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Quality Care and Patient Safety – A Call for Patient Engagement, Participation and Accountability

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Commentary

Reports such as, "Medical errors kill enough people to fill four jumbo jets a week" [1] and "To Make Hospitals Less Deadly, a Dose of Data" [2], are just two out of many articles that have recently been published in reputable newspapers. On May 10th, 2013, New York-CBS News made an announcement regarding "Wrong Kidney Removed from Patient at a NYC Medical Center" [3]. This kind of gruesome publicity makes healthcare professionals wonder why we have not yet achieved better quality care and safety for patients admitted to our healthcare systems.

The answer may be simpler than we think. It has to do with the fact that "We cannot solve our problems with the same thinking we used when we created them". While this statement was asserted by Albert Einstein decades ago, it has been widely accepted as a valid principle, ever since. The thinking that the staff of hospitals should be more seriously compliant with quality care and patient safety standards has been the thinking for many decades [4]. Yet, punitive actions to poorly performing caregivers has never been advisable [5,6]. On the contrary, most hospitals advocate a blame free environment for their individual employees. This is based on the concept that system flaws are most of the times the main culprits of medical errors and poor outcomes, and not the individual caregivers. However, this longtime approach has not benefited the healthcare network systems, as if it has, we would not have read or heard about so many serious medical errors time and again. It should also be emphasized that "every system is perfectly designed to achieve the results it gets"[7]. Thus, if the system yields errors, it would make sense to address the responsible designers of that system and determine if for a specific incident, a system failure is due to designer's failure.

Our thinking should be changed and a new paradigm should be enforced. This new paradigm should be designed to encourage patients to be more seriously engaged in their own quality care and safety. They should speak up, ask questions, seek explanations, and review pertinent literature and express concerns about their care. So, why most patients do not do so? Because adequate patient involvement and engagement in their own care requires more clinical transparency and more comprehensive disclosure of management plans and outcomes. It is strongly believed that properly engaged patients can provide valuable feedback about their care and prevent errors. This feedback may be perceived as internal unsolicited audit.

For many years we have tried to identify ongoing and longstanding issues regarding quality care and patient safety by utilizing external audits. These audits aimed primarily at ascertaining hospitals' compliance with quality standards and patient safety measures. In order for periodic external audits, such as those done by the Joint Commission (JC), [8] to be meaningful, the external auditors need input from internal auditors [9] to prevent snapshot results [10]. Medical errors have gone from being the 8th to the 3rd leading cause of preventable death in USA [10] and no periodic external audits have been able to change that gruesome statistics. External auditors of healthcare systems go through cumbersome processes of planning and scoping of their audit objectives followed by collection of evidence of noncompliance regarding specific relevant standards. Corrective actions are expected to be implemented at a later stage. This approach gives rise to two types of risks; 1. detection risk and 2. implementation risk [11]. Detection risk is the risk that the audit process may not detect specific system errors or flaws at the time it is carried out. Implementation risk is the risk that any implementation of an improved process may only be sustainable for a short period.

This article intends to describe a new paradigm for improving quality care and patient safety that does not need to rely solely on external auditors. The newly proposed paradigm focuses on providing three categories of guidelines to patients and for patients, to enable them to participate in their care during hospitalization, and accomplish better outcomes for themselves. These guidelines are user friendly and are described in three categories; 1. patient guidelines for prevention of infections; 2. guidelines for prevention of misinformation; and 3. guidelines for prevention of mistreatment' (table 1). It should be emphasized that these categories do not provide all possible pertinent guidelines and may be revised as deem appropriate by hospitals' leadership. Moreover, it would behoove patients to have the guidelines available to them as quick reference to their clinical engagement framework. Similarly, hospitals should consider having a proactive approach and provide this reference

to all admitted patients in order to achieve better compliance with quality and safety standards.

Table 1: Patient Involvement and Engagement Guidelines for Self-Prevention of Infections, Misinformation and Mistreatment

Prevent Serious Infections	Prevent Misinformation	Prevent Mistreatment
Demand that caregivers wash their hands with soap and wipe their medical equipment (i.e. statoscope) with alcohol before touching you.	Ask to be identified by 2 identifiers before anything is done or given to you.	Ask about prevention of possible serious thromboembolism (VTE) in your legs.
	Verify that there is a written order for it in your name.	Ask if a blood culture was sent before taking antibiotics for pneumonia. If not – ask for this to be done.
	Verify that a 'time out' is planned to be done before doing procedures on you and ask to see its details.	Ask if you meet criteria for a pneumococcal and/or influenza vaccine.
Demand that caregivers wear gloves when doing your wound care or handling your in-body catheters.	Verify that you know your full management plan. Demand a professional translator if necessary.	Ask your caregivers to prevent progression of a possible heart attack by doing a PCI no later than 90 minutes after your arrival with symptoms.
	All treatment plans should be revealed to you including those that are optional and exceed the capabilities of the medical center you are in.	Ensure that your child receives steroids during hospitalization for asthma.
	Ask to be transferred to a center that can provide the full service you need.	Ask for a timely ECHO evaluation for heart failure symptoms.
Ask daily whether your in-body catheters are needed, or else, they should be removed immediately.	Ask not to be discharged before all tests and imaging results are done and have been reported to you.	If your caregivers evaluate you for stroke, ensure that they give you aspirin immediately, and consider rtPA treatment.

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