

How to change adverse event reporting to risk management practice

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Development project

Authors: Ritva Inkinen, project manager (patient safety) and Tanja Lönnberg, specialized nurse in nephrology.

Organisation: Tampere University Hospital, Finland

Background:

Finland's National Patient Safety Strategy was published by The Ministry of Social Affairs and Health in January 2009. Tampere University Hospital patient safety- related development work was started in 2007 by introducing electric adverse event reporting system (HaiPro).

One of the key objectives in Tampere University Hospital strategy for the years' 2008- 2012 executive program is to increase patient safety through development projects. So far, in addition the electric AE- reporting it has been tested analytical methods finding risks in described key processes of patient care.

In nephrology unit (ward, dialysis unit, outpatient clinic) it has been drawn guidelines for a minimum registration of patient data and the checklist for patient discharging is in use. Problems in medication process and its documentation are systematically clarified twice a year by using prevalence.

Purpose:

Tampere University Hospital is starting a large construction project. The purpose is to create the largest nephrology expertise center in Finland. The main focus in creating and planning this center is focusing in patient safety, safe working conditions, employee welfare and risk management.

Method:

We have analyzed 316 AE-reports informed in nephrology unit. We described the result of the analysis by using fish bone-technique. The risks we found were analyzed by FMEA-tool. Disability rate of the risks were defined and existing barriers and their effectiveness were clarified. We also identified the risks which necessarily required barriers, and disability rate of the risks were redefined. In planning process we prepaid cost estimate for needed barriers.

The whole staff (75 persons) participated in planning of the new expertise center by answering a questionnaire. Everyone evaluated existing and possible risks in safety of patient care, working conditions and employee well-being. The staff also produced solutions for different problems. The whole material was also analyzed by fish bone-technique and FMEA. Welfare of the staff was clarified by the survey. Patients' expectations and hopes for the new center were also identified by a questionnaire.

Conclusion:

This development project is ongoing. So far we have noticed that by committing the staff in beginning of the planning process, help them to understand the patient care process as a whole and not just an individual activity. The staff learns to identify harms and risks in patients' care processes from systems perspective, not individual errors.

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