

# The Patient Safety Improvement Team as a management tool of patient safety

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## Context

The Mar Health Park is an integrated health care services, a large park of Health joins on health care knowledge, teaching and research in the city of Barcelona (Spain). It brings together all levels of health care: acute health, geriatric care, mental health, outpatient and primary care.

The **Patient Safety Improvement Team (PASIT)** sets up for the analysis, intervention and evaluation of health care. It's integrated of clinical and nursing leaders and managers of the organization and professionals. The aim is prevent new errors from learning from errors.

## Problem

Identify systemic problems from medical errors that have caused harm to patients. PASIT through the commitment of managers and leaders of the entity agree on the measures the organization must take to correct the medical errors of care have been identified. The initiatives of PASIT can adequately protect the health of citizens or significantly ameliorate the deep problems in developing of health policies.

## Objective

To detect deviations and medical errors from the health care with a harm to the patient and/or his family. This target is realized through the methodology of root-cause analysis, evaluation and development of issues of cases. PASIT act as the directing and coordinating authority on health care.

## Strategy for change

The success of health care interventions is not only to identify the most effective processes of care, also the commitment and implication of professionals, above all, professionals engaged in leadership roles that lead to development and innovative projects through the participative management and improvement opportunities.

Obtaining and publishing information for future actions to avoid diversion back into health care are key elements, but inadequate if you do not have an effective reporting scheme in which the professionals involved are part of the change.

## Effects of changes

The PASIT has identified errors in patient identification, errors in administration of medication, internal communication barriers between departments and deficient health care information written on clinical records.

The measures were:

- Review of operational procedures in health care areas
- Establishing new procedures cross between different care units
- Specific training professionals of different specialties
- Review of clinical records and simple informed consents

## Lessons learnt and message for others

- The integration of the units government in the organization to obtaining knowledge of the reality of health care and the need for implementation of effective solutions.
- The global health needs assessment mechanisms which involve the great leaders of the organization and professionals through an analysis methodology based scientific evidence.
- The creation of the PASIT as a **management team** of medical errors contributes to produce cultural change and improved results in quality, safety and efficiency of health services.