Patient Safety Culture and Adverse Events in surgical context

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NORNA 07.09.2023

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Adverse Events (AEs)

“Unintended actions or an omission
that leads to or can lead to
harm or injuries
related to healthcare
and not to the underlying disease»

Jung, 2019, Vikan et al, 2023

Adverse events (AEs)

10% of patients in high-income countries

50% are estimated to be preventable

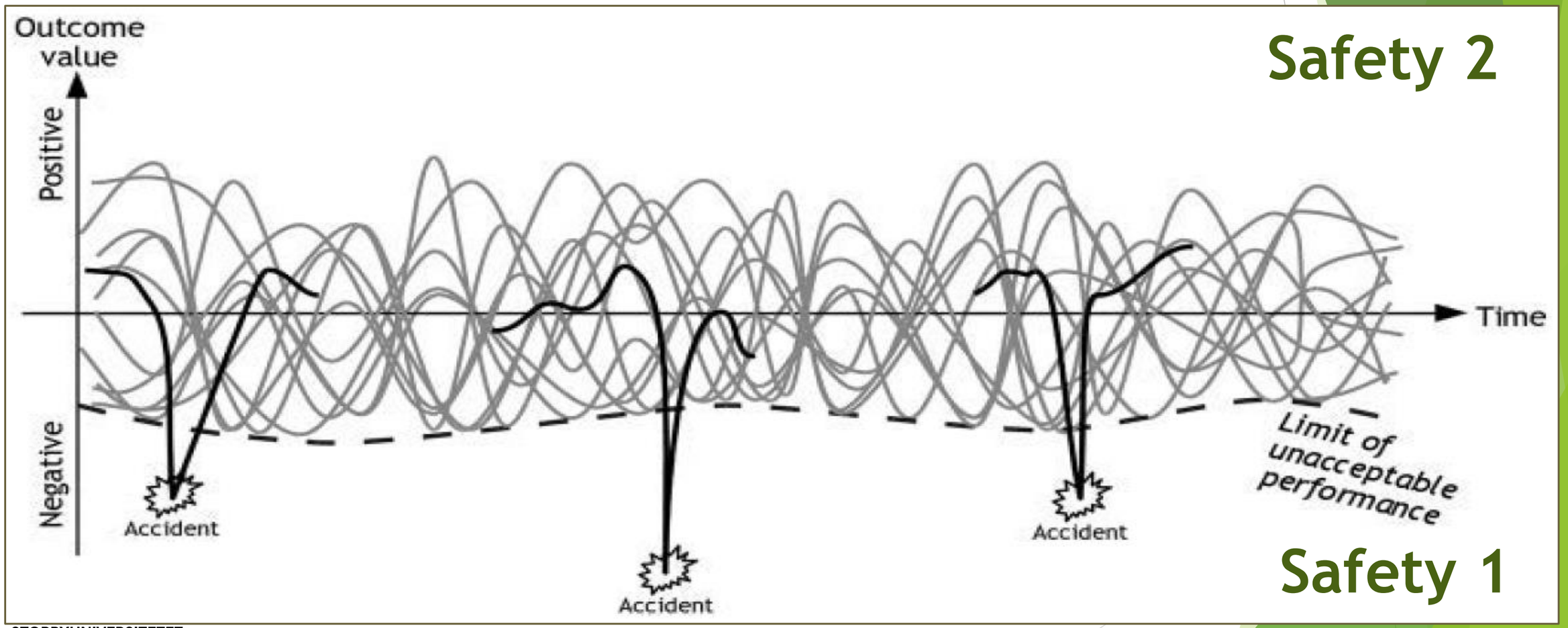
60% are related to surgery context

15% of costs in hospitals in OECD-countries

Measurement AEs

OECD, 2017, National Academies of Science, 2018, Schwendimann et al, 2018, WHO 2021

Safety 1- and Safety 2- perspective



Hollnagel, 2015 and 2018

Safety 2: Key potentials in resilience

Hollnagel, 2015 and 2018

Patient Safety Culture

"The overall attitudes and patterns of behaviours related to the patient safety work at multiple levels in an organization;

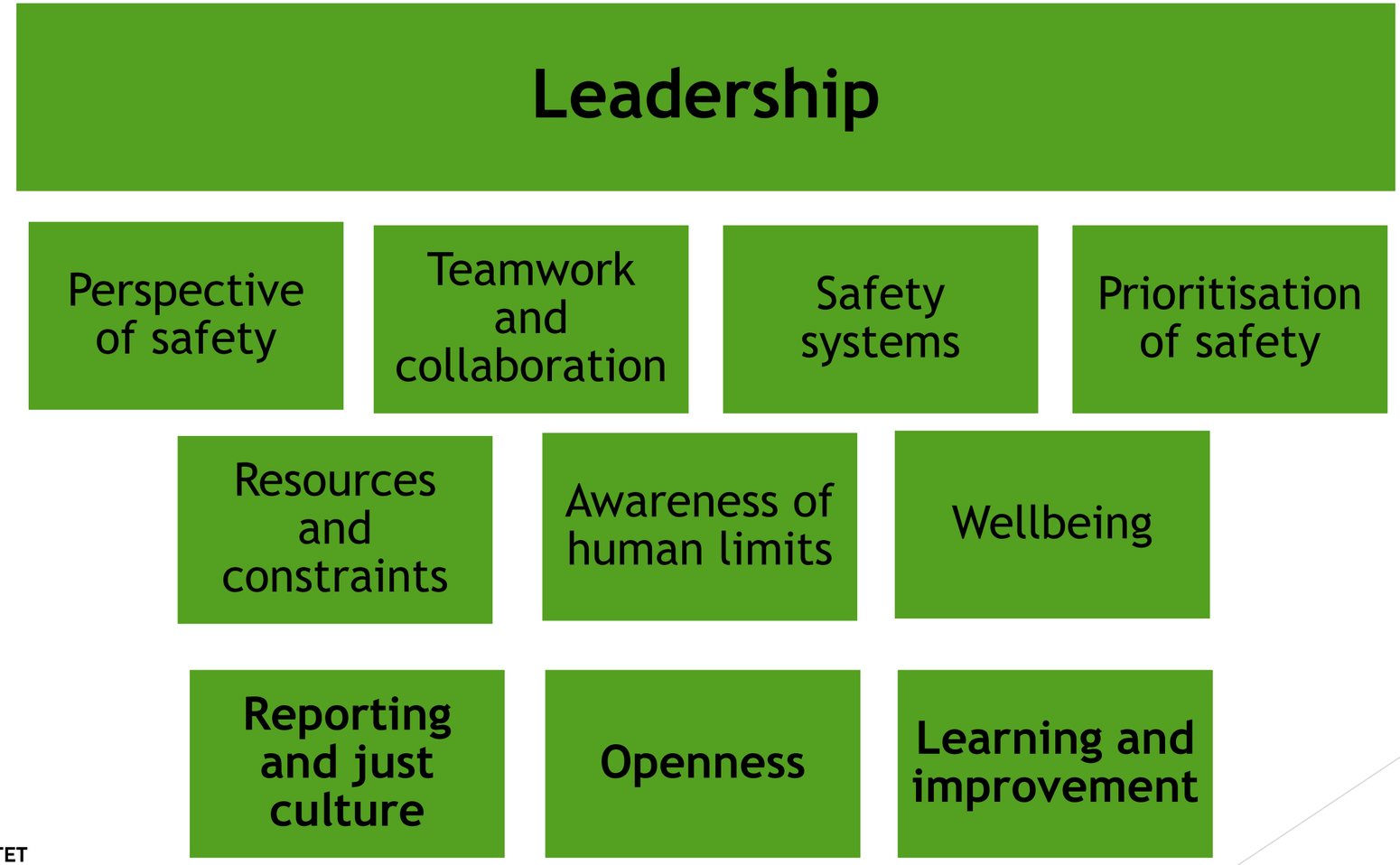
The product of individuals` and groups` shared values, beliefs and norms influencing their actions both in preventing AEs in care delivery and when an AE occurs"

AHRQ, 2023, Vikan, 2023

Recommended tools: Safety Attitude Questionnaire and Hospital Survey of Patient Safety Culture

Churruca, 2021, Malik, 2020

Dimensions in Patient Safety Culture



Churruca, 2021

A culture of openness

- Reporting and just culture
- Openness
- Learning and improvement

Churruca, 2021

Study 1- The association between patient safety culture and adverse events – a scoping review

Objective:

- To summarize the evidence on the association in healthcare services
- Map the applied research methodology and characteristics in the included studies
- Study the strengths and limitations of the evidence

Methods: PRISMA ScR checklist

The association between patient safety culture and adverse events – a scoping review | BMC Health Services Research | Full Text (biomedcentral.com)

Study 1- Results

An increased Patient Safety Culture- score is associated with reduced rates of AE in 76% of the evidence

Multicenter design

High-income countries

In-hospital

Methodological variations, variation in quality

Study 1: Conclusion

- Increased Patient Safety Culture (PSC)- scores seem to be associated with more positive outcomes for the patient
- There is a need for more uniform use of tools validated in its context
- There is a need for high-quality, longitudinal and prospective studies to support the findings
- PSC assessment needs to be considered with other structural and processual factors
- A need for an in-depth understanding of the concepts and their association, including the context`s complexity, structural and processual factors

Study 2: The surgical team

Objectives:
To elaborate the understanding of patient safety culture and adverse events Identify themes of interest for quality improvement and education To explore and identify the perceived causes for AEs in the OR department
Methods:
Individual interviews Participants: The surgical team Reflexive thematic analysis

Study 3: Previous surgical patients

Objectives:
• To explore patient`s perceptions of patient safety and adverse events in a surgical context • Identify themes and issues to support quality improvement • To generate hypotheses to guide further research and quality improvement intervention designs
Methods:
Interviews with previous surgical patients Reflexive thematic analysis

NPE, 2023, Thomas 2021, Hågensen 2019

- The AE-rates is too high, and 60% is related to surgical context
- Increased PSC scores seem to be associated with reduced AE rates
- PSC dimensions are complex, and should be assessed with uniform tools and related to structural and processual factors
- Surgical departments should work systematically with their PSC; Be open and learn from AEs and successfull experiences!
- Follow my work!
  https://www.researchgate.net/profile/Magnhild-Vikan?ev=hdr_xprf
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Project members

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Thank you for listening!

Comments or questions?