



Review Article

WHAT ARE WE DOING IN TURKEY TO IMPROVE JOINT COMMISSION INTERNATIONAL'S PATIENT CENTERED CARE STANDARDS (COP)?

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ARTICLE INFO

Article History:

Received 14th October, 2015
Received in revised form
29th November, 2015
Accepted 15th December, 2015
Published online 31st January 2016

Keywords:

Accreditation
Fundamental,
Coordination.

ABSTRACT

Accreditation process includes a series of problems that are identified as consistency with mission and vision, patient privacy, patient records and documentation, working with quality data, employee performance and allowances, working with a clinical guide, working in accordance with patient transfer standards, pharmaceutical prescription system, blood and blood products, data analysis performance improvement. COP, ranking fifth in the JCI's patient centered standards, contains 22 standards and 74 measurable elements. The COP 2 standard, however, contains 5 standards and 18 corresponding measurable elements which are regarded as the fundamental features of a patient care planning and coordination and significant indicators for nursing care. This study aims at establishing the extent to which the COP 2 standard is being met in Turkey and at Acibadem Healthcare Group (AHG), and making a critique of the possible consequences for nurses in case they are not met and promoting awareness regarding the COP 2 standard in general.

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INTRODUCTION

Purposes of the COP 2 Standard and its Measurable Elements

The COP 2 Standard should be a process intended for integrating and coordinating the care provided to the patients.

Purpose of the COP 2

The care that is provided to the patients is a dynamic process which may involve a good number of healthcare professionals and healthcare facilities, departments and services. When the aim is set on integrating and coordinating the care activities, it is possible to achieve efficient care processes, effective use of human and other resources and better patient outcomes. Therefore the leaders should adopt more suitable tools and techniques to better integrate and coordinate the care towards their patients (i.e. use of care teams, joint care planning forms for multidisciplinary patient visits, integrated patient records, case managers). (See also AOP.4, description of purpose)

The patient file/records should be able to support and reflect the integration and coordination of the care provided. In the same vein, conclusions drawn from joint care team meetings or similar case discussions should also be entered into the patient's file. (See also COP.5, ME 2)

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Measurable Elements of the COP 2

- The care plan should be integrated and coordinated among different areas, departments and services. (See also ACC.2, ME 3)
- The care provided should be integrated and coordinated among different areas, departments and services.
- The conclusions reached at the end of all kinds of care team meetings or the discussions of similar nature should be entered into the patient's file.

COP 2. 1. Standard: Care provided to the patient should be planned and entered into the patient's file.

Purpose of the COP. 2.1

Patient care processes should be planned thoroughly so as to be able to achieve the best possible outcomes. The data obtained from the preliminary evaluation of the planning process and the thorough reassessments should be used with a view to identifying and prioritizing other care types in order to meet the requirements of treatments, procedures, nursing care and the patient. The patient and their relatives should be included in this planning process. The plan should be entered into the patient's file. The care plan should be established within 24 hours following the in-patient admission. Based on the reassessment findings of the clinicians participating in the patient's care, such a plan should be updated in such a way as to reflect the patient's developing condition.

The care planned for a particular patient should be related to that patient's identified needs. Those needs may change as the result of new information from a routine reassessment (for instance abnormal laboratory or radiography results) or may be evident from a sudden change in the patient's condition (for example loss of consciousness). As needs change so should the plan for the patient's care. While the relevant changes can be entered into the file as additional notes to the initial plan, they can also be reflected as revised or new care objectives or help trigger the development of a new plan.

Note: Rather than allowing each clinician enter a separate care plan, a single integrated care plan that reflects the measurable development (goals), as expected by each and every discipline, should be opted. Patient care plans should be tailor made, objective and reflect realistic care goals so as to facilitate the care plan's reassessment and revisability.

Measurable Elements of the COP. 2. 1

- It should be planned by the physician, nurse or other healthcare professionals responsible for each and every patient's care within no later than 24 hours following the in-patient admission.
- The planned care should be personalized and based on the initial assessment findings of the patient.
- The planned care should be entered into the patient's file in the form of measurable development (goals).
- Expected development (goals) should be updated or revised in accordance with the clinicians' reassessment of the patients.
- Physician in charge should review and verify the care planned for each patient and take notes regarding such observations. (*See also* ACC.2.1, ME 1)
- The care plan should be implemented. (*See also* COP.2.3, description of purpose)
- The care provided to a patient should be entered into the patient's file by the healthcare professional that has actually tended to the patient. (*See also* ASC.5.2, ME 1; ASC.7.2, description of purpose; and
- COP.2.3, ME 1)

Standard COP 2.2

The persons that are authorized to make requests should enter their requests in a standard column in the patient file.

Purpose of the COP. 2.2

One of the patient care activities is the performance of the orders (for instance laboratory testing, administration of medications, nursing care and nutrition therapy orders). Diagnostic, surgical and other procedures should be ordered by persons who are qualified to do so. Such orders should be easily accessible if they are to be do performed in a timely manner. Entering orders in a common form or a standard column will make it easier for their implementation. Issuing orders in writing helps the personnel understand the specifics of an order, when the order is to be carried out, and who is to carry out the order.

Orders can be written on an order for that is to be transferred to the patient's file on a periodic basis or at discharge.

Each institution should make a decision as to:

- which orders should be issued in writing rather than verbally;
- which diagnostic viewing and clinical laboratory testing orders should specify clinical indication/grounds;
- what exceptional practices that may be necessary in such specialized care areas as emergency service and intensive care unit;
- who has the authority to issue orders; and
- where the orders will be entered in the patient file.

Measurable Elements of the COP. 2. 2

- Orders should be issued in writing when necessary and in line with the corporate policies. (*See also* MMU.4, ME 1)
- In diagnostic viewing and clinical laboratory testing orders, clinical indication/grounds should be specified when the situation calls for interpretation.
- Only the authorized personnel should be able to write down the orders.
- Orders should be entered into a standard column in the patient's file.

Standard COP. 2.3

Procedures conducted should be entered into the patient's file.

Purpose of the COP. 2.3

Diagnostic and other procedures that have been performed and the results thereof should be entered into the patient's file. Examples of such procedures may include endoscopies, cardiac catheterization/angiography and other invasive and non-invasive and therapeutic procedures. (For surgical procedures, see ASC.7.2, ÖE 2 and COP.2.1, ME 6)

Measurable Elements of the COP. 2. 3

- Procedures performed should be entered into the patient's file. (*See also* COP.2.1,
- ME 7)
- The results of the procedures performed should be entered into the patient's file.

Standard COP 2.4

The patients and their relatives should be informed about the care and treatment results including the unexpected results.

Purpose of the COP. 2.4

The process of care and treatment consists of an ongoing assessment and reassessment, planning and implementation of care and the evaluation of the results/outcomes of such implementations. The patients and their relatives should be informed of the assessment results and the care and treatment planned for them and should participate in the decision making process regarding their care.

In order for this cycle of information to be completed, the patients should be informed of the care and treatment results. Such information also includes the announcement of unexpected care results.

Measurable Elements of the COP. 2. 4

- The patients and their relatives should be informed with respect to the results of their care and treatment. (See also PFR.2.1.1, ME 1)
- The patients and their relatives should be informed of unexpected results regarding their care and treatment. (See also PFR.2.1.1, ME 2)

What is the Status of Meeting the COP 2 Standard in Turkey?

The following data reflects the status of meeting the COP 2 standard in Turkey based on the commonly identified findings according to the study conducted by Health Quality Improvement Society (SKİD).

What is the Status of Meeting the COP 2 Standard at Acibadem Healthcare Group (AHG)?

The following data reflects the status of meeting the COP 2 standard based on the findings established following the JCI inspection conducted at AHG during the years between 2008 and 2011.

What Do the COP 2 Standards Protect Us Against?

The following table addresses the case scenarios and the situations that we may encounter based on the detailed measurable elements of the COP 2 standard.

Table 1. The Status of Meeting the COP 2 Standard in Turkey

	Standard	Met	Measurable Elements (ME)	Not Met / Partially Met
COP.2	It should be a process intended for integrating and coordinating the care provided to the patients.	3	ME 3- The conclusions reached at the end of all kinds of care team meetings or the discussions of similar nature should be entered into the patient's file.	1
COP.2.1	Care intended for the patient should be planned and entered into the patient's file.	3	The planned care should be entered into the patient's file in the form of measurable development (goals).	9
COP.2.1	Care intended for the patient should be planned and entered into the patient's file.	5	Physician in charge should review and verify the care planned for each patient and take notes regarding such observations.	4
COP.2.1	Care intended for the patient should be planned and entered into the patient's file.	7	The care provided to a patient should be entered into the patient's file by the healthcare professional that has actually tended to the patient.	2
COP.2.2	Persons authorized to carry out orders should enter such orders into a standard column in the patient's file.	2	In diagnostic viewing and clinical laboratory testing orders, clinical indication/grounds should be specified when the situation calls for interpretation.	1
COP.2.2	Persons authorized to carry out orders should enter such orders into a standard column in the patient's file.	4	Orders should be entered into a standard column in the patient's file.	1

Table 2. The Status of Meeting the COP 2 Standard at AHG

JCI COP 2	Standard	Measurable Elements (ME)	Partially Met	Not Met
COP 2	It should be a process intended for integrating and coordinating the care provided to the patients.	ME 3- The conclusions reached at the end of all kinds of care team meetings or the discussions of similar nature should be entered into the patient's file.	2	-
		ME 2- The planned care should be personalized and based on the initial assessment findings of the patient.	-	1
COP 2.1	Care intended for the patient should be planned and entered into the patient's file.	ME 3- The planned care should be entered into the patient's file in the form of measurable development (goals).	3	-
		ME 4- Expected development (goals) should be updated or revised in accordance with the clinicians' reassessment of the patients.	1	-
COP 2.2	Persons authorized to carry out orders should enter such orders into a standard column in the patient's file.	ME 1 - Orders should be issued in writing when necessary and in line with the corporate policies.	3	-
		ME 3 - Only the authorized personnel should be able to write down the orders.	1	-
	Procedures performed should be entered into the patient's file.	ME 1 - Procedures performed should be entered into the patient's file.	2	-
COP 2.3		ME 2 - The results of the procedures performed should be entered into the patient's file.	-	1
COP 2.4	The patients and their relatives should be informed about the care and treatment results including the unexpected results.	ME 2 - The patients and their relatives should be informed of unexpected results regarding their care and treatment.	1	-
TOTAL			13	2

Table 3. Safeguards of the COP 2 Standard

JCI COP 2	Standard	Safeguards	Example
COP 2	It should be a process intended for integrating and coordinating the care provided to the patients.	<ul style="list-style-type: none"> √Multidisciplinary care √Holistic approach √Efficient use of human resources √Timely planning and implementation of care √Conducting case analysis √Effect on discharge process √Legal basis (Laws and regulations) 	Embolization risk may be prevented by ensuring earlier mobilization of the patient through the cooperation between the physician, nurse and physiotherapist following an orthopedics surgery.
COP 2.1	Care intended for the patient should be planned and entered into the patient's file.	<ul style="list-style-type: none"> √Management of time and human resources √Legal proof √Strengthening of multidisciplinary communication √Being fully aware of the patient's clinical sheet 	Planning the care of a patient, who prior to a heart surgery had maintained high blood pressure and had respiratory distress, against both post surgery complications and post anesthesia risks is the best kind of proof especially against legal procedures and serves as a significant indicator that the patient was assessed by a holistic approach.
COP 2.2	Persons authorized to carry out orders should enter such orders into a standard column in the patient's file.	<ul style="list-style-type: none"> √Easy monitoring √Time management 	The fact that orders regarding early nutrition, mobilization and general self care requirements are overseen at the same stage by all the disciplines in charge of the patient care following an abdominal surgery may help facilitate time planning in specific individual disciplinary practices in a more efficient manner.
COP 2.3	Procedures performed should be entered into the patient's file.	<ul style="list-style-type: none"> √Assessment convenience √Prevention of unnecessary repetitions of orders and implementations √Observance of their effect on the patient 	Scheduling the next implementation for a patient being kept in an intensive care unit, after having performed the initial implementation for planning the patient's care monitoring process, makes it easier for taking a common action and contributes to the time management for performing the implementations in a timely manner.
COP 2.4	The patients and their relatives should be informed about the care and treatment results including the unexpected results.	<ul style="list-style-type: none"> √Protection and being aware of the rights and obligations of the patients and their relatives √Legal proof √Respect to the patients' relatives √Clarifying the current condition of the patient 	<p>Example 1 – An important legal basis is established by informing the parents of a child patient, who is about to undergo a risky brain surgery, of the effects, side effects and possible future risks of the treatment prior to the child's surgery.</p> <p>Example 2 – Informing a bedridden patient of the procedures to be performed on him against the pressure wound development risk and recording such information both ensures that the risk will not come across as a problem and that the care coordination of the patient will be maintained.</p>

Procedures, Instructions and Forms that Meet the COP 2 Standard at AHG

All the procedures, instructions and forms that we use at AHG have been reviewed under the relevant standard headings.

6. Reviewing the Events Reported on the Media in Terms of the COP 2 Standard

Reports of Medical Errors in Turkish Media

In their study entitled "A retrospective review of medical practices" that was published on *Dirim Medical Journal* in 2009, Gül Ertem, Esra Öksel and Ayşe Akbıyık talk about the following general characteristics of the news coverage of medical malpractices. They have studied 18 newspapers and determined the following keywords while conducting their research: "erroneous medical practice", "doctor's fault", "nurse's fault", "wrong treatment", "erroneous medication practices", "erroneous surgical operation", "left permanently disabled". The time span of the newspapers they studied was between 01 January 2003 and 31 December 2007 and the sample of the study consists of 172 news articles.

United Nations Medical Malpractice Balance Sheet

(Sütlaş 2005)

250.000 in-patients die each year in the USA as a result of "medical malpractices".

In other words 250.000 people in the USA die each year when they would otherwise survive should they choose not to go to the hospital:

- 12.000 patients die because of "unnecessary surgical operations".
- 7.000 patients die because of "wrong medication treatment in the hospital".
- 31.000 patients die because of "other errors committed in the hospital".
- 80.000 patients die because of the "infections contracted during their stay in the hospital".
- 120.000 patients die because of the "side effects of the medication they are prescribed".

Effects of the Medical Malpractice on Healthcare System¹

We can identify the effects of medical malpractices in 4 dimensions; namely patients, patients' relatives, physicians and the healthcare system. When the financial aspect of medical malpractices is taken into account, one can observe such negative financial consequences as prolongation of treatments and stays in hospital, treatment of new injuries and complications and increase in medication expenses. Pecuniary damage is also coupled by non pecuniary damage on the part of the patient (Menachemi 2002). When 30.000 patient records were examined in 51 state hospitals in New York, the rate of medical malpractice was established as 3.7%.

Table 4. Procedures, Instructions and Forms that Meet the COP 2 Standard at AHG

JCI COP 2	Standard	Measurable Elements (ME)	Procedures, Instructions and Forms Meeting the Standard
COP 2	It should be a process intended for integrating and coordinating the care provided to the patients.	ME 1- The care plan should be integrated and coordinated among different areas, departments and services.	√Patient Care Plan Instruction
		ME 2- The care provided should be integrated and coordinated among different areas, departments and services.	√Patient Care Plan Instruction
		ME 3- The conclusions reached at the end of all kinds of care team meetings or the discussions of similar nature should be entered into the patient's file.	√Multidisciplinary Patient Care Plan Form √Nurse Monitoring Form √Physician Monitoring Form NOTE: There is no procedure or instruction that clearly states this criterion.
COP 2.1	Care intended for the patient should be planned and entered into the patient's file.	ME 1 - It should be planned by the physician, nurse or other healthcare professionals responsible for each and every patient's care within no later than 24 hours following the in-patient admission.	√Patient Assessment Procedure √Adult In-Patient Assessment and Examination Form √Child In-Patient Assessment and Examination Form √Newborn Assessment and Examination Form √Dietician Assessment and Monitoring Form for In-Patients √Physiotherapy Assessment and Consultation Form of In-Patients √Respiratory Physiotherapy Assessment and Monitoring Form
		ME 2- The planned care should be personalized and based on the initial assessment findings of the patient.	√Patient Care Plan Instruction √Patient Assessment Procedure
		ME 3- The planned care should be entered into the patient's file in the form of measurable development (goals).	√Patient Care Plan Instruction √Patient Care Plan Form
		ME 4- Expected development (goals) should be updated or revised in accordance with the clinicians' reassessment of the patients.	√Patient Care Plan Instruction √Multidisciplinary Patient Care Plan Form √Patient Assessment Procedure √Nurse Monitoring Form √Physician Monitoring Form √Dietician Assessment and Monitoring Form for In-Patients √Physiotherapy Assessment and Consultation Form of In-Patients √Respiratory Physiotherapy Assessment and Monitoring Form
		ME 5- Physician in charge should review and verify the care planned for each patient and take notes regarding such observations.	√Physician Monitoring Form NOTE: There is no procedure or instruction that clearly states this criterion.
		ME 6 – Care plan should be implemented	√Patient Care Plan Instruction √Patient Care Plan Form
		ME 7 - The care provided to a patient should be entered into the patient's file by the healthcare professional that has actually tended to the patient.	√Patient Care Plan Instruction √Patient Assessment Procedure √Multidisciplinary Patient Care Plan Form √Patient Care Monitoring Form √Physician Order and Medication Practice Form √Dietician Assessment and Monitoring Form for In-Patients √Physiotherapy Assessment and Consultation Form of In-Patients √Respiratory Physiotherapy Assessment and Monitoring Form

Of the said medical malpractices, 70% of them led to injuries for 6 months or less, 3% to permanent disablement and injuries, and around 14% to death (Brennan et al. 1991). The emotional aspect of medical malpractices involves a decrease in moral strength and motivation on the part of the healthcare personnel, lack of confidence in patients and physicians and a general dissatisfaction with the healthcare system in society (Kohn, Corrigan 2000). Kohn, Corrigan (2000), Leape (2000) and Weingart et al. (2000) talk about the difficulty of identifying medical malpractices. Reason behind this is the fact that the healthcare personnel shy away from reporting their medical malpractices and errors. Moreover, it is difficult for healthcare personnel to tell whether it is a medical malpractice or simply worsening of the patient's condition in the event of a negative situation. In this respect, VanGesst and Cummins (2003) United Nations National Patient Safety Foundation states that it is difficult to identify medical malpractices and thus a multidisciplinary cooperation is necessary to achieve this end.

When they studied the side effects of a wrong prescription in a research and training hospital, Classen et al. (1997) found that 2.4% of the stays in hospital actually resulted from wrong medication treatment. Consequently, this led to a major statistical increase in the number of stays in hospital, costs and mortalities. The link between the medical malpractices due to personnel insufficiency and patient safety is important (Mayo and Duncan, 2004). Rogers et al. (2004) establish that the ratio of medical malpractices committed by nurses working for 8 hours or less on daily basis is 1.6% while the ratio of medical malpractices committed by those who work for 12.5 hours is 6%. Moreover, in the study he conducted on the employees of two training and research hospitals at the United Nations, Carter (2004) list the reasons of medical malpractices as "workload of healthcare personnel", "overtime", "time pressure in administering treatment", "lack of a team leader", "lack of sufficient communication and cooperation among personnel".

Table 4. Procedures, Instructions and Forms that Meet the COP 2 Standard at AHG cont.

JCI COP 2		Measurable Elements (ME)	Procedures, Instructions and Forms Meeting the Standard
COP 2.2	Persons authorized to carry out orders should enter such orders into a standard column in the patient's file.	ME 1 - Orders should be issued in writing when necessary and in line with the corporate policies.	<ul style="list-style-type: none"> √Multidisciplinary Patient Care Plan Form √Patient Care Monitoring Form √Physician Order and Medication Practice Form √Dietician Assessment and Monitoring Form for In-Patients √Physiotherapy Assessment and Consultation Form of In-Patients √Respiratory Physiotherapy Assessment and Monitoring Form <p>NOTE: There is no procedure or instruction that clearly states this criterion.</p>
		ME 2- In diagnostic viewing and clinical laboratory testing orders, clinical indication/grounds should be specified when the situation calls for interpretation.	<ul style="list-style-type: none"> √Examination Order Forms (This section is available in all the current and printed publication forms for every section, except for electronic orders) <p>NOTE: There is no procedure or instruction that clearly states this criterion.</p>
		ME 3 - Only the authorized personnel should be able to write down the orders.	<ul style="list-style-type: none"> √Examination Order Forms √Patient Care Monitoring Form √Physician Order and Medication Practice Form √Dietician Assessment and Monitoring Form for In-Patients √Physiotherapy Assessment and Consultation Form of In-Patients √Respiratory Physiotherapy Assessment and Monitoring Form <p>NOTE: There is no procedure or instruction that clearly states this criterion.</p>
		ME 4- Orders should be entered into a standard column in the patient's file.	<ul style="list-style-type: none"> √Examination Order Forms √Physician Order and Medication Practice Form √Dietician Assessment and Monitoring Form for In-Patients √Physiotherapy Assessment and Consultation Form of In-Patients √Respiratory Physiotherapy Assessment and Monitoring Form <p>NOTE: There is no procedure or instruction that clearly states this criterion.</p>
COP 2.3	Procedures performed should be entered into the patient's file.	ME 1 - Procedures performed should be entered into the patient's file.	<ul style="list-style-type: none"> √Patient Care Monitoring Form √Nurse Monitoring Form √Physician Monitoring Form √Dietician Assessment and Monitoring Form for In-Patients √Physiotherapy Assessment and Consultation Form of In-Patients √Respiratory Physiotherapy Assessment and Monitoring Form
		ME 2 – The results of the procedures performed should be entered into the patient's file.	<ul style="list-style-type: none"> √Nurse Monitoring Form √Physician Monitoring Form √Dietician Assessment and Monitoring Form for In-Patients √Physiotherapy Assessment and Consultation Form of In-Patients √Respiratory Physiotherapy Assessment and Monitoring Form
COP 2.4	The patients and their relatives should be informed about the care and treatment results including the unexpected results.	ME 1- The patients and their relatives should be informed with respect to the results of their care and treatment.	<ul style="list-style-type: none"> √Training Procedure for Patients and their Relatives √Procedure for the Rights and Obligations of Patients and their Relatives √Training Form for Patients and their Relatives √Informed Consent Forms (All)
		ME 2 - The patients and their relatives should be informed of unexpected results regarding their care and treatment.	<ul style="list-style-type: none"> √Training Procedure for Patients and their Relatives √Procedure for the Rights and Obligations of Patients and their Relatives √Training Form for Patients and their Relatives √Informed Consent Forms (All)

Maxifield et al. (2005) suggest that the insufficient communication, cooperation and team work among the healthcare personnel constitute a significant reason for medical malpractices. In his study, Rizzo (2006) refers to the study conducted by Maxifield et al. and points out that 84% of the physicians and 62% of the nurses maintain a low level of communication between the healthcare personnel. Kohn, Carrigan (2000) suggest that the following are viable strategies in terms of minimizing medical malpractices: standardization and promotion of medical studies, improving the

communication between the physician and patient, physician and physician and physician and auxiliary healthcare personnel, patients' involvement in treatment decisions, prioritization of in service trainings with a view to improving the knowledge, skills and talents of the healthcare personnel, and consolidation of a team work culture. McNutt et al (2002) studies the sources of medical malpractices in 3 stages: ¹ Quoted from: Top M., Gider Ö., Taş Y., Çimen S. Hekimlerin Tıbbi Hatalara Neden Olan Faktörlere İlişkin Değerlendirmeleri: Kocaeli İlinde Bir Alan Çalışması. Hacettepe Sağlık İdaresi Dergisi

6. Reviewing the Events Reported on the Media in Terms of the COP 2 Standard

		Event	Published by	Published on	Related COP 2 Standard
2005	Wrong Surgical Operation	In the health care scandal that took place at Atatürk University Medicine Faculty in persons were reported to have been paralyzed of the wrong surgical operation they underwent their kyphosis condition. As a result of initiated by the patients in question, the court Erzurum Atatürk University should pay 2 million thousand Turkish Liras in compensation.	HÜRRİYET Sağlık-Yaşam eki	28 March 2013	COP 2.3
2012	Wrong Injection	Having been brought to a private hospital in Güngören due to high fever, Menşürnur Karayılan (8 y.o.) was reported to have been unable to walk as a result of the antifebrile shot injected to her left leg. The doctors in another hospital, where the child was taken to afterwards, stated that the condition developed as a result of a wrong injection and that the child faced the risk of becoming permanently disabled.	HABERTÜRK	19 December 2012	COP 2.1
2012	Prosthesis Implanted on the Wrong Leg	It was claimed that Hamide Çolakoğlu (79), who was originally admitted to the Okmeydanı Training and Research Hospital due to the complaints on left kneecap, had a prosthesis implanted on her wrong leg. Having fell on her left kneecap 7 years ago and carried on with her life with injections for a while, Çolakoğlu decided to undergo a surgery in November 2011 and she said that she specified it in the in-patient and appointment form she was given that it was her left leg.	SABAH	30 October 2012	COP 2.3
2013	Wrong Treatment	Having been born in İzmit Maternity Hospital in 2011, Yağmur was discharged from the hospital with clean bill of health only to be hospitalized three days later. Having been brought to the hospital with complaints of high fever, it was established that the baby had two holes on her heart and her left lung was not developing, as a result of which a hole was drilled into her throat whereby an aspiration catheter was inserted. The child was brought to the hospital with the same complaints eight months later where she was taken under treatment in Kocaeli University Pediatric Intensive Care Unit. She was taken out of intensive unit in 2012, but this time the aspiration hose inserted into her throat for taking culture sample caused internal bleeding in Yağmur's throat. When the bleeding could not be stopped, her parents sought help in other hospitals. Having her heart stopped for 20 minutes due to bleeding and failed to receive oxygen for an extended period of time, she sustained a major damage to her brain and nearly her entire body functions shut down. Her parents filed a claim for compensation against the hospital and doctors, which included 1 million pecuniary damages and 10 million for non pecuniary damages.	SABAH Haberleri Yaşam	3 June 2013	COP 2.1
2013	Wrong diagnosis	Another healthcare scandal took place in İzmir Ege University Hospital in January 2013. Having gone to the hospital 24 days after her surgery due to the complaints of chest pain, feeling of distress and discharge from sutures, Aygül Ünay reported that she got depressed when she was diagnosed with "Acute Lymphoblastic Leukemia". The figure reflected on the balance sheet as a result of such wrong diagnoses was a total "55 thousand liras" in compensation, consisting of non pecuniary damages (50 thousand) and pecuniary damages (5 thousand).	Haberler.com haberi	14 January 2013	COP 2.1

Table 1. Number of news articles published with respect to the medical malpractices between 2000 and 2007

Year	Number of News Articles	%
2000	2	1,2
2001	7	4,1
2002	6	3,5
2003	9	5,2
2004	30	17,4
2005	34	19,8
2006	31	18,0
2007	53	30,8

The number of news articles published on medical malpractices increased by 29.6% between the years 2000 and 2007.

Table 2. The person reported to be responsible for the malpractice according to the news articles

Personnel	Number	%
Doctor	112	2,3
Nurse	21	
Laboratory Worker	4	9,9
Doctor, nurse	17	5,2
Doctor, laboratory worker , hospital	9	3,5
Operating room team	6	1,7
Healthcare personnel	3	

While 65% of the medical malpractices reported on the media during the years between 2000 and 2007 stemmed from doctors' actions, 12% of them resulted from that of nurses'.

Table 3. The type of hospitals where medical malpractices occurred

Hospital type	Number	%
Unidentified	22	38,4
Private hospital	66	31,0
Public hospital	55	16,9
University hospital	29	8,1

Of the malpractices reported on the media between the years 2000 and 2007, 38% of them occurred in private hospitals and %32 in public hospitals.

Table 4. The clinics where medical malpractices occurred

Unit	Number	%
Unidentified	14	43,6
Operating room (anesthesia)	10	0,6
Operating room (surgical)	75	11,0
Internal Diseases	1	6,4
Pediatric	19	1,2
Emergency	11	5,8
Dermatology	2	
Orthopaedics	10	13,4
Gynecology	23	2,9
Laboratory	5	
Cardiology	1	0,6
Eye	1	0,6

Of the medical practices reported on the media between the years 2000 and 2007, 44% of them occurred in the surgical field. According to the literature, majority of the medical malpractices (26%) occur in the Gynecology department (Akşam 2011). The gynecology medical malpractice rate is estimated as 13% in the table above.

Table 5. Recorded types of medical malpractice

Type of malpractice	Number	%
Medication error	15	17,4
Wrong diagnosis	18	11,6
Wrong treatment (pharmacological)	30	
Lack of attention	20	8,7
Negligence	15	19,2
Imprudence	33	4,1
Erroneous laboratory results	7	19,8
Erroneous surgical operation	34	10,5

Of the medical malpractices reported on the media between the years 2000 and 2007, 20% of them were identified as erroneous surgical operations, 19% of them as imprudence.

Table 6. Reason behind malpractice

Reason of error	Number	%
Unidentified	18	3,5
Extreme exhaustion, fatigue	6	16,9
Lack of attention, imprudence	29	62,1
Lack of expertise, being new in the practice	107	7,0
Negligence	12	4,1

Of the medical malpractices reported on the media between the years 2000 and 2007, 62% of them resulted from lack of expertise and being new in the practice, 17% from lack of attention/imprudence.

Table 7. Patient's condition after medical malpractice

Latest condition of the patient	Number	%
Unidentified	7	49,4
Deceased	85	31,4
Permanently Disabled	54	1,7
Taken ill (infectious)	3	13,4
Taken ill (worsening of general condition)	23	4,1

As a result of the medical practices reported on the media between the years 2000 and 2007, 49% of the patients lost their lives, 31% of them remained permanently disabled.

Table 8. Sanction on the person responsible for malpractice

Sanction type	Number	%
Unidentified	7	
Submitted to the court	117	2,3
Jail sentence	4	1,2
Disqualification	2	0,6
Suspension of promotion	1	23,8
Compensation penalty	41	34,3

Of the medical malpractices reported on the media between the years 2000 and 2007, 68% of the persons responsible for malpractice were subject lawsuits while 24% of them were awarded compensation penalty.

- The fact that only the 40% of the patient files that have been examined included the existing symptoms noted by the emergency physician
- The fact that the diet orders of only 30% of the diabetic patients have been arranged in accordance with their diet routines and requirements
- The fact that only the 70% of the open and closed patient file that have been examined contained written physician care plan orders and it was established that no care plan was arranged by the physician in some cases.

When all these findings are taken into account, it is clear that a joint cooperation of physicians and nurses is essential in the integration and coordination process of the care being provided to the patient. The fact that the care plan varies from patient to patient, arrangement of special care plans for patients and creation of such patient care plans not only by nurses but also by physicians will ensure the sustainability of the care being provided. Moreover, informing patients and their relatives of the medical procedures about to be implemented by way of informed consent forms is highly important in terms of ensuring that the healthcare professional are being protected before the law.

When the domestic and foreign literature regarding this matter for the last 5 years (2008-2013) is searched through the keywords including "care", "patient care", "patient care standard", "care plan", "assessment of patients", "assessment of nurses", "training of patients and their relatives", "nursing records", "care records", one can come across the following table: Human factor (fatigue, insufficient training, lack of communication, lack of time, wrong decisions etc.) Corporate factors (workplace structure, policies, administrative/financial structure, leadership, feedback, misstaffing etc.). Technical factors (insufficient automation, insufficient devices, missing devices, lack of support in decision making)

According to the Eurobarometer studies entitled "Special Eurobarometer No: 241" conducted by the European Commission, 18% of the EU citizens reported that either they or one of their family members were subject to a medical malpractice incident, and 11% of them reported that they were subject to a medical malpractice incident due to a pharmaceutical that was not prescribed by the physician, while the ratio of being subject to medical malpractice in Turkey, according to the same study, was established as 14% and the ratio of being subject to medical malpractice due to medication not prescribed by the physician as 10% (European Commission 2006). According to the study conducted by Ertem et al (2009) 65.2% of the medical malpractices are committed by physicians, while 12.2% of them are committed by nurses.

Patient Deaths

The article published in Medimagazin on 3 June 2013 informs that, with the amendment of the Civil Servants Law, the doctors who cause the disability or death of the patients in their care will be temporarily disqualified from the practice. According to this legal arrangement, if the physicians are found to have caused a slight injury to their patient by violating their job descriptions or neglecting or delaying their job requirements while performing their duties, they will be temporarily disqualified from the practice for a period from 3 months to 1 year, and if they repeat the same actions within the next 5 years the penalties they will face will be doubled. The doctors who cause sever disability or death of their patients will be temporarily disqualified from the practice for a period from 1 year to 3 years, and if they repeat the same actions within the next 5 years they will be permanently disqualified (Süzer, 2013).

Conclusion

AHG has run into problems with some of the processes of the COP 2 throughout the JCI inspection. The problems encountered are listed as follows:

- Inability to monitor standard care in the post-anesthesia room
- Unavailability of consent forms created against complications and risks for surgical and medical areas
- The fact that the conclusions of the multidisciplinary chemotherapy committee meetings set up for oncology patients were not recorded
- The fact that the blue code notification form was not filled out accurately, and the patient care plan was not created in an individual specific manner
- The fact 90% of the nurses in emergency and endoscopy units started intravenous infusion without receiving orders from physicians
- The fact there were no records in the patient's file as to the removal of a catheter by an anesthesiologist from a patient to whom an epidural catheter has been originally inserted for analgesia
- Lack of individual nurse and physician plans in the 5 open files that have been examined, and the fact that only 60% of the open and closed patient files contained individual stories and physiological system evaluation

REFERENCES

- Ege Postası. Yanlış Teşhis İçin, Hastaneden 55 Bin Lira Tazminat İstiyor. Ege Postası İzmir. <http://www.egepostasi.com/izmir/yanlis-teshis-icin-hastaneden-55-bin-lira-tazminat-istiyor-h6810.html> (Erişim tarihi: 18 Haziran 2013).
- Ertem, G., Oksel, E., Akbıyık, A. Hatalı Tıbbi Uygulamalar(Malpraktis) ile İlgili Retrospektif Bir İnceleme. <http://www.frik.com.tr/TUR/Dirim/pdf/2009/osm/konu1.pdf> (Erişim tarihi: 18 Haziran 2013).
- European Commission. Special Eurobarometer- Medical Errors. http://ec.europa.eu/public_opinion/archives/ebs/ebs_241_en.pdf (Erişim tarihi: 18 Haziran 2013).
- Habertürk. Yanlış İğne Sakat Bıraktı İddiası. Habertürk Sağlık. <http://www.haberturk.com/saglik/haber/804863-yanlis-igne-sakat-birakti-iddiasi> (Erişim tarihi: 18 Haziran 2013).
- Hürriyet. Yanlış Ameliyata Büyük Ceza. Hürriyet Sağlık-Yaşam. <http://www.hurriyet.com.tr/saglik/22912173.asp> (Erişim tarihi: 18 Haziran 2013).
- Joint Commission International. Accredited Organization Resource Center. <https://www.jointcommissioninternational.org/Resources/> (Erişim tarihi: 18 Haziran 2013).
- Sabah. Yanlış Bacağa Protez Takıldı İddiası. Sabah Yaşam. <http://www.sabah.com.tr/Yasam/2012/10/30/yanlis-bacaga-protez-takildi-iddiasi> (Erişim tarihi: 18 Haziran 2013).
- Sabah. Yanlış Tedavi Mağduru Yağmur Artık Gülmüyor. Sabah Yaşam. <http://www.sabah.com.tr/Yasam/2013/06/03/yanlis-tedavi-magduru-yagmur-artik-gulmuyor> (Erişim tarihi: 18 Haziran 2013).
- Sütlaş M. Tıbbi Yanlış Uygulama(Mal Praktis) Ve Mesleki Mesuliyet(Sorumluluk) Sigortası Üzerine Bazı Saptamalar. <http://www.saglikhakki.org/kotuyg-sig.htm> (Erişim tarihi: 18 Haziran 2013).
- Süzer E. Hastanın Ölümüne Sebep Olan Doktora Ağır Ceza. Bugün Gazetesi. <http://www.medimagazin.com.tr/hekim/hukuk-etik/tr-hasta-olduren-doktora-agir-ceza-2-17-51551.html> (Erişim tarihi: 18 Haziran 2013).

- Top M., Gider Ö., Taş Y. and Çimen S. Hekimlerin Tıbbi Hatalara Neden Olan Faktörlere İlişkin Değerlendirmeleri: Kocaeli İlinden Bir Alan Çalışması. Hacettepe Sağlık İdaresi Dergisi. [http://www .sid.hacettepe.edu.tr/Makale/112/2.pdf](http://www.sid.hacettepe.edu.tr/Makale/112/2.pdf) (Erişim tarihi: 18 Haziran 2013).
- Yılmaz M. En Çok Tıbbi Hata Kadın Doğumda. <http://www.aksam.com.tr/yasam/saglik/en-cok-tibbi-hata-kadin-dogumda--16357h/haber-16357> (Erişim tarihi: 18 Haziran 2013).
