Workshop
Patient Safety Indicator

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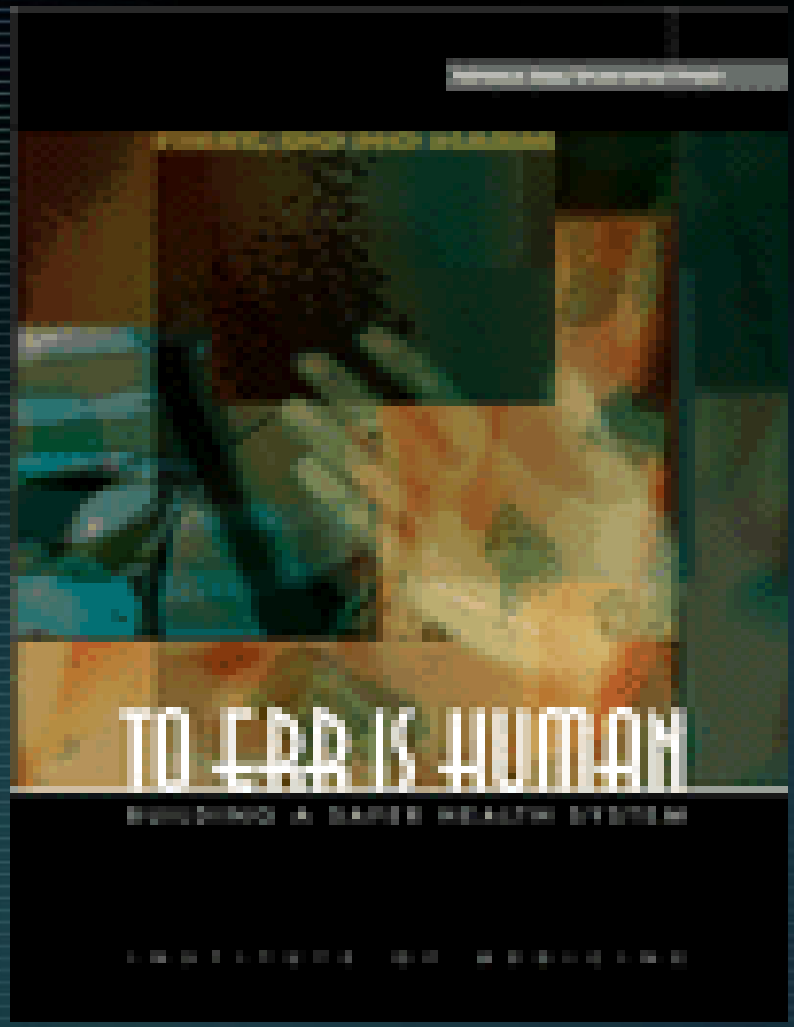
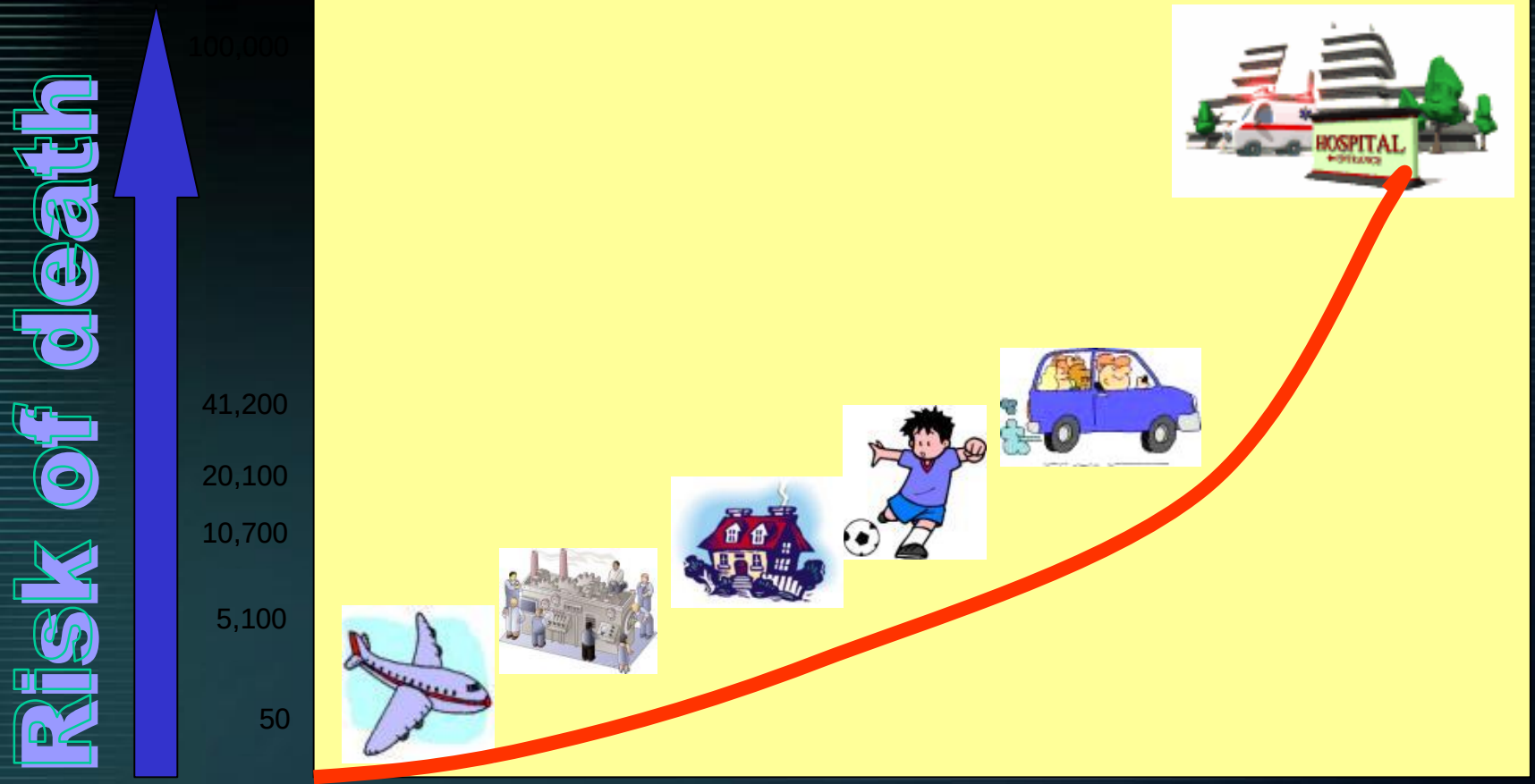
TO ERR IS HUMAN:
BUILDING A BETTER HEALTH SYSTEM
Institute of Medicine - November 1999



- 2.9%-3.7% dari admisi rs mengalami adverse events
- 44,000-98,000 kematian/th
- $17-29 billion
- 7000 kematian akibat medication errors

The Problem



STUDI DI UNIT ICU

- 97% medication error di ICU di 2 rumah sakit pendidikan di Indonesia

- 1.7 errors/patient/day di RS Pendidikan di Jerussalem

Self-Reported

- 85% anestesist di Canada pernah melakukan errors atau near-miss

- Fenomena “hanya 1 seumur hidup….” (kematian ibu bersalin, pelatihan bidan)

Apakah pelayanan kesehatan aman?

Review 2405 sentinel events oleh JCAHO, 1995-29 Jan 2004

2.570 pasien tercatat dalam sentinel events

1,935 (75%) diantaranya berakibat kematian

Empat Penyebab Utama:

- Pasien bunuh diri	374
- Komplikasi operasi/pasca operasi	315
- Operasi pada sisi yang keliru	300
- Medication error	282

Medical Error di Pelayanan Primer

(Sandars & Esmail 2003)

- 5 – 80x dalam setiap 100,000 konsultasi
- Prescribing error: 11% dari total resep

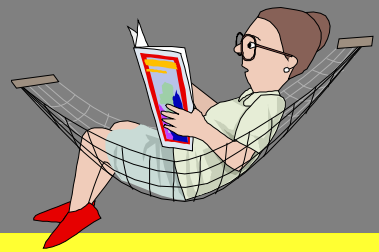
PUSKESMAS (Utarini, 2000):

•Ketidaksepakatan diagnosis: 67,2% pada malaria dan 59,1% pada tuberkulosis

•Treatment errors: 78% (ISPA) dan 87,7% (Diare)

James Reason's bottom line

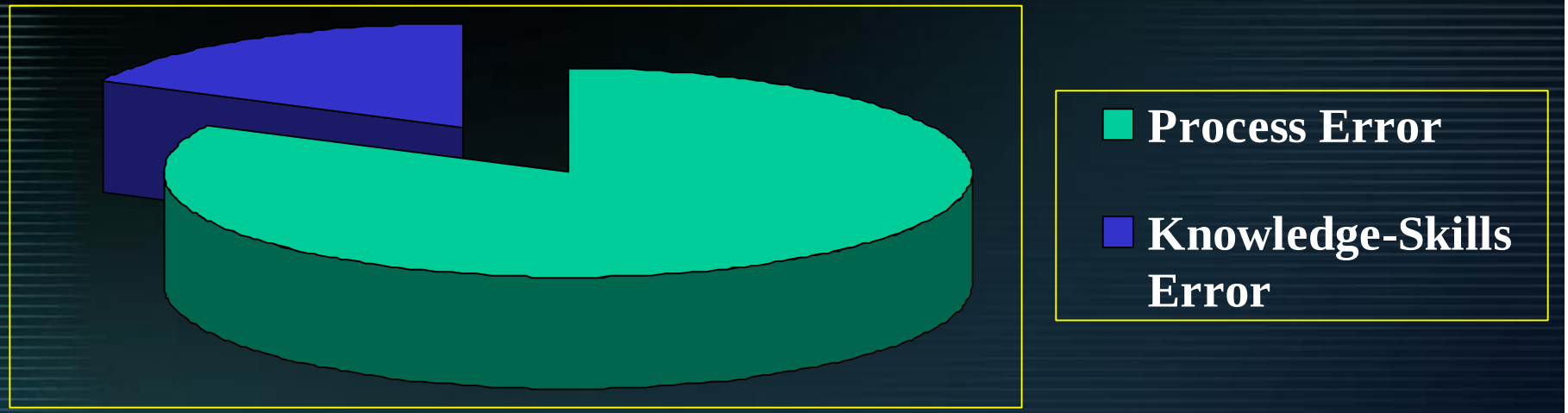
Fallibility is part of the human condition



We can't change the human condition

We can change the conditions under which people work

Profesi kesehatan



Manajemen

Quality and Clinical Indicator

Mutu

Mutu Klinik

Safety

Pikirkan:

- Apa makanan favorit bapak ibu?
- Makanan tersebut terdapat di restoran favorit mana?
- Mengapa restoran tersebut favorit?

Nyaman, murah, cepat layanannya

Makanan enak

Tidak keracunan

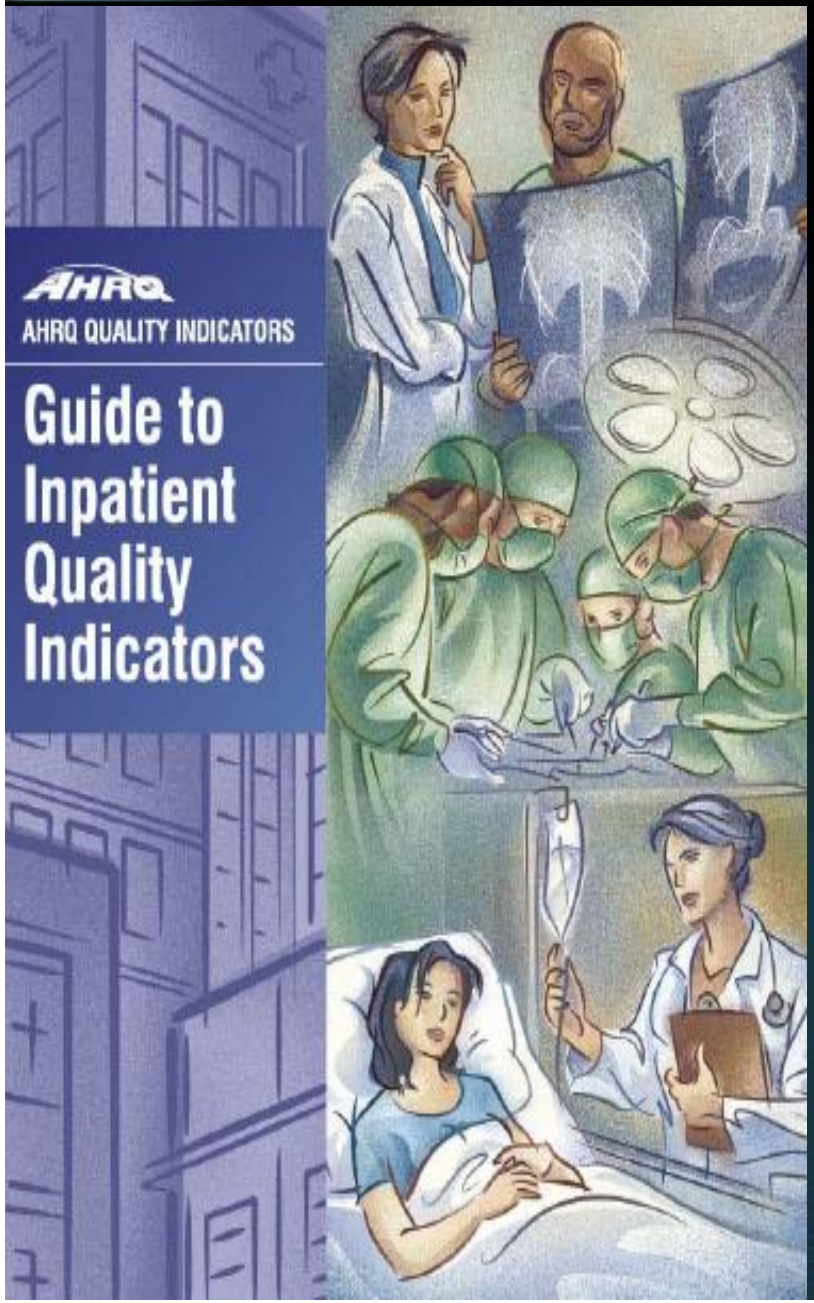
Indikator dapat juga dikembangkan dari dimensi mutu

- **Access**
- **Efficacy**
- **Efficiency**
- **Safety**
- **Approriateness**
- **Continuity of care**
- **Technical competence**
- **Amenities**
- **Human relations**

Makan pagi terlambat
1 jam

Keterlambatan pada pasien gastritis berat

Pasien puasa, jadwal prosedur TACE mundur, kompleksitas prosedur meningkat karena gastritis



- **VOLUME**: proxy, indirect measures of Q
- **MORTALITAS PROSEDUR TERTENTU**: prosedur yang bervariasi
- **MORTALITAS KONDISI TERTENTU**: kondisi yang bervariasi
- **UTILISASI PELAYANAN**: indikasi overuse, underuse, misuse

Volume Indicators

Esophageal resection volume

Pancreatic resection volume

Pediatric heart surgery volume

Abdominal aortic aneurysm (AAA) repair volume

Coronary artery bypass graft (CABG) volume

Percutaneous transluminal coronary angioplasty (PTCA) volume

Carotid endarterectomy (CEA) volume

Mortality Indicators for Inpatient Procedures

Esophageal resection mortality rate

Pancreatic resection mortality rate

Pediatric heart surgery mortality rate

AAA repair mortality rate

CABG mortality rate

PTCA mortality rate[12]

CEA mortality rate[5]

Craniotomy mortality rate

Hip replacement mortality rate

Mortality Indicators for Inpatient Conditions

Acute myocardial infarction (AMI) mortality rate[13]

AMI mortality rate, without transfer cases

Congestive heart failure (CHF) mortality rate

Acute stroke mortality rate

Gastrointestinal hemorrhage mortality rate

Hip fracture mortality rate

Pneumonia mortality rate

Utilization Indicators

Cesarean delivery rate

Primary Cesarean delivery rate

Vaginal birth after Cesarean (VBAC) rate[6]

VBAC rate, uncomplicated

Laparoscopic cholecystectomy rate

Incidental appendectomy in the elderly rate

Bilateral cardiac catheterization rate

Patient Safety Indicator

Manfaat standar kinerja

- Perbaikan mutu yang dilakukan dapat dinilai dan dibandingkan
- Dapat dibandingkan antar sarana pelayanan/tenaga kesehatan berdasarkan indikator yang disepakati, shg ada saling tukar menukar informasi
- Peluang perbaikan lebih mudah dikenali
- Meningkatkan partisipasi dan komitmen tenaga kesehatan
- Meningkatkan pemahaman terhadap efektivitas intervensi, penyusunan SOP, dll.

BEBERAPA INDIKATOR PATIENT SAFETY

Benda asing tertinggal dlm tubuh pasien	9 per 100.000 tindakan invasif
Komplikasi akibat anestesi	55 per 100.000 anestesi
Kejadian Decubitus	22,7 per 1.000 pasie rawat inap > 4hari
Dehiscensi pasca operasi	1,95 per 1.000 operasi
Accidental cut or laceration	3,29 per 100.000 operasi

PENUTUP:

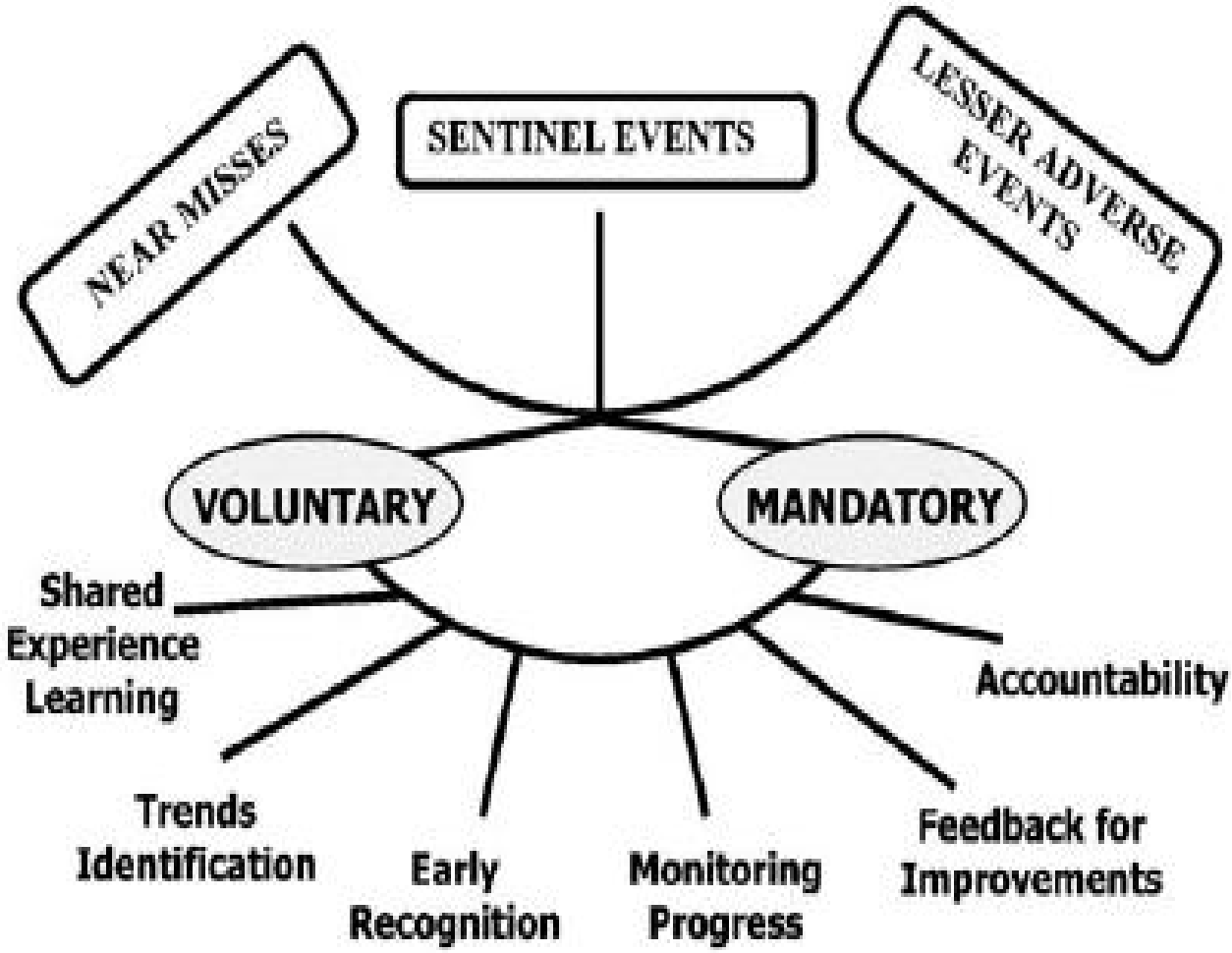
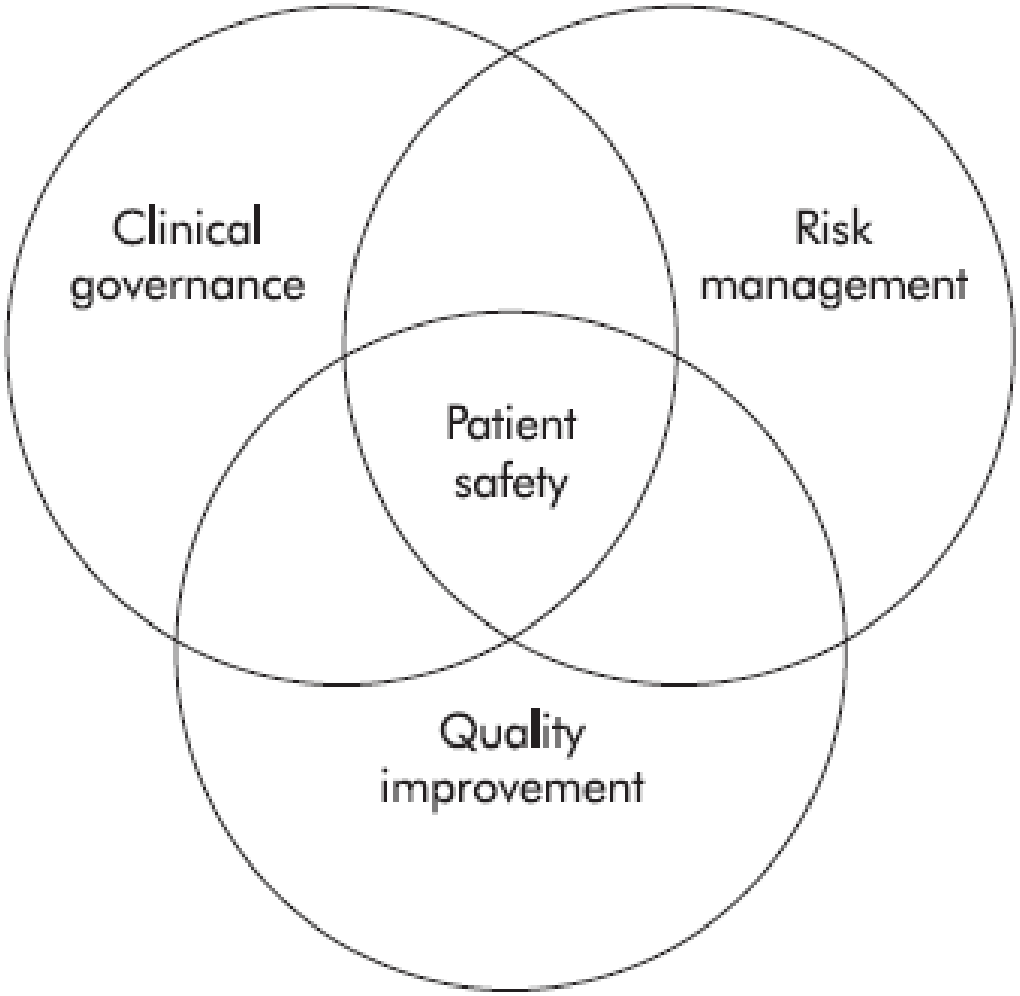


Fig. 3. Perceived benefits of an effective reporting system.

Inter-relations menuju Patient Safety

National patient safety surveillance



Walk safely…
Eat safely…