

Anesthesia patient safety foundation calls on health care systems to make systemic changes to stop medical errors

May 26 2022



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The Anesthesia Patient Safety Foundation (APSF), a related organization of the American Society of Anesthesiologists (ASA), has



released a statement on the criminalization of medical errors with a call to action to all health care systems and organizations to establish comprehensive mechanisms to mitigate the risk of future errors.

The APSF, founded in 1985, is the first organization created to focus solely on patient safety. For more than 35 years, the APSF has played a significant role in the reduction of harm from anesthesia and advocates for perioperative patient safety.

"We are deeply saddened and concerned by each adverse event that results in harm to a patient during any aspect of health care delivery, especially when the causes are preventable," said Daniel J. Cole, M.D., FASA, former ASA president and current APSF president. "We offer our heartfelt condolences to all patients and their loved ones who have been harmed by preventable adverse events."

Criminalization of medical errors, such as in the recent prosecution and conviction of a nurse in Tennessee "is counterproductive to the pursuit of prevention of harm to future patients and health care professionals," according to the APSF statement. It advocates "for systemic changes that will enhance health care's culture of safety and will reject the acceptance of 'normalization of deviance' that enables unsafe medical practices." Examples of these changes include:

- Using prefilled syringes when possible;
- Using barcode/RFID technology for removal of medications from an automated dispensing cabinet (ADC);
- Developing a multidisciplinary medication safety committee that meets regularly to evaluate all safety threats in the health care system;
- Creating a culture, reflected in policy, where all providers have a defined mechanism to report near misses and medication errors, and are encouraged to speak up without fear of retaliation and



provide actionable change when patient safety threats are observed.

The statement calls on "all <u>health care systems</u>, professional societies, health care professionals and appropriate government agencies to take energetic, collaborative action to create and continuously improve systems of care so that such errors are nearly impossible."

The statement maintains that "criminal prosecution provides no comprehensive mechanism for exploring the underlying causes of patient harm, including policy failures, implementation hurdles or the impact of human factors to mitigate the <u>risk</u> of future error."

The recent case of criminalization of <u>medical errors</u> importantly "illustrates how serious errors and adverse outcomes continue to occur and that there does not yet appear to be a nationwide safe and just culture among health care institutions that fosters reporting of poor systems of care, near misses or errors to prevent future error and patient harm. For that reason, the APSF urges that cases like this never be pursued by prosecutors, who should have the best interests of patients and society at heart."

The statement also addresses:

- When it may be appropriate to prosecute health care professionals for errors
- What health care organizations must do to prevent errors and acknowledge those that occur
- What health care professionals can/should do to combat medication errors and failure to monitor, as well as improve an organization's safety culture
- What APSF will do if a perioperative professional is prosecuted for an error unjustly



• What APSF will do to foster <u>patient safety</u> prompted by events such as this recent case.

More information: Link to statement: <u>Position Statement on</u>
<u>Criminalization of Medical Error and Call for Action to Prevent Patient</u>
<u>Harm from Error</u>

Provided by American Society of Anesthesiologists

Citation: Anesthesia patient safety foundation calls on health care systems to make systemic changes to stop medical errors (2022, May 26) retrieved 20 June 2024 from https://medicalxpress.com/news/2022-05-anesthesia-patient-safety-foundation-health.html

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