World Health Organization

Patient Safety

A World Alliance for Safer Health Care

Patient Safety Workshop

Learning From Error

PATIENT SAFETY WORKSHOP

LEARNING FROM ERROR

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Contents

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Foreword

After an error that has harmed a patient has occurred, we often ask the question: how did this happen?

It can be very tempting to apportion blame to just one issue or person. But this is too simple. It presupposes that it is possible or right to implicate a single contributing factor. Since the World Health Organization launched WHO Patient Safety in 2004, our experience has been that this is rarely the case.

There is an urgent need to strengthen the defences in the health-care system as a whole. As much as possible, we need to do this without blaming individual health-care workers. That is not to say that individuals should never be held accountable for their actions. However, relying on the blame approach alone is likely to drive problems underground and impede an honest and effective strategy to improve patient safety.

First, we need to understand the extent of the problems that face health-care workers and patients. Medical error rates have been quoted to be in the region of 5-15% per hospital admission in the developed world. Information about the overall state of patient safety in transitional and developing countries is less well known, due to data shortage.

Second, we need reporting systems that are easily accessible to all health-care workers and which facilitate learning. We have learnt that it is possible to get health-care workers to report incidents, but converting the data collected into real systems change is challenging.

Third, we need to have an accurate way of classifying medical errors so that we can share knowledge internationally and make sense of information from different reporting systems.

Fourth, we need strategies to reduce harm to patients. This means dedicated research to identify the best mechanisms, effective dissemination of new ideas and enthusiastic adoption of them.

Making health care safer has to focus on the patient. I am continually moved by the accounts of medical error that affect people's lives. The consequences are far-reaching: they can destroy lives, affect human relationships and threaten trust in the health-care system. Patients are too often the victims of unsafe care and their points of view need to be heard within health care.

Ensuring safer care is an enormous challenge. By running this workshop, you are helping the international health-care community make another step towards this ambitious but essential goal.

Sir Liam Donaldson
Chair, WHO Patient Safety

GUIDANCE FOR COURSE ORGANISERS

Purpose of the workshop

This workshop explores how multiple weaknesses present within the hospital system can lead to error. It aims to provide all health-care workers and managers with an insight into the underlying causes of such events. Although the workshop materials revolve around an error involving the inappropriate administration of vincristine, the underlying principles of why an error occurs are universal and the learning objectives can be applied in any error-related situation.

Vincristine: what went wrong?

Vincristine, a widely used chemotherapeutic agent, should only be administered intravenously and never by any other route. Many patients receiving intravenous vincristine also receive other medication via a spinal route as part of their treatment protocol. This has led to errors where vincristine has accidentally been administered via a spinal route, which leads to death in almost every case. Over the last 35 years, this error has been reported approximately 55 times in a variety of international settings. However, errors related to the accidental administration of vincristine via a spinal route continue to occur.

Learning objectives

By the end of this workshop, participants should:

1. Understand why errors occur
2. Begin to understand what actions can be taken to improve patient safety
3. Be able to describe why there should be greater emphasis on patient safety in hospitals
4. Identify local policies and procedures to improve the safety of care to patients

Who should be invited to participate in this workshop?

A multidisciplinary approach is recommended, but this may be adapted as required. This patient safety workshop is designed to be suitable for health-care workers (e.g. nurses, doctors, midwives, pharmacists), health-care workers in training (e.g. nursing students, medical students, residents), health-care managers or administrators, patient safety officers, and any other groups involved in delivering health care.

Who should facilitate the workshop?

This booklet should enable any health-care worker to facilitate a workshop. You may find it helpful to consult a health-care worker familiar with error prevention and root

Session One: root cause analysis
After watching the drama on the DVD, a trainer should briefly review the concept of learning from error using techniques such as root cause analysis and then divide the workshop into small groups. Blank fishbone templates (Copy Sheet One) are provided and can be photocopied and distributed to the groups to help guide analysis of the patient safety incident seen on the DVD. Each group should then present their findings to the workshop. Trainers are provided with a fishbone analysis diagram with a few suggestions under each heading to prompt discussion, if needed.

Session Two: five factors in system errors
The second part of the DVD analyses the drama in the light of five factors that can reduce error in health care. After watching this, a facilitator can distribute photocopies of questions to consider (Copy Sheet Two) and divide the workshop into small groups. The questions to consider are designed to provide a structure for participants to discuss their own experience of delivering health care, and to identify factors in their own organization which could potentially be changed to reduce the risk of error. It may be easier for each group to consider one area of analysis than for each group to attempt to consider all areas. Groups can then feed back, in the plenary session, to the workshop as