Fundamentals of Clinical Risk Management in

Volume 1

OBSTETRICS

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INTRODUCTION

Clinical Risk Management (CRM) is a systematic approach ensuring patient safety. CRM in Obstetrics is about preventing medical error that may lead to adverse events and harm. It demands a complex system, wide effort, a wide range of actions in performance, improvement, infection control, safe use of medicines, safe clinical practice and safe environment of care.

Medical errors not only result in additional costs for hospitalization, litigation, hospital acquired infections, lost income, disability but also cause erosion of trust, confidence and satisfaction among the public and health care providers.

Basic concept of patient safety is eliminating preventable medical mistakes, guarding against the impact of human error and establishing systems to safeguard patient's health and wellbeing. Obstetrics is a high-risk specialty where two challenges are found:

Safety of mother and of baby.

These responsibilities start from the antenatal period and continue through the intrapartum course to postpartum period. Labor is the most critical & high-risk time where the clinical situation can change very quickly and without warning, so it is vital to have systems in place to ensure patient safety.

HISTORY OF CRM

The concept of patient safety is not new. The Hippocratic Oath refers to causing no harm to patients. The formal process of Clinical risk management has arisen from a recognition that mistakes do occur and a conscious drive to reduce these mistakes.

To start, the processes of CRM arose from the response to rising litigation in obstetrics. USA is the front runner in this field and these concepts are now accepted in Europe & elsewhere; India being one of the major players. Although the initial aims of CRM were to reduce payouts from litigation claims but now "Patient safety" is the main drive."

The profile of Patient Safety started to emerge in 1991. In 2002, World Health Assembly passed a resolution calling member states to work for safety of patient.

In Oct. 2004 World alliance for patient safety was formed who have identified certain challenges in relation to safety of patients. 1st challenge is "Clean care is safe care" (2005) and second as "Safe surgery saves life" (2008), 3rd challenge identified as tackling "Antimicrobial resistance" 2010.

In July 2007 Jakarta declaration was made for south East Asia region, which highlighted the role of involvement of patient for patient safety.

Patient Safety is a serious global public health issue. In recent years countries have increasingly recognized the importance of improving patient safety.

PATIENT SAFETY

Patient safety means prevention of harm to Patients during hospital care. It is all about:

1. Eliminating preventable medical mistakes by care givers
2. Guarding against the impact of human error
3. Establishing systems to safeguard patient's health & wellbeing.

Magnitude of problem should be assessed and its solution including preventive means discussed and implemented to stop further occurrence.

India specific concerns of patient safety are:

1. Lack of awareness
2. Lack of baseline data
3. Lack of availability of a system for patient safety
4. Lack of dedicated financing

After signing of India pledge on patient safety (by Director General of Health Services in July 2006), the Director General of Health Services Ministry of Health & Family Welfare, government of India has taken up patient safety issues on priority basis in the form of a new initiative.

HOSPITAL PATIENT SAFETY INITIATIVE

The aims of this initiative are Successful, healthy outcome of patient care (safe and error free), the most expert and advanced medical care available for patients and comfort and peace of mind for patients & providers.

"To Err is Human" which set out a comprehensive strategy by which government health care providers, industry and consumers can prevent medical errors.

Most commonly errors occur from system failures rather than individual error. Strategy for improvement sited a four-tier approach other than:

1. Leadership
2. Research to enhance knowledge on patient safety
3. Identification and Mandatory reporting of incidents
4. Raising performance standards
5. Expectations from professional groups
6. Purchasers of healthcare
7. Implementation of safety systems to ensure safe practice at delivery level
8. Learn from clinical error

To ensure quality care in maternity services patient safety should be the aim rather than going into the blame game.

The objectives of clinical risk management in maternity area is to establish standard approach to risk management in maternity services, assist health services timely and effective management of incidents. It ensures a consistent and coordinated approach to identification, notification, investigation, analysis of incidents and near-misses with appropriate action on all. It maintains a lessons learn repository for sharing with all and maintains the cross pollination of successes.

The expectations for a good outcome of mother & baby are ever increasing and it is not only the case for so called “Low risk Pregnancies” but with advances in health care the expectations for “High risk Pregnancies” are also increasing. We should be aware of the fact that every pregnancy is a high risk one unless we achieve the goal to have an uneventful delivery with a healthy baby & mother.

The basic concept of patient safety is that no patient should suffer from preventable harm. Effective measures should be taken for elimination of preventable medical mistakes and guarding against the impact of human error. Establishing systems to safeguard patients health and wellbeing should remain the priority.

Key steps involved in patient safety are:

- ☞ Development of patient and staff safety policies & procedures
- ☞ Action plan and accountability framework for patient safety

- ☞ Spread of awareness of patient and staff safety across the organization through induction and ongoing training programs
- ☞ Establishment of a “Blame free” culture.
- ☞ Development of a simple, easy to use daily reporting system
- ☞ Analysis of data & trends and institution of corrective and preventive actions.

Some of the challenges that can be easily identified in relation to patient safety in our country are around lack of awareness & realization of its importance even among the doctors, absence of scientific baseline data and lack of dedicated funds for promoting patient safety.

In July 2007 Jakarta declaration was made for on South East Asian region, which highlighted the role of involvement of “patient for patient safety.”

The purpose of patient safety committees is to review the various safety issues in the hospitals and develop a comprehensive system to report all adverse events, analyze them and take corrective actions. Corrective actions may require capacity building, changing systems, improving information system, planning and implementation of interventions, standard procedures and developing feedback channels from patients.