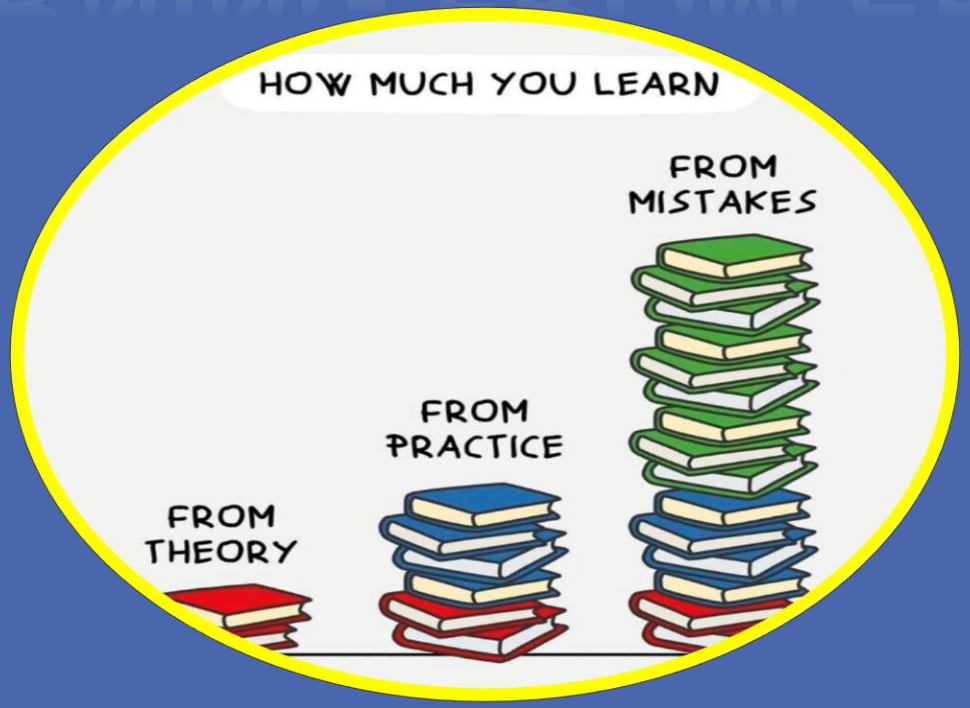
LEARNING FROM ERRORS



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INTRODUCTION

Learning from Errors is a powerful concept in both personal development and professional growth.

Analyze mistakes to understand what went wrong, why it happened, and how to prevent it in the future.

Statistics & Impact

- WHO : 1 in 10 patients experience harm during healthcare.
- 3 million deaths globally each year (WHO, 2023).
- Burnout among nurses : ⬆ medical errors (SE Healthcare, 2025).
- Results of errors : longer hospital stays, disabilities, higher treatment costs, and eroded patient trust.
- Need for sensitization and proactive error prevention in nursing practice.

Common Types of Errors

- Patient Identification Errors
- Communication Errors
- Documentation Errors
- Medication errors
- Clinical Judgment or Decision-Making Errors
- Equipment-Related Errors
- Falls and Injury Prevention Errors
- Ethical or Legal Violations

Causes of Errors

Human Factors

- Fatigue
- Distraction
- Stress or burnout
- Inexperience
- Complacency

System/ Process Failures

- Understaffing
- Lack of supervision
- Inadequate training
- Faulty processes

Technological Failures

- Malfunctioning
- Incorrect use
- Overreliance

Environmental Factors

- Poor lighting or ergonomics
- Noisy or chaotic work settings
- Disorganized workspaces

To err is Human , To disclose and learn is wisdom

Approach to errors- Productive and not Punitive

Sustenance

01 Implementing a Culture of Safety

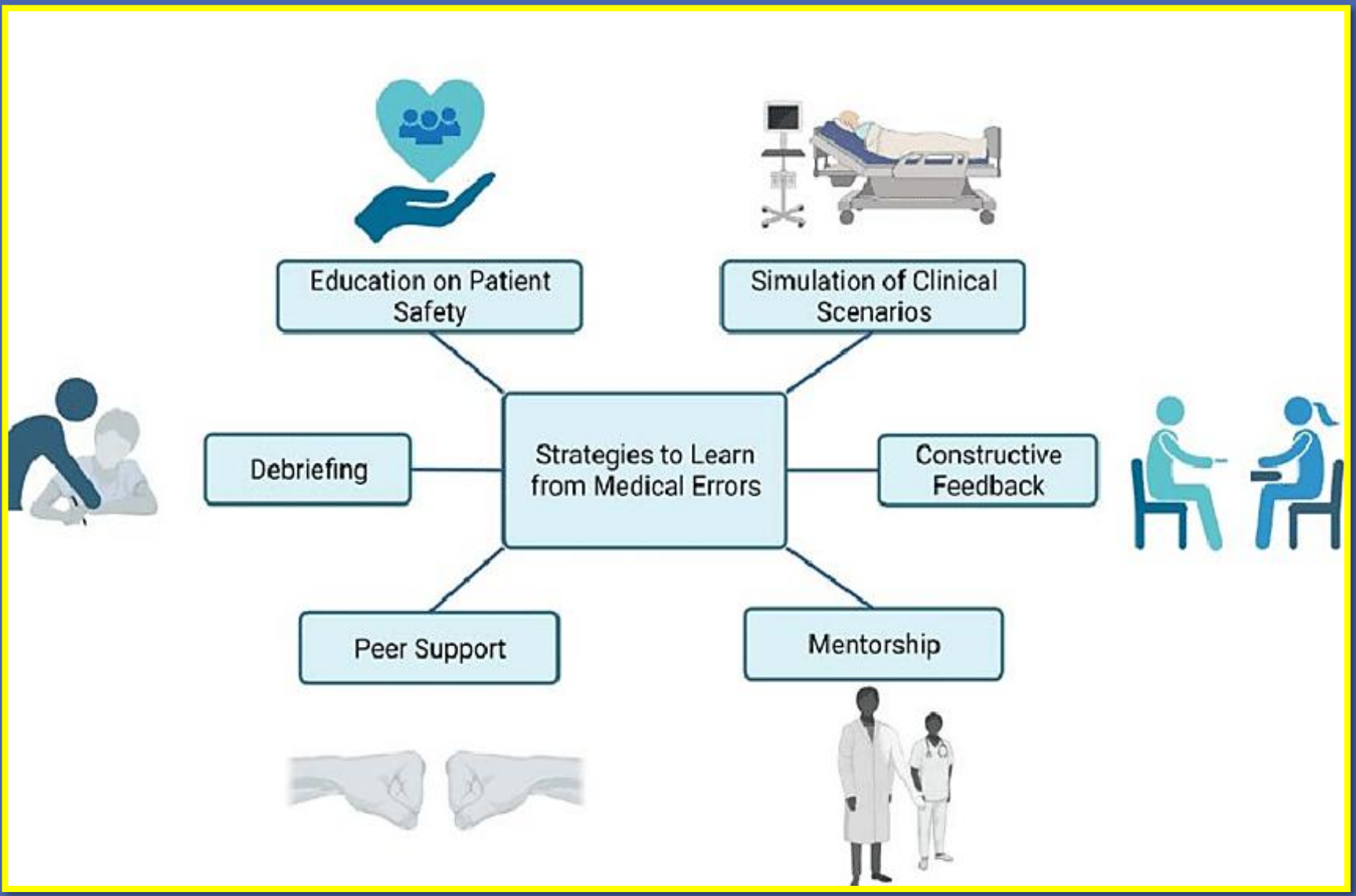
02 Providing Adequate Training and Education

03 Utilizing Technology

04 Implementing Standard Guidelines and Protocols

05 Encouraging Patient Involvement

Learning & Development – Most Cost Effective

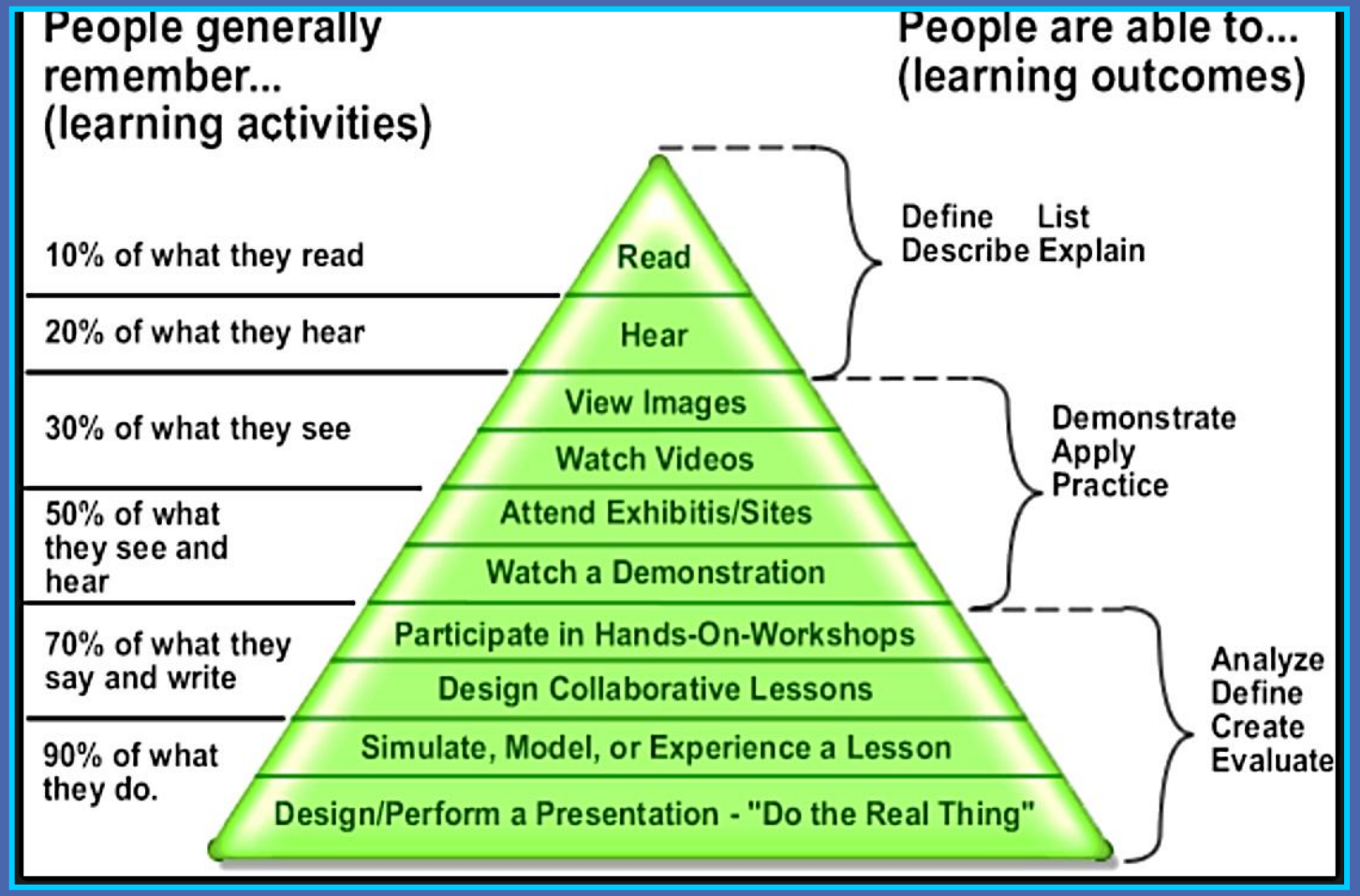


Simulation of Scenarios-Learn by Doing

Visualize Real-World Consequences

Risk-Free Learning Environment

The Learning Pyramid

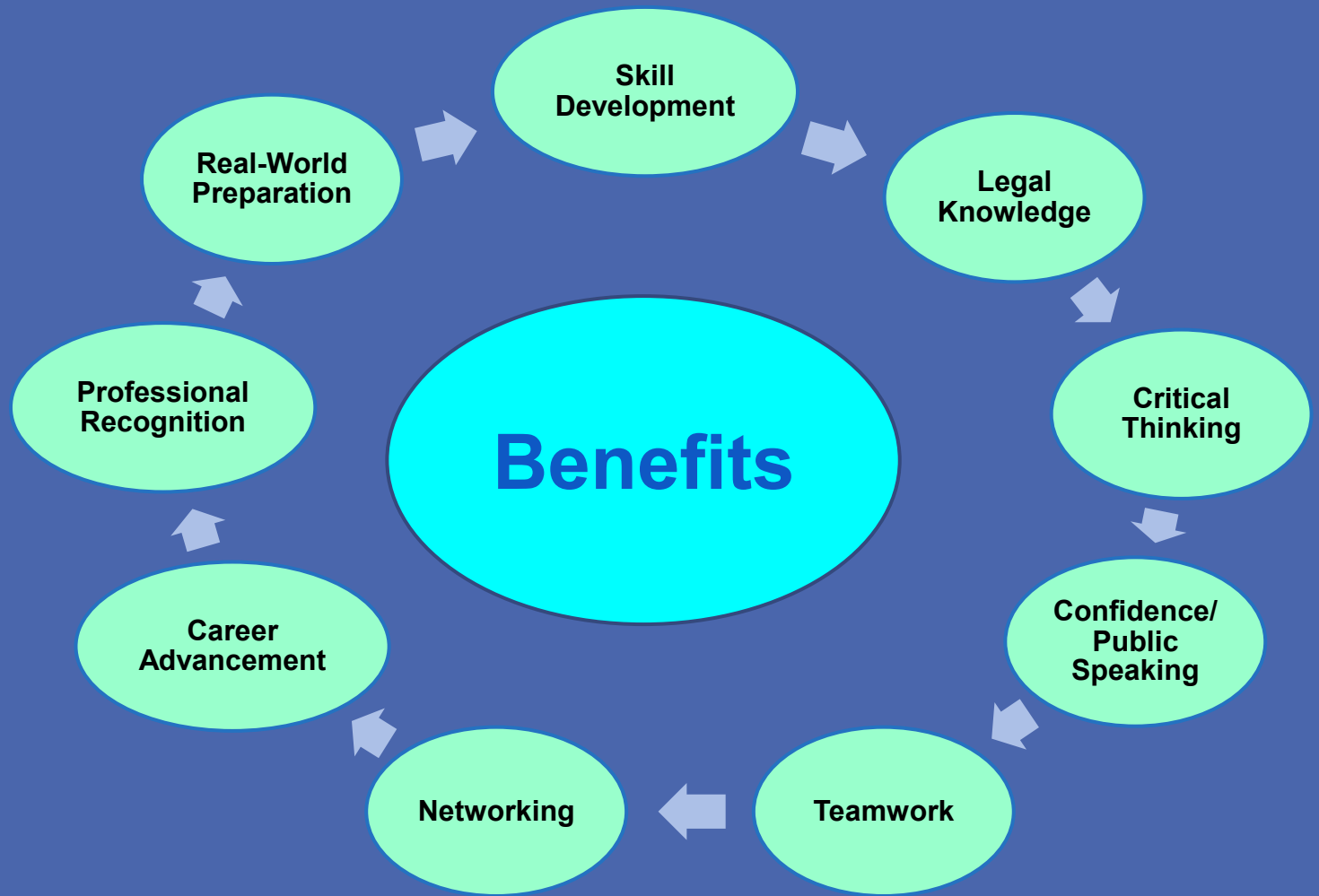


Enables Skill Development and Competency

Deeper Learning and Retention

Moot Court

Moot court is an indispensable part of legal education, equipping students with the practical skills, confidence, and professional connections needed for a successful legal career.



Moot Court Execution

Execution

- Moot Court schedule –Learning planner
- Moot Court Script
- Depict the Incident
- Enact court room situation
- Videos of real life stories and legal cases pertaining to Healthcare errors.

Landmark Healthcare Cases

Indian Medical Association vs. V.P. Shantha (1995)
Court: Supreme Court of India
Significance:Brought medical services under the Consumer Protection Act, 1986.
Held that patients can sue doctors and hospitals for deficiency in service.It clarified that private medical practitioners, government hospitals (charging fees), and nursing homes are liable under consumer law.

Dr. Laxman Balkrishna Joshi vs. Dr. Trimbak Bapu Godbole (1969)
Court: Supreme Court
Significance:Established the standard of care required from medical professionals.
Stated that a doctor owes a duty of care in deciding whether to take a case, what treatment to give, and how to administer the treatment.

Kusum Sharma vs. Batra Hospital & Medical Research Centre (2010)
Court: Supreme Court
Significance:Set out guidelines for deciding medical negligence.
Held that medical professionals cannot be held negligent merely because a treatment didn't succeed.

Spring Meadows Hospital vs. Harjot Ahluwalia (1998)
Court: Supreme Court
Significance:Awarded compensation to both the child patient and the parents.
Recognized that parents can be "consumers" in a contract for their child's medical treatment.Involved a wrong injection leading to permanent brain damage.

Anuradha Saha Case – Dr. Sukumar Mukherjee & Others (2009–2013)
Court: Supreme Court and National Consumer Disputes Redressal Commission (NCDRC)
Significance:One of the highest compensation awards in Indian medical negligence history (₹11 crore+).
Involved wrong treatment of toxic epidermal necrolysis leading to the death of a US-based child psychologist.

Glimpse of Moot Court Conducted

Scenarios :

1. Pressure injury post Bariatric surgery : increased LOS and financial burden
2. Peripheral line inserted into artery : lead to limb amputation.
3. Knee brace not removed prior to MRI : Dislocation causing injury to patient abdomen and internal organs
4. Accidental delining of abdominal drain resulted in significant blood loss , ICU transfer ,increased length of stay, sepsis.
5. Emphasize on IPSG – Wrong sample, wrong reports, wrong treatment, Infection, Fall.

VIDEO

How it has Helped us?

- ✓ Sensitize nurses on Legal implications of minute /simplest error
- ✓ Enhance awareness across the team about the various incidence
- ✓ Boost staff confidence
- ✓ Increased accountability and reporting.
- ✓ Transparency in error reporting
- ✓ One’s mistake another's learning
- ✓ Reinforce the protocols

Conclusion

Learning from medical errors is a critical component of improving patient safety. It is important to foster a culture that encourages the reporting and analysis of errors. By taking a proactive approach to learning from errors, medical professionals can improve patient outcomes, reduce healthcare costs, and ultimately save lives.


Thank You