Holiday snaps, 2021...

ERRORS IN HEALTHCARE

WHY THEY OCCUR AND YOUR ROLE IN MAKING YOUR OWN HEALTHCARE SAFER

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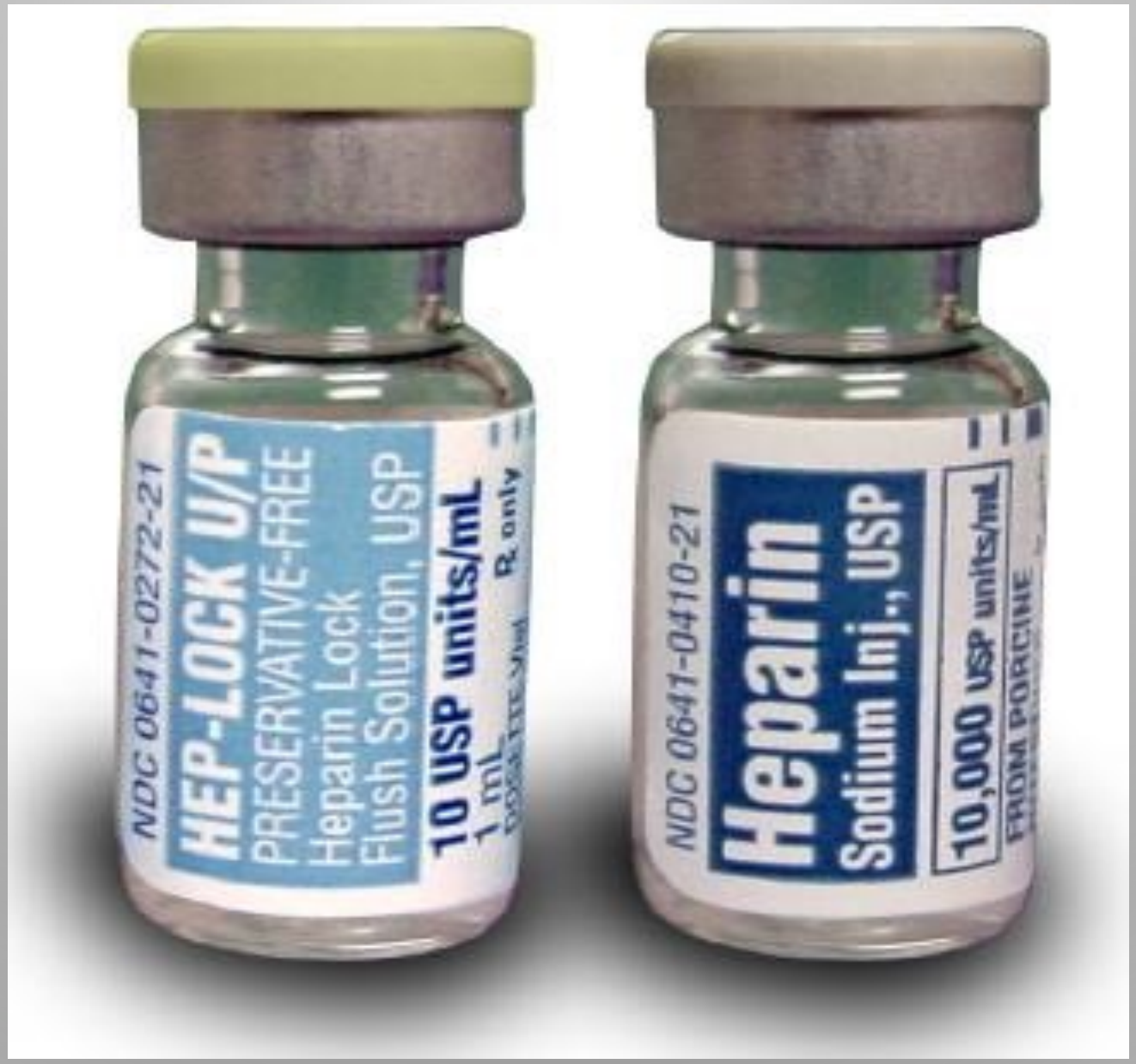
WE ALL MAKE MISTAKES

- HAVE ANY OF YOU MADE A MISTAKE IN THE LAST WEEK?
- THE LAST TWO WEEKS?

- WHAT WAS THE MISTAKE?
- WHAT HAPPENED?
- DID IT DO ANY HARM?
- HOW DID YOU FEEL ABOUT IT?
- DID YOU LEARN ANYTHING FROM IT?

IT'S EASY TO MAKE A MISTAKE



SOME SOLUTIONS ARE SIMPLE

WHO HAS

TRAVELLED ON A EUROPEAN TRAIN?

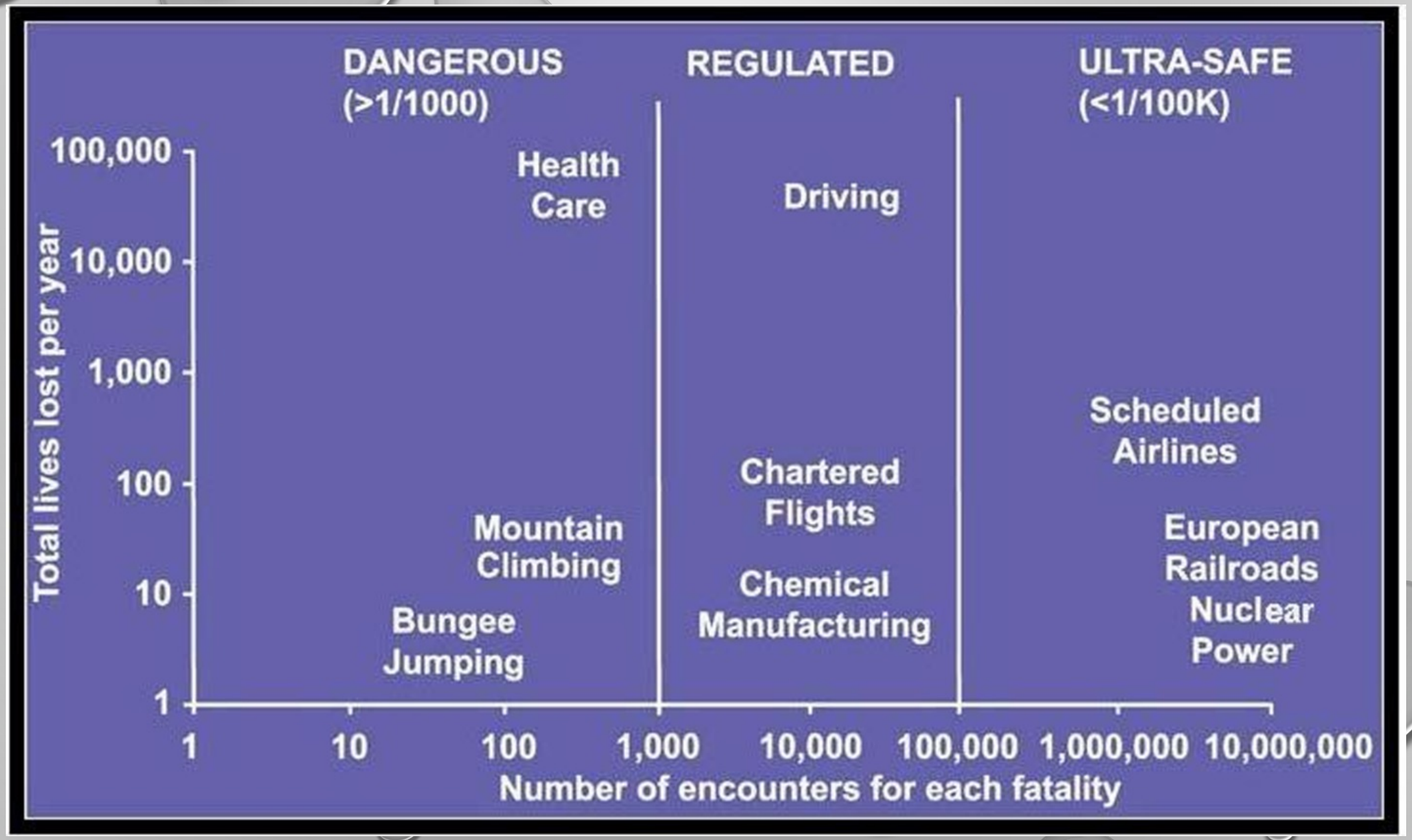
ON A COMMERCIAL AIRLINE?

ON A CHARTERED FLIGHT?

BEEN A PATIENT IN HOSPITAL?

BEEN MOUNTAIN CLIMBING?

BEEN BUNGY JUMPING?


DANGEROUS
(>1/1000)
REGULATED
ULTRA-SAFE
(<1/100K)
Total lives lost per year
100,000
10,000
1,000
100
10
1
Health Care
Driving
Scheduled Airlines
Chartered Flights
Mountain Climbing
European Railroads
Nuclear Power
Chemical Manufacturing
Bungee Jumping
1
10
100
1,000
10,000
100,000
1,000,000
10,000,000
Number of encounters for each fatality

HOSPITALS ARE NOT ALWAYS SAFE

8% OF HOSPITAL ADMISSIONS IN AUSTRALIA ARE ASSOCIATED WITH A **REPORTED** ADVERSE EVENT WHICH **COULD HAVE BEEN PREVENTED.**

THIS CAUSES 18,000 UNNECESSARY DEATHS EACH YEAR

SOME PEOPLE ARE MORE VULNERABLE

- THE YOUNG
- THE OLD
- THE NON-ENGLISH SPEAKING
- THE MENTALLY ILL

HEALTHCARE HAS **DISTINCTIVE FEATURES** THAT INCREASE THE RISK

- DIVERSE ACTIVITIES AND EQUIPMENT
- HUGE NUMBERS
- 'HANDS ON' WORK: SMALL MARGINS OF SAFETY
- UNCERTAINTY AND INCOMPLETE KNOWLEDGE

FACTORS COMPROMISING PATIENT SAFETY

FATIGUE

DISTRACTIONS

INTERRUPTIONS

POOR SUPERVISION

NOT CHECKING

MORE FACTORS COMPROMISING PATIENT SAFETY

POOR TEAM-WORK

POOR COMMUNICATION

LACK OF KNOWLEDGE

LACK OF COMPLIANCE WITH STANDARDS

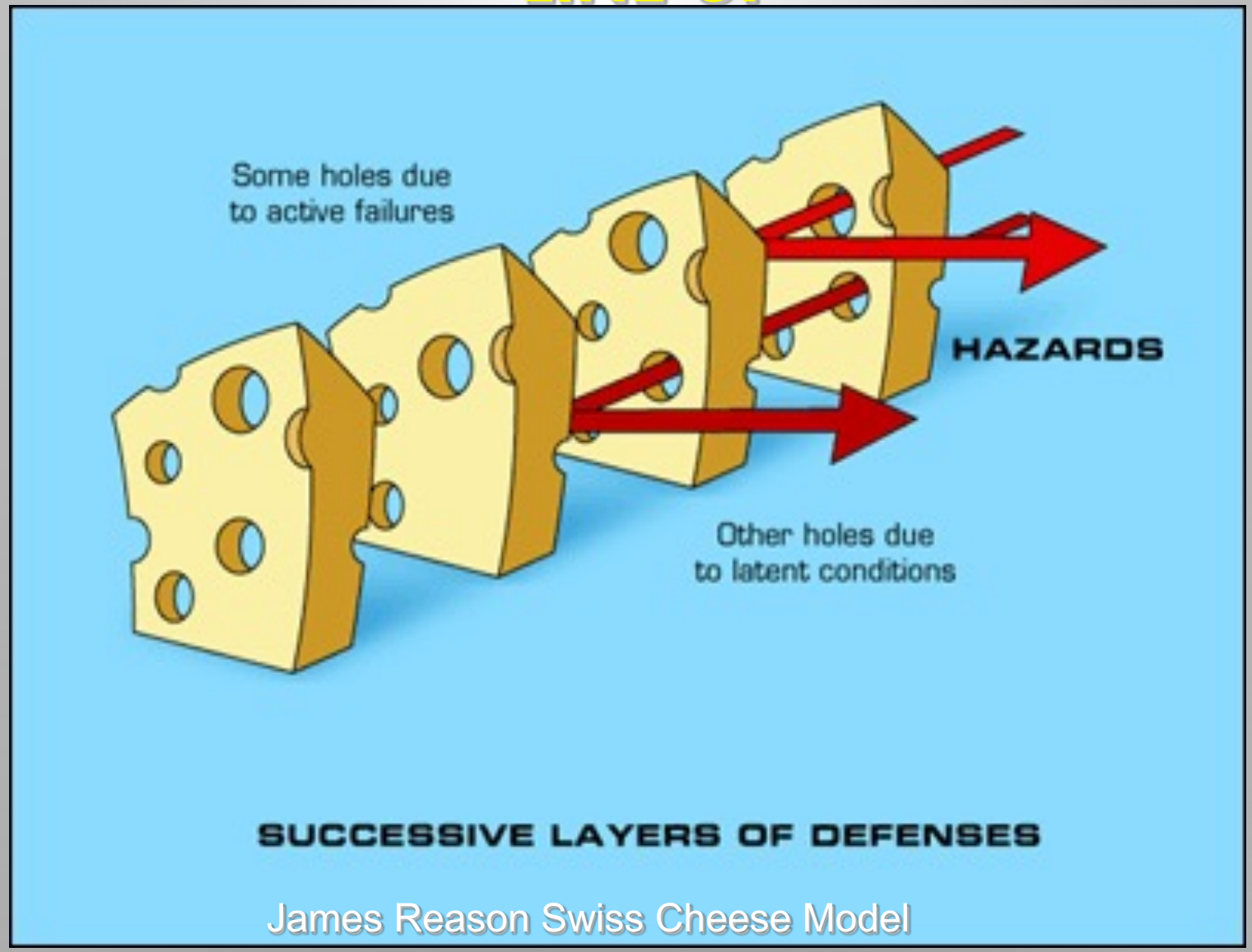
LACK OF STANDARDIZED EQUIPMENT

OVER-RELIANCE ON TECHNOLOGY

EXAMPLES OF ERRORS

- COMMUNICATION FAILURE
- FAILURE TO TAKE PRECAUTIONS
- AVOIDABLE DELAY IN TREATMENT
- INADEQUATE HISTORY OR PHYSICAL EXAMINATION
- FAILURE TO ORDER THE MOST APPROPRIATE TESTS
- FAILURE TO ACT ON TEST RESULTS
- PRACTISING OUTSIDE AREA OF EXPERTISE

SWISS CHEESE: SOMETIMES THE HOLES LINE UP



James Reason Swiss Cheese Model

PENALTIES OF BLAMING INDIVIDUALS (QANTAS SHOWED THE WAY)

MAY CAUSE FEAR IN STAFF

FAILURE TO IDENTIFY ERROR TRAPS

MANAGEMENT HAVING ITS EYE ON THE WRONG BALL

A BLAME CULTURE AND A REPORTING CULTURE CANNOT CO-EXIST

WHEN WE ANALYSE THE FACTORS WHICH LEAD TO ERRORS, WE USUALLY FIND THAT THERE ARE SEVERAL FACTORS, THE PERSON WHO CAUSED THE ERROR JUST BEING THE END OF A SEQUENCE OF CONTRIBUTING FACTORS

A SERIES OF ERRORS CAN YOU SPOT THEM?

IN JANUARY 2004 GRAHAM REEVES WAS ADMITTED FOR REMOVAL OF A BADLY DISEASED RIGHT KIDNEY.

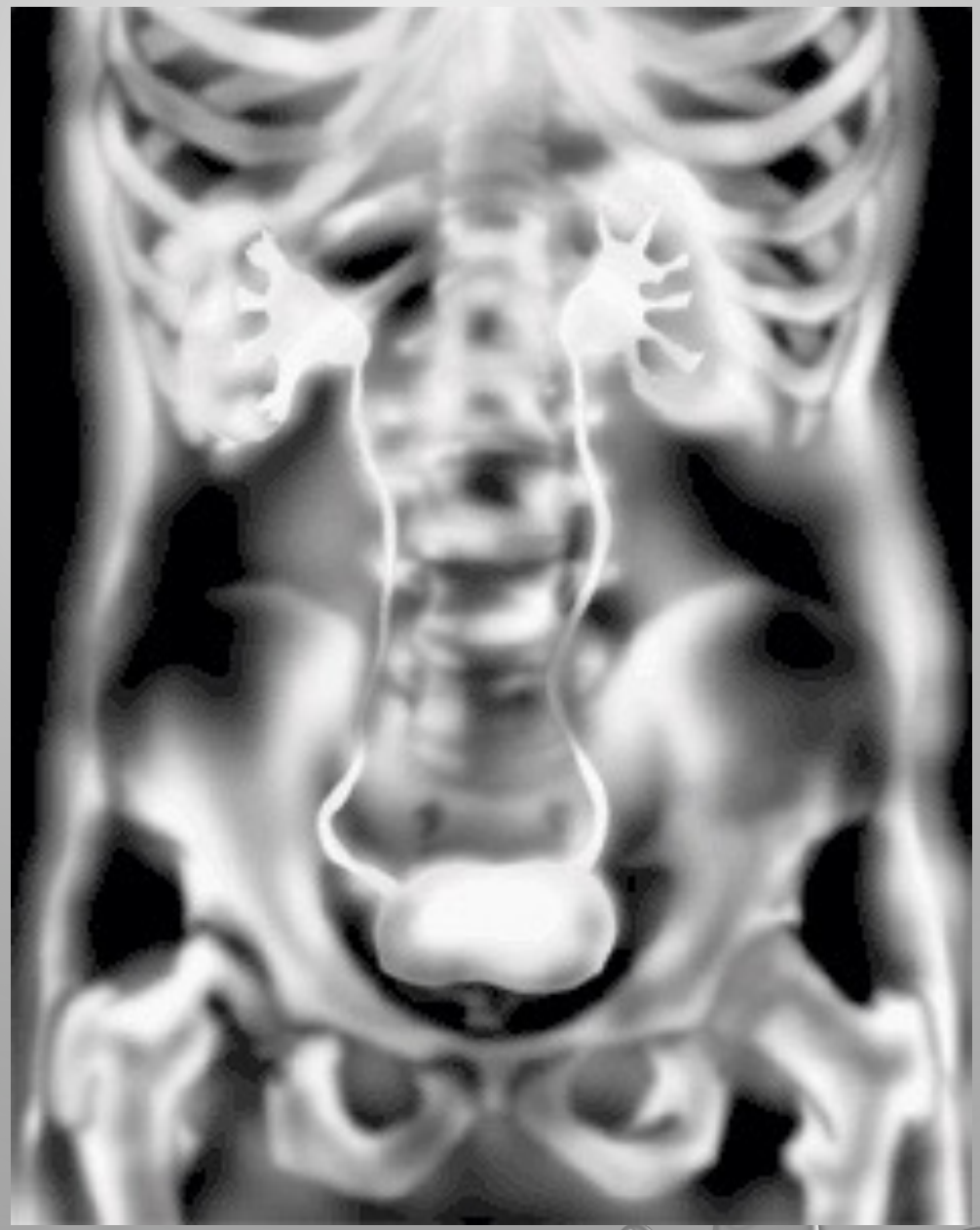
HE HAD SEEN THE SURGEON A MONTH BEFORE WHO DOCUMENTED THE NEED FOR REMOVAL OF THE RIGHT KIDNEY IN HIS CASE NOTES.

THE HOSPITAL ADMISSION SLIP WRONGLY SAID LEFT KIDNEY REMOVAL.

THIS ERROR WAS TRANSCRIBED TO THE THEATRE LIST.

ONE OF THE SURGEONS CHECKED THE X-RAY IN THEATRE. BUT IT WAS THE WRONG WAY ROUND AND HE MISREAD THE DISEASED KIDNEY AS THE ONE ON THE LEFT. THE OTHER SURGEON DID NOT LOOK AT THE X-RAY.

EARLY IN THE OPERATION, A MEDICAL STUDENT LOOKED AT THE FILMS AND SAID SHE THOUGHT IT WAS THE RIGHT KIDNEY WHICH SHOULD BE REMOVED.



THE SURGEON TOLD HER SHE'D MADE A MISTAKE AND CONTINUED OPERATING, REMOVING THE NORMAL KIDNEY

MR REEVES DIED 5 WEEKS LATER

THERE WERE 6 ERRORS IN THIS CASE

WHAT WERE THEY?

1. A TRANSCRIPTION ERROR

1. A TRANSCRIPTION ERROR

2. THE X-RAY WAS THE WRONG WAY AROUND

1. A TRANSCRIPTION ERROR

2. THE X-RAY WAS THE WRONG WAY AROUND

3. THE LEAD SURGEON DID NOT CHECK MR. REEVE'S NOTES IN THEATRE

1. A TRANSCRIPTION ERROR

2. THE X-RAY WAS THE WRONG WAY AROUND

3. THE LEAD SURGEON DID NOT CHECK MR. REEVE'S NOTES IN THEATRE

4. THE OTHER SURGEON DID NOT CHECK NOTES OR X-RAY

1. A TRANSCRIPTION ERROR

2. THE X-RAY WAS THE WRONG WAY AROUND

3. THE LEAD SURGEON DID NOT CHECK MR. REEVE'S NOTES IN THEATRE

4. THE OTHER SURGEON DID NOT CHECK NOTES & X-RAY

5. THE MEDICAL STUDENT WAS IGNORED

1. A TRANSCRIPTION ERROR

2. THE X-RAY WAS THE WRONG WAY AROUND

3. THE LEAD SURGEON DID NOT CHECK MR. REEVE'S NOTES IN THEATRE

4. THE OTHER SURGEON DID NOT CHECK NOTES & X-RAY

5. THE MEDICAL STUDENT WAS IGNORED

6. MR. REEVES WAS NOT PART OF THE TEAM

THERE WAS ALSO A 7TH ERROR **COMPLACENCY**

ASK QUESTIONS:

WHY IS IT DONE THIS WAY?

IS THERE A BETTER WAY?

DON'T ACCEPT THE STATUS QUO

10 QUESTIONS WE SHOULD ASK

1. WHAT IS THIS CONDITION (OR TEST) CALLED?

(ASK YOUR DOCTOR TO WRITE IT DOWN FOR YOU)

10 QUESTIONS

2. WHAT ARE MY OPTIONS? FOR EXAMPLE, ARE THERE OTHER TREATMENTS THAT ARE SIMPLER, OR SAFER?

10 QUESTIONS

3. FOR PROCEDURES OR FOR MEDICATIONS ASK: WHAT ARE THE RISKS AND SIDE EFFECTS?

10 QUESTIONS

4. DO I REALLY NEED THIS TEST? OR THIS TREATMENT? OR THIS PROCEDURE? HOW EFFECTIVE IS IT?

10 QUESTIONS

5. WHEN WILL I GET THE RESULTS? DO YOU LET ME KNOW OR SHOULD I COME BACK FOR THEM?

10 QUESTIONS

6. WHAT WILL IT COST ME?

10 QUESTIONS

7. CAN I HAVE ANOTHER OPINION?

10 QUESTIONS

8. WHAT WILL HAPPEN IF I DON'T DO ANYTHING?

10 QUESTIONS

9. FOR A SURGICAL PROCEDURE, ASK “HOW MANY TIMES HAVE YOU DONE THIS OPERATION AND WHAT ARE YOUR RESULTS?”

10 QUESTIONS

10. IT IS OK TO ASK THE COMMON, OFTEN UNVOICED, CONCERN OF MANY PATIENTS, PARTICULARLY PARENTS: “WHAT CAUSED IT?” “IS IT MY FAULT?” “CAN I PASS IT ON TO OTHERS?”

DISCUSSION AND QUESTIONS

ERRORS IN HEALTHCARE

OR

THE TENERIFE AIRPORT DISASTER

MEDICAL EDUCATION

HEALTHCARE IN VIETNAM

CHILD HEALTH

TENERIFE AIRPORT DISASTER

ON 27 MARCH 1997 KLM FLIGHT 4805 AND PAN AM 1736 WERE DIVERTED TO TENERIFE BECAUSE OF A TERRORIST INCIDENT AT LAS PALMAS WHERE THEY WERE ORIGINALLY TO LAND.

SEVERAL HOURS LATER LAS PALMAS REOPENED AND THE PLANES PREPARED TO DEPART FROM TENERIFE. BY NOW THERE WAS A FOG.

PAN AM WAS TOLD TO TAXI ALONG THE RUNWAY, THEN TURN INTO ANOTHER RUNWAY FOR TAKE OFF.

KLM WAS GIVEN CLEARANCE FOR THE **ROUTE** BUT **NOT** CLEARANCE FOR **TAKE OFF**.

THE KLM CAPTAIN MISTOOK THE ROUTE APPROVAL MESSAGE AS TAKE OFF CLEARANCE AND ACCELERATED DOWN THE RUNWAY.

THE FOG PREVENTED THE KLM CREW SEEING PAN AM IN FRONT OF THEM.

NEITHER JET COULD BE SEEN FROM THE CONTROL TOWER

- THE KLM FLIGHT ENGINEER HEARD A CALL FROM PAN AM AND SUSPECTED SOMETHING WAS WRONG. HE WAS OVER-RULED BY HIS CAPTAIN.
- TEN SECONDS BEFORE THE COLLISION, THE PAN AM CREW SAW THE RAPIDLY APPROACHING KLM PLANE, BUT IT WAS TOO LATE
- 583 PASSENGERS AND CREW DIED