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ORIGINAL ARTICLE

# Towards a safety culture in the neonatal unit: Six years experience☆

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**KEYWORDS**
Culture of safety;
Newborn;
Adverse events;
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Prevention;
Critical incident reporting

**Abstract**
*Introduction:* A safety culture is the collective effort of an institution to direct its resources towards the goal of safety.
*Material and methods:* An analysis is performed on the six years of experience of the Committee on the Safety of the Neonatal Patient. A mailbox was created for the declaration of adverse events, and measures for their correction were devised, such as case studies, continuous education, prevention of nocosomial infections, as well as information on the work done and its assessment.
*Results:* A total of 1287 reports of adverse events were received during the six years, of which 600 (50.8%) occurred in the neonatal ICU, with 15 (1.2%) contributing to death, and 1282 (99.6%) considered preventable. Simple corrective measures (notification, security alerts, etc.) were applied in 559 (43.4%), intermediate measures (protocols, monthly newsletter, etc.) in 692 (53.8%), and more complex measures (causal analysis, scripts, continuous education seminars, prospective studies, etc.) in 66 (5.1%). As regards nosocomial infections, the prevention strategies implemented (hand washing, insertion and maintenance of catheters) directly affected their improvement. Two surveys were conducted to determine the level of satisfaction with the Committee on the Safety of the Neonatal Patient. A rating 7.5/10 was obtained in the local survey, while using the Spanish version of the Hospital Survey on Patient Safety Culture the rate was 7.26/10.

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*Conclusions:* A path to a culture of safety has been successfully started and carried out. Reporting the adverse events is the key to obtaining information on their nature, aetiology and evolution, and to undertake possible prevention strategies.


**PALABRAS CLAVE**
Cultura de seguridad;
Recién nacido;
Acontecimientos adversos;
Calidad asistencial;
Prevención;
Declaración de acontecimientos adversos

**Caminando hacia una cultura de seguridad en la unidad neonatal: experiencia de 6 años**

**Resumen**
*Introducción:* La cultura de seguridad es el esfuerzo colectivo de una institución para encaminar la totalidad de los recursos hacia el objetivo de la seguridad.
*Material y métodos:* Se analizan 6 años de experiencia de la Comisión de la Seguridad del paciente neonatal. Se creó un buzón para la declaración de acontecimientos adversos y se diseñaron medidas para su corrección, así como información del trabajo realizado y su valoración.
*Resultados:* Durante 6 años se han recibido 1.287 notificaciones de acontecimientos adversos de las cuales 600 (50,8%) ocurrieron en la UCI neonatal. Quince (1,2%) graves contribuyeron a la muerte del paciente; 1.282 (99,6%) acontecimientos adversos se consideraron evitables. Se adoptaron medidas correctoras simples (notificación, alertas, etc.) en 559 (43,4%), medidas intermedias (protocolos, boletín, etc.) en 692 (53,8%) y medidas más complejas (análisis causa-raíz, libretos, formación continuada, trabajos prospectivos, etc.) en 66 (5,1%). Respecto al trabajo sobre las infecciones relacionadas con la asistencia sanitaria, se demostró cómo las estrategias de prevención (lavado de manos, inserción y mantenimiento de vías) repercuten directamente en su disminución. Se realizaron 2 encuestas, obteniendo un grado de satisfacción de la comisión de 7,5/10. Con la versión española del Hospital Survey on Patient Safety Culture se obtuvo un grado de cultura de seguridad de 7,26 sobre 10.
*Conclusiones:* Se ha iniciado un camino hacia la cultura de seguridad. La declaración de los acontecimientos adversos es un elemento clave para obtener información sobre el tipo, la etiología y la evolución, y decidir posibles estrategias de prevención.


## Introduction

*Quality of care*, according to Avedis Donabedian, is the expected model of health care to maximise the level of patient welfare, once the balance of benefits and losses expected in every phase of the care process has been assessed.[1] According to the Council of Europe, it is the degree to which the treatment dispensed increases the patient's chances of achieving the desired results and diminishes the chances of undesirable results, according to current knowledge.[2] There are various different definitions of this term, describing the concept according to a series of criteria, such as effectiveness, efficiency, appropriateness, equity, safety, respect, prevention, continuity, coordination, etc.[3–7]

*Patient safety* (PS) means reducing the risk of unnecessary harm associated with health care to an acceptable minimum according to current knowledge, available resources and the context in which the care is provided. Concern for PS can be regarded as an international movement involving all the agents that provide health services, from health policy planners to health care professionals.[8] Safety is an important component of the definitions of quality proposed by Donabedian, the Institute of Medicine and the Joint Commission (JCAHO).[1,4,6]

In the JCAHO's view, the essential basis of PS is *health care error prevention*, which must be managed proactively, identifying the risk and the changes that need to be applied to reduce it, determining who is responsible for implementing each of the planned actions, when each action should be carried out and what method should be used to assess their efficacy.[9] A necessary prerequisite is that health care culture should evolve towards a culture of safety that looks for the weaknesses in the system instead of blaming the individuals who work in it.

The *culture of safety* is the set of values, attitudes and behaviours in an organisation that are directed to making its activities safe for its clients, by creating methods of work that promote them. This culture is essential in health care quality management; for this reason it has been incorporated into health care organisations and is a priority when it comes to developing a proactive health care risk management system that detects problems before they occur. A culture of safety requires an information system to collect,