PATIENT SAFETY AND INTERNATIONAL PATIENT SAFETY GOALS (IPSGS) IN THE FIELD OF RESPIROLOGY

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ABSTRACK

Patient safety is an effort conducted to prevent and overcome unexpected problems occurring in the hospital. Patient safety in health care organization is the most important goal that needs to be achieved and monitored in regular basis. The International Patient Safety Goals (IPSG) are important guidelines at the international level to promote specific improvements in the process of providing safe and high quality patient care. The patient safety standard which is stated in IPSG is consist of 6 elements: (1) patient identification correctly; (2) increasing communication effectively; (3) increasing the safety of the high-alert medication; (4) certainty of accurate location, procedure accuracy, and patient-surgery accuracy; (5) reducing the risk of infection related to health service, and (6) reducing the risk of patient harm resulting from falls.

Keywords patient safety, international patient safety goals, patient safety standard

ABSTRAK

Keselamatan pasien adalah upaya yang dilakukan untuk mencegah dan mengatasi permasalahan tak terduga yang terjadi di rumah sakit. Keselamatan pasien dalam perawatan kesehatan merupakan tujuan paling penting yang harus dicapai dan dipantau secara teratur. *International Patient Safety Goals* (IPSG) merupakan pedoman penting di tingkat internasional yang bertujuan untuk mendukung perbaikan spesifik dalam proses penyediaan pelayanan pasien yang aman dan berkualitas tinggi. Standar keselamatan pasien yang dinyatakan dalam IPSG terdiri dari 6 elemen: (1) identifikasi pasien dengan benar; (2) meningkatkan komunikasi secara efektif; (3) meningkatkan keamanan obat-obatan kewaspadaan tinggi; (4) keakuratan lokasi, akurasi prosedur, dan akurasi pembedahan pasien; (5) mengurangi risiko infeksi yang terkait dengan pelayanan kesehatan, dan (6) mengurangi risiko bahaya pasien akibat jatuh.

Kata kunci: keselamatan pasien, *international patient safety goals*, standar keselamatan pasien

Patients may be harmed despite receiving perfect care (i.e., from an accepted complication of surgery or a side effect of medication), it is important to separate *adverse events* from *errors.* Patient safety literature commonly defines an error as "an act or omission that leads to an unanticipated, undesirable outcome or to substantial potential for such an outcome." Adverse events, in contrast, are injuries due to medical management rather than the patient's underlying illness is distinction is crucial. For example, when a patient who was appropriately prescribed warfarin for chronic atrial fibrillation develops a gastrointestinal bleed despite a therapeutic international normalized ratio, an adverse event, not a medical error, has occurred. Conversel, if the international normalized ratio

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was supratherapeutic because the physician prescribed a new medication without checking for possible drug interactions, a medical error would have occurred.[1]

Following is a list of the International Patient Safety Goals (IPSG) and their intent statements, that their objection are to promote specific improvements in patient safety especially in the field of respiratory and critical disease, highlight problematic areas in health care, and describe evidence-and expert-based consensus solutions to these problems.[2,3]

IPSG.1 Identify Patients Correctly

The organization develops an approach to improve accuracy of patient identifications. Wrong-patient errors occur in virtually all aspects of diagnosis and treatment. Patients may be sedated, disoriented, or not fully alert; may change beds, rooms, or locations within the organization; may have sensory disabilities; or may be subject to other situations that may lead to errors in identification. The intent of this goal is twofold: first, to reliably identify the patient as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual patient.[2,3]

Policies and/or procedures are collaboratively developed to improve identification processes—in particular, the processes used to identify a patient when giving medications, blood, or blood products; taking blood or other specimens for clinical testing (pleural aspiration, FNAB); or providing any other treatments or procedures (pleurodesis, WSD, Bronchoscopy, etc.). The policies and/or procedures require at least two ways to identify a patient, such as the patient's name, identification number, birth date, or other ways. The patient's room number or location cannot be used for identification. The policies and/or procedures clarify the use of two different identifiers in different locations within the organization, such as in ambulatory care or other outpatient services, the emergency department, or operating theatre. Identification of the comatose patient with no identification is also included. A collaborative process is used to develop the policies and/or procedures to ensure that they address all possible identification situations.[2,3]

IPSG. 2 Improve Effective Communication

The organization develops an approach to improve the effectiveness of communication among caregivers. Effective communication—which is timely, accurate, complete, unambiguous, and understood by the recipient—reduces errors and results in improved patient safety. Communication can be electronic, verbal, or written. The most error-prone communications are patient care orders given verbally and those given over the telephone, when permitted under local laws or regulations. Another error-prone communication is the reporting back of critical test results, such as the clinical laboratory telephoning the organization to report the results of a critical lab value. The organization collaboratively develops a policy and/or procedure for verbal and telephone orders that includes the writing down, legibly (or entering into a computer), the complete order or test result by the receiver of the information; the receiver reading back the order or test result; and the confirmation that what has been written down and read back is accurate. The policy and/or procedure identify permissible alternatives when the read-back process may not always be possible, such as in the operating theatre or in emergency situations in the emergency department or intensive care unit.[2,3]

IPSG. 3 Improve the Safety of High - Alert Medications

The organization develops an approach to improve the safety of high-alert medications. When medications are part of the patient treatment plan, appropriate management is critical to ensuring patient safety. High-alert medications are those medications involved in a high percentage of errors and/or sentinel events, medications that carry a higher risk for adverse outcomes, as well as look-alike, sound- alike medications. Lists of high-alert medications are available from organizations such as the World Health Organization or the Institute for Safe Medication Practices. A frequently cited medication safety issue is the unintentional administration of concentrated electrolytes (for example, potassium chloride [equal to or greater than 2 mEq/mL concentrated], potassium phosphate [equal to or greater than 3

mmol/mL], sodium chloride [greater than 0.9% concentrated], and magnesium sulfate [equal to or greater than 50% concentrated]). Errors can occur when staff are not properly oriented to the patient care unit, when contract nurses are used and not properly oriented, or during emergencies. The most effective means to reduce or eliminate these occurrences is to develop a process for managing high-alert medications that includes removing the concentrated electrolytes from the patient care unit to the pharmacy.[2,3]

The organization collaboratively develops a policy and/or procedure that identifies the organization's list of high-alert medications based on its own data. The policy and/or procedure also identifies any areas where concentrated electrolytes are clinically necessary as determined by evidence and professional practice, such as the emergency department or operating theatre, and identifies how they are clearly labelled and how they are stored in those areas in a manner that restricts access to prevent inadvertent administration.[2,3]

IPSG. 4 Ensure Correct-Site, Correct- Procedure, Correct-Patient Surgery

The organization develops an approach to ensuring correct-site, correct-procedure, and correct-patient surgery. Wrong-site, wrong-procedure, wrong-patient surgery is an alarmingly common occurrence in health care organizations. These errors are the result of ineffective or inadequate communication between members of the surgical team, lack of patient involvement in site marking, and lack of procedures for verifying the operative site. In addition, inadequate patient assessment, inadequate medical record review, a culture that does not support open communication among surgical team members, problems related to illegible handwriting, and the use of abbreviations are frequent contributing factors.[2,3]

Organizations need to collaboratively develop a policy and/or procedure that is effective in eliminating this alarming problem. The policy includes a definition of surgery that incorporates at least those procedures that investigate and/or treat diseases and disorders of the human body through cutting, removing, altering, or insertion of diagnostic/ therapeutic scopes. The policy applies to any location in the organization where these procedures are performed. Evidence-based practices are described in The (US) Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery.

The essential processes found in the Universal Protocol are :

marking the surgical site;
a preoperative verification process; and
a time-out that is held immediately before the start of a procedure.

Marking the surgical site involves the patient and is done with an instantly recognizable mark. The mark should be consistent throughout the organization, should be made by the person performing the procedure, should take place with the patient awake and aware, if possible, and must be visible after the patient is prepped and draped. The surgical site is marked in all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine). The purpose of the preoperative verification process is to verify the correct site, procedure, and patient;

ensure that all relevant documents, images, and studies are available, properly labelled, and displayed; and verify any required special equipment and/or implants are present.

The time-out permits any unanswered questions or confusion to be resolved. The time-out is conducted in the location the procedure will be done, just before starting the procedure, and involves the entire

IPSG. 5 Reduce the Risk of Health Care - Associated Infections

The organization develops an approach to reduce the risk of health care–associated infections. Infection prevention and control are challenging in most health care settings, and rising rates of health care–associated infections are a major concern for patients and health care practitioners. Infections common to many health care settings include catheter-associated urinary tract infections, bloodstream infections, and

pneumonia (often associated with mechanical ventilation). Central to the elimination of these and other infections is proper hand hygiene. Internationally acceptable hand hygiene guidelines are available from the World Health Organization (WHO), the United States Centers for Disease Control and Prevention (US CDC), and various other national and international organizations. The organization has a collaborative process to develop policies and/or procedures that adapt or adopt currently published and generally accepted hand hygiene guidelines and for the implementation of those guidelines within the organization.

IPSG. 6 Reduce the Risk of Patient Harm Resulting from Falls

The organization develops an approach to reduce the risk of patient harm resulting from falls. Falls account for a significant portion of injuries in hospitalized patients. In the context of the population it serves, the services it provides, and its facilities, the organization should evaluate its patients' risk for falls and take action to reduce the risk of falling and to reduce the risk of injury should a fall occur. The evaluation could include fall history, medications and alcohol consumption review, gait and balance screening, and walking aids used by the patient. The organization establishes a fall-risk reduction program based on appropriate policies and/or procedures. The program monitors both the intended and unintended consequences of measures taken to reduce falls. For example, the inappropriate use of physical restraints or fluid intake restriction may result in injury, impaired circulation, or compromised skin integrity. The program is implemented

REFERENCES

1. Watcher, RM. Goldman-Cecil Medicine (25th Edition): Quality Care of Patient Safety. 2016;(12):44-46.e2
2. Join Commision International. International Patient Safety Goals (IPSG). Accessed-at-March-5th-2018:-https://www.jointcommissioninternational.org/pathway/jci2017/documents/CLABSI_infographic_final.pdf
3. Cipto Mangunkusumo Hospital–Faculty of Medicine Indonesia university. Guidance on implementation of hospital quality and safety for doctors. 2015.