

Transforming patient Health Care at the Bedside



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Hospital Nacional de Pediatría J.P. Garrahan(510 beds)
120 Intensive Care beds (NICU, PICU and Transplant Units)
290 Inpatient Care beds
30 Emergency beds
70 Day Hospital beds

Introduction

Improving patient safety requires a transformation in how we currently care for patients. Not only healthcare organizations must adopt a new paradigm of care that holds patient safety as a core value and practice, also healthcare personnel has to change their beliefs and knowledge regarding this topic. To be able to learn from errors it is important to consider all adverse events, including those that do not cause patient injury. Medication errors are an important problem in pediatrics and effective strategies for preventing them are needed. In the process of medication, nursing work has a critical and direct impact on patient safety. The administration has almost no barriers to avoid harm. Experts in risk management explain system failures and system-driven errors over direct human error and accentuate the crucial role that organizational systematization has in ensuring safety.

At our institution, during 2005-2006, we have conducted a survey of global safety climate and culture. Based on these results we design a program specially oriented towards training nurses and young pediatric doctors in this area.

The aim of our project is training on patient safety issues. Preventable adverse events and near misses can only be found if they are sought out.

Safety Culture Improves Healthcare



Methods

Over a 2-year period we plan to train the whole nurse and pediatric residents staff who primarily work with hospitalized patients. The core skills pediatric workshop is divided into 2 modules focused on situations of risk teamwork, potential adverse events, medication related errors and decision-making.

The goal is to get ability and skills to improve patient safety based on experienced personnel. Quantitative and qualitative measures of the efficiency of training will be applied

Conclusion

After the pilot study was ended we concluded: a) We have a lack of adherence to the workshop, and b) the rate of Post-test correct answers was less than expected. For the future we plan to promote more participation and improve the learning situations to increase performance. We are also working on redesigning our evaluation tools, extending the questionnaires and conduct a survey of events adverse detection

Discussion

No single method can be universally applied to avoid errors in practice. Medical knowledge and technology are expanding at an incredible rate, making it difficult for the healthcare providers to keep pace with advancing knowledge. Hospitals and other health-care providers today are being pressed more than ever to use technologies for reducing medical errors. The implementation of these strategies have a limited success not only by the economic costs but also because even in the best case scenario errors are sometimes inevitable. Simplification and standardization are desirable design principles, since they can significantly contribute to the prevention of adverse events. We hypothesize that the knowledge skills learned during this program spill over into emergencies practice. Out of this course, we hope to be able to propose an institutional auditing of patient safety by design rules and procedures within the hospital. We envision coping with adverse event on the healthcare process. **We designed a plan focus in work on environment and integration of information, improving professional knowledge.**

Pilot study

We conducted 2 workshops
53 voluntary participants
(33 nurses; 17 pediatric residents and 3 technicians & pharmacists)

Anonymous Multiple choice Pre-test & Post-test (6 questions each)

Module 1:

Introduction on safety patient.
Medication process.
Taxonomy.
Use of potential harm drugs.

Module 2:

Review
Based case simulation. (potential risky situation)
Root-cause analysis.
Conclusion to improve quality and safety.

Preliminary results

Qualitative analysis

Participants demonstrated genuine interest on the program.

Nurses are eager to be involved in patient safety.

Residents have a protected environment where to share practical experiences.

Increase ability on adverse events detection (post questionnaire).

Quantitative analysis

57% of participants responded both questionnaires.
22% improve in post-test correct answers.