Healthcare Organization Commitment

Contact Details

Name
José María Busto Villarreal

Phone
+5217717121422

Email
jose.busto@ssh.gob.mx

Position
Head of the Second Level of Healthcare Attention

Organization Name
Secretaría de Salud

Commitment Details

How many hospitals are represented in this commitment?

<table>
<thead>
<tr>
<th>Last Report</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>

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 Update
During 2018, we sought to comply with the initial strategy proposed, which was divided into: stage of promotion, data recovery, definition of priority action lines in patient safety and training in the analysis of adverse events and control panels. We changed the technological platform of reporting from SIRAIS Platform to “SISTEMA NACIONAL DE REPORTE DE EVENTOS ADVERSOS” (NATIONAL SYSTEM OF ADVERSE EVENTS REPORTING), because of the update from the federal health level. First of all, we discovered that there was a general lack of knowledge at the administrative, nursing, medical and operational support areas staff; that is why for us, the first year of participation in the Patient Safety Movement was called: CONSCIOUSNESS AND TRAINING IN PATIENT SAFETY. A first and second phase of training was carried out (first and second semester of 2018); assuming the diversity of locations of the hospitals, it was decided to regionalize the educational exercise to cover the whole, in the first semester the emphasis was: the responsibility of each stakeholder involved in health care, the importance of reliable and safe care, legal concepts of patient safety, topics that were strengthened with the implementation of a distance educational platform on the online moodle domain, in the second semester it was covered information about how to report adverse events and how to implement control panels. According with the importance of the topic, the information was
made known in associated events, both in person and through distance platforms (tele-
education), bringing as a result a total of 4800 trained people. By having trained staff it was
possible to: a) tropicalize the patient safety information in each hospital in order to cover
their recognized needs in patient safety in the observable scenario, b) disseminate
information with the rest of the staff and, c) the implementation of mailboxes for the
reporting of adverse events was achieved d) to reach innovation from units according to the
needs, such as the implementation of identification tables used in each hospital bed. The
main impact of the first stage of the project is the change in patient safety culture when
reporting 231 adverse events. After this change in the culture of patient safety, in 2019, the
program will extend its efforts to quality systems in patient safety that focus on the analysis
of the advers events, which will be unified for all hospitals, through state knowledge sharing
forums that will generate a state strategy; it will also have as a mission, the expansion of
information through publications in magazines and newsletters.

Other
Challenge 1 - Culture of safety

Please describe any best practices your organization has learned through your
commitment and share valuable lessons or challenges that were overcome
TO SHARE KNOWLEDGE: For the State of Hidalgo, and all its Hospitals, it was
indispensable to permeate with information to all the people involved in health care,
knowledge allows to generate awareness thus, implementation of actions in order to correct
errors; most of the year was dedicated to the learning curve, not only of the service leaders,
but also to people who directly or indirectly impact on patient safety; knowing the basic
principles of patient safety, their Implications and awareness of empathy towards patients
and their families was an important area of opportunity. SELF KNOWLEDGE. Through
valuable information from regional trainings, each hospital unit reviewed their opportunity
areas taking actions to improve and reduce errors, aligned with patient safety according to
their statistical information, the task was not easy, due to that there was no record of
adverse events about which actions should be taken accordingly. PARTICULAR
STRATEGIES. The culture of patient safety has different branches, based on a general
strategy, each hospital raised its particular needs and trained its staff according to the topics
with the greatest impact, for example: hand washing, adverse event system, essential
actions for patient safety, infections associated with health care, clinical record, use of
medications, critical patient care, Biohazardous and Infectious Waste, red car, accreditation
card, risks of falls, among others. USE OF TECHNOLOGY. Distance education corresponds
to an important milestone of opportunity, due to the remoteness of some hospitals or
health care units, the implementation of adequate use of technology, was essential to
reduce the inequality gap, as a result: expand opportunities of valuable knowledge for
medical, administrative and operational support staff. The use of technology platforms for
the reporting of adverse events served as a key to promote further analysis at a hospital and
state level.
## Impact Details

<table>
<thead>
<tr>
<th>Initial Commitment</th>
<th>Commitment Update</th>
<th>Project Next Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives Lost 0</td>
<td>Lives Lost 5</td>
<td>Lives Lost -225</td>
</tr>
<tr>
<td>Lives Spared Harm Target</td>
<td>Actual Lives Spared Harm in last 12 months 277139</td>
<td>Lives Spared Harm Target for following calendar year 318368</td>
</tr>
<tr>
<td>Lives Saved Target 0</td>
<td>Actual Lives Saved in last 12 months (might differ from initial target) 230</td>
<td>Projected Target of Lives Saved for following calendar to try to finish commitment 276</td>
</tr>
<tr>
<td></td>
<td>New Lives Lost (lives lost – actual lives saved) -225</td>
<td></td>
</tr>
</tbody>
</table>

### Acknowledgement

Yes, I acknowledge that this commitment may be used for external communication and publicly announced at the World Patient Safety, Science & Technology Summit. Furthermore, I agree that this commitment may appear on the website of The Patient Safety Movement Foundation or the Masimo Foundation. I also give permission for my commitment to be used in support of the promotion of the World Patient Safety, Science & Technology Summit as well as The Patient Safety Movement initiative.