KICK-OFF MEETING

for hospital and ward managers

MAP4E 16/1/KA202/23016
The project has been supported by the European Commission.

M1-KICK-OFF MEETING

Hospital manager and Ward managers

AGENDA

- brief presentation of the project MAP4E
- brief summary on the basics of patient safety (Introduction to patient safety)
- why a project about handover?
- description of the local training program
- benefits
- surveys before the trainings

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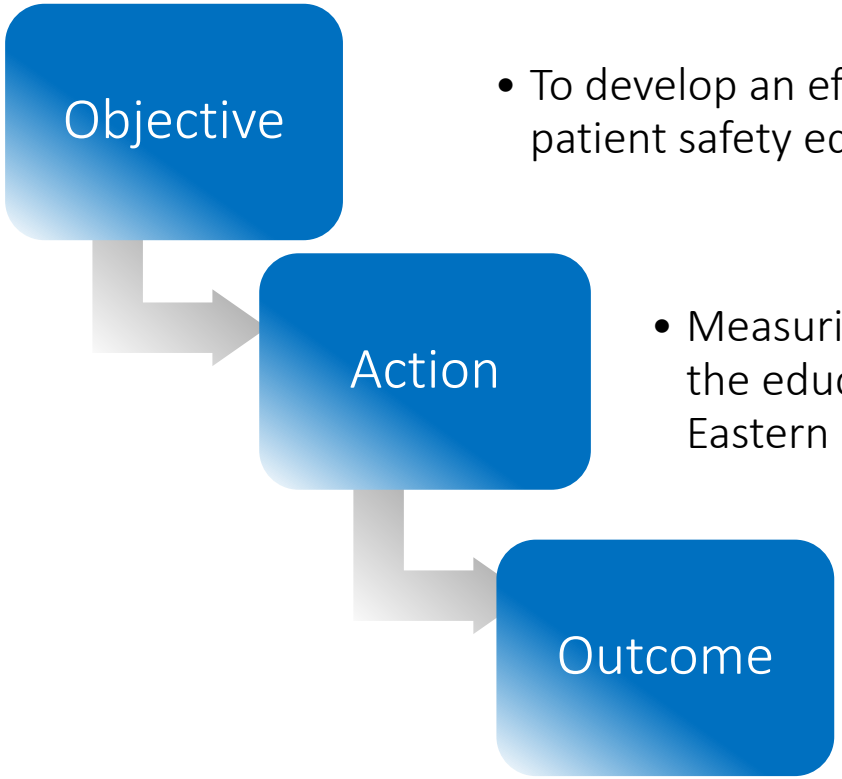
Brief presentation of MAP4E

Principles of MAP4E project

Funded by Eramus + KA2- Cooperation for Innovation and the Exchange of Good Practices . Strategic Partnerships for vocational education and training.



- To develop an effective methodology for patient safety education
- Measuring the effectiveness of the educational methodology in Eastern European institutions
- Recommendation on effective patient safety educational methodology including a minimum curriculum for teaching programs in Europe

MAP4E partners

Hungary (HU) –

Project leader; drafting recommendation on teaching material; developing, testing and evaluating educational methodology; composing final recommendations.

Poland (PL)–

Participation in developing and testing educational methodology; participation in evaluating results and composing final recommendations.

Spain (ES) –

Providing professional input based on best practices and experiences in patient safety; guidance on developing educational methodology; participation in evaluating results and composing final recommendations.

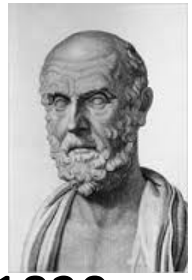
Basic on Patient Safety

Quality of care dimensions

Patient safety background

- Code of Hammurabi (-1760?):

Medical liability



- Hipócrates (-460):

"Primum non nocere"

- Florenece Nightingale (1820-1910):

Measures of prevention

- Phillipp Semmelweis (1818-1865):

Hand hygiene

- Ernest Codman (1869-1940):
  Registration of errors

- Beecher and Todd (1954)

Deaths associated with anesthesia and surgery (Ann Surg; 1954)

- Anesthesia Patient Safety Foundation (1985)

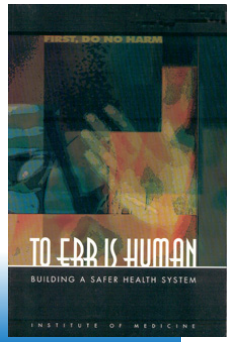
"Patient safety"

- Brennan et al: (1991)

Incidence of AE and negligence in hospitals (NEJ, 1991)

- IOM (1999):

To err is human



- System errors
- Patient safety has to be a priority
- Culture of safety

From a simple and ineffective medicine …

…to another much more effective and complex

Patient safety. What are we talking about ?

- *"the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. An acceptable minimum refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment"* (WHO, ICPS, 2009)

- "the prevention of harm to patients." (IOM)

- *"the reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes"*. (Canadian Patient Safety Dictionary)

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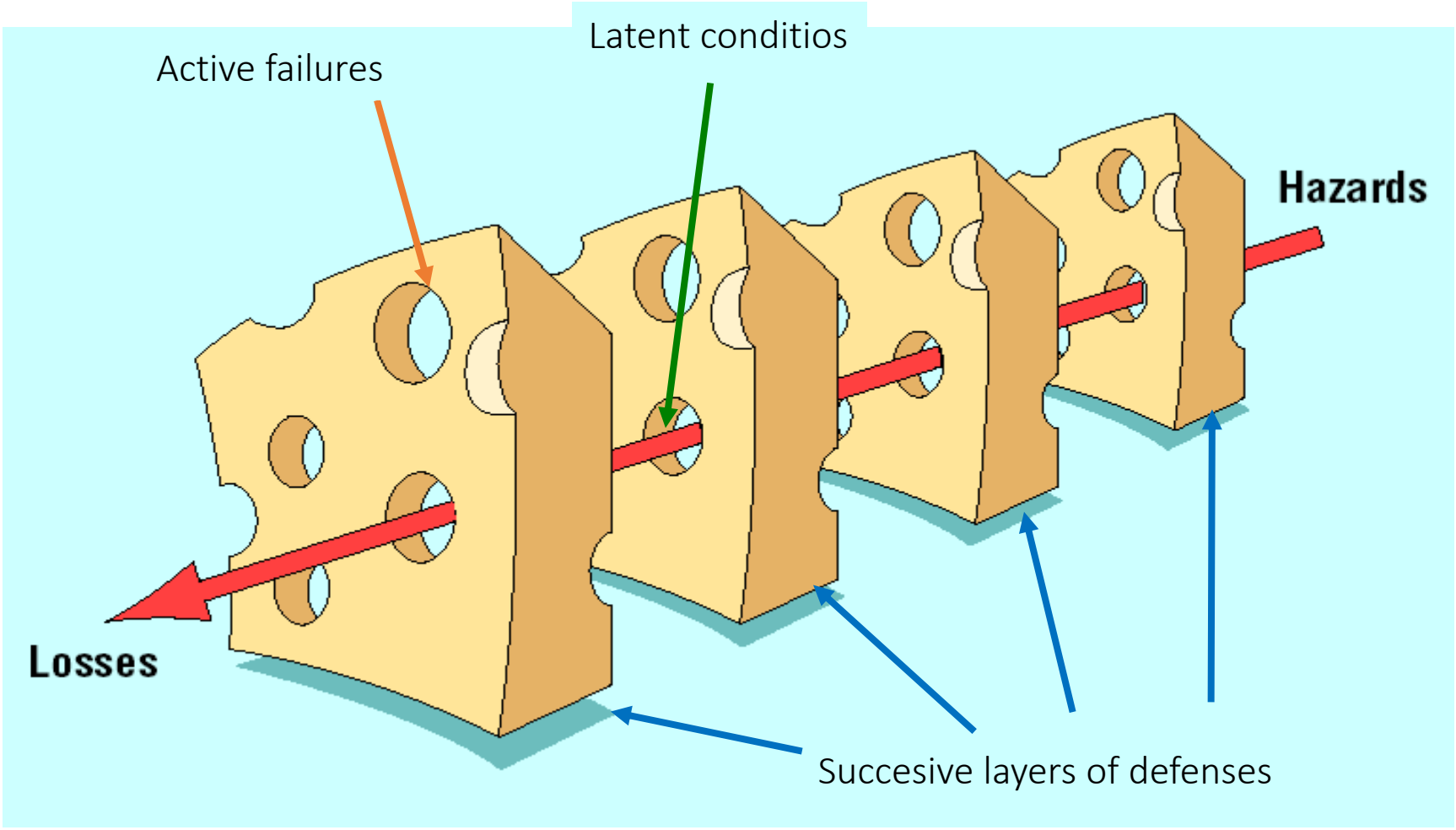
Human beings make mistakes because the systems, tasks and processes they work in are poorly designed

Lucian Leape. Harvard School of Public Health

Reason´s Swiss Cheese Model



Source: Reason J. Human error: models and management. BMJ. 2000;320:768–70.
doi: 10.1136/bmj.320.7237.768.

What patient safety means?

S ense that clinical errors exist

A ctions to prevent them

F ollow the evidence to control them

E nquire into adverse events

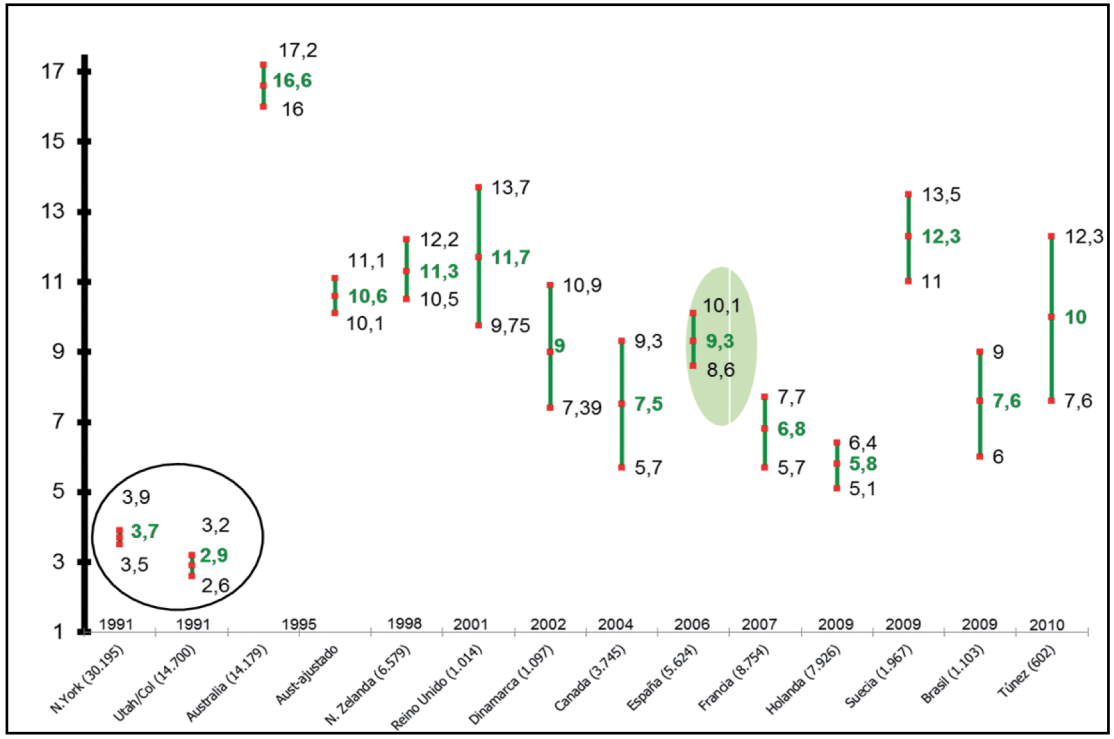
T ake appropriate improvement measures

Y our responsibility

Patient Safety levels

* National Health System

Frequency of adverse events in hospitals: 9,2% (IC95%: 4,6-12,4%)



Source: National Patient Safety Estrategy from the Spanish´s National Health System 2015-2020. MSSSI, 2015

Error management

The incidence and nature of in-hospital adverse events: a systematic review

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ABSTRACT

Introduction: Adverse events in hospitals constitute a serious problem with grave consequences. Many studies have been conducted to gain an insight into this problem, but a general overview of the data is lacking. We performed a systematic review of the literature on in-hospital adverse events.

Methods: A formal search of Embase, Cochrane and Medline was performed. Studies were reviewed independently for methodology, inclusion and exclusion criteria and endpoints. Primary endpoints were incidence of in-hospital adverse events and percentage of preventability. Secondary endpoints were adverse event outcome and subdivision by provider of care, location and type of event.

Results: Eight studies including a total of 74 485 patient records were selected. The median overall incidence of in-hospital adverse events was 9.2%, with a median percentage of preventability of 43.5%. More than half (56.3%) of patients experienced no or minor disability, whereas 7.4% of events were lethal. Operation- (89.6%) and medication-related (15.1%) events constituted the majority. We present a summary of evidence-based interventions aimed at these categories of events.

Conclusions: Adverse events during hospital admission affect nearly one out of 10 patients. A substantial part of these events are preventable. Since a large proportion of the in-hospital events are operation- or drug-related, interventions aimed at preventing these events have the potential to make a substantial difference.

Adverse events (AEs) in hospitals are now widely agreed to be a serious problem, annually killing more people than breast cancer or AIDS.[1] An AE is usually defined as an unintended injury or complication resulting in prolonged hospital stay, disability at the time of discharge or death and caused by healthcare management rather than by the patient's underlying disease process.[2 3] Aside from the direct harm to the patient, AEs are a considerable financial burden to the healthcare system. In 1999, it was estimated that the total costs of preventable AEs in the USA lie between $17 billion and $29 billion annually.[4]

In recent years, the focus in thinking about AEs has shifted from the person approach—blaming individuals for errors—to the systems approach. The systems approach assumes that people will make mistakes, and that the system that surrounds them should provide a safety net for these mistakes. Therefore, efforts to eliminate AEs should be directed towards a particular system.[5] This new approach has shifted the focus of the debate on AEs from the legal consequences associated with personal responsibility, to a more constructive point of view, clearing the way for thinking about solutions.

In the aftermath of the 2001 Institute of Medicine report "To err is human,"[1] many large studies have been performed concerning AEs, some of them nationwide. Although many of these studies used similar methods, they report substantially different incidences. A general overview of data on in-hospital AEs is lacking.

To make the important step towards solutions, it is necessary to gain a more detailed understanding of this problem: what percentage of events is preventable, where do the majority of events happen and which type of event is the most frequent? This will enable identification of categories of AEs that are most susceptible to interventions to improve patient safety.

To gain an insight into the overall incidence, preventability, outcome and subdivision by location, provider and type of in-hospital AEs and the evidence related to relevant patient safety interventions, we conducted a systematic review of available data from the literature.

METHODS

Literature search

Two authors (ENV, MAB) independently performed a formal computerised search of the medical databases Medline (January 1966 to February 2007), Cochrane and Embase (January 1980 to February 2007). Keywords used were "adverse events" and "preventable." Clinical studies published in peer-reviewed journals in the English language were identified. A manual cross-reference search of the eligible papers was performed to identify additional relevant articles.

Selection

In order to be able to reliably compare the data, we defined an AE as follows: an unintended injury or complication resulting in prolonged hospital stay, disability at the time of discharge or death and caused by healthcare management rather than by the patient's underlying disease process. All studies that used this or a similar definition to evaluate the incidence of AEs in adult hospital patients and that included a minimum of 1000 patient records were eligible for inclusion. Studies that evaluated errors without linking them to outcomes and studies relying only on computerised screening data were excluded. Studies that evaluated specific types of AEs only (for example, adverse drug events only) and studies that evaluated specific populations (for example, ICU patients only) were excluded. No abstract publications without subsequent full-text

UNLOCKED

Qual Saf Health Care 2008;17:216–223. doi:10.1136/qshc.2007.023622

De Vries EN et al. The incidence and nature of in-hospital adverse events: a systematic review.Quality & Safety in Health Care. 2008;17(3):216-223.

Learning form other high risk industries

Human factors and patient safety behaviours

- Leadership
- Team working
- Effective communication
- Shared awareness
- Standardizing procedures
- Learning: simulation

World Health Organization

WHO Patient Safety Program

2005-2006:
Clean care is safer care

2008:
Safe surgery safe lives

2017:
Medication without harm

2010:
Antimicrobial resistance

Actions

- Patient for patient safety
- Reporting & learning system
- Patient safety solution
- High 5´s
- Research
- Education and training
- Knowledege & managemen

http://www.who.int/patientsafety/

Good practices recommended

AHRQ Evidence for PSP (2013)	NQF PSP for better healthcare (2010)	JC National PS goals (2014)	WHO Nine patient safety solutions (2007)
HAIs	HAIs	HAIs	HAIs
•Hand hygiene	•Hand hygiene	•Hand hygiene	•Hand hygiene
•CLABSI, VAP	•CLABSI, CAUTI, VAP	•CLABSI, CAUTI	
•CAUTI	•SSI, MDRO	•SSI	
MEDICATION	•MEDICATION	MEDICATION	MEDICATION
•High risk medications	•High risk medications	•Medication reconciliation	•High risk medications
•Medication reconciliation			•Medication reconciliation
•NO dangerous abbreviations			•"Look alike, sounds alike"
SURGERY	SURGERY	SURGERY	SURGERY
OTHER	OTHER	OTHER	OTHER
•PU, Falls, Patient safety culture	•PU, Falls		
	•Culture		•Patient Identification
•Handover	•Handover	•Patient Identification •Handover	•Handover

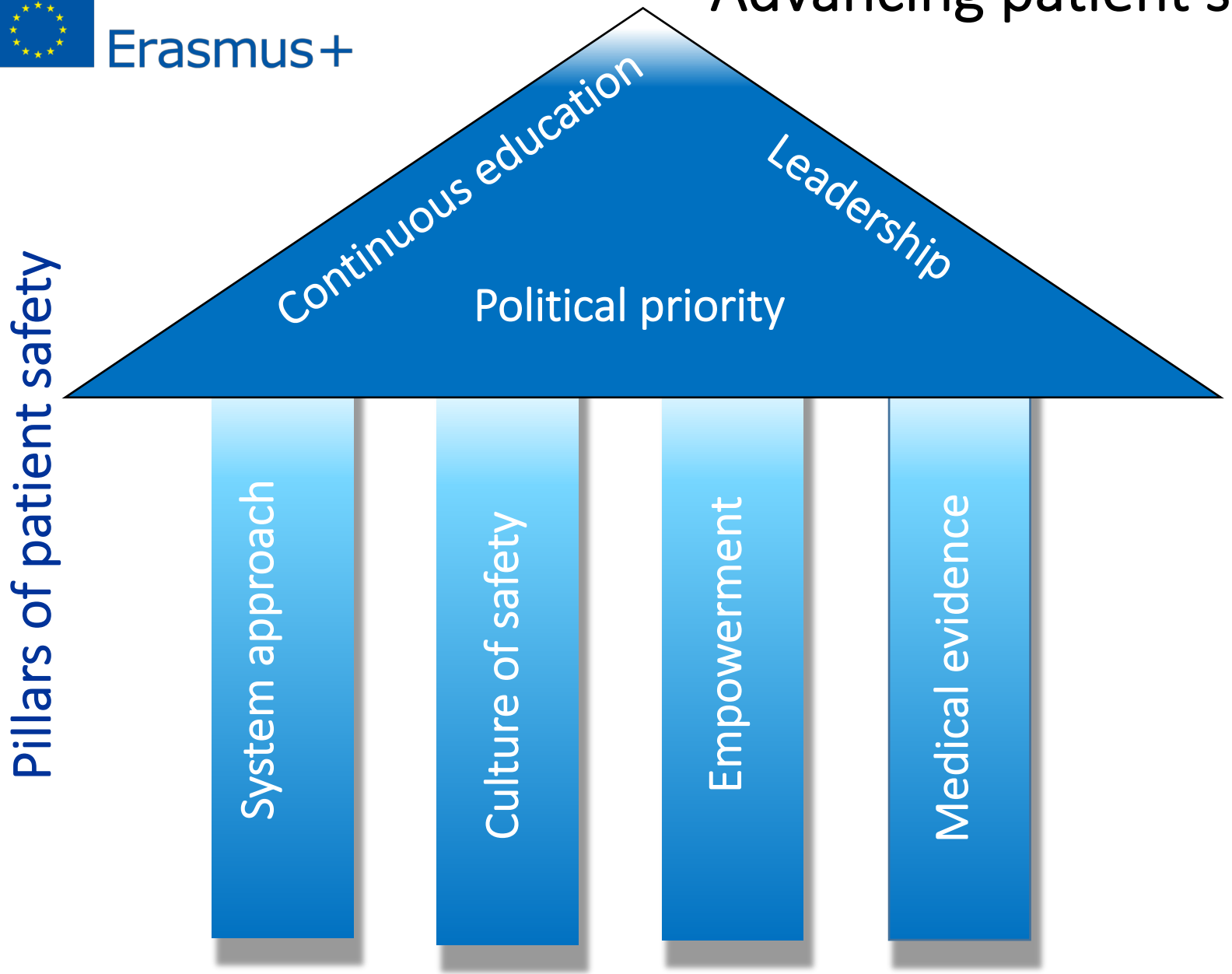
Emerging threats for patient safety

Watch out!

- Increase in multimorbidity: complex cases
- Increasingly complex care: multidisciplinary teams
- Budget constraints
- Antimicrobial resistance: to do ‘more with less’

Adapted form: Patient Safety 2030. NHS. 2015

Advancing patient safety



Adapted from: Patient Safety 2030. NHS. 2015

Why a project about handover

Severe adverse events: background

- communication errors are found very often
- most of them are connected to handover processes
- It is the basis for transferring care of patients across shifts and across care settings
- critical for maintaining continuity and safety of patient care
- inadequate practice of handover can lead to unnecessary readmissions, medication errors, diagnostic follow-up errors and physically harms
- significant extra costs for the hospitals

Handover
What are we talking about?

- "..the process of passing patient-specific information from one caregiver to another, from one team of caregivers to the next, or from caregiver to the patient and family for the purpose of ensuring patient care continuity and safety." WHO

- The transfer of information (along with authority and responsibility) during transitions in care; to include an opportunity to ask questions, clarify, and confirm (AHRQ-TeamSTEPPS)

- 'the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.' (Australian Medical Association in their 'Safe Handover: Safe Patients' guideline . AMA, 2006)

Communication Challenges

- Language barrier
- Distractions
- Physical proximity
- Personalities
- Workload
- Varying communication styles
- Conflict
- Lack of information verification
- Shift change

Adapted from AHRQ-TeamSTEPPS

Handover (or Hand-off)

Where patient care handover occurs?

Admission in primary care

Physician sign-out to a covering physician

Nursing change of shift

Transfer between units or facilities

Discharge of the patient back home/other facility

Across the continuum of care

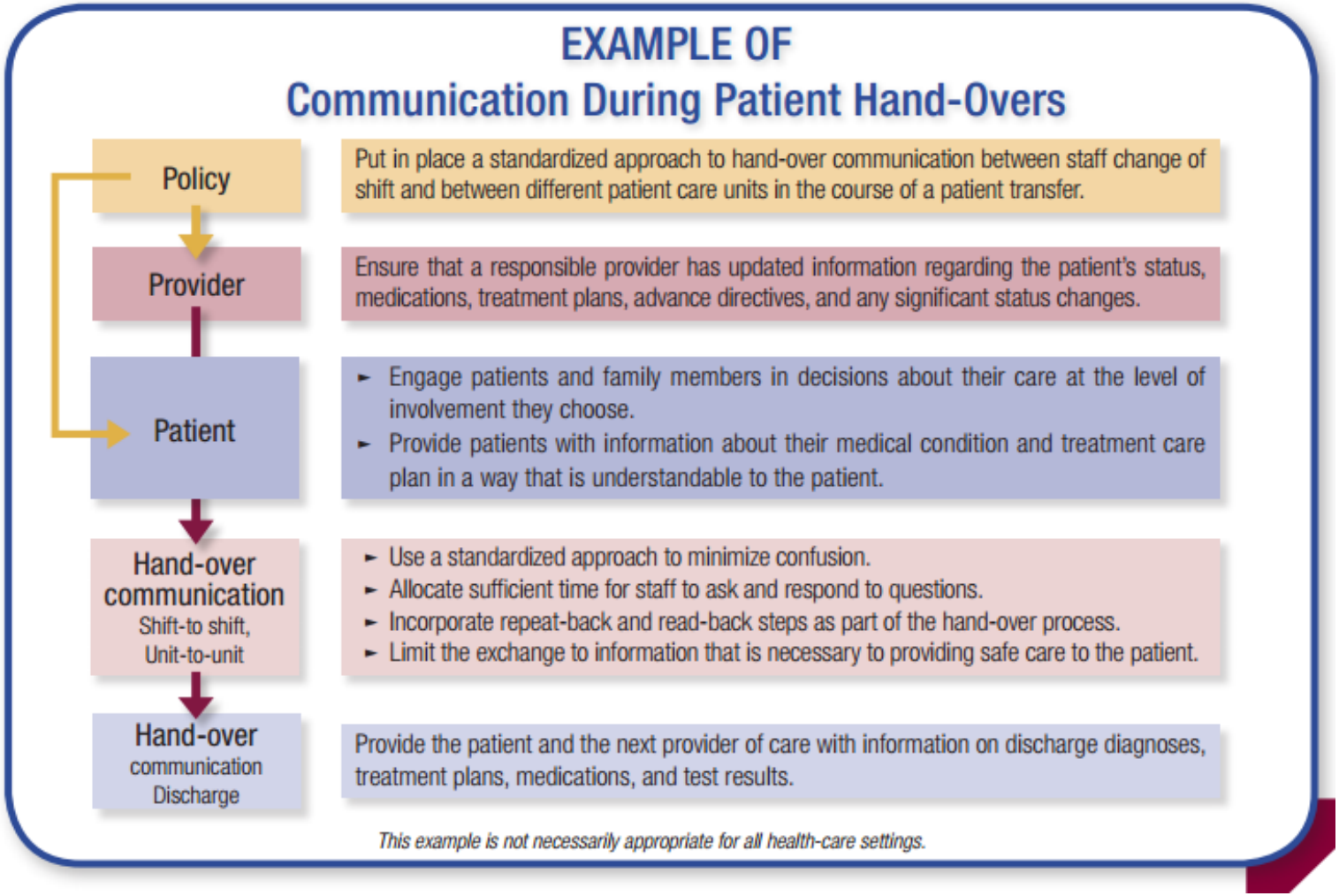
Identifiable risks in Handover

- Breakdown in communication
- Frequency of interruptions
- Lack of space
- Time constraints
- Handover during the weekend
- Incomplete or omitted information
- Irrelevant information and repetition
- Speculation
- Non-compliance

Handover Communication

- The information needs to be provided in a prioritized, clear, concise and chronological manner.
- Information should contain
  - patient care plan,
  - treatment,
  - current condition and a
  - any recent or anticipated changes.

Components that make a good Handover



Source: *WHO (2007) Communication during patient handovers*

Local training program

- Target population: choosing the Wards to participate in the training
- Duration of the training program
- Organization of the training program at the hospital

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Benefits

Benefits

For the professionals and the organization:

- to take part in an international project
- a participation certificate from the Semmelweis University
- to improve the handover processes of the hospital
- to publish their results, and good-practices they have worked out.

For the coordination:

- to collaborate with the Semmelweis University in a research project including participation certificate

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Surveys before the trainings

Survey on Patient Safety Climate

- The MAP4E survey is based on AHRQ Hospital Survey on Patient Safety Culture
- Description of the survey
- Results feed-back to the Hospital board and Hospital coordinator

Survey on handover safety

- Description of the survey developed by MAP4E handover project
- Results feed-back to the Hospital board and Hospital coordinator

Questions?

MAP4E 16/1/KA202/23016
The project has been supported by the European Commission.