Patient Safety on the Day Surgery Pathway

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“When I was a young surgeon.....”
Patient Safety Timeline

1990’s  Many countries report large numbers of patients harmed and killed by medical errors

2002  55th World Health assembly Resolution WHA 55.18

“To strengthen the safety of healthcare & monitoring systems”

2004  World Alliance for Patient Safety

“First do no harm”
Prevalence of Adverse Healthcare Events

Preventable deaths
• 70,000 medical errors
• 7,000 medication errors

Koln LT, Corrigan JM, Donaldson MS
To err is human-Building a safer health system.
Patient Risk in Medicine

Medical Care
- Underlying Condition
- Treatment

Patient Safety Incidents
- Preventable events or circumstances that could have, or did, result in unnecessary harm to the patient
Patient Safety Incidents

Adverse Event
Harm to the patient

Near Miss
Could have harmed but was not

No-harm event
No harm to the patient
Surgical Procedures

Life – Saving Surgery

Acceptable Risk

Life – Enhancing Surgery

No Risk
Safety

Nuclear

Aviation
Is Ambulatory Surgery safe?

Yes.......and No !!!!
The risks may be less but are always present

Factors contributing to adverse events
• Medical complexity
• System failures
• Human error
Medical Complexity

- Technology
- Drugs
- Environment
System Failures

- Poor communication
- Staffing levels
- Drug similarities
- Equipment failure
Human Error

- Patient assessment
- Interpretation of tests
- Performance
- Inadequate training
- Overwork
- Personal
General Anaesthetic Safety

Brain damage or Death
1 in 6795 to 1 in 200200

Cause
- Aspiration
- Asphyxiation
- Anaphylaxis

Due to
- Equipment failure
- Human error

Lagasse RS Anesthesia Safety: Model or Myth
Anesthesiology 2010, 97(6):1609-17
Swiss Cheese Model of Accident Causation

“a trajectory of accident opportunity“
Strategies for Patient Safety

Supervision
Protocols
Guidelines
Handovers
Theatre briefings
Checklists
Situational awareness
Never events 2015-16

- Wrong site surgery
- Wrong implant/prosthesis
- Retained foreign object post-operation
- Mis-administration of potassium-containing solutions
- Wrong route administration of medication
- Overdose of insulin due to abbreviations or incorrect device of Insulin
- Overdose of methotrexate for non-cancer treatment
- Overdose of midazolam during conscious sedation
- Failure to install collapsible shower or curtain rails
- Falls from unrestricted windows
- Chest or neck entrapment in bedrails
- Transfusion or transplantation of ABO-incompatible blood components or organs
  - Misplaced naso- or oro-gastric tubes
- Scalding of patients
Second Victim

• Health care professional
  - distress
  - shame
  - guilt
  - fear
  - depression
Summary

- Changing attitude to patient safety
- Life-enhancing surgery on the ambulatory pathway
- Factors contributing to adverse events
- Strategies to enhance patient safety
- Situational awareness
Situational Awareness