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ORIGINAL ARTICLE

Patient safety and nursing implication: Survey in Catalan hospitals☆

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KEYWORDS
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Abstract
Objective: This study aims to describe the implementation of the patient safety (PS) programmes in Catalan hospitals and to analyse the level of nursing involvement.
Method: Multicenter cross-sectional study. To obtain the data two questionnaires were developed; one addressed to the hospital direction and another to the nurse executive in PS. The survey was distributed during 2013 to the 65 acute care hospitals in Catalonia.
Results: The questionnaire was answered by 43 nursing directors and 40 nurse executive in PS. 93% of the hospitals responded that they had a PS Programme and 81.4% used a specific scoreboard with PS indicators. The referent of the hospital in PS was a nurse in 55.8% of the centres. 92.5% had a system of notification of adverse effects with an annual average of 190.3 notifications. In 86% of the centres had a nurse involved in the PS programme but only in the 16% of the centres the nurse dedication was at full-time.

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The nurse respondents evaluate the degree of implementation of the PBS programme with a note of approved and they propound as improvement increase the staff dedicated to the PS and specific academic training in PS.
Conclusions: The degree of implementation of programmes for patient safety is high in Catalan acute hospitals, while the organisational structure is highly diverse. In more than half of the hospitals the PS referent was a nurse, confirming the nurse involvement in the PS programmes.

PALABRAS CLAVE
Seguridad del paciente;
Enfermería;
Cuestionario;
Hospitales

Seguridad del paciente e implicación de enfermería: encuesta en los hospitales de Cataluña

Resumen
Objetivo: El presente estudio pretende describir la implementación de los programas de seguridad del paciente (SP) de los hospitales catalanes y analizar el nivel de implicación de las enfermeras.
Método: Estudio descriptivo multicéntrico y transversal. Para la obtención de los datos se elaboraron dos cuestionarios, uno dirigido a la dirección y otro al referente de SP que se distribuyeron entre los 65 hospitales de agudos de Cataluña en 2013.
Resultados: El cuestionario lo respondieron 43 direcciones de enfermería y 40 referentes de enfermería de SP. El 93% de los hospitales respondió disponer de programa de SP y el 81,4% monitoriza los resultados mediante un cuadro de indicadores específico. El referente en SP del centro es enfermera en el 55,8% de los centros. El 92,5% disponen de un sistema de notificación de efectos adversos con un promedio de 190,3 notificaciones anuales y el 86% de los centros dedican enfermeras a la SP aunque únicamente el 16% a jornada completa.
Los referentes de enfermería valoran el grado de implementación del programa SP con un aprobado y proponen como mejora aumentar el personal con dedicación a SP y disponer de formación académica específica.
Conclusiones: El grado de implementación de los programas de SP es elevado en los hospitales catalanes aunque la estructura organizativa presenta una gran diversidad. En más de la mitad de los centros el referente en SP es una enfermera, confirmándose la implicación de las enfermeras en estos programas.

What is known?

Ever since the publication of ''To err is human'' in 1999, patient safety has taken on a global dimension, has entered political agendas and is a matter of public debate.

Promoting patient safety requires multidisciplinary work. However, some studies have established a relationship between nursing care, quality of care given and patient safety, highlighting the importance of nursing leadership and there being sufficient nurses in the provision of safe care.

What does it contribute?

The results confirm that patient safety programmes have been widely implemented in Catalonia's hospitals since the Patient Safety Alliance was set up. Nurses are very much involved in the application of these programmes. However, there is wide diversity in the organisational structure of these programmes and there is little specific training on patient safety.

Introduction

In December 1999, the Institute of Medicine of the National Academy of Sciences of the USA raised the alarm with a report estimating that approximately 98,000 hospital patients die each year due to medical errors.[1] In 2004, the World Health Organisation created the Patient Safety Alliance.[2] Its objectives were to promote and develop patient safety knowledge and culture amongst professionals and patients at all levels of health care, to design and establish systems for informing and notifying adverse events in order to learn from the experience, to implement safe practice as recommended by National Health System centres, to promote research into PS and encourage the participation of patients and the public in developing PS policies.

It was then that PS took on a global dimension, entered political agendas and became a subject of public debate.

Improved safety is imperative for health care professionals and organisations alike. In 2005, driven by the Health Department of the Government of Catalonia, the Patient Safety Alliance was set up in Catalonia with a view to involving all stakeholders in the promotion of safety.