DOWNLOAD PDF MEDICAL ERRORS ARE A SERIOUS PROBLEM QUALITY INTERAGENCY COORDINATION TASK FORCE THE

Chapter 1 : Academy of Managed Care Pharmacy

Quality Interagency Coordination Task Force recommendations. Shortly after the release of the IOM report, President Clinton directed the Quality Interagency Coordination Task Force (QuIC) to develop a plan of action to reduce the incidence of medical errors.

Equipment Lab reports They can happen during even the most routine tasks, such as when a hospital patient on a salt-free diet is given a high-salt meal. But errors also happen when doctors and their patients have problems communicating. For example, a recent study supported by the Agency for Healthcare Research and Quality found that doctors often do not do enough to help their patients make informed decisions. You have a right to question anyone who is involved with your care. Understand that this is your body and life. You must be an active participant in what happens to it. The goal of all medical treatment is to take the best possible care of you. Your help in achieving this goal is mandatory. That means taking part in every decision about your health care. Research shows that patients who are more involved with their care tend to get better results. Medicine Make sure that all of your doctors know about everything you are taking. This includes prescription and over-the-counter medicine, and dietary supplements such as vitamins and herbs. At least once a year, bring all your medicines and supplements with you to your doctor. It can also help your doctor keep your records up-to-date, which can help you get better quality care. Make sure your doctor knows about any allergies and adverse reactions you have had to medicines. This can help you avoid getting a medicine that can harm you. When your doctor writes you a prescription, make sure you can read it. Ask for information about your medicine in terms you can understandâ€”both when your medicine is prescribed and when you receive it. What is the medicine for? How am I supposed to take it, and for how long? What side effects are likely? What do I do if they occur? Is this medicine safe to take with other medicines or dietary supplements I am taking? What food, drink or activities should I avoid while taking this medicine? When you pick up your medicine from the pharmacy, ask: Is this the medicine that my doctor prescribed? A study by the Massachusetts College of Pharmacy and Allied Health Sciences found that 88 percent of medicine errors involved the wrong drug or the wrong dose. If the medicine looks different than you expected, ask the pharmacist about it. If you have any questions about the directions on your medicine labels, ask. Medicine labels can be hard to understand. Ask your pharmacist for the best device to measure your liquid medicine. Research shows that many people do not understand the right way to measure liquid medicines. For example, many use household teaspoons which often do not hold a true teaspoon of liquid. Special devices like marked syringes help people to measure the right dose. Being told how to use the devices helps even more. Ask for written information about the side effects your medicine could cause. If you know what might happen, you will be better prepared if it doesâ€”or if something unexpected happens instead. That way, you can report the problem right away and get help before it gets worse. A study found that written information about medicine can help patients recognize problem side effects and then give that information to their doctor or pharmacist. Hospital Stays If you have a choice, choose a hospital at which many patients have the procedure or surgery you need. If you have more than one hospital to choose from, ask your doctor which one has the best care and results for your condition. Research shows that patients tend to have better results when they are treated in hospitals that have a great deal of experience with their condition. When you are being discharged from the hospital, ask your doctor to explain the treatment plan you will use at home. This includes learning about your medicines and finding out when you can get back to your regular activities. Also ask about follow-up care. Research shows that at discharge time, doctors think their patients understand more than they really do about what they should or should not do when they go home. Surgery If you are having surgery, make sure that you, your doctor and your surgeon all agree and are clear on exactly what will be done. Doing surgery at the wrong site for example, operating on the left knee instead of the right is rare. But even once is too often. Ask your doctor to sign, mark and intraoperatively X-ray your spine surgery site. Know the site and side of the procedure as well

as what is being done. In your presurgical conference, or when the decision to do surgery is made , look at the X-rays and other images and see the problem areas marked. Mark your patient education diagram site and side to correspond to the other images. Questions for your doctor s can include: Exactly what will you be doing? How long will it take? What will happen after the surgery? How can I expect to feel during recovery? Ask about the expected good results and possible bad results of the anticipated procedure. Know that certain circumstances or findings may change the scope of the surgical procedure. Tell the surgeon, anesthesiologist and nurses if you have allergies or have ever had a bad reaction to anesthesia. Take copies of your patient education diagrams with you to the hospital. After your doctor has explained your surgery and you fully understand the procedure, sign the operative permit and make sure the diagram site and side are marked correctly. Make at least 5 copies and take them with you. Copies should go to: Family member or friend who will act as your advocate in the hospital. Explain the procedure to them with the possible results. The nurse in charge of your care. Tape a copy to your bed or IV pole for anyone to reference and take it with you to the surgery. Choose a doctor who you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. Make sure that someone such as your personal doctor is in charge of your care. This is especially important if you have many health problems or are in the hospital. Make sure that all health professionals involved in your care have important health information about you. Do not assume that everyone knows everything they need to know. It is a good idea to find out why a test or treatment is needed and how it can help you. You could be better off without it. Ask about the results. Find out when and how you will get the results of tests or procedures. Call your doctor and ask for them. Ask what the results mean for your care. Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources. For example, treatment recommendations based on the latest scientific evidence are available from the National Guidelines Clearinghouse on the Internet at: Ask your doctor if your treatment is based on the latest evidence. Sources To Err is Human. Building a Safer Health System. National Academy Press; Available on the Internet. Five Steps to Safer Health Care patient fact sheet. Disclaimer This material is made available by the North American Spine Society for educational purposes only. It is not intended to represent the only, nor necessarily best, method or procedure appropriate for the medical situations discussed; rather it is intended to present an approach, view, statement or opinion of the Patient Safety Task Force which may be helpful. This document should not be construed as including all proper methods of prevention or excluding other acceptable methods reasonably directed to obtaining the same results. The ultimate judgment regarding any specific method is to be made in light of all circumstances presented and the needs and resources particular to the locality or institution. NASS disclaims any and all liability for injury or other damages resulting to any individual and for all claims which may arise out of the use of techniques discussed.

Chapter 2 : Clinton-Gore Administration Announces New Actions to Improve Patient Safety

1. To reduce errors. 2. Implement a system of public accountability. 3. develop a robust knowledge base about medical errors. 4. Changing the culture in health care organizations to promote the recognition of errors and improvement of patient safety.

Medical errors Medical errors in the United States of America Medical errors cause between 44, and 98, deaths annually in the United States and rank as the eighth leading cause of death, killing more Americans than motor vehicle accidents, breast cancer or AIDS. The presentation focused on how to reduce medical errors. The definition of such an error is a medical intervention the intended consequences of which do not occur. They are preventable defects in the health delivery system. Types of error Medical errors often involve drugs, such as a patient getting the wrong prescription or dosage, or mishandled surgeries, such as amputation of the wrong limb. However, there are many other types of medical errors. How errors occur Errors can occur at any point in the health care delivery system: Medication errors are preventable mistakes in prescribing and delivering medication to patients, such as prescribing two or more drugs whose interaction is known to produce adverse effects or prescribing a drug to which the patient is known to be allergic. Research is helping to characterize these errors and to suggest how to prevent them. Surgical errors accounted for two-thirds of all adverse events and 1out of 8 hospital deaths in a recent retrospective study in Colorado and Utah. Diagnostic inaccuracies may lead to incorrect and ineffective treatment or unnecessary testing which is costly and sometimes invasive. Also, inexperience with a technically difficult diagnostic procedure can affect the accuracy of the results. Research has made major contributions. System failures are the most frequent source of medical errors. They arise from the organization of health care delivery and the way that resources are provided to the delivery system. Research is helping to identify the systemic factors contributing to preventable adverse events. Failures in disseminating pharmaceutical information, in checking drug doses and patient identities, and in making patient information available are system errors that accounted for adverse drug events in over half of the hospitals studied. Unfortunately, very little data exist on the extent of the problem outside of hospitals although it is highly likely that many errors are likely to occur elsewhere. For example millions of prescriptions are estimated to be filled improperly each year. Preventing errors The Federal Government of the United States is committed to improving the quality of health care. One of the ways of achieving this objective was to establish a Quality Interagency Coordination Task Force QuIC and identifying means to address the problem of medical errors has been a major focus of the work of this Task Force. Work groups have been set up on five key areas in this respect: Patient and Consumer Information Raising public awareness of the problem is being addressed. Two reports have been released on the subject: Identifying opportunities for improving clinical quality An inventory is being developed of all the measures and risk adjustment methods being used by Federal agencies. This documents their uses, strengths and weaknesses and examines how to institute appropriate risk adjustment methods to account for factors outside the control of the delivery system. Improving clinical quality Two areas have been selected in an effort to improve clinical quality of care. These are diabetes and depression. For diabetes, the work group is focusing on having all programmes agreeing to use the Diabetes Quality Indicator Project measures of care. It is hoped that health care provider performance can be improved based on these indicators. For depression, the work group is developing an evidence-based guideline to improve the identification and treatment of depressed individuals. It is believed that standardization of treatment policies and protocols will avoid confusion and reliance on memory, which is known to be fallible and responsible for many errors. Developing the workforce This work is to determine how best to expand and improve the current methods of ensuring the skills of the health care workforce and to equip health care workers with the necessary skills to improve the care they deliver. Research is being developed on this issue. Improving information systems Use of information technology such as hand-held computers will eliminate reliance on handwriting for ordering medication and

other treatment needs. Information systems which will assist in avoidance of similar-sounding and look-alike names and packages of medication need to be enforced. More information may be obtained from the Website of the Agency for Healthcare Research and Quality at http: The survey, reported in a broadcast on February 7, , found that each year a third of the population failed to complete a course of prescribed medication while one in 10 collected prescriptions but did not even start to take them. A quarter of all adults admitted to having unused medicines in their homes. To illustrate the size of the waste problem, TV presenter Angela Rippon was shown visiting a Cambridgeshire pharmacy where returned medicines worth several hundred pounds were awaiting destruction. A Cambridge general medical practitioner, Mr Mike Knapton, told the programme that repeat prescribing, which made up two-thirds of all prescriptions, was responsible for much of the wastage. The programme concluded by stating that, according to the Department of Health, drug wastage was to be added to the agenda for discussions on the following day between Lord Hunt Parliamentary Under Secretary of State and the Society. The Pharmaceutical Journal, Vol.