Запорізький державний медичний університет

SAFETY II – ІННОВАЦІЯ СУЧАСНОЇ АНЕСТЕЗІОЛОГІЇ ТА ІНТЕНСИВНОЇ ТЕРАПІЇ

С.Воротинцев
ЗДМУ

Київ, 19.04.2019

Я не маю конфлікту інтересів

Evolution of Safety in Health Care

1. Standardization	Rule formation Harvard practice standards: 1985
2. Compliance	Rule adherence Just culture: 2000
3. Mindful flexibility	Rule adaptation Resilient health care: 2010

Sven Staender, Euroanaesthesia 2018

European Board of Anaesthesiology EBA U.E. M.S.

European Society of Anaesthesiology ESA

SPECIAL ARTICLE

The Helsinki Declaration on Patient Safety in Anaesthesiology

Jannicke Mellin-Olsen, Sven Staender, David K. Whitaker and Andrew F. Smith

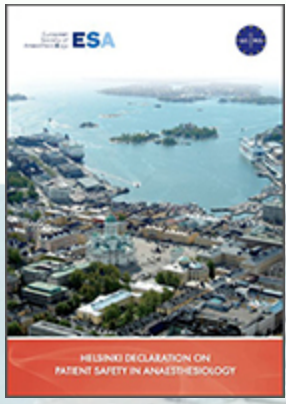
Anaesthesiology, which includes anaesthesia, perioperative care, intensive care medicine, pain therapy and emergency medicine, has always participated in systematic attempts to improve patient safety. Anaesthesiologists have a unique, cross-specialty opportunity to influence the safety and quality of patient care. Past achievements have allowed our specialty a perception that it has become safe, but there should be no room for complacency when there is more to be done. Increasingly older and sicker patients, more complex surgical interventions, more pressure on throughput, new drugs and devices and simple chance all pose hazards in the work of anaesthesiologists. In response to this increasingly difficult and complex working environment, the European Board of Anaesthesiology (EBA), in cooperation with the European Society of Anaesthesiology (ESA), has produced a blueprint for patient safety in anaesthesiology. This document, to be known as the Helsinki Declaration on Patient Safety in Anaesthesiology, was endorsed by these two bodies together with the World Health Organization (WHO), the World Federation of Societies of Anaesthesiologists (WFSA), and the European Patients' Federation (EPF) at the Euroanaesthesia meeting in Helsinki in June 2010. The Declaration represents a shared European view of that which is worthy, achievable, and needed to improve patient safety in anaesthesiology in 2010. The Declaration recommends practical steps that all anaesthesiologists who are not already using them can successfully include in their own clinical practice. In parallel, EBA and ESA have launched a joint patient safety task-force in order to put these recommendations into practice. It is planned to review this Declaration document regularly.

Eur J Anaesthesiol 2010;27:592–597

Keywords: education, patient safety, perioperative care, standards

Received 15 March 2010 **Revised** 9 April 2010
Accepted 19 April 2010

Patient safety Actions



Helsinki Declaration Requirements

1. Monitoring Standards
2. Protocols
3. Sedation Standards
4. Safe Surgery Lives Checklist
5. Annual Report Patient Safety
6. Annual Report Patient Morbidity & Mortality
7. Audits and Incident Reporting Systems

Eur J Anaesthesiol 2010; 27:592–597

Professor Erik Hollnagel

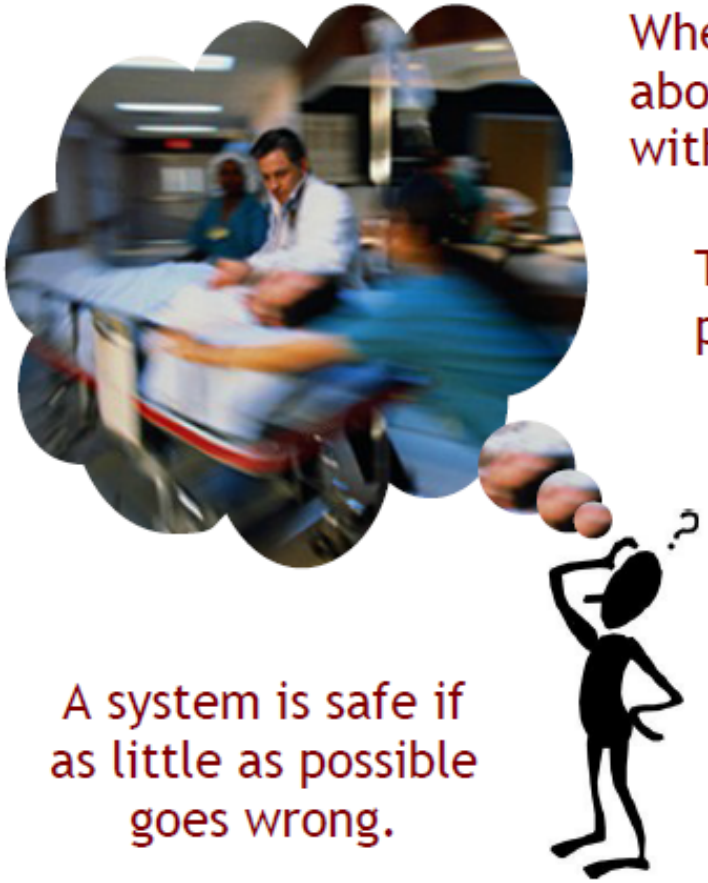
Professor Jeffrey Braithwaite

Professor Robert L Wears

From Safety-I to Safety-II: A White Paper

How do we think about safety?

Region Syddanmark



When we think about safety, we usually think about accidents - about (low probability) events with adverse outcomes.

The central aim of patient safety is to prevent or at least reduce harm to patients.

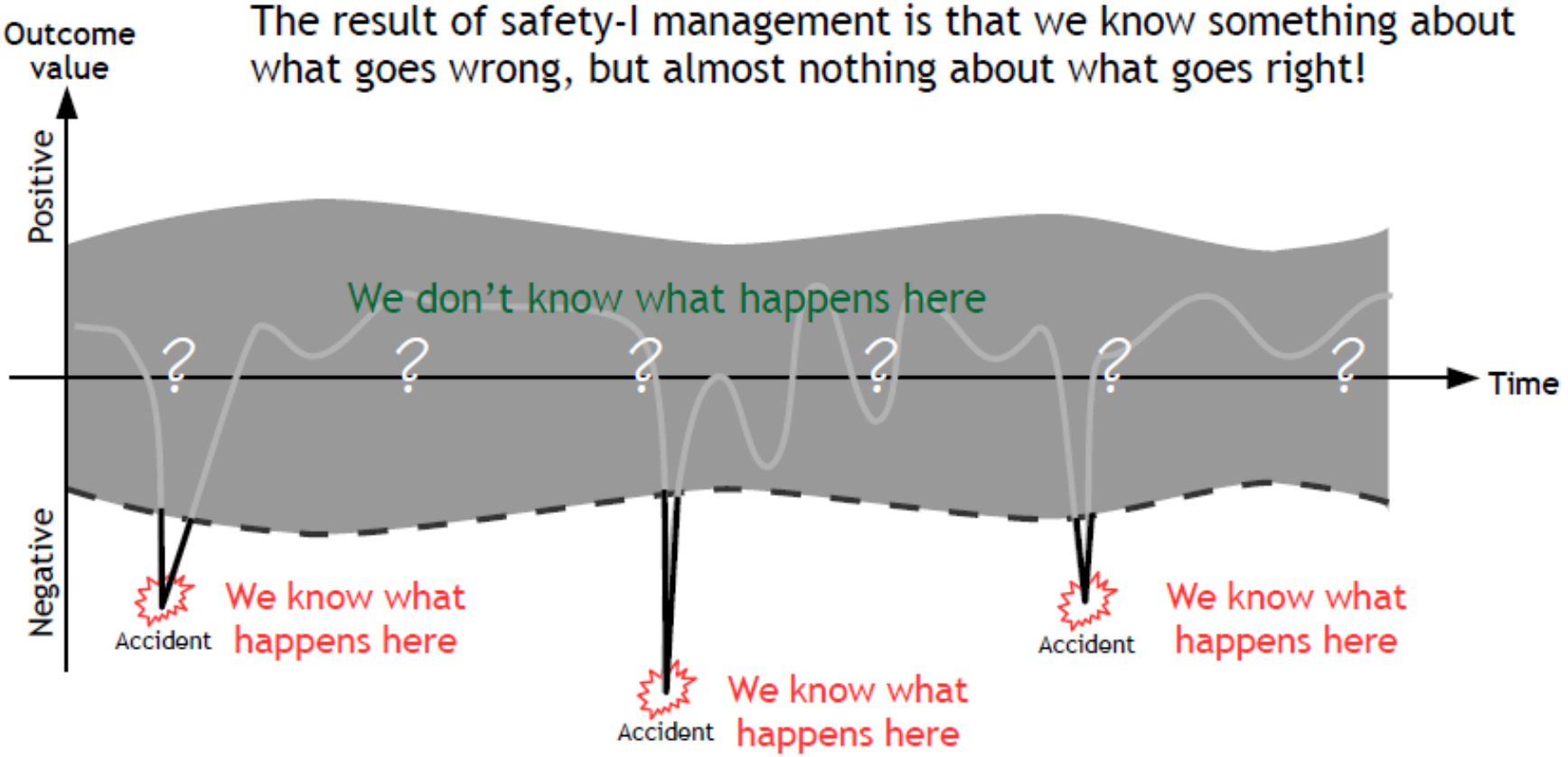
A system is safe if as little as possible goes wrong.

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

Safety is:
'freedom from accidental injury'
'avoiding injuries or harm to patients from care that is intended to help them.'

Do we really know how the system works?

Safe tysyn thesis



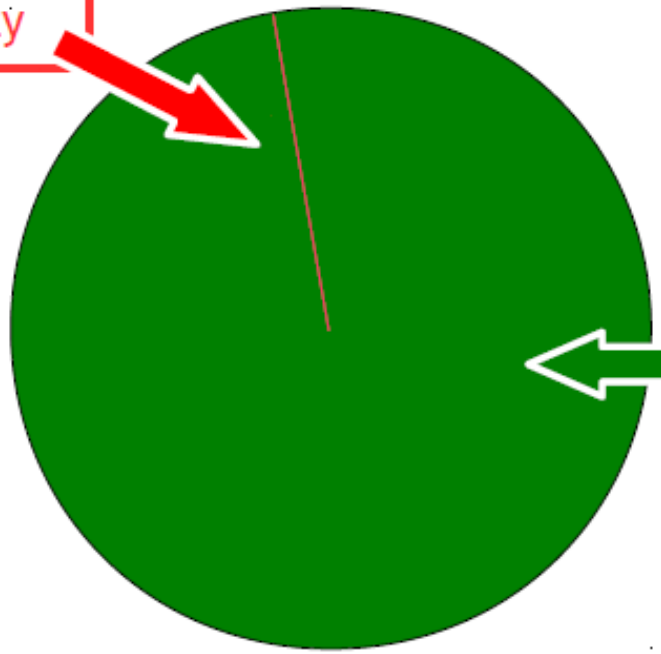
What should we be looking for?

Safe tysyn thesis

10^{-4} := 1 failure in 10.000 events

Adverse outcomes =
Absence of safety

Easy to see
Complicated aetiology
Difficult to change
Difficult to manage



'Difficult' to see
Uncomplicated aetiology
Easy to change
Easy to manage

Intended outcomes =
Presence of safety

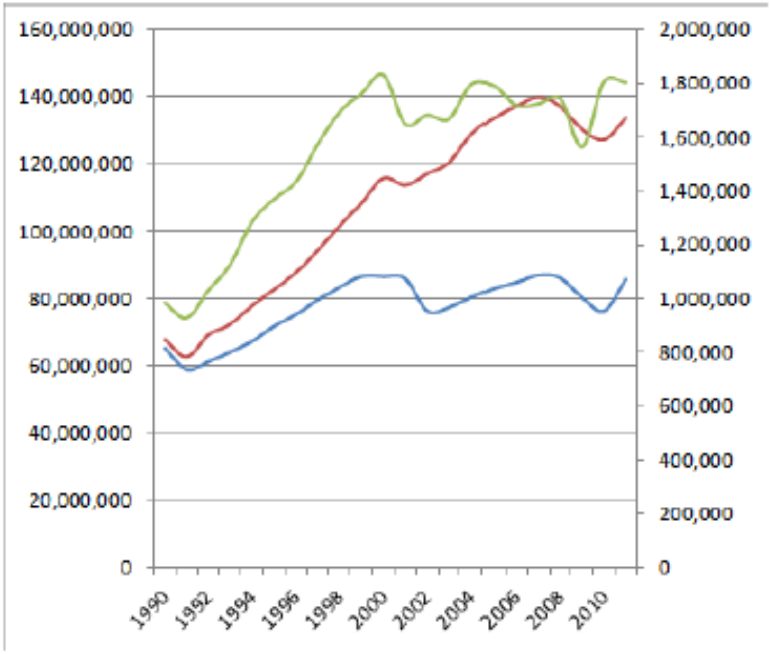
1 - 10^{-4} := 9.999 "successes"
in 10.000 events

Thinking about safety

Region Syddanmark

A system is safe if as much as possible goes right.

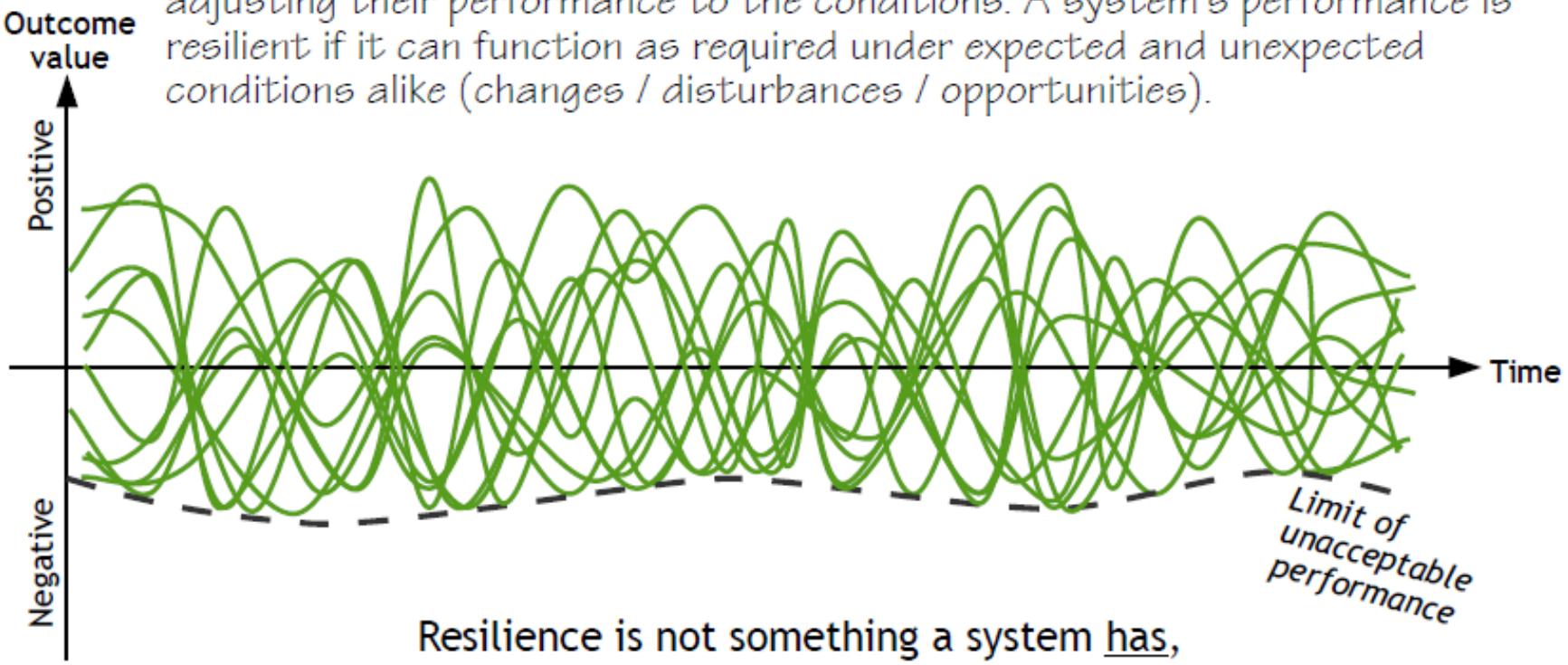
We should think about safety in terms of how many things go well and how frequently we succeed.



The focus of resilience

Safe tySyn thesis

Resilience is an expression of how systems cope with everyday situations by adjusting their performance to the conditions. A system's performance is resilient if it can function as required under expected and unexpected conditions alike (changes / disturbances / opportunities).



Resilience is not something a system <u>has</u>,
but something a system <u>does</u>.

What should we be looking for?

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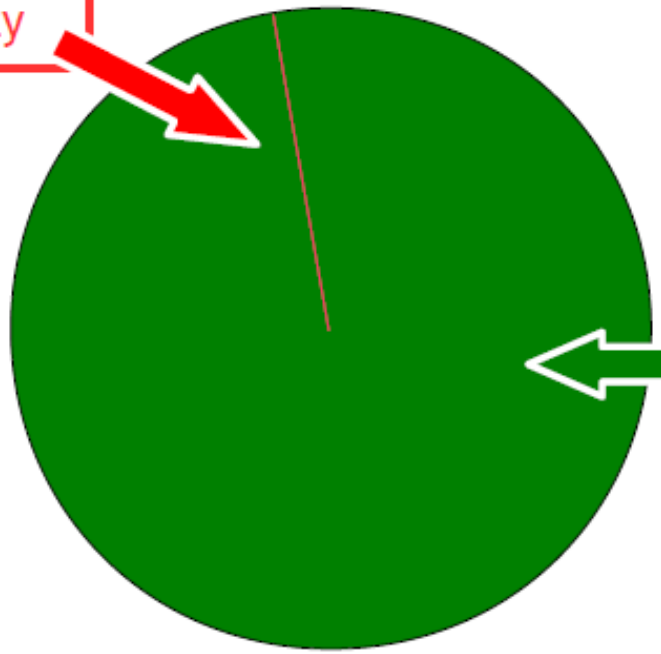

'Difficult' to see
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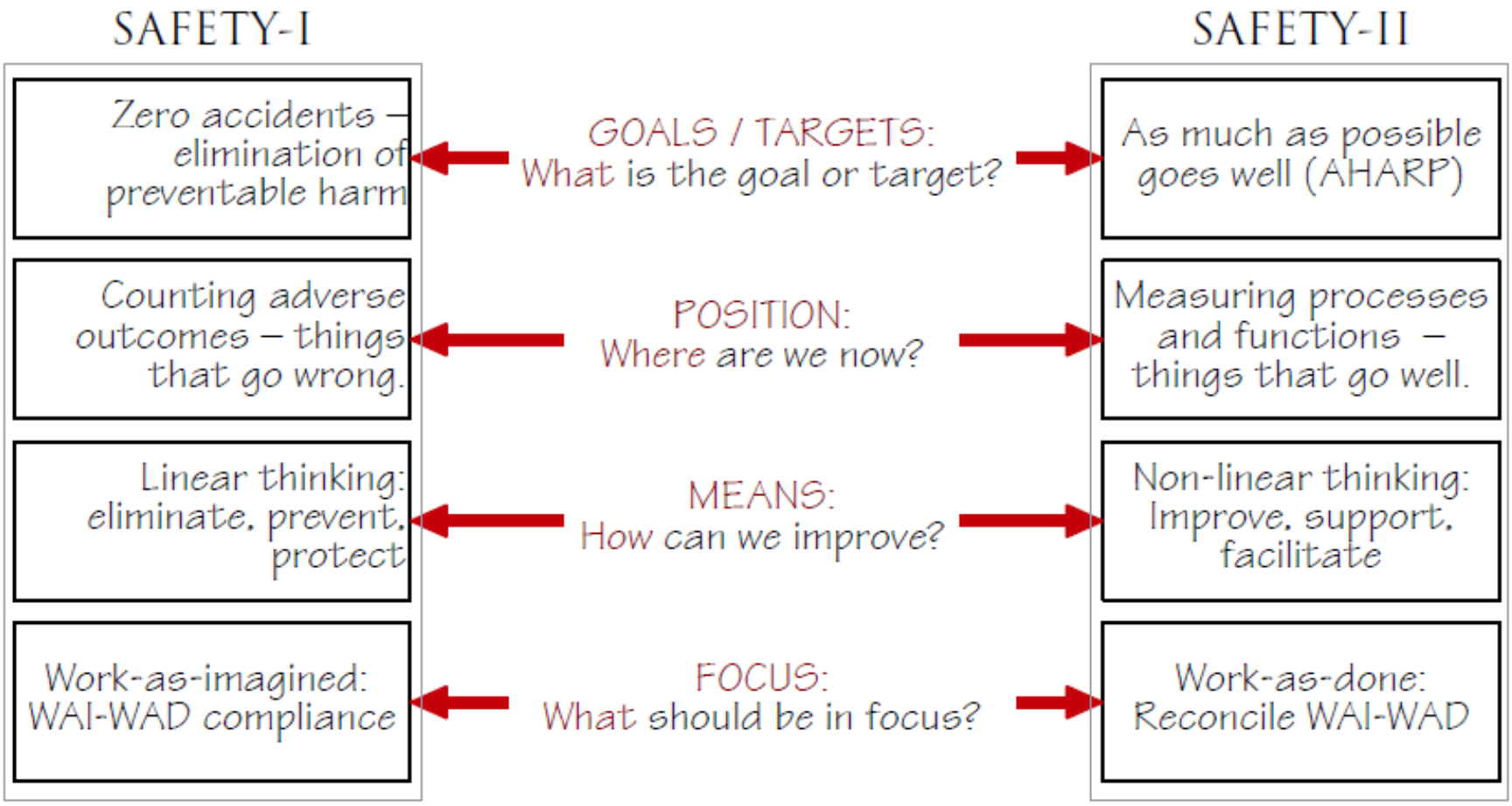
Two types of safety management



Safety through analysis or synthesis?

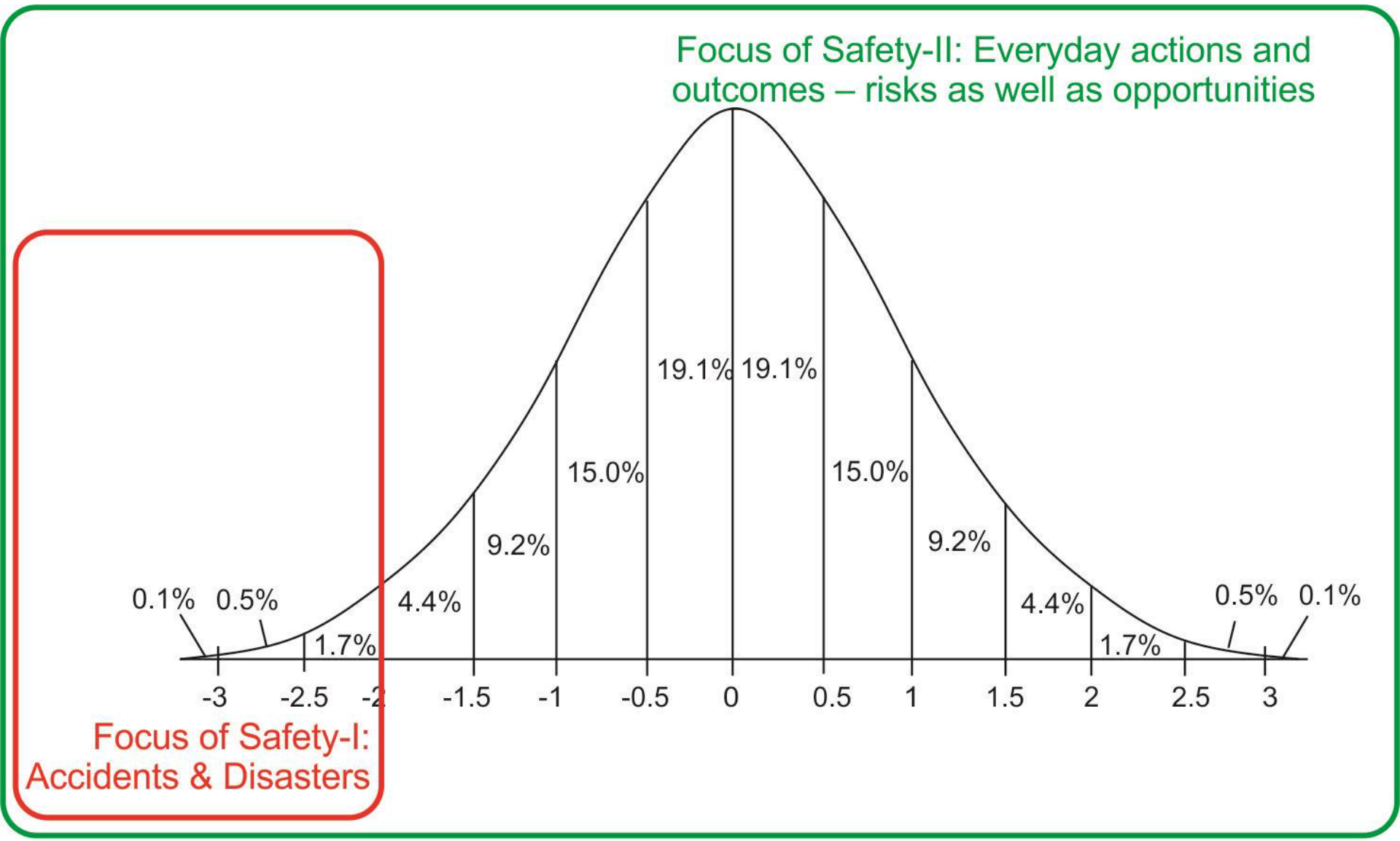
Safe tysyn thesis

Safety-I:
Safety through analysis

Prevent, eliminate, constrain.
Safety, quality, etc. are different and require different measures and methods.

Safety-II:
Safety through synthesis

Support, augment, facilitate.
Safety, quality, etc. are inseparable and need matching measures and methods.


Focus of Safety-II: Everyday actions and outcomes – risks as well as opportunities
19.1%
19.1%
15.0%
15.0%
9.2%
9.2%
4.4%
4.4%
1.7%
1.7%
0.1%
0.5%
0.5%
0.1%
-3
-2.5
-1.5
-1
-0.5
0
0.5
1
1.5
2
2.5
3
Focus of Safety-I: Accidents & Disasters

Five things to do now

MACQUARIE University

1. Look for what goes right
2. Focus on frequent events
3. Remain sensitive to the possibility of failure
4. Be thorough as well as efficient
5. Investing in safety, the gains from safety

AIHI

[Hollnagel, Wears and Braithwaite. (2015) From Safety-I to Safety-II: a white paper]

Дякую за увагу

https://youtu.be/7wHZw7mJ_BU

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