2do Congreso Argentino de Medicina Interna Pediátrica

Sociedad Argentina de Pediatría

Mesa Redonda

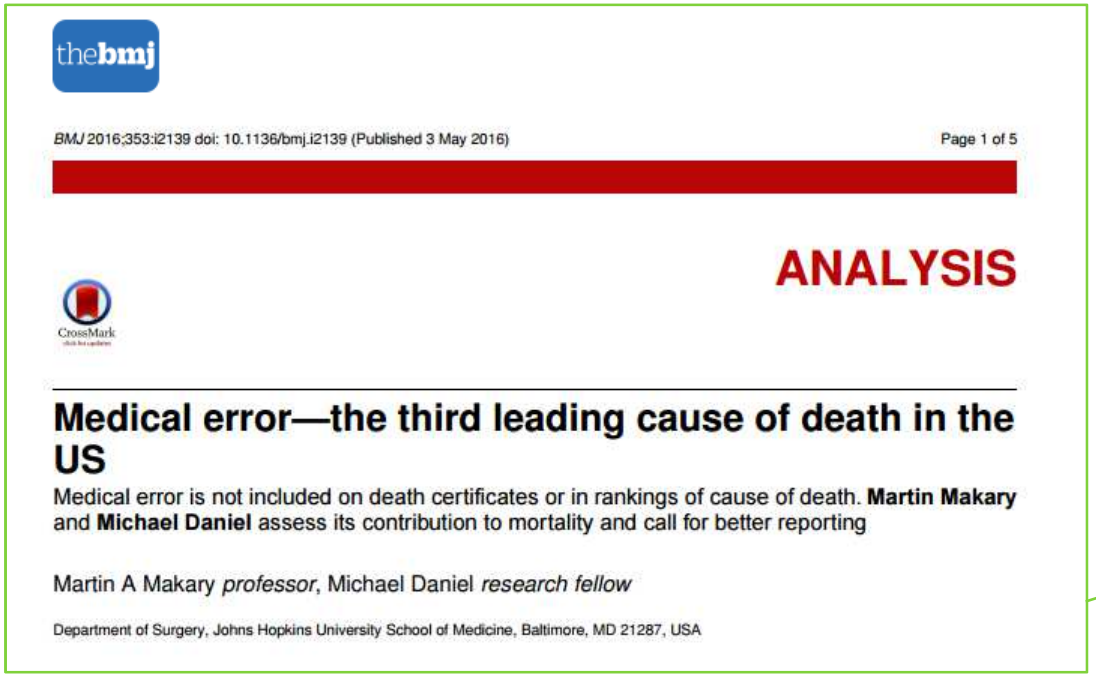
La Comunicación y la Seguridad del Paciente

Introducción

- 1999 - Informe del Instituto de Medicina de EEUU (IOM)

Errar es humano: Construyendo un Sistema de Salud Más Seguro

44.000 - 98.000 muertes en sus hospitales a causa de errores médicos.



thebmj

BMJ 2016;353:i2139 doi: 10.1136/bmj.i2139 (Published 3 May 2016)

ANALYSIS

Medical error—the third leading cause of death in the US

Medical error is not included on death certificates or in rankings of cause of death. **Martin Makary** and **Michael Daniel** assess its contribution to mortality and call for better reporting

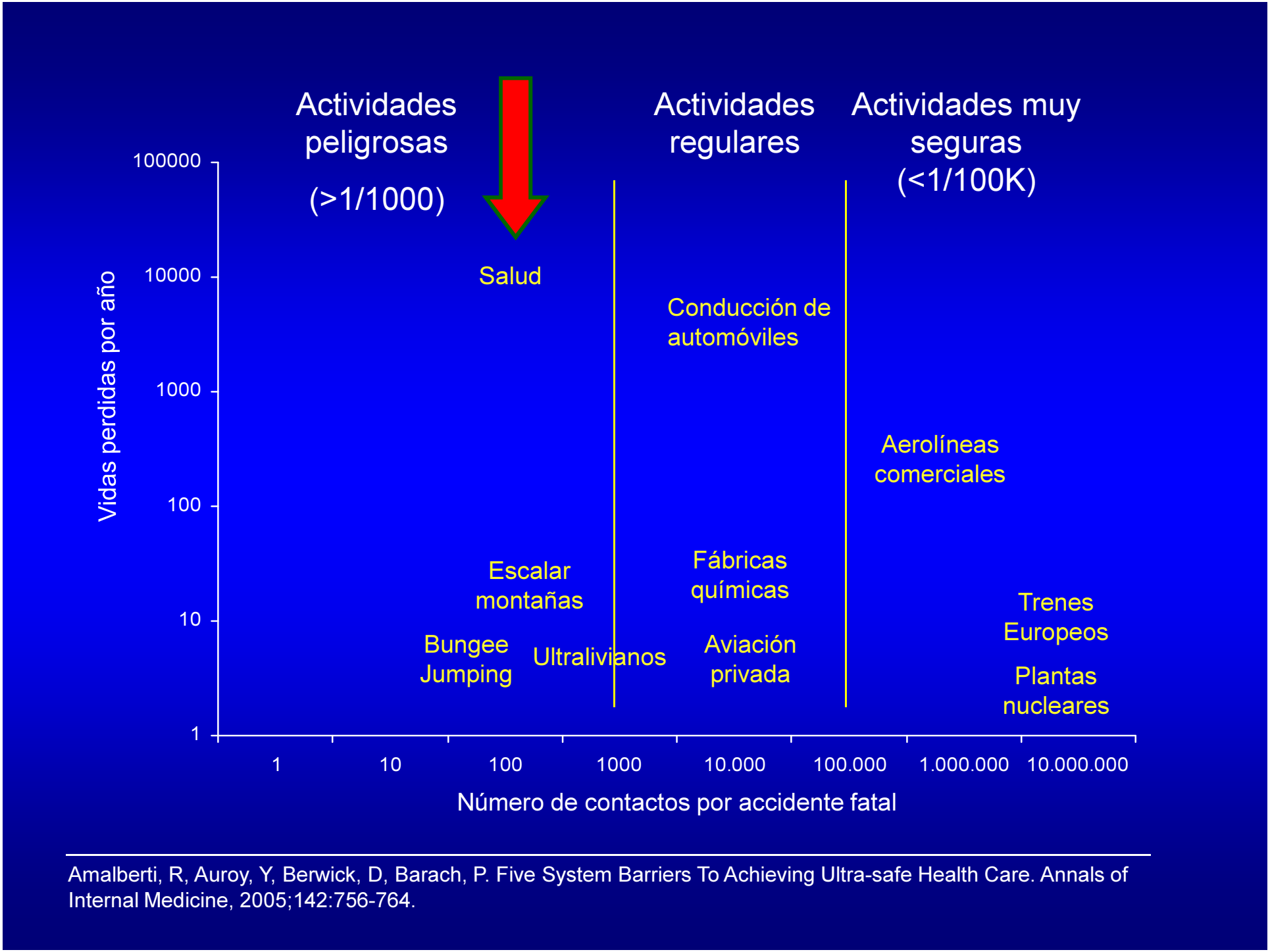
Martin A Makary *professor*, Michael Daniel *research fellow*

Department of Surgery, Johns Hopkins University School of Medicine, Baltimore, MD 21287, USA

...si esta tasa se aplica a todos los ingresos hospitalarios en EEUU registrados en 2013:

¡más de 400.000 muertes al año!

¡4 veces la estimación del IOM!



Amalberti, R, Auroy, Y, Berwick, D, Barach, P. Five System Barriers To Achieving Ultra-safe Health Care. Annals of Internal Medicine, 2005;142:756-764.

Most Frequently Identified Root Causes of Sentinel Events Reviewed by The Joint Commission by Year

The majority of events have multiple root causes
(Please refer to subcategories listed on slides 5-7)

2012 (N=901)		2013 (N=887)		2014 (N=7)	
Human Factors	614	Human Factors	635	Human Factors	547
Leadership	557	Communication	563	Leadership	517
Communication	532	Leadership	547	Communication	489
Assessment	482	Assessment	505	Assessment	392
Information Management	203	Information Management	155	Physical Environment	115
Physical Environment	150	Physical Environment	138	Information Management	72
Continuum of Care	95	Care Planning	103	Care Planning	72
Operative Care	93	Continuum of Care	97	Health information technology-related	59
Medication Use	91	Medication Use	77	Operative Care	58
Care Planning	81	Operative Care	76	Continuum of Care	57

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.

The Joint Commission

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Root Cause Information for Delay in Treatment Events Reviewed by The Joint Commission

(Resulting in death or permanent loss of function)

2004 through 2014 (N=971) *The majority of events have multiple root causes*	
Communication	787
Assessment	753
Human Factors	701
Leadership	662
Information Management	279
Continuum of Care	253
Care Planning	170
Physical Environment	147
Medication Use	74
Patient Rights	27

The Joint Commission

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Educación médica

Arch Argent Pediatr 2017;115(1):82-88 / 82

Diagnóstico de situación de seguridad del paciente en Argentina. Estudio transversal

The current status of patient safety in Argentina: Cross sectional study

Dra. Lucrecia Arpi[a,b], Dr. Néstor D. Panattieri[a,c], Farm. Cristina Godio[a,d], Dra. Verónica Sabio Paz[a,c] y Dra. Nora Dackiewicz[a,b]

6424 pediatras de todo el país

- 45%: no había pase, o no era sistemático y estructurado entre médicos
- 70%: no hacía pase con enfermería o era muy informal

Comunicación Efectiva

Procesos médicos actuales

- ✓ involucran numerosas interfaces entre personas con diferentes niveles de educación e instrucción ocupacional

- ✓ se ha vuelto fundamental el trabajo en equipo y la comunicación efectiva entre todas las partes (incluyendo al paciente y su familia).

Comunicación Efectiva

Communicare

"compartir algo, poner en común"

Mesa Redonda

Disertantes

- **Nora Dackiewicz:** *Comunicación del Error*

- **Lucrecia Arpí:** *Transferencia entre áreas*

- **Facundo Jorro Barón:** *Traspaso de Información dentro de un área*

Secretaria: Claudia Negrette

Coordinador: Néstor D. Panattieri