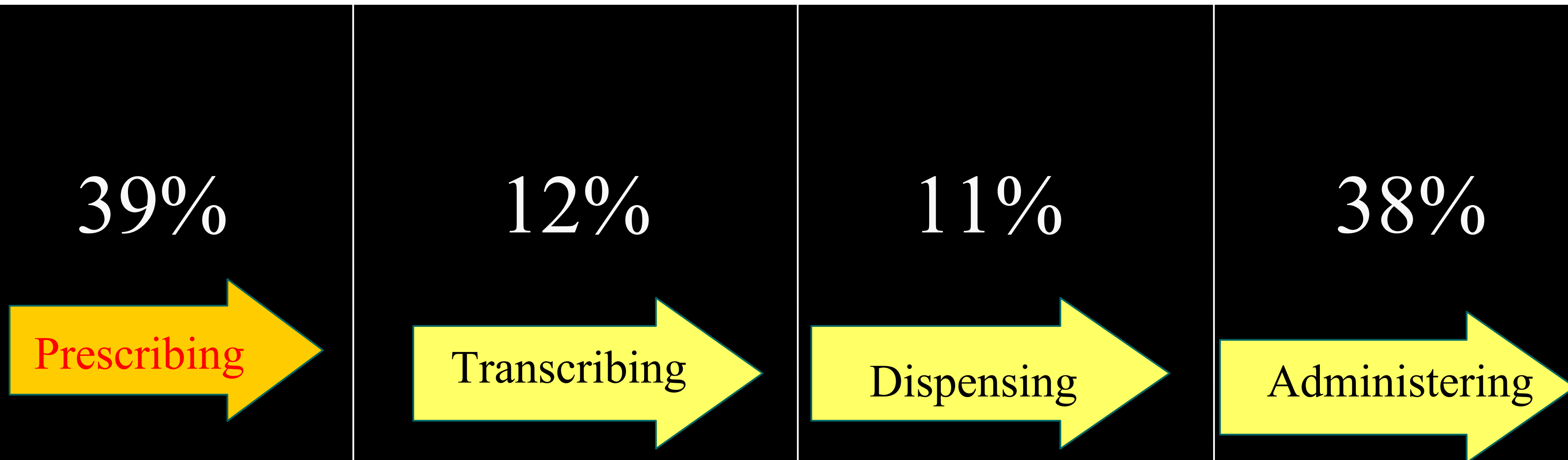
Association of Medical Colleges

Patient Safety and Graduate Medical Education

February 2003
A Report and Anotated Bibliography by the Joint Committee of the Group of Resident Affairs and Organization of Resident Representatives

Patient Safety CME Curriculum
Patient Safety: The Other Side of the Quality Equation
Under Grant from
The Agency for Health Care Research and Quality
Principal Investigator
Christel Mottul-Pilson PhD,

Failure points where medication errors occur



JAMA 1995 Jul 5,274(1):29

Curicullum Patient Safety for Medical Student

- Background: Increasing recommendations to educate physicians –in training about safety
- Goals: are introduce student to:
  - The prevalence and origins of medical errors
  - The Physician's responsibility and role in prevention of error
  - Avenues for communicating an error to a patient
- Curricullum Methods:
  - Didactic
  - Required reading
  - Videotape/Feedback Session

- A. Didactic
  - Discussion of medical error and non error
  - Read aloud excerpt from one real medical error
  - Family Physician & Medical error
  - Brieft review of definition, epidemiology, non error and systems vs individuals
- B. Required Readings
- C. Videotape/Simulation
  - 4-6 student per 3 hours session
  - Preparation ½ hours
  - Each student is videotaped with actor for 10-15 minutes
  - Group review and feedback

Curriculum Patient Safety for Medical Staff

- Introduction to patient safety
- Seven Steps to Patient Safety
- Patient Safety Standard
- Simple investigation
- Risk assessment and redesign process
- Root Cause Analysis (RCA)
- Failure Mode Effect analysis (FMEA)
- Effective Communication and Communicating Bad News

Curicullum Patient Safety for Hospital Manager

- Introduction to patient safety
- Patient Safety Standard
- Effective Communication and Communicating Bad News
- How to build a safety culture thas is open and fair
- How to lead and support staff in patient safety
- How to integrate risk management activity
- How to promote reporting system
- How to involve patients and the public in patient safety program
- How to learn and share safety lesson
- How to implement solutions to prevent harm

Kesimpulan

- **Patient Safety adalah isu terkini, besar, penting, relatif baru dimulai sejak th 2000an**
- **Gerakan Keselamatan Pasien Rumah Sakit** telah dicanangkan oleh **Menteri Kesehatan pada Seminar Nasional PERSI tgl 21 Agustus 2005, di JCC**
- **Rekomendasi untuk memasukan Patient Safety dalam kurikulum Fakultas Kedokteran makin meningkat**
- **Pengalaman pendidikan dan training patient safety di beberapa negara dapat dijadikan masukan bagi pengembangan kurikulum dan training patient safety di Indonesia**

Sekian

- Terimakasih