



REVIEW

Real-time random safety audits: A transforming tool adapted to new times[☆]

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PALABRAS CLAVE

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Paciente crítico;
Auditorías de seguridad

Abstract Real-time random safety audits constitute a tool designed to transfer knowledge from the sources of scientific evidence to the patient bedside. It has proven useful in critically ill patients, improving safety in the process of critical patient care, turning unsafe situations into safe ones in daily practice, and ensuring adherence to scientific evidence. In parallel, the design and methodology involved affords process indicators that will make it possible to know how we provide care for our patients, evolution over time (with regular feedback for professionals), the impact of our interventions, and benchmarking.

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Análisis aleatorios de seguridad en tiempo real, una herramienta transformadora adaptada a los nuevos tiempos

Resumen Los análisis aleatorios de seguridad en tiempo real son una herramienta que ha sido creada como un método de traslación del conocimiento desde las fuentes de la evidencia científica hasta la cabecera del paciente. Ha demostrado ser útil en el entorno del paciente crítico, en términos de mejora de la seguridad en el proceso de cuidados al paciente crítico, transformando situaciones inseguras en seguras en el día a día, garantizando la adherencia a la evidencia científica. Paralelamente, por su diseño y metodología ha permitido

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disponer de indicadores de proceso que hará posible conocer cómo realizamos la atención a nuestros pacientes, la evolución en el tiempo (y el feedback periódico a los profesionales), el impacto de nuestras intervenciones y el benchmarking.

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Introduction

Intensive medicine lives immersed in a period of deep transformation that requires new healthcare scenarios, new ways of looking at the setting, and new roles. In these times of change, intensive care units (ICU) are no longer the playing ground of superspecialized professionals to become places beyond the constraints of the physical walls whose destiny is dictated by the economy of knowledge – the actual base of research and teaching.¹ However, this renovation does not come without the problems that have been dragging us down for a long time and for which we still have not found a solution. One of them is the huge gap between clinical practice and scientific evidence.²

On the other hand, as professionals of one of the most basic specialties within the healthcare system, our responsibility (both individual and collective) should embrace the quality of healthcare as a paradigm in order to achieve the goals that our society demands. Efforts made to be specific within this setting have allowed us to develop models of excellence that have been exported everywhere, such as the European Foundation for Quality Management (EFQM),³ whose landmarks are based on leadership, process management, professional satisfaction, the value measured by the patients, the results adjusted to the means, the promotion of creativity and innovation, the development of alliances, and the promotion of the system sustainability.⁴

In this context, sending out an invitation to face such a change without suggesting one *position* that will help face such a transient period or, most important, without suggesting the appropriate *tools* to lead such an effort, is purely demagogical.

When it comes to *position*, teamwork is a concept we should conquer again: one setting where members collaborate, interact, and share knowledge and resources, and where we depend on one another to be able to carry out our tasks.⁵ This requires training (e.g. drills and simulations), the creation of efficient working stations where situational awareness operates⁶ and effective communication becomes an essential part of the process. In complex situations like clinical practice, effective communication not only means building up the structure of a team but also sharing the mental models needed that, by the way, are conditioned by knowledge and experience.^{7,8}

Tools can be of two different types. Some are transversal tools like clinical information systems (CIS). There is growing experience with CIS and their healthcare and organizational results are promising^{9–11} but they will also improve safety and teamwork and, eventually, lay the foundations of new clinical research.^{12,13} There are other kinds of operative

tools that are representative of strategic leverage. Ideally these tools are effective in complex settings, have their origin in adaptative leadership, guarantee the adherence of users to better scientific evidence, accompany process execution, and facilitate effective communication. During the last few years, different tools coming from other industries have been introduced in the healthcare setting aimed at improving teamwork, facilitating effective communication among healthcare providers, and improving the safety of patients. Some of these tools have been modified and even re-designed in order to adapt them to specific settings. [Table 1](#) shows the most widely used tools that share elements among them.¹⁴

Our group has been working on the design of one tool that, on top of meeting the requirements of operative tools, feels close to healthcare providers since their help will be necessary in one of the top health priority areas – clinical safety.¹⁵ This is how the real-time random safety audits (RTRSA) have been born. As discussed below, RTRSA can interact with the CIS to safeguard the safety and quality of data while providing significant clinical information (process indicators).¹⁶

Safety. Types of errors. Proactive or reactive measurements

The meaning of clinical safety is intimidating to us, the healthcare providers. You only need to come close to the most basic terms to start feeling a certain sense of unease: errors, incidents, adverse events.

When someone thinks of clinical safety for more than five minutes, the essence of the problem becomes evident: it is elusive and really hard to measure.¹⁷ How do I know that my ICU is safe? How should I know that in my ICU we are coming dangerously close to an unsafe threshold of risk? How can I improve safety in my ICU?

Among these errors, the errors of commission (incorrect implementation of one measure or action from the way it was originally planned or indicated) are more evident (e.g. the administration of inadequate doses of drugs due to prescription errors), easier to see, and usually draw more our attention than the errors of omission do (failure to implement one measure or action from the way it was originally planned or indicated). The latter are particularly disturbing; they are more insidious and hard to see; they may be covered and protected by habits and routines, and the clearest example of this is the lack of adherence to good clinical guidelines. Paradoxically, this happens more frequently in patients with more serious conditions¹⁸ and has

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