Healthcare Organization Commitment

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Commitment Details

Commitment Name
The enhancement of adverse events report in the Automated Health Incident Registry System (SIRAIS) platform.

What Patient Safety Challenge does your Commitment address?
Challenge 1 - Culture of Safety

Commitment Start Date
10/01/2018
How Many Hospitals Will This Commitment Represent

16

Action Plan
Patient safety is defined as the reduction of the unnecessary risk of harm related to healthcare to an acceptable minimum, which refers to the collective notions of current knowledge, the resources available and the context in which the attention was provided. The Mexican Federal Government, supporting patient safety initiatives promoted by the World Health Organization since 2007, has recognized patient safety as a fundamental component of the improvement of quality in health services, established in the National Development Plan 2013-2018 and in the Sectoral Health Program of the same period. For this reason, in the different hospitals of the state, considering the different levels of complexity of each one, several elements oriented to patient safety are put into practice, in such a way that the users of the health system are increasing their knowledge about this topic and ask for better conditions to improve quality in the processes implemented from the perspective of patient safety. The Knowledge Management Process (GC) covers the entire way of generating, storing, distributing and using knowledge. This process involves the treatment of large volumes of data generated in the various health information systems, making it necessary to use information technologies to achieve efficiency in their analysis and application. With the aim of promoting growth, development, communication and the preservation of knowledge within hospitals as organizations, the GC enables health professionals to achieve quick and assertive responses related to the decisions they need to make in the field of healthcare, based on the leadership that is generated in the Patient Quality and Safety Committee (COCASEP). The aim is to disseminate and share the tacit and explicit knowledge with the members of the hospital teams and with other health professionals. In this way, each hospital has greater capacity to decide on the actions that should be generated from their own data, focusing on the need to understand each other as organizations that work with knowledge to develop new products, new processes and new ways or more flexible organizational arrangements for greater safety and quality of care. As part of the strengthening of technological tools to impact on better patient safety conditions, the Automated Health Incident Registry System (SIRAIS) is created, whose objective is to contribute to the progress of the patient safety culture, privileging the report of clinical processes and procedures, medication and falls, establishing improvement measures, strengthening skills in worker’s performance and promoting the culture of registration. The main objective of this commitment is not only the implementation and consolidation of the reporting culture using the SIRAIS platform as a tool, but also the use of technology as a way of continuous improvements. STEPS TO FOLLOW a) Promote: Train the management staff of each Hospital about the SIRAIS Platform (website navigation, benefits and use). Train the personnel that will carry out the capture in the electronic platform (password and user) for each hospital unit. Train the multidisciplinary team that has direct and indirect contact with the user (patient) who participates in the care processes. Carry out a diffusion campaign of simultaneous way on "Culture of Safety" in the different hospitals. b) Explore in the SIRAIS platform the adverse events reported for the intelligent recovery of relevant data.
in patient safety. There are no institutional policies to organize and manage the created knowledge. So then, the analysis is not conducted and put into bibliographic or databases; so, the first thing is to identify this information. i. Identify the causes associated with adverse events reported in the SIRAIS platform. c) Define priority lines in patient safety (According to SIRAIS platform classification). i. Medication ii. Documents of the medical records iii. Infection associated with medical care iv. Blood products v. Medical devices and equipment vi. Surgical or medical procedures vii. Falls viii. Pathologies / Clinical laboratory / Imaging ix. Others d) Define key performance indicators in patient safety and measure them. As part of this prioritization process we must explore the intervention alternatives, since it does not make sense to address a problem if no solution is available. Therefore, in addition to the importance of the problem, we must consider the effectiveness of the intervention (demonstrated ability to produce the desired effect) and the feasibility of the intervention (legal, ethical, political, economic, sociocultural and organizational), considering the population to which it is addressed and the level of prevention it affects. i. Essential Actions for patient safety ii. Clinical Practice Guidelines and Algorithms iii. Guidelines and Nursing Care Plans. iv. Methodology of the use of the SIRAIS platform for the control of risk. v. Identification of threats and the vulnerability of risks and their prioritization. vi. Implementation of systems for the prevention, reduction and control of adverse events related to medical care. e) Develop a control panel to follow up on reported adverse events: There are no permanent programs related to the development of scientific information search and retrieval skills; critical analysis of the bibliography and better management of the scientific evidence. Perform analysis of the events reported by any hospital unit and follow up on clinical sessions where the event was presented (unified format). i. Information management ii. Information life cycle iii. Information systems, management and consultation iv. Search protocol v. Analysis and critical reading of literature vi. Safeguarding information vii. Document management f) Review, redesign and organize documents, manuals, protocols and routines related to activities associated with patient safety (related to adverse events) through a multidisciplinary committee on patient safety and root cause analysis. Semi-annual evaluation of the predominant adverse events (in all the state). g) Development of Knowledge Management (GC) systems in healthcare equally focused on promoting honesty and cooperation in the reporting and mitigation of adverse events in patients; also promote that personnel recognize risk in conditions and practices. i. Evaluate the Knowledge Management (GC) system from the comparison with other organizations. h) Share knowledge, through practice communities and manuals and use them into practice through practice based on evidence. i) Follow up the SIRAIS platform and use it as a tool to generate statistics for carrying out improvement projects in the different processes of each hospital unit.

**Commitment Timeline**

We divide the process into: look at the approach, implantation, measurement and continuous improvement. We aim to look at the approach during January (step A, B and E), February (step C and D) and march (step E), on this transition we will start with the implantation through step F during March to June and step G through June to August, with a implantation check on December with step F. Having a measurement stage from March to October by the step D and a measurement of step C from November to December. We
endeavor to have a continuous improvement stage from August to December, focusing on steps H and I.

**Impact Details**

**Lives Lost in Last Calendar Year**
0

How many lives do you expect to spare from harm in the next calendar year?
0

How many lives do you expect to save in the next calendar year?
0

**Methodology for Determining Lives Saved**
For the first stage, unfortunately there is no information available to have a baseline and to project the impact of the commitment; for the next year there will be information to recognize the impact and to compare information.