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Safety culture in the surgical services: Case study

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Abstract Adverse events are a reality in health care, with particular interest in the surgical patient, so it is crucial that one knows its dimension, in order to avoid them whenever possible. The internalization of a culture of safety as a priority, by professionals, can contribute to the development of systems that lead to safer care. It can be reduced the occurrence of events and their negative impacts, especially during the hospitalization days and on the additional costs associated. Thus, we developed an exploratory study in a Local Health Unit, with the aim of understanding the culture of safety in surgical services for the year 2008, and if it was influenced by three dimensions: leadership, teamwork and communication. The obtained results show that the security culture is influenced by all of these three dimensions, observing that the existing culture on such services is at an intermediate level classified as acceptable.

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1. Introduction

It is becoming increasingly recognized that the provision of care involves a series of events arising from multiple circumstances and variables that influence health outcomes. These events, are designated as adverse since they are unintended and unwanted, have significant impacts on the health system, either for patients or for professionals, and also for the institutions.

Several studies (Leape et al., 1991; Vicent, Neale, & Woloshynowych, 2001; WHO, 2002; Wilson et al., 1995),

reveal that the incidence of adverse events ranges between 3.8% and 16%, of which 48% are associated with surgery. The implications of these events are relevant in terms of increased length of hospital stay, temporary or permanent disability or even death of patients. In addition, they are associated with substantial economic costs. The concern is even greater when it turns out that about half of these events were avoidable.

Thus, for IMS (2013) and Francis (2013) patient safety in general and surgical patients in particular, needs to be reinforced in healthcare units as a priority in order to prevent the occurrence of adverse events, especially when they are avoidable. This design is possible, if there is a strong culture or a common positive safety culture (Francis, 2013) and efforts to develop the implementation of instruments and tools for monitoring and evaluate the causes of the events.

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The present study aims to know the overall safety culture associated with surgical patient safety, for the particular case of the Local Health Unit (LHU) of Guarda, EPE. It is also intended identify whether there is a reporting system for adverse events and opportunities for improvement to reduce these adverse situations. In this perspective, we developed an exploratory study in a Local Health Unit, in order to know the culture of safety in existing surgical services for the year 2008, and whether it is influenced by three dimensions of safety culture: leadership, teamwork and communication. The results show that safety culture is influenced by any of these three dimensions, noting that the existing culture in these services is located at an intermediate level, classified as acceptable.

In order to achieve the proposed objectives, it begins by presenting a theoretical part which will be held in the literature review and the theme underlying the formulation of hypotheses and a second empirical part, based on analysis of data obtained through a questionnaire.

2. Literature review

Health care is a high risk and "complex industry", involving a large number of people and processes. Health care brings benefits for the patient, but can also cause damage (WHO, 2002). The great warning about this kind of events came in November 1999 when a report was published by the Institute of Medicine (IOM) of the United States, estimating that between 44 000 and 98 000 people (or more) die each year in hospitals as a result of medical errors which could be avoided or prevented (IOM, 2000).

Leape et al. (1991) in a study conducted in the United States, performed on a sample of 30 195 records identified adverse events in 3.7% of the cases that have resulted in crippling injuries caused by medical treatment. They pointed out complications with medication in 19%, wound infection in 14% and technical complications in 13%. In these cases, about 48% of all events identified are associated with surgery. But more worrying is that about half of these events were avoidable. Once errors are recognized their causes must be analysed so that preventive measures can be applied. Errors are problems that will not go away. Thus, clear definition of clinical responsibilities is needed (Alberti, 2001). It is also necessary that they are clearly identified and communicated within the organization of health care, so they can be monitored and avoided.

In this way would have been avoided suffering for patients and professionals, especially in cases where there were severe disability or death of patients, representing the latter cases, about one third of adverse events detected (Vicent et al., 2001).

In Canada in a study for the year 2000, it was found that the incidence of adverse events occurring in relation to hospital admissions stands at 7.5%. Among the adverse events it is judged that 36.9% could be avoidable and also are verified other dramatic consequences such as the death of patients in 20.8% of cases (Baker et al., 2004).

According to WHO (2002), the economic impact in the UK as a result of adverse events, is situated at a cost of about 2000 million pounds per year as a result of additional

hospitalization time and were still paid about 400 million pounds in compensation processes of victims.

In order to pay attention to these concerns about patient safety, WHO initiated in 2002 a series of measures with the international community, this led to the creation of the *World Alliance for Patient Safety* in May 2004. The principal aim was to implement and strengthen evidence-based systems to facilitate the development of policies and practices for patient safety in all member states (WHO, 2006) and create a common taxonomy on these issues (WHO, 2007).

As a result patient safety refers to freedom from accidental or preventable injuries produced by medical care. Thus, practices or interventions that improve patient safety are those that reduce the occurrence of preventable adverse events (WHO, 2007). Regarding the adverse event it refers to an event which resulted in damage to the patient, implying damage loss of structure or function of the body and/or any deleterious effects arising therefrom (WHO, 2007).

When it relates to patient safety, the aim is to prevent unnecessary damage occurring in patients with the provision of health care, i.e., prevent the occurrence of adverse events (WHO, 2007). In any way, the risk of adverse events and medical errors cannot be completely eliminated, but the knowledge that they acquire about their occurrence, gives the care providers more opportunities to improve the quality of provision (Jonsson & Ovretveit, 2008).

However each phase of care contains a degree of uncertainty. Whether we like or not, there are risks due to side effects of drugs or drug interaction, inherent risks due to medical devices, use of defective or substandard products, human fault or latent failures in the system. The adverse events may then result in care practical problems, resulting from products or devices during the procedures or problems derived from organizational systems (WHO, 2002).

The *National Steering Committee on Patient and Safety* (2002) of Canada adds that the ageing population, the resource constraints, the lack of qualified human resources, in addition to the challenges and restructuring within the health care organizations, also pose difficulties for systems, thus contributing to the increased likelihood of adverse events, sometimes with lethal consequences.

It is widely recognized that health care can improve, reducing human errors and system failures, it is necessary to understand the main causes of the problems. However the fact that information about errors in health care is not being obtained and handled routinely, makes it more difficult to find these same problems (Walton, Shaw, Barnet, & Ross, 2005).

However it is not enough to recognize that errors exist. It is also necessary a clear identification and communication within the organization and it is essential to understand its evolution, in the sense that they can be avoided. Report the event is no more than to give it visibility, and it is then necessary to encourage their communication. It is important to create an organizational culture change, based on communication, assertiveness and team training (Lembitz & Clarke, 2009).

According to Francis (2013), a shared positive safety culture requires: shared values in which the patient is the priority of everything done; zero tolerance of substandard care; empowering front-line staff with the responsibility and freedom to deliver safe care; recognizing them for

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