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المؤتمر الدولي الأول لسلامة المرضى

مستشفى جامعة السلطان قابوس

31 يناير – 2 فبراير

SELECTED ABSTRACTS

Educating Future Leaders in Patient Safety: World Health Organisation patient safety curriculum guide

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Patient safety education of future health care staff has the potential to improve the safety of patients worldwide by creating a basis for students to build on in professional life. The World Health Organisation (WHO) embarked on this project to assist the development of patient safety education in health care and contribute towards safer care by developing and disseminating globally the WHO Patient Safety Curriculum Guide. The Guide, published by in 2009, is a comprehensive guide for implementation of patient safety education in medical schools worldwide. It contains information for all levels of staff and lays the foundation for capacity building in essential patient safety principles and concepts. It has been tested in 12 sites (medical schools/universities) in 9 countries worldwide. The evaluation study indicated that the WHO Guide is highly valued and has a clear structure and excellent content. It also showed that 1) faculty are very open to incorporating patient safety topics into the existing curricula; 2) learners' perceptions of their knowledge of patient safety issues significantly increased, and 3) significant improvements in the 'know how' of the before and after cohorts were observed. The requirement of health professionals' education to develop and integrate patient safety learning into the curricula of the different professions is a challenge for many institutions because of the limited education and training of faculty staff in patient safety concepts. It is for this reason that WHO began, in early 2010, to develop a multi-professional guide to facilitate the education and training in patient safety of dentists, doctors, nurses, midwives, pharmacists through the introduction of safety topics in curricula. An Expert Working Group comprised of experts from around the world was called to contribute towards the development of the multi-professional edition. The testing and evaluation of the multi-professional edition of the WHO Guide is being planned for 2011 in 12 sites representing dental, midwifery, nursing and pharmacy schools around the world. WHO is focusing on raising awareness about patient safety education; it plans to disseminate the multi-professional edition of the Curriculum Guide worldwide and lead global efforts to mobilise resources and increase commitment to patient safety education.

Addressing Global Patient Safety Issues: An advocacy toolkit for patients organizations

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When we receive health care we expect, as a basic right, that it will be safe and of good quality; however, this is not always the case with patient safety incidents affecting patients all over the world, regardless of the status of national health care systems. In November 2008, the International Alliance of Patients Organizations (IAPO) launched an advocacy toolkit with the aims to equip patient advocates with a basic understanding of a range of important patient safety issues and provide a range of basic information and tools. IAPO has a core value of providing capacity building resources for patients' organisations and involving patients and patients' organisations in debate and policy-making at the international, regional, national and local levels. The toolkit, "Addressing Global Patient Safety Issues: An Advocacy Toolkit for Patients' Organizations", is the first multi-issue resource for patient groups, providing the means for patients and patients' organisations to engage in the provision of health care and contribute to a quality and safe health care system, and a reduction in harm to patients. IAPO's Toolkit presents information so patients' organisations can develop their understanding of the issues and enable them to get involved in information provision to patients and participate in policy debates in a meaningful way to improve patient safety. The toolkit focuses on a number of specific patient safety issues for example: Counterfeit Medicines, Risk Benefit Choice, Reuse of Single Use Medical Devices, Medical Errors etc. Each section of the toolkit has an introduction explaining the issue and guiding the reader through the different materials available. IAPO is involved in a number of patient safety initiatives and these initiatives are highlighted in the Toolkit (IAPO is on the Steering Group for Patients for Patient Safety, the patient involvement strand of the World

Health Organization's World Alliance for Patient Safety and a member of the World Health Organization initiated International Medical Products Anti-Counterfeiting Taskforce).

Patient's Safety Challenges in Oman: Need for collaborative thinking

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Health care services in Oman have witnessed tremendous improvements during the last few years. That was reflected in the number of health care facilities available and the number and type of specialised and sub-specialised health care services introduced recently. This improvement is coupled with assurance of good quality and safe health care service provision. However, such a noble target is faced with challenges that require in-depth analysis and then appropriate actions to avoid any dents in the successes already achieved by the health care system in Oman. One challenge is the changing trend of diseases from acute illnesses requirng few visits to health care facilities to chronic diseases, such as diabetes, that need frequent visits and the use of poly-therapy. This carries its own risk to patients and staff alike. Other challenges are the pushing and pulling factors that have affected the stable supply of skilled and competent health care professionals. This ultimately affects the quality and safe provision of services. Such a challenge is linked to the increasing cost of health care services, given the introduction of new modalities of treatment and equipment. The mass media present another challenge as issues they bring to public notice may impact the trust and the health care seeking behaviour of the community, thus affecting the quality and safe provision of services. Patient empowerment, on the other hand, is further challenge; if used appropriately it will help health care providers to make the patients and the community active players in any quality and safety assurance system. Finally, legislative rules and regulations play a major role in strengthening and sustaining the relationship between health care systems and patients, thus helping to build up a good rapport. The media and legislative rules and regulations on the delivery of good quality and safe health care services can use words that could widen the gap between health care providers and patients thus negatively affecting trust levels. In summary, the success of a health care system in delivering good quality and safe services is guaranteed if such challenges are faced and analysed, and then acted upon accordingly.

What Does Patient Centered Care Look Like?

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Patients are the most powerful drivers of quality improvement and patient safety. It is now an accepted fact that achieving high levels of patient satisfaction is fundamental to the clinical success of health care organisations; however patients still feel marginalised rather than empowered and involved in their care. While it is vital to ensure patients are treated with dignity and respect, research has also shown that patient centred organisations have achieved higher compliance with patient safety initiatives. Examples of this include: decreased rates of hospital acquired infections, decreased surgical complication, decreased mortality rates, improved clinical outcomes, greater compliance with medication safety and higher levels of staff satisfaction and retention. Yet despite the above, evidence suggests that while clinicians think it is important to ask patients about their expectations they are failing to perform this step. This presentation will examine international trends and the reasons why focusing on the patient is so important. Different frameworks for involving patients in their own care and in influencing service design and quality improvement projects will be explored. These will range from International programmes such as the Kings Fund Point of Care Project in the UK and Planetrees Designated Hospital Programmes in the US. International accreditation programmes will be assessed from the service users' point of view. Strategies for acquiring and using patient feedback will be examined. The trend of measuring patient satisfaction has now shifted towards patient experience tools. Patient satisfaction questionnaires are viewed as an entry point, but due to their subjective nature should be supported by other measures such as focus groups and open interviews. Learning from adverse events and patient complaints is another source of rich data that can be used to improve services. Finally, some results of key surveys and the importance of using results of measures to create change will be addressed.

Influence of Media on Health Norms

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Mass media are an integral part of the social environment in which people, especially young people grow up. Television, radio, movies and music videos can contribute to setting social norms. Socio-environmental models of health and well-being have considered mass media as an important and overwhelming force of social influence and socialisation for individuals and families. Media play a very important role in formulating the community culture so combined efforts by decision makers, health authorities and media experts could become a positive force in developing a positive health culture thus beneficially impacting both individuals and the community as a whole. Media can have both positive and negative effects. A number of issues and themes may be relevant to designing and implementing media programmes for young people such as the fact that– adolescents experience frequent strong emotions. Adolescents could be taught about the ways in which emotions can affect their thinking and therefore their behaviour and how to control them to make better decisions. Over self-confidence makes people feel they know something (whether they actually do or not) and means they will be unlikely to seek the additional information needed for good decision making. Teenagers need a variety of messages as no single message will be effective. They must be believable, and concrete and focus on social, health and legal risks. Exaggerating the prevalence of negative behaviors may encourage some youngsters to try risky behaviours because they perceive that everyone is doing it. The consequences of avoiding risky behaviors as well as the consequences of engaging in such behaviours should be stressed. Young people may fear the social consequences more than they fear the long-range health risks. Adolescents distinguish between experimental risky behavior and regular risky behavior, but may make decisions about engaging in a behaviour as if it were a one-time occurrence.

Subtracting Insult from Injury - Disclosure of medical errors

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Patients are often in vulnerable physical or psychological states, even with routine procedures. Therefore, when harm from an unexpected event occurs, especially from someone they trust, reactions can be severe and traumatic. A common human response to something going wrong is to ask: 'What happened?' A health care provider goes through the same issues after an error and equally powerful emotions are felt, such as shame, humiliation, fear, panic, guilt, anger and self-doubt. In response to this stress, physicians employ several coping mechanisms, including denial and distancing. "Physicians felt upset and guilty about harming the patient, disappointed about failing to practice medicine to their own high standards, fearful about a possible lawsuit, and anxious about the error's repercussions regarding their reputation" (Gallagher, Waterman & Ebers, 2003, p. 1005). This is compounded by fear of litigation, which causes physicians to feel guarded in their dealings with patients following an error. Health care professionals who are at the so-called "sharp end" of medical error are called the "second victim."

A common perception among physicians is that good doctors do not make mistakes. Because of this, physicians learn to keep mistakes to themselves rather than risk the judgment of their peers. In fact, the pressure to be perfect is so great that doctors admit they would lie to colleagues or patients to cover up a mistake. Out of concern for liability exposure, some doctors have given up their practices, limited the kinds of procedures they perform, or restricted the types of patients they see. Some patients resort to threatening lawsuits to solve a medical problem. Growing evidence indicates that apologies reduce litigation and offer great, though unquantifiable, emotional benefits for patients, families, and health care providers. A trusting relationship between provider and patient is the bedrock of medical care. Following an adverse medical event, patient and provider relationships face their greatest test. The key to success is open patient–provider communication and a true sense of caring. An apology helps to maintain a patient–provider relationship which should be followed by personal, repeated attention to the needs of the patient and family.

Safety in Health Care - Partnership

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In 2004, the World Health Organization (WHO) launched the World Alliance for Patient Safety. The main goals were: coordination and acceleration of international improvements in patient safety, ensuring the perspective and viewpoint of patients, families and health care consumers in developed and developing countries, and work in such areas as research, reporting and learning, designing and implementing solutions, classification for patient safety and a global patient safety challenge. Twenty-one participants were selected through an international call for applications from 19 countries from all WHO six geographical regions. This helped to create the Global Patient Voice, Statement of Purpose – London Declaration. The most important issue here is to encourage patients to be actively involved in their treatment. Leaders in patient safety should teach patients to initiate conversations about their condition and diagnosis, how to ask about the results of their treatment and the medicine dosage, and how to read leaflets about their care. It is important to ask caregivers how particular patient populations can be better reached and to promote staff collaboration at all levels and as well as strive for open communication.

Protocol for Prevention of Wrong Site Surgery

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Wrong site, wrong side, wrong person and wrong procedure are disastrous to the patient and to the surgeon involved, hence they must be prevented. Despite all the universal precautionary measures, wrong site surgery is still more common than surgeons are willing to accept. This results either from misinformation or misperception. A simple, practical protocol for prevention of wrong surgical event is presented with multiple checks incorporated into the system: involving many personnel and several stations. These include the outpatient department (OPD), ward, operating theatre reception area and finally the operating room. The checks are done at every stage in an easy, clear-cut manner as the patient is handled: initially by the clinician at the clinic, the anaesthetist at the pre-anaesthesia assessment, nurses in the OPD, in the ward or short-stay, and nurses in the premed room, and finally the operating surgeon, anaesthetist, circulating and scrub nurses in the operating room during the "time-out". This paper focuses on the role of various health care personnel, the consent techniques, the pre-op marking of the surgical site and the role of "time out" in the OT. The various problems that can be encountered include patient- and clinician-related factors. The protocol implements a system which prevents caregivers from committing errors and enables them to catch errors before they cause harm. The key to preventing wrong site surgery is multiple independent checks of critical information.

Integrating Patient Safety Indicators with Quality Performance Measures

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In health care it is well-known that what you cannot measure, you can not improve. As health care professionals we seek continual improvement of the health care service we provide; therefore, the use of reliable indicators to measure service performance is a necessity in order efficiently to identify potential problems and make corrective actions. Furthermore, through trend analysis over a period of time, across communities or regions and over a population, we are able to establish preventive measures and mechanisms to avoid reoccurrence. When the 2001 Institute of Medicine study entitled "To Err is Human" was brought to the public's attention, it became

clear that such measures in fact extend beyond the acute care and needs of the patient, to multiple dimensions of care and coping with the needs and expectations of the patient, family and community. In modern and specialised hospitals and health care institutions, quality performance measures are being used for applications beyond quality improvement, building on performance demonstration projects for excellence. They respond to the multi-processes, disciplines and specialities of health care delivery and quality care. Measures include audit, peer review, key performance indicators and continuous quality initiatives. Seeking continual improvement with concern for the safety of the patient and the environment raises the need for patient safety awareness and the implementation of indicators which integrate with the established quality performance measures, ultimately resulting in multiple dimensional indicators. In response to this need of multiple dimensional, accessible quality and safety indicators in a hospital environment, this presentation aims to identify and emphasis the importance of developing and implementing a family of measures. These can be used by health care providers, policy makers, statisticians and researchers with their own inpatient data to identify variations in the quality of inpatient and outpatient care and to move towards excellence in quality health care provision and safety for all.

Nurses Perceptions of Safety Culture at Hamad Medical Corporation (HMC) in the State of Qatar

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The safety culture in any health care organisation depends on the improvement of the safety measures delivered to increase patient care and learn from lessons, and the proactive strategies in place to prevent future errors. We evaluated registered nurses' perceptions of safety culture in the units where they provide nursing care at Hamad Medical Corporation (HMC). The Agency for Health care Research and Quality's (AHRQ) patient safety culture instrument (Hospital Survey of Patient Culture) was modified and used for the purpose of this study. A total of 800 questionnaires were distributed to randomly selected nurses from 8 targeted clinical services with a response rate of 57%. The results of this study were compared with those from American hospitals using the original AHRQ survey. Ranking of subscales for this study in terms of strengths and areas needing improvement were almost identical to the ranking US hospitals results, with teamwork within units ranking highest and indicating a strength; and the subscale non-punitive response to errors the lowest, and indicating an area for improvement. Positive response rates in terms of safety culture for this study were generally lower on most subscales compared to the US results and may reflect the intensity of patient safety improvement activity in the US over the last eight years. This was done in response to the Institute of Medicine's report on medical errors in 1999. Results from this study are presented with a baseline measurement for safety culture at HMC and suggestions as to how the instrument that can be adapted for use in other Middle Eastern health care organisations.

Improving Quality and Safety in Health Care through Connected Technology - A chief executive officer's perspective

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The role of health service Boards of Governance now is far greater than simply ensuring that financial and corporate matters are appropriately managed. The emergence over the past 10 years of the principle of Clinical Governance now requires Boards and Chief Executive Officers (CEOs) to be accountable for the quality and safety of all those who enter their facilities whether they be patients, staff or visitors. While modern patient administration and clinical information systems provide sophisticated functionality to support quality of care objectives, recent developments enabling health care organisations to harness the data collected in these systems in real-time is empowering these organisations to make smarter, faster, more informed decisions than ever. Connected systems with embedded business intelligence capabilities enable CEOs to track key performance indicators in a single view, triggering alerts to enable early intervention. At a higher level, Boards can receive reports that signal areas of concern while ensuring that clinicians and managers are more accountable for the activities that occur throughout their hospitals.

Improving Patient Safety using Quality Tools and Techniques

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Patient safety is a discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery. Patient safety is also an attribute of health care systems; it minimises the incidence and impact of adverse events and maximises recovery from them. The focus is on how to improve patient safety in health care. By using different tools and techniques, two of the tools represented will include: failure mode and effect analysis (FMEA) and root cause analysis (RCA). These tools were used to avoid events and improve or maintain the quality of care. FMEA was used prospectively to identify potential areas of failure where experimental characterisation of the process at the desired speed of change could be assessed. Retrospectively RCA was used to characterise the safety of a process by identifying potential areas of failure and learning about the process from the staff's point of view. Using a flow chart of the process, before beginning the analysis, got the team to focus and work from the same document. Information learned from the FMEA was used to provide data for prioritising improvement strategies, serve as a benchmark for improvement efforts, educate and provide a rationale for diffusion of these practice changes to other settings, and increase the ability of the team to facilitate change across all services and departments within the hospital. Using FMEA facilitated systematic error management which was important to good clinical care in complex processes and settings. It depended on a multidisciplinary approach, integrated incident and error reporting, decision support, standardisation of terminology, and education of caregivers.

Patient Safety at Sultan Qaboos University Hospital

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Sultan Qaboos University Hospital (SQUH), opened in 1990, is the leading teaching hospital for medical students, medical and surgical residents and nursing students in Oman. In addition to teaching and conducting medical scientific research it provides excellent clinical services and the health care quality standards are in compliance with international norms. Patient safety is one area of quality practised at SQUH. The International Patient Safety Goals recognised by the World Health Organization have been adopted by many health care institutions in order to provide safe care for their patients. These Goals address the following crucial patient safety subjects: improving the accuracy of patient identification; making communication more effective; improving the safety of using high-alert medications; ensuring correct-site, correct-procedure, correct-patient surgery; reducing the risk of health care associated infections, and reducing the risk of patient harm resulting from falls. Currently patient identification is addressed by using both verbal and visual verification techniques and patient ID bands contain the full name of the patient and medical record number; they are matched during investigations and procedures and prior to administering medications. Electronic labels are used for blood samples and medications. Newborns receive two ID bands in the delivery suite and another one is placed on mothers' wrist. Identifications of both caller and receiver are used when communicating critical laboratory values. The values are read out with the unit and the receiver must read back the report; both documented medical records and numerical digits pronounced separately. There are restrictions for verbal medication orders. High alert medications are handled with extra care. Preoperative checklists and the 'time out' technique are practiced to ensure correct site procedures and correct patient surgery. Various measures exist to reduce health care related infections: use of antiseptics and sterilisation procedures together with the implementation of hand hygiene and surveillance of nosocomial infections. Finally, measures are in place to reduce risks of patient falls by giving instructions to the patient, as well as the use of bed bars.

Medical Error(s) Disclosure and its Impact on Malpractice Litigation

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Regardless of all attempts made to minimise medical errors, they still nonetheless occur and place significant financial burdens on health services as well as having a negative impact on health professionals. The debate continues on the advantages and disadvantages of disclosing medical errors to patients or their relatives. There are still a number of barriers related to medical error disclosure, due to issues related to the health system, patients, and law. However, emerging evidence from hospitals where medical error disclosure to patients/relatives is systemically employed shows that disclosure has reduced litigation liabilities considerably. It is therefore imperative that efforts be made to train health workers in medical error disclosure as this will consequently have a positive impact on patient safety and may reduce endless litigations against physicians and the health system.

A Study to Analyze the Use of Internet as a Tool in Increasing Safety of Medical Devices

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High quality, well designed medical devices are required to provide safe and effective clinical care for patients as well as ensuring the health and safety of health care practitioners and users. The Internet is a very important source of information for health care providers providing immediate access to updated information in health care technology. Factors limiting practitioner access to the Internet have been identified and the literature shows that access to the Internet varies across and within health professions. There has, however,been no identified empirical research investigating practitioner access to or use of the Internet in medical device technology assessment. This study sought to establish the professional use of Internet-based tools by Sultan Qaboos University Hospital (SQUH) practitioners in increasing the safety of medical device use. In this study, both qualitative and quantitative approaches were used, including interviews with 30 practitioners from nurses, technologists, doctors, to consultants and biomedical engineers. In addition, a one page survey questionnaire was distributed 75 randomly selected 75 practitioners. They were asked different questions related to their use of the Internet as a tool to increase patient safety. Also preventive maintenance (PM) records of 400 equipment items were analysed for device recalls or alerts. In conclusion, the Internet as a vital source of information was widely used by SQUH practitioners; however, there was no indication that they used it to obtain safety updates on medical devices. Nonetheless, more than 70% of the practitioners were willing to be part of a systematic approach to using the Internet as a tool to increase medical devices safety. This study provides baseline data to establish an Internet based approach in increasing the safe use of medical devices.

A Safe Patient Journey through Patient Flow Management

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Patient flow management plays a key role in the hospital; it helps health care organisations achieve safe and advanced outcomes of patient care, through improving patient access to acute care services and their safe and effective flow through the hospital towards discharge. However, it also allows real-time information about their patients without multiple calls to various departments and staff. It should be a collaborative process that assesses, plans, implements, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality outcomes. An effective patient flow

management system actively manages patient care from admission through the entire continuum of care. Each hospital should have a core patient flow management team with operational responsibility for bed management and discharge planning. The main three goals for the Patient Flow Manager are: improve Accident & Emergency performance; facilitate reductions in the length of stay, and improve the patient experience. The flow of patients through an acute hospital depends upon a complex set of relationships between many departments, services and people. Conquering developments in the way patients move through such a complex system requires a synchronised approach to admission, treatment and discharge of patients based on core principles of system efforts. It requires hospitals to unpick the complexity of their existing processes so they can understand where the key bottlenecks exist within their clinical units. It also requires a fundamental commitment to providing safe, effective, efficient and timely care whereby services are designed first and foremost according to patient needs. Successfully improving flow across an organisation requires an extraordinary level of commitment to a complex and exhaustive change process. It also requires acknowledgement that there may, at times, be a requirement to tackle issues that have previously been 'taboo' within the organisation.

Improve the Accuracy of Patient Identification

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Sultan Qaboos University Hospital (SQUH) is committed to provide a safe environment for all of its patients. The vision of the SQUH Nursing Directorate vision is to strive for safe practice for their in and outpatients. One of the main goals for the Joint Commission of National Patient Safety in USA is to promote patient safety in the practice of the organisations (JCI, 2010). The National Patient Safety Goals make an effort to improve the health care before patient errors occurs. SQUH has adopted six patient safety goals. One of the goals is Patient Identification. It is internationally recognised as a goal which is adopted by major patient safety agencies like the World Health Organization, JCI, Center for Patient Safety and other agencies who deal with patient safety and aim to reduce errors and improve patient identification. There are many causes of patient identification errors during admission, discharge and transfer. The failure to identify, or the misidentification of a patient, can lead to medication errors, transfusion errors, wrong-site of surgery and wrong diagnosis. A randomised audit with closed-ended questions was distributed to the nursing staff. Data from unannounced audits of patient identification were plotted and shared with the Nursing Directorate and staff nurses. The results of the audit bring significant improvement and awareness among the staff about patient identification with clear expectations to immediately stop the line if a patient identification error is identified. Patient identification accuracy is an essential procedure in patient safety and, in many hospitals, correct patient identification and wearing of an identification band are essential procedures to meet accreditation standards. Policies in patient identification vary from hospital to hospital to comply with standard practices of patient identification.

Safe Care is the Soul of Your Care

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Yearly hundreds of thousands of patients worldwide either die or end up with disabilities because of errors committed by health care providers. Such statistical reports shocked the international community and prompted the World Health Organization and other organisations to take strong action. They have made efforts had taken place to identify the sources of these errors; astonishingly, the causes were negligence and ignorance of the basic rules and regulations that had been set in place to ensure patient safety. The poster shows three areas that affect patient safety. Caricature illustrations have been used to show four situations which are then described below. 'To Err is Human' is not only statement but an undeniable fact as has been proven by many studies. In 2009, the World Health Organization (WHO) announced that their study conducted in 2004 found that of 187–281 millions surgeries performed, 5–10% resulted in death due to complications and that half of these were preventable. When patient identification rules are followed before surgery, the risk of errors and their negative or even fatal consequences decreases. Some of the studies have rated medication error as the highest cause for morbidity and mortality related medical injuries. They found that most of these errors occur during medication administration. Therefore, Joint Commission International or JCI (an internationally recognised body for accreditation of health care institutions) has set Medication Safety as one of the highest priority goals for patient safety.

The Internet and Psychiatry, Effect on Suicidal Behaviours

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The Internet is increasingly used to access health data and information. This explosive growth brings threats as well as opportunities. The Internet has a remarkable effect on medicines and psychiatry. It can promote the idea of several harmful behaviours, such as suicidal attempts. It is extremely easy to access information about suicide from the Internet. Recent articles have described use of the Internet by individuals to obtain instructions on how to complete a suicide. Editorials and discussions have focused on the existence of these sites and the information they provide. A large number of websites and discussion groups provide information identifying methods of self-harm. One site described using guns, overdosing, slashing one's wrists, and hanging as the "best methods to commit suicide." The researchers used popular search engines to find pages using simple terms like "painless suicide" and "how to kill yourself" and were disturbed to find that only a fifth of the resultant sites offered support or prevention. Vulnerable individuals have been sharing information about suicide. There are examples of interactive notes followed by a suicide fatality. Many studies have reported a significant degree of clustering of suicides following media coverage of a suicidal event or personal contact with a suicide victim. The Internet can potentially influence people's thoughts and behaviours when it comes to suicide; however, it can be utilised to prevent such events. Comprehensive studies should be conducted to support Internet use for suicide prevention.

Together We Shine - Media, patient safety and nurses

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The role of media in promoting patient safety around the world has been well established. It is fast becoming one of the most effective ways to monitor patient safety and provide real time commentary. Movement toward these media networks is evident as the health care industry recognises the importance and benefits of spread using media. The news media have been an important force in prompting patient safety improvement efforts around the world. It was the news media's history of skepticism about the medical profession that ultimately changed the attitude of health care industry towards patient safety. However, allowing media to be a part of the patient safety initiative has also proven to be effective in not only reducing errors, but also empowering patients and families as partners of health care. The media is influential at the level of individual patient, his/her family and society at large. The media can promote patient safety in the following ways: Disturb, stir up, encourage debate; Set agendas - "Tell people what to think about"; Legitimise - "If the newspapers are talking about safety, it must be important"; Reporting cases to the world - the world is interested; Reporting data; Explaining error: Why does it happen? What can be done? and Generating political commitment for improvement. What we need currently is a cultural and a political change in the health care industry towards consciousness of patient safety issues. The willingness on part of the health care industry to accept the errors and remedy them will emerge only through a cultural shift. Nurses have always been advocates of patient safety. Changes in attitudes and culture will not occur if efforts are not united. A joint effort of the nurses with the media will ensure that appropriate attention is given to patient safety issues. The formulation of a joint committee with members from the local media at every hospital will be the first step in this endeavour.

Patient Safety Goals

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Patient safety has become a serious global issue in recent years. This was the result of many reports and studies initiated for patient safety. In 1999, a report by the Institute of Medicine estimated that as many as 44,000 to 98,000 people die in U.S. hospitals each year as the result of lapses in patient safety measures. One study found that there is one chance in 1,000,000 of travellers being harmed in aircraft; in comparison there is a one in 300 chance of a patient being harmed during health care. Another study showed that at any given time 1.4 million people worldwide suffer from infections acquired in hospitals. Another study estimated that in developed countries as many as one in 10 patients is harmed while receiving hospital care; this could be caused by a whole range of errors or adverse events as stated by World Health Organization (WHO) in 2010. Therefore, countries have increasingly recognised the importance of improving patient safety. In 2002, WHO Member States agreed upon a World Health Assembly resolution on patient safety. The Joint Commission International (established in 2002 to help accredit health organisations) set The National Patient Safety Goals (NPSGs) which address specific areas of concern in regards to patient safety. NPSGs underwent an extensive review process in 2009 resulting in revised 2010 NPSGs. To highlight the importance of this global movement, we use informative and eye-catching posters throughout our hospital to communicate and reinforce the awareness and importance of PSGs to health care workers. PSG Posters are based on the 2008 National Patient Safety Goals of the WHO and The Joint Commission.

Medication Market in Patient Safety

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Patient safety and medical error have become major issue socially and legally worldwide. Technology can play a role in preventing the possibly fatal consequences of such errors. The electronic medication administration record (eMAR) bar code is an important way to improve medication safety. eMAR is a combination of technologies that ensures that the correct medication is administered in the correct dose at the correct time to the correct patient. When nurses use this combination of technologies, medication orders appear electronically in a patient's chart after pharmacist approval. Alerts are sent to nurses electronically if a patient's medication is overdue. Before administering medication, nurses are required to scan the bar codes on the patient's wristband and then on the medication. If the two do not match the approved medication order, or it is not time for the patient's next dose, the system issues a warning. Moreover, several studies have shown that the eMAR system reduces the rate of error not only in medication administration, but even in the order transcription, and as well as reducing potential adverse drug events. Furthermore, it plays a role in educating the nurses, doctors and pharmacists. For instance, bar code scanning requires the nurse to check heart rate prior to administration of diagoxin. In conclusion, bar codes can be beneficial only if health care providers use them properly so training is vital to assure the success of eMAR.

Parental Knowledge and Compliance with Neutropenia Care Guidelines in Children Admitted with Leukaemia at SQUH, Oman

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Leukaemia, cancer of the blood forming tissues, is the most common form of childhood cancer (American Cancer Society, 2007). Acute leukaemia is the most common malignancy in children in Oman. It accounts for over one-third of all childhood cancers, 75% of them being acute lymphoblastic leukaemia (ALL). The paediatric hemato-oncology unit at Sultan Qaboos University Hospital (SQUH) is the National Referral Centre for childhood leukaemia in Oman. Despite advancements in the management of childhood leukaemia, the complexity and challenge of caring for children continues. Chemotherapy is the mainstream treatment for child hood leukaemia. Aggressive chemotherapy protocols result in neutropenia in approximately half of all patients receiving chemotherapy (Ozer et al.,

2000). Thus, neutropenia continues to be a significant and potentially life-threatening side effect of treatment. In a paediatric setting, the families of children are actively involved in the management and care of leukaemia. Hence, it is necessary to ensure that they provide a safe therapeutic environment for children in the neutropenia stage in the hospital and at home. The study examined parental knowledge and compliance with neutropenia care guidelines in children admitted with leukaemia at SQUH. The objectives of the study include assessing the knowledge and compliance of parents regarding neutropenia in children admitted with leukaemia; identifying the information needs of parents of children with neutropenia; exploring the factors affecting compliance in the home care of children with neutropenia, and to examine compliance of parents with neutropenia care guidelines and selected factors.

Patient Safety - A shared responsibility for ensuring quality care

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Patient safety is one of the nation's most pressing health care challenges. Statistical reports suggest that 1 in 10 patients globally are adversely affected by health care errors. Worldwide 1.4 million people suffer from hospital acquired infection (World Health Organization, 2009). Patient safety is defined by the Institute of Medicine as "the prevention of harm to patients". The current emphasis is on the health care system focussing on preventing error, learning from the errors that have taken place in other health care set ups else, and building a culture of safety that involves health care professionals, organisations and patients. Patient safety, as a vital component of quality nursing care, requires that safe care is delivered in an appropriate, timely, efficient, equally to all individuals seeking health care. This paper highlights the role of health team members in providing safe care by ensuring the necessary communication, leadership, and mutual support with constant situation monitoring. It is the responsibility of the health care team to give their best performance, to increase their level of knowledge and to have a positive attitude towards safer health care. Teamwork and shared responsibility will ensure better health care, minimise errors and thus promote better health care outcomes

Role of the Media in Patient Empowerment

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The mass media have become an integral part of our daily life; we spend most of our time in front of the TV, on the Internet or reading newspapers. Mass media have long been an attractive method for implementing and discharging institutional responsibility for the promotion of good health practices as well as the prevention of various social and health problems. The huge amounts of information available has affected peoples' attitudes to health related issues including outcomes. An issue of great importance for public health today is how to develop programmes that change behaviour in order to improve the health of our population. Over time people's knowledge about health related issues has increased in terms of their ability to make their own decisions regarding their health management. It is no longer just the word of the health care provider that ensures better health outcomes for the patient; the responsibility is now shared by the health care provider and the patient. Mass media indeed could be used effectively in providing the proper information so that clients can cooperate with the health care provider to improve their life style and health outcomes; however, this study shows that mass media can also transfer poor information to people. It also illustrates how mass media contributes to people's knowledge of their rights to participate in their health care plan; how people interact and deal with the media; whether they believe in the information broadcasted by the media, and whether they apply that information in their life.

Nurses' Role in Patient Empowerment and Autonomy for Safe Care: SPEAK UP

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The words "empowerment and autonomy" have been broadly defined as an enabling process through which individuals or communities take control of their lives and their environment. In this millennium, patients are no longer just the receivers but also the partners of care. As such, patients have the right and power to change the way the health care system functions. In order to do this, they need to be empowered with the necessary information. Nursing places patient empowerment and autonomy as a central remit of nurses; however, achieving genuine patient empowerment is not easy and requires individuals and organisations to alter their beliefs, values and behaviours. The word empowerment builds upon the Latin root potis, from which we derive both the words power and freedom. Patient empowerment or autonomy in the health care context means to promote autonomous self-regulation so that the individual's potential for health and wellness is maximised. Empowerment requires an individual to have the autonomy to take care of him or herself and make choices about care from among the options identified by the doctor. Patient empowerment begins with information and education and includes seeking out information about one's own illness or condition, and actively participating in treatment decisions. Autonomy means that patients actively participate in their treatment and are empowered to be assertive and communicate their concerns. This paper describes how a nurse-led campaign, 'SPEAK UP" can empower patients for safe care through education and autonomy. ***S***peak up if you have questions or concerns; ***P***ay attention to the care you are receiving; ***E***ducate yourself about your condition; ***A***sk a trusted friend to be your advocate; ***K***now your medications (what and why); ***U***se a health provider that measures safety; ***P***articipate in all decisions about your care.