



ORIGINAL

Analysis of contributing factors associated to related patients safety incidents in Intensive Care Medicine[☆]



M.C. Martín Delgado^{a,*}, P. Merino de Cos^b, G. Sirgo Rodríguez^c, J. Álvarez Rodríguez^d, I. Gutiérrez Cía^e, B. Obón Azuara^f, Á. Alonso Ovies^d, Grupo SYREC

^a Servicio de Medicina Intensiva, Hospital Universitario de Torrejón, Torrejón de Ardoz, Madrid, Spain

^b Servicio de Medicina Intensiva, Hospital Can Misses, Ibiza, Spain

^c Unidad de Cuidados Intensivos, Hospital Universitario Joan XXIII, Instituto de Investigación Sanitaria Pere Virgili, Universidad Rovira i Virgili, Tarragona, Spain

^d Servicio de Medicina Intensiva, Hospital Universitario de Fuenlabrada, Fuenlabrada, Madrid, Spain

^e Servicio de Medicina Intensiva, Hospital Clínico Universitario, Zaragoza, Spain

^f Servicio de Medicina Preventiva y Salud Pública, Hospital Clínico Universitario, Zaragoza, Spain

Received 8 April 2014; accepted 4 June 2014

Available online 12 June 2015

KEYWORDS

Patient safety;
Incidents;
Adverse events;
Risk management;
Intensive Care
Medicine

Abstract

Objective: To explore contributing factors (CFs) associated to related critical patients safety incidents.

Design: SYREC study post hoc analysis.

Setting: A total of 79 Intensive Care Departments were involved.

Patients: The study sample consisted of 1.017 patients; 591 were affected by one or more incidents.

Main variables: The CFs were categorized according to a proposed model by the National Patient Safety Agency from United Kingdom that was modified. Type, class and severity of the incidents were analyzed.

Results: A total 2965 CFs were reported (1729 were associated to near miss and 1236 to adverse events). The CFs group more frequently reported were related patients factors. Individual factors were reported more frequently in near miss and task related CFs in adverse events. CFs were reported in all classes of incidents. The majority of CFs were reported in the incidents classified such as less serious, even though CFs patients factors were associated to serious incidents. Individual factors were considered as avoidable and patients factors as unavoidable.

[☆] Please cite this article as: Martín Delgado MC, Merino de Cos P, Sirgo Rodríguez G, Álvarez Rodríguez J, Gutiérrez Cía I, Obón Azuara B, et al. Análisis de los factores contribuyentes en incidentes relacionados con la seguridad del paciente en Medicina Intensiva. Med Intensiva. 2015;39:263–271.

* Corresponding author.

E-mail address: mmartin@torrejonsalud.com (M.C. Martín Delgado).

PALABRAS CLAVE

Seguridad del paciente;
Incidentes;
Eventos adversos;
Gestión del riesgo;
Medicina Intensiva

Conclusions: The CFs group more frequently reported were patient factors and were associated to more severe and unavoidable incidents. By contrast, individual factors were associated to less severe and avoidable incidents. In general, CFs most frequently reported were associated to near miss.

© 2014 Published by Elsevier España, S.L.U.

Análisis de los factores contribuyentes en incidentes relacionados con la seguridad del paciente en Medicina Intensiva

Resumen

Objetivo: Analizar los factores contribuyentes (FC) que intervienen en la aparición de incidentes relacionados con la seguridad del paciente crítico.

Diseño: Análisis *post hoc* del estudio SYREC.

Ámbito: Un total de 79 servicios de Medicina Intensiva.

Pacientes: Un total de 1.017 pacientes, de los que se incluyeron 591 en los que se notificó al menos un incidente.

Variables de interés principales: FC categorizados según una adaptación del modelo propuesto por la National Patient Safety Agency del Reino Unido. Tipo, clase y gravedad de los incidentes relacionados con la seguridad del paciente.

Resultados: Se notificaron 2.965 FC (1.729 se comunicaron en incidentes sin daño y 1.236 en eventos adversos). El grupo de FC más frecuente fue el relacionado con el paciente. Los FC relacionados con el profesional se notificaron más en los incidentes sin daño. En cambio, los relacionados con la tarea se comunicaron más en los eventos adversos. Se declararon FC en todas las clases de incidentes. La mayoría de FC se notificaron en los incidentes menos graves aunque los FC relacionados con el paciente se asociaron a incidentes de mayor gravedad. Los incidentes que se asociaron a los FC relacionados con el profesional se consideraron evitables y los FC relacionados con el paciente, inevitables.

Conclusiones: Los FC relacionados con el paciente fueron los más frecuentes y se relacionaron con los incidentes más graves y considerados inevitables. Los relacionados con el profesional se notificaron en las categorías menos graves y se consideraron evitables. La identificación de FC fue más frecuente en los incidentes sin daño.

© 2014 Publicado por Elsevier España, S.L.U.

Introduction

The critical patient care environment is extremely complex. In Departments of Intensive Care Medicine (DICMs), factors such as the seriousness of the patient condition, the communication barriers, the invasive therapeutic and diagnostic procedures used,¹ and the volume of information managed all contribute to the appearance of incidents related to patient safety.²

Although not all healthcare related incidents that occur in the DICM actually affect the patients, some of them can cause temporary damage requiring additional observation and care, prolonging hospital stay and—in some cases—causing permanent damage or even death.³

Two aspects must be underscored in this regard. Firstly, most incidents detected in the DICM are avoidable.⁴ Secondly, although errors can occur in all areas of the hospital, patients admitted to the DICM are more vulnerable, and the consequences are more serious.^{5,6}

In the patient safety context, it is admitted that most incidents related to medical care are a consequence of

active error on the part of the professionals, favored by factors latent within the system. The analysis of these factors, applied to clinical safety, has been carried out based on the results of safety analyses in other fields such as aviation.⁷

A modern approach by those institutions that aim to effectively address patient safety with the purpose of reducing the number of incidents related to medical care inevitably includes knowledge of the causes underlying such incidents and their contributing factors (CFs).⁸ Furthermore, in-depth knowledge of these factors makes it possible to distinguish between those that influence an isolated incident and those which are common to incidents within a certain institution or Department.⁹

The systematic classification of CFs and their analysis should allow the development of strategies for improving the defenses and failures of the system. In Spain there is no exhaustive information on incidents related to medical care in the critical care setting, and the lack of data is even more manifest when considering the factors related to the appearance of such incidents.¹⁰ For this reason, a collaborative agreement was established between the Spanish Ministry of

Download English Version:

<https://daneshyari.com/en/article/3114010>

Download Persian Version:

<https://daneshyari.com/article/3114010>

[Daneshyari.com](https://daneshyari.com)