Patient Safety:
Review penelitian terkini

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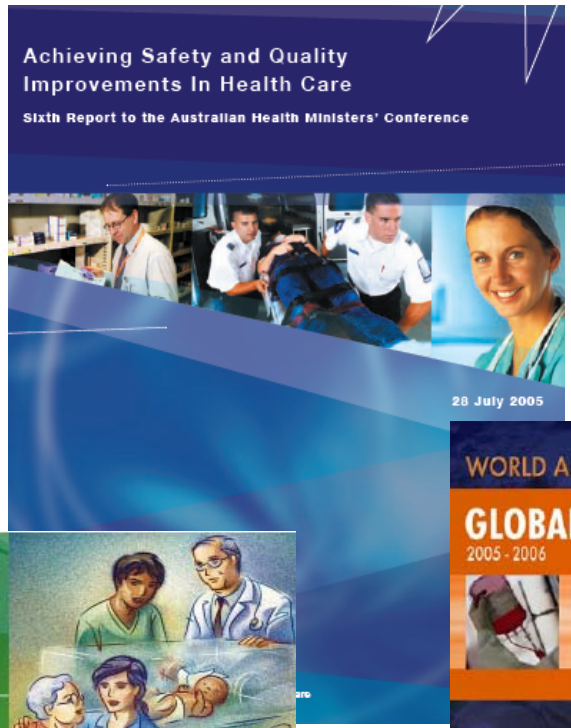
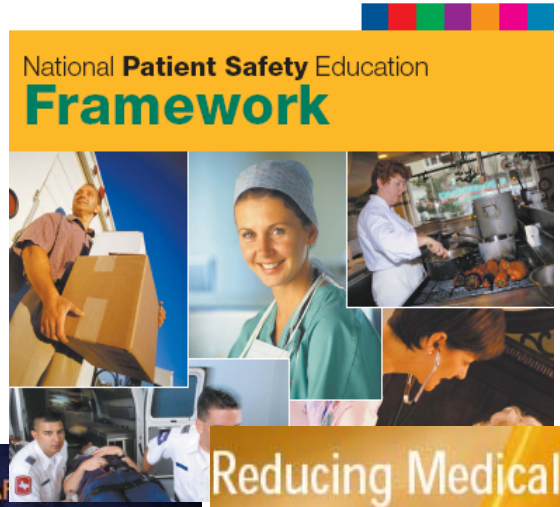
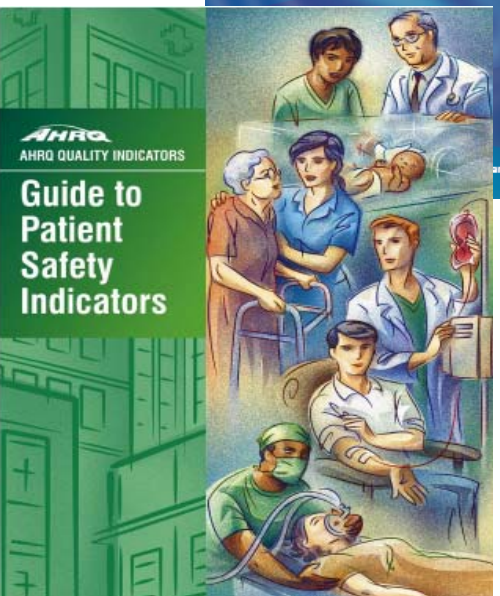
Struktur Presentasi:

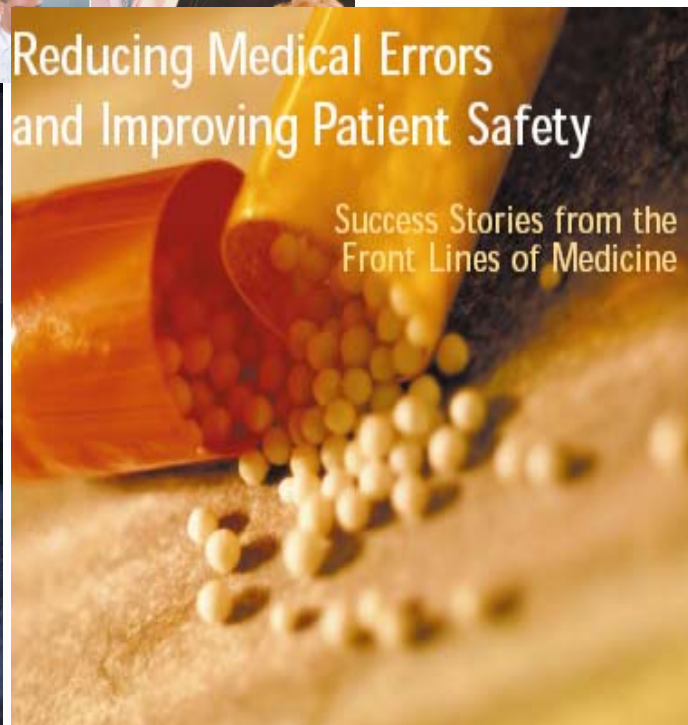
- Strategi searching literatur
- New but old phenomenon?
- Progress terminologi dan prevalensi
- Intervensi Patient Safety
- Agenda Penelitian Patient Safety

Referensi Patient Safety: Tambang Emas









New but Old Problem?: ADE

1970:
3% of all admission
29,000 deaths

1993:
5% of all admission

1994:
106,000 deaths

2000:
1,900,000 ADR (25% preventable)
180,000 fatal or death (50% preventable)

2004:
No change 1995-2000

Table 1. Nosocomial Infections in the United States.*

Variable	Year	
	1975	1995
No. of admissions ($\times 10^{-6}$)	37.7	35.9
No. of patient-days ($\times 10^{-6}$)	299.0	190.0
Average length of stay (days)	7.9	5.3
No. of inpatient surgical procedures ($\times 10^{-6}$)	18.3	13.3
No. of nosocomial infections ($\times 10^{-6}$)	2.1	1.9
Incidence of nosocomial infections (no. per 1000 patient-days)	7.2	9.8

*Data are from Weinstein[4] and Jarvis.[5]

The problem of patient safety has been repeatedly identified in the medical literature since the mid 1950s, but regular revelations about patient deaths and injuries resulting from treatment have had almost no effect on the actual practice of medicine. Only very recently has the medical profession made a systematic effort to reduce or eliminate the many preventable deaths and injuries that occur in hospitals each year. This review traces the diffusion of innovation in medical error reduction to the public shaming of the profession that occurred as a result of stories that appeared in the news media. The focus is on the USA, but news stories about patient safety are sparking a similar process throughout the western world.

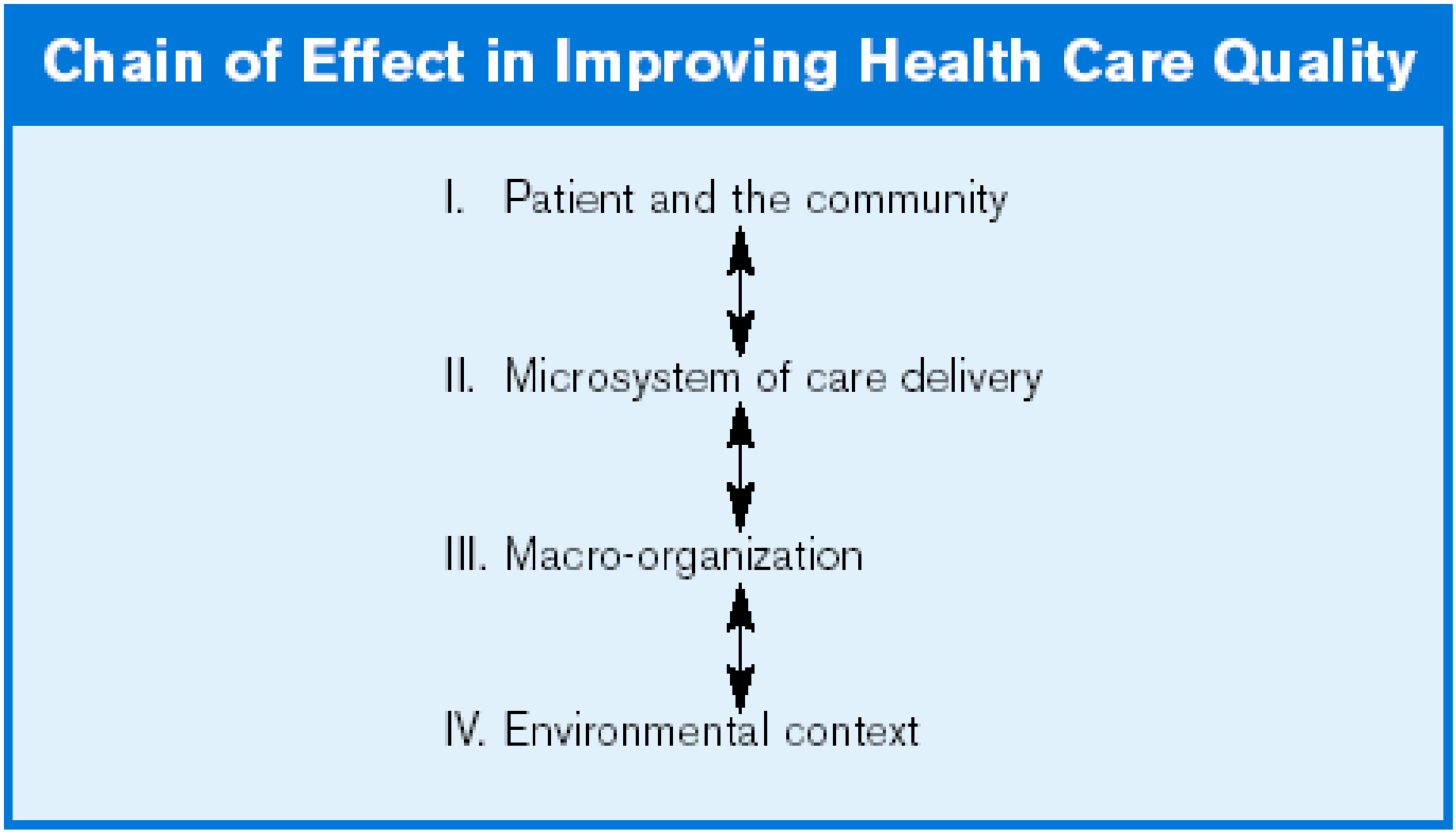
What's New?

- Paradigma
- Support stakeholder
- Perubahan perilaku

Terminologi: JCAHO Classifications

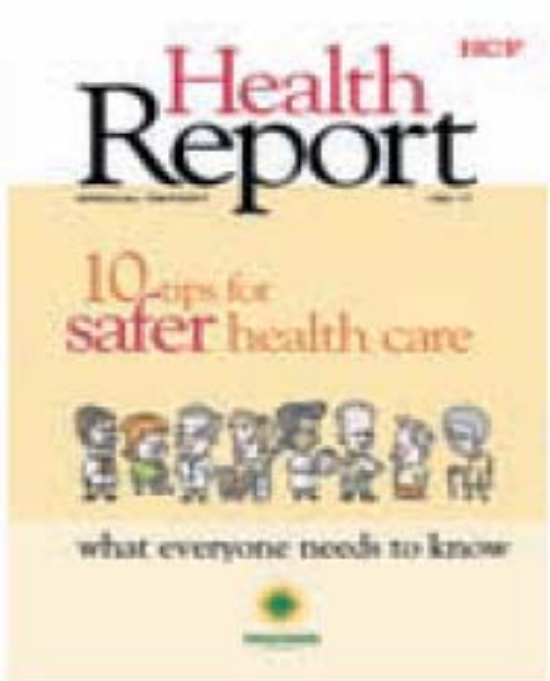
- Impact: fisiologis, fisik, non-medis
- Type: komunikasi, manajemen pasien, kinerja klinis
- Domain: setting pelayanan, kualifikasi staf, ciri pasien, target
- Cause: Systems, human
- Prevention and mitigation: Universal, selektif, indikatif

The Berwick Model



Courtesy: WHO

Figure 1. Stop sign for fall prevention.



Lima Prinsip Komunikasi Efektif

- Pasien/keluarga sebagai partner
- Mengkomunikasikan risiko
- Open disclosure
- Menggunakan consent
- Sensitif budaya dan mempunyai pemahaman yang baik

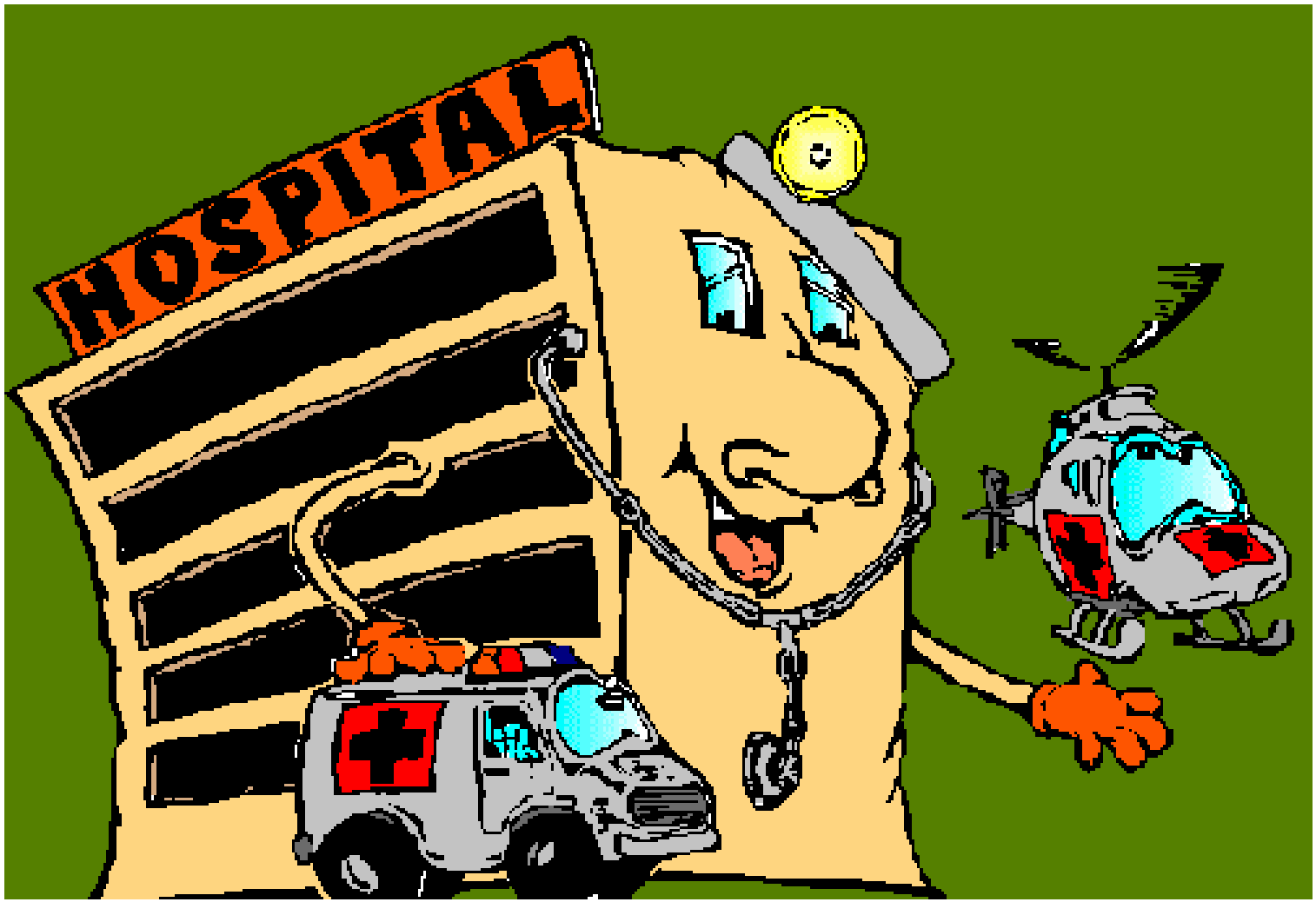
Sistem Mikro

Evidence Intervensi:

- Clinical Intervention (STRONG EVIDENCE)

- Nonmedical intervention (LESS STRONG)
  - Bar coding
  - Computerized Physician Order Entry
  - Use of simulators
  - Training high reliability teams

Sistem Makro: Organisasi

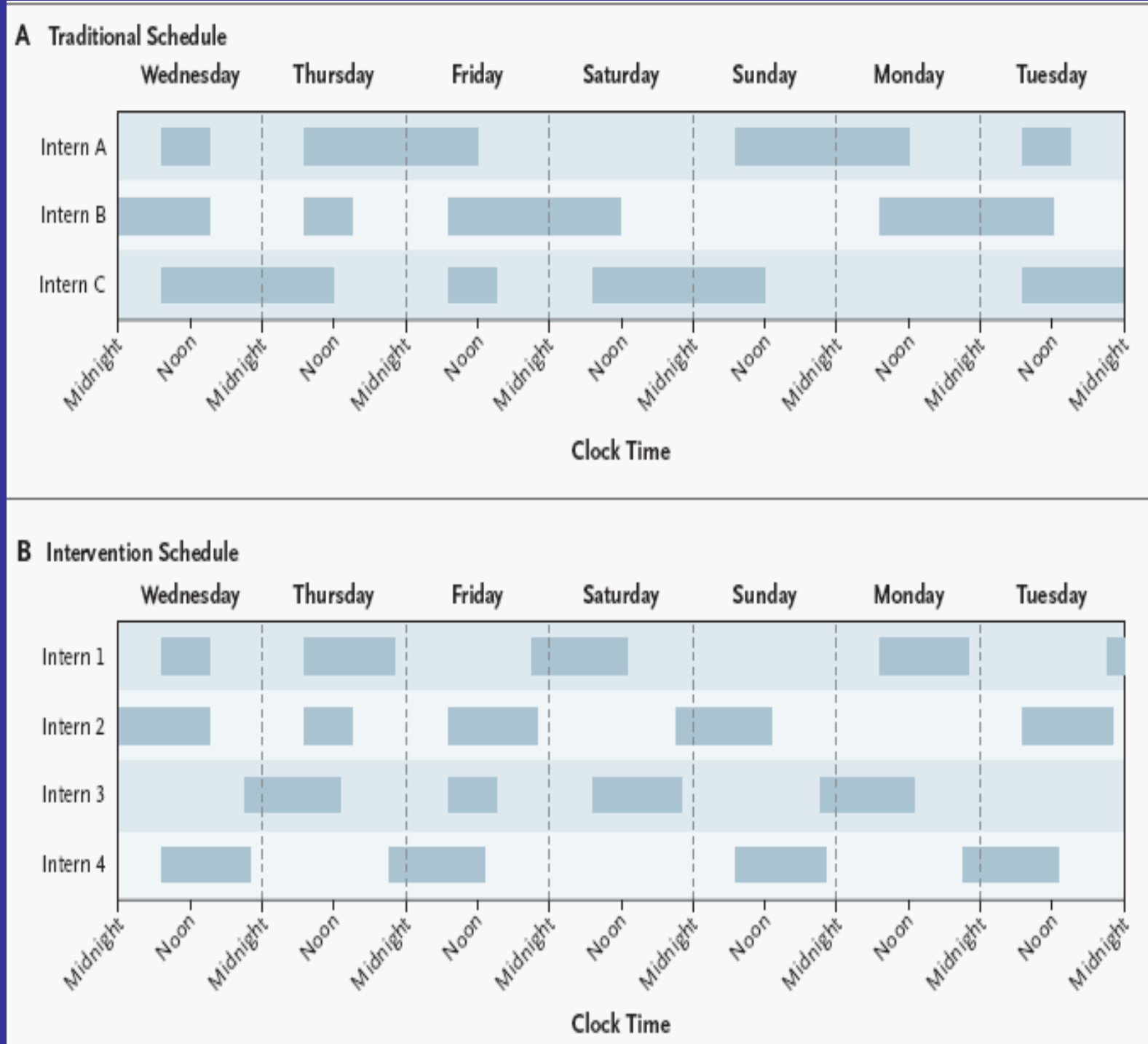


Evidence Intervensi

- Patient safety program at home (HOUSE, USA)
- Patient safety risk management (radiation oncology) (Canada)
- Nursing staff level and training
- Patient safety culture and safety climate survey: leadership, policies-procedures, staffing, communication, reporting

- Kemungkinan infeksi nosokomial bakteremia pada bayi berkurang pada unit NICU yang mempunyai “dedicated infection control nurse” dan jumlah hand washbasins
- Pelatihan, disertai dengan kepemimpinan organisasi yang mendukung perbaikan mutu dapat membantu meningkatkan persepsi nurse leader terhadap patient safety
- Meningkatnya proporsi perawatan yang diberikan oleh RN menurunkan LOS, pnemonia, ISK, perdarahan gastrointestinal, cardiac arrest

LINGKUNGAN:
Kebijakan, Regulasi


A Traditional Schedule
Wednesday
Thursday
Friday
Saturday
Sunday
Monday
Tuesday
Intern A
Intern B
Intern C
Midnight
Noon
Clock Time
B Intervention Schedule
Intern 1
Intern 2
Intern 3
Intern 4

- Residen melakukan error serius 20% lebih tinggi pada penjadwalan tradisional dibanding intervensi
- Kesalahan diagnosis yang serius terjadi 5,6 kali lebih tinggi pada penjadwalan tradisional dibanding intervensi

Voluntary Surveillance system:
Surgical site infection in 50 hospitals, Dutch

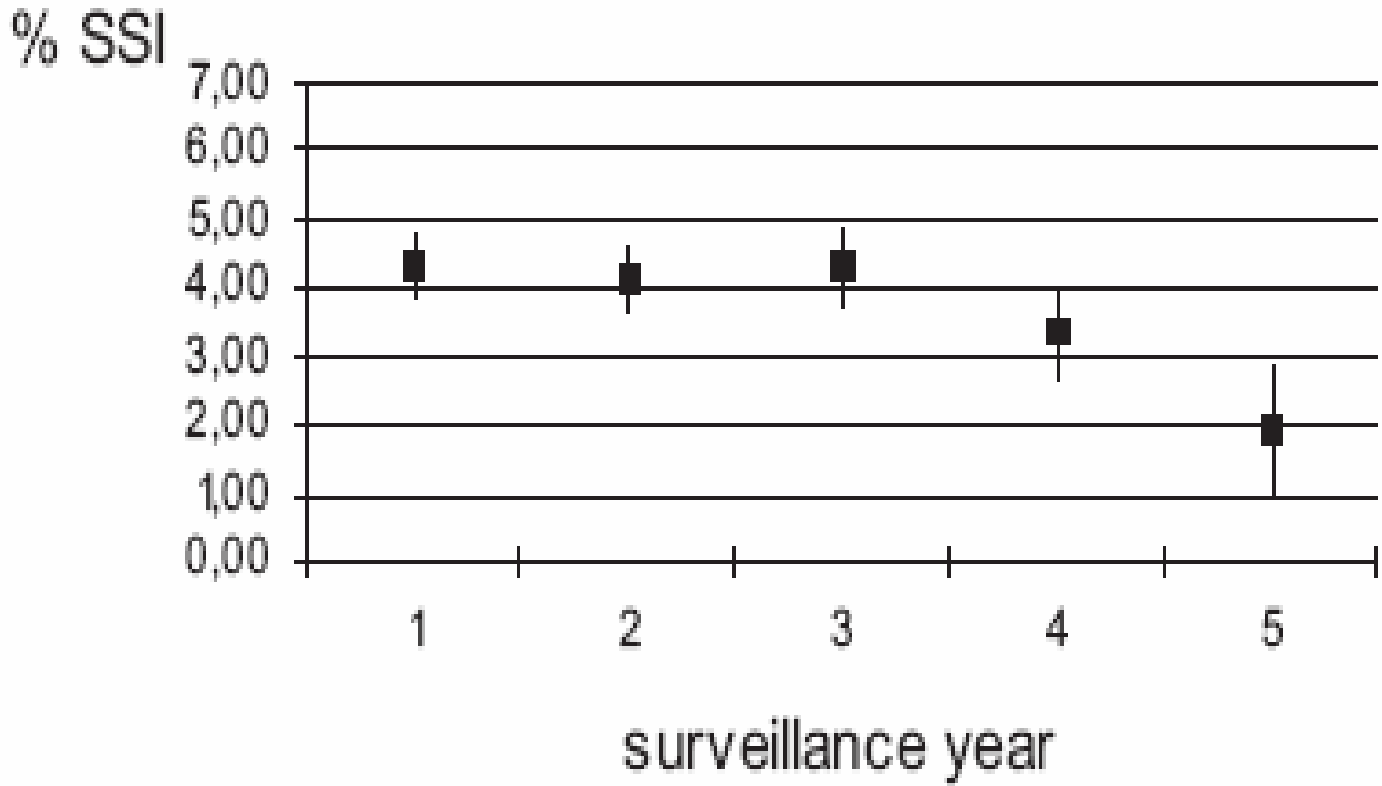


Figure 1 SSI rates with 95% confidence intervals per surveillance year for all hospitals.

Enam Area Prioritas Penelitian Patient Safety

1. Reporting, analysis health system error dan penelitian safety improvement;
2. Clinical informatics
3. Center of excellence patient safety research and practice
4. Evaluasi intervensi patient safety
5. Efek kondisi kerja tenaga kesehatan terhadap mutu pelayanan
6. Partnership mutu dengan pasien: pendidikan, diseminasi dan penelitian

The Future…

"The best way to predict the future is to create it."

Peter Drucker