Adverse event reporting culture in eye care organizations

Introduction:

As health care professionals our first duty is to ensure that we 'Do No Harm' as Florence Nightingale taught us long back. Japanese say that "Mistake is a Treasure", we learn from our mistakes and staff should be encourage to report any errors instead of being fearful of any penalty.

The World Health Organization defines Patient Safety as "The absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum". Within the broader health system context, it is a framework of organized activities that creates cultures, processes, procedures and behaviors ensuring patient safety.

The occurrence of adverse events can pose significant challenges in Eye care organization. An incident reporting culture involves encouraging staff to promptly report any adverse events including no harm or near misses.

A positive reporting culture fosters:

- Learning from mistakes
- Implementing improvements
- Enhancing overall healthcare

We will share the used quality tools of 'Five Why' and 'Fishbone Analysis' to create a structure for analyzing common adverse events occurring in eye care hospitals.

Objectives:

1. Adverse events reporting helps in strengthening the SOPs at an eye care organization such that future never events can be prevented, in case of any untoward events, staff are prepared to handle adversities. Training of healthcare professionals in continuous quality improvement at their organisation in patient care

2. **Identify potential areas of collaboration**

   Encourage more eye centres to adopt Patient Reported Experience Measures (PREM) for monitoring safety of cataract surgery patients

   PREM Tool for Enhancing Cataract Surgery Safety in Indian Hospitals

   We wanted to improve patient satisfaction and patient safety at our organisation for the patients undergoing Cataract Surgery. We have used the tool Patient reported experience measures (PREM). This is a unique tool which works by asking pertinent questions to patients and evaluate if their safety was given importance before, during and after the surgery. Measures to reduce errors like wrong patient, wrong IOL and wrong eye can be strengthened if the PREM results are not satisfactory. Also, certain questions help us to find out if patient's understanding regarding how and when to seek urgent care after surgery is clear. This helps in detecting post

operative infections at the earliest. Thus, our Patients can help us find out if enough steps are taken during their care to ensure safe surgery.

3. **Facilitate a platform for discussion**

   Between teams from different eye care organisations on risk management and prevention of adverse events
   The adverse events resource from SEVA foundation can be a resource document for organisations to take forward their incident reporting culture

Expected Outcomes:

1. **Increased Awareness:** of HCO about risk mitigation and prevention of adverse events

2. **Potential Collaborations:**

   To use resources of Corrective Action and Preventive Action for adverse evets in the existing resource document of SEVA foundation and add inputs from other organizations in ongoing effort to strengthen this culture

3. **Actionable Steps:**

   Start a structured incident reporting culture in your organisation, which encourages staff to report all incidents including No Harm and Near Miss without any fear of any penalty

4. **Strengthened Network:**

   In case of sentinel event, help build a support group which can help investigate and reduce any future such episodes.

Roles and Responsibilities:

Zamindar's Eye Foundation:

- **Lead the Webinar:**

  Talk about the importance of adverse incident reporting culture
  - Dr Zamindar
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- **Engage in Discussion:**

  Discuss the barriers to the reporting of adverse events in eye care organisation
  - Dr Zamindar

- **Concluding Remarks:**

  Question & Answer
  - Dr Zamindar
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Date/Time: **27th February, Thursday, from 4 to 5 pm**

Resource persons:

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