PATIENT SAFETY

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- The simplest definition of patient safety is the prevention of errors and adverse effects to patients associated with health care.
- But in fact, patient safety is a discipline as old as medicine itself.

- Millennia ago, Hippocrates recognized the potential for injuries that arise from the well intentioned actions of healers. Greek healers in the 4th Century B.C., drafted the Hippocratic Oath and pledged to "prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.“
- Since then, the directive *primum non nocere* (“first do no harm) has become a central tenet for contemporary medicine.
- The citizens of the historical Republic of Dubrovnik were the first to open a lazaret (quarantine) where sailors had to spend a certain amount of time before disembarking into Dubrovnik.

- Ignaz Semmelweis (1847.) discovered the sources of sepsis
- Marx von Pettenkofer, who achieved great success in the areas of hygiene and public health during times of cholera epidemic
- Florence Nightingale who established the first school for nurses and which gave priority to hygiene

- In the United States, the full magnitude and impact of errors in health care was not appreciated until the 1990s, when several reports brought attention to this issue.[In 1999, the Institute of Medicine (IOM) of the National Academy of Sciences released a report, *To Err is Human: Building a Safer Health System*

- After this, most countries of Western Europe and Australia begin developing patient safety, under the guidance of principles of the aircraft and oil industries.
- At first only patient safety in hospitals was talked about, until only in recent times patient safety in primary healthcare became an important topic.
- And so WHO developed a series of tools and manuals for patient safety in hospitals, while WHO begins to collect experts from the area of patient safety in primary health care only in 2012.

- The largest project in Europe on patient safety was started by prof. Aneez with colleagues from Poland, Germany, Austria, the Netherlands – Linneaus – Learning from international Networks about Errors and Understanding Safety in Primary Care. The project “Towards safer rural practice” was developed as part of this larger project.

The EURIPA/EQuiP Strategy

- Understand the problem
- Engage with partners
  - EURIPA, EQuiP& LINNEAUS EURO-PC
- Literature review
- Planning meeting
- Developing tools
  - Patient Safety Culture Tool (Developed from MaPSaF)
  - Patient involvement tool
  - Education tool
- Translate the tools & choose pilot countries
- Disseminate &Evaluate

Rural Patient Safety Literature Review

- Under developed research area – especially rural context
- Lack of evidence from many countries in Europe
- Research from USA, Australia and UK dominated findings
- **Treat findings with caution**
- **Each local area will be different**

Corbett 2012

Types of errors

1. Errors in prescribing medication.
2. Errors in getting the right laboratory tests done for the right patient at the right time.
3. Errors related to filing systems.
4. Errors in dispensing medications.
5. Errors in responding to abnormal laboratory test results

Classification of process errors in primary care

- **Clinician factors**
  - Clinical judgment
  - Procedural skills error
- Communication factors
  - Clinician–patient
  - Clinician–clinician or health care system personnel
- Administration factors
  - Clinician
  - Pharmacy Ancillary providers (physical therapy, occupational therapy, etc)
  - Office setting
- Blunt end factors
  - Personal and family issues of clinicians and staff
  - Insurance company regulations
  - Government regulations
  - Funding and employers
  - Physical size and location of practice
  - General health care system

Classification of preventable adverse events in primary care

- Diagnosis
  - Related to symptoms
    - Misdiagnosis
    - Missed diagnosis
    - Delayed diagnosis
  - Related to prevention
    - Misdiagnosis
      - Missed diagnosis
      - Delayed diagnosis
- Treatment
  - Drug Incorrect
  - Incorrect dose
  - Delayed administration
  - Omitted administration
- Preventive services
  - Inappropriate
  - Delayed
  - Omitted
  - Procedural complication

SIGURNOST PACIJENATA

SUSTAV ZA ELEKTRONSKU PRIJAVU GREŠKE

- Naslovnica
- O projektu
- Registracija
- Česta pitanja
- Pravne napomene

- Prijava
- **Počni izvještaj !**
- Kontakt

Naslovnica

Dobrodošli na portal www.kohom-siguranpacijent.org predviđen za anonimnu elektronsku prijavu liječničke pogreške. Portal je namijenjen liječnicima primarne zdravstvene zaštite u cilju edukacije i prevencije neželjenih postupaka. Objektivizacija greške iznimno je važan preduvijet za utvrđivanje odgovornosti čimbenika zdravstvenog sustava jer se kroz pravovremeno evidentiranje i procjenu može kvalitetno unaprijediti praksa i liječničko zvanje.

Ukoliko niste prijavljeni u sustav, zatražite nasumično generirane pristupne podatke na mail adresu podrska@kohom-siguranpacijent.org i unutar 24 sata na vašu mail adresu će stići pristupni podaci. Na ovaj način je osigurana anonimnost i omogućeno je liječnicima praktičarima da što kvalitetnije ispune parametre o medicinskom incidentu.

Ukoliko imate pristupne podateke, prijevite se u sustav na linku Prijava.

Za više informacija posjetite web stranicu www.kohom.hr ili pošaljite upit koristeći našu kontakt formu.

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Česta pitanja

Što je medicinska pogreška?

Medicinska pogreška je postupak ili skup postupaka koji su na direktan ili indirektan način doveli pacijenta u nepovoljan položaj, a koji je moguće definirati kroz ozljedu, pogoršanje zdravlja, narušavanje ili gubitak zdravstvenih prava pacijenata uslijed liječničkog djelovanja, nedjelovanja, propusta ili krive procjene.

Kategorije greške

Osnovne 3 kategorije pogreške koje se obrađuju kroz izvještavanje preko sustava siguran pacijent su:

- Pogreška nastala dolaskom pacijenta, prije primanja u obradu
- Pogreška nastala tijekom medicinske obrade (uključujući i nastavnu terapiju)
- Pogreška nastala zbog medicinskog sustava i administrativnih postupaka

Zašto je dobro prijaviti pogrešku?

Učinjena pogreška po svojoj definiciji implicira nastalu štetu, popravljivu ili nepopravljivu. No, sustav omogućuje da se iz pogrešaka uči te da kolege liječnici, imajući uvid u izvještaje, steknu pozornost u radu u elementima koji su im do tad bili strani, nejasni ili nisu bili dovoljno visoko na ljestvici prioriteta. "Primum non nocere" je temeljna obveza svakog liječnika i poznavanje individualne pogreške omogućuje prevenciju sustavnog propusta.

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Prijava pogreške:

Opišite nastalu pogrešku detaljno (Osobe uključene, postupci koji su bili neuspješni,...)

Detalji pogreške (Lijekovi koji su uključeni, oprema koja je korištena,...)

Nastavak >>

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Prijava pogreške:

Gdje je nastala pogreška?

- Ordinacija
- Sestrinska soba
- Rehabilitacijska ustanova
- Rodilište
- Ljekarna
- Bolnica
- Dom zdravlja (zajedničke prostorije)
- Nepoznata ustanova

Datum nastaka pogreške:

DAN MJESEC GODINA VRIJEME

Nastavak >>

Thank you

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