2012.06.26.

通報的價值

【營造正向通報文化】

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臺大醫院 副院長

體會Incident Reporting System 的運作 …. ….

Story (I) : What happened ? …

- The patient was for bronchoscopy, a short but stimulating procedure. So the plan was to use boluses of alfentanil and mivacurium. Both these drugs were in correctly labelled 10 ml syringes.
- Inadvertently I gave mivavurium prior to alfentanil. But I did not realise my error… …
- A few minutes later, patient initially appeared drowsy but agitated, breathing became shallow and saturation dropped to 85%. He developed multple VEs.

Story (I) : What happened ? …

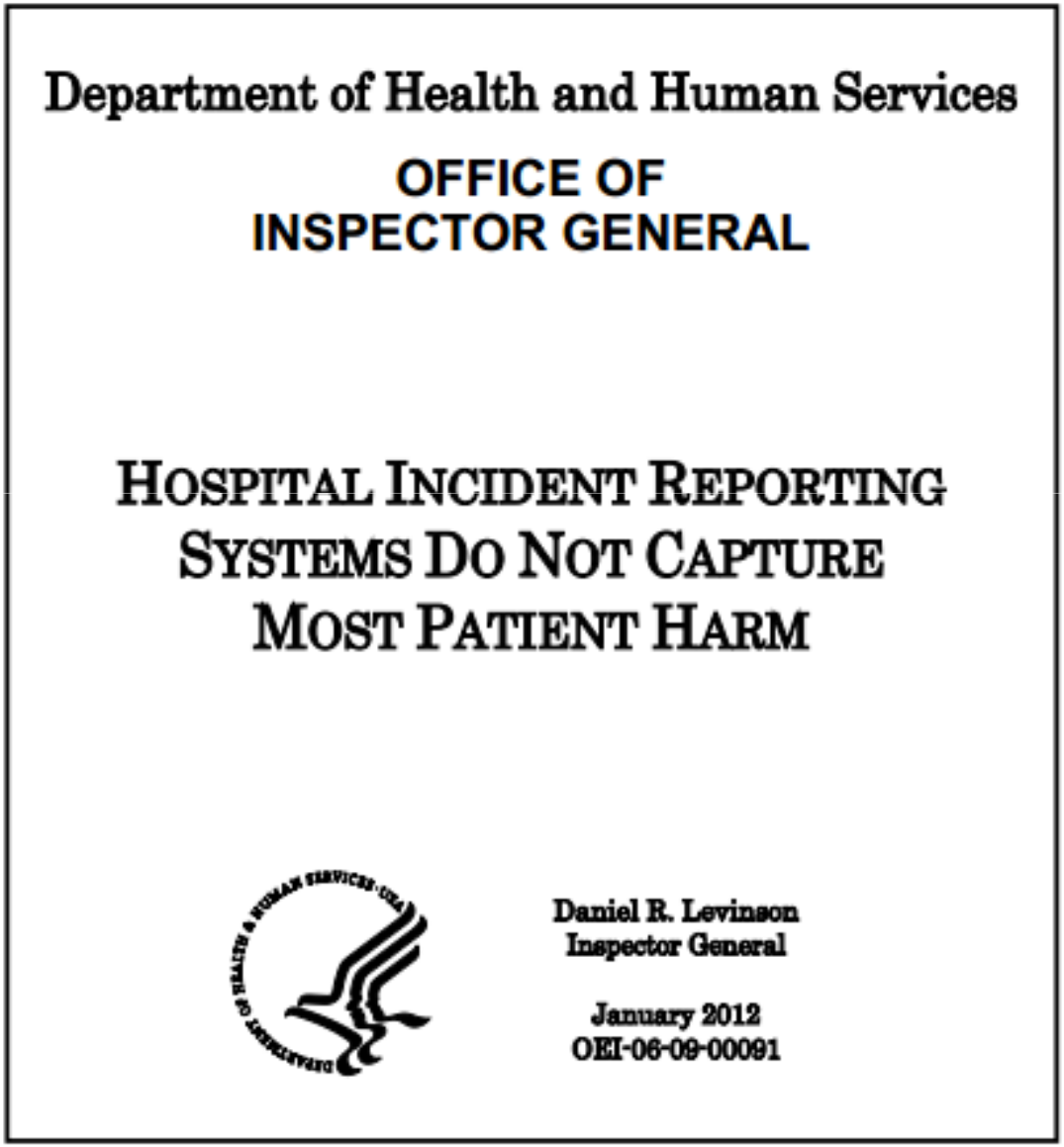
- On realising my error some propofol was given, the trachea intubated.
- Over a short period of time, his saturation and ECG returned to normal.
- We continued with the procedure. On recovery he and his families were informed of what had happened.

Story (I) : What lessons learned …

1. Correctly labelling syringes is not enough.

2. Staff were using a number of drugs that they don’t usually use

Q1. 為什麼要有 Incident Reporting System ?



Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

HOSPITAL INCIDENT REPORTING
SYSTEMS DO NOT CAPTURE
MOST PATIENT HARM

Daniel R. Levinson
Inspector General

January 2012
OEI-06-09-00091

Q2. 為什麼要有 Incident Reporting System ?

- All sampled hospitals (n=189) had incident reporting, and administrators rely heavily on these systems to identify problems.
- Hospital staff did not report 86% of events, partly because of staff misperceptions about what constitutes patient harm.
- Hospital accreditors, when evaluating hospital safety practices, focus on how event information is used rather than how it is collected.

Q3. 什麼是有效的 Incident Reporting System ?

- Institution must have a supportive environment that protects the privacy of staff who report occurrences.
- Reports should be received from a broad range of personnel.
- Summaries of reported events must be disseminated in a timely fashion.
- A structured mechanism must be in place for reviewing reports and developing action plans.

(http://psnet.ahrq.gov/primer.aspx?primerID=13)

Q4. 哪些會阻礙 Incident Reporting System ?

Top 5 self-perceived barriers to incident reporting for doctors

1. No feedback on incident follow-up (57.7%)
2. Form too long; lack of time (54.2%)
3. Incident seemed "trivial" (51.2%)
4. Ward was busy, forgot to report (47.3%)
5. Not sure who is responsible to make report (37.9%)

And, the most important is … … ?

(Qual Saf Health Care. 2006;15:39-43)

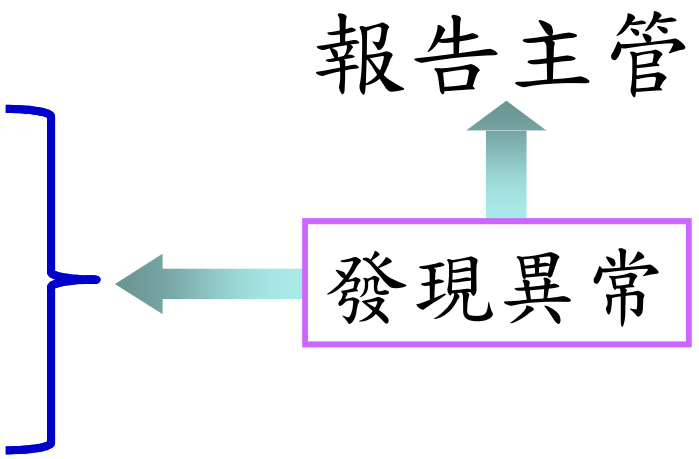
Q5. 如何建構醫院的 Patient Safety Culture …？

分享: 台大醫院品管中心的模式

您應該要知道: 異常事件通報

通知品管中心:

1. 書面
2. 電話：66666
3. 網路：



http://portal.ntuh.gov.tw/General/Login.aspx

新大樓二樓---投訴服務處

- **顧客意見**提供我們本院品質持續改善的機會
- 抱怨/不滿意 ➡ 醫療爭議 ➡ 壓力/名譽
- 解決/改善 ➡ 風險管理 ➡ 品質提升

分機

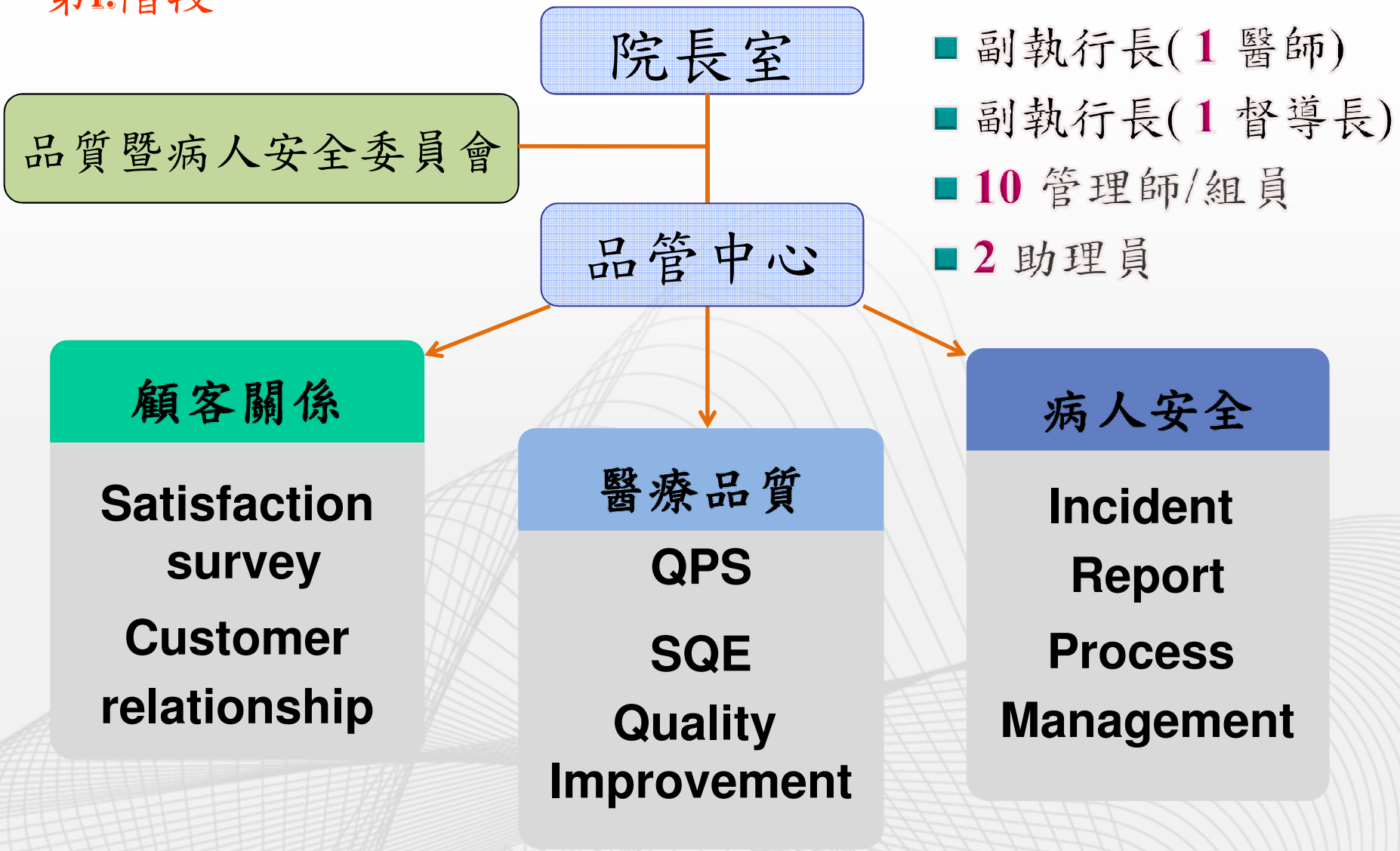
63072

63073

62877

品管中心的定位:【品質文化扎根】+【組織再造工程】

第I.階段



風險管理計畫與架構

- 品管中心與安全衛生室每年共同訂定本院風險管理計畫與架構。
- 共同評估及分析就進行分析與評估風險，訂定年度FMEA主題。

a) risk identification

b) risk prioritization

c) risk reporting

d) risk management

e) investigation of AE

f) management of related claims

醫學教育的提升

第III.階段

Proposed Components of a Medical School Curriculum in Health Policy.	
Systems and principles	U.S. health care system, financing, and payment
	Models of care management and control
	Health insurance
	Health care safety net
	Health information technology
	Physician workforce
Quality and safety	Quality indicators, measures, and outcomes
	Quality improvement
	Patient safety
Value and equity	Medical economics
	Medical decision making
	Comparative effectiveness
	Health disparities
Politics and law	History and consequences of major health care legislation
	Adverse events, medical errors, and malpractice

(N Engl J Med 2011; Feb. 24: 695-7)

醫學系四年級課程大綱(1/2)

週次	日期	單元主題	授課老師
第1週	9/14	課程綜覽：我們為什麼要談「醫療品質」？	洪冠予醫師
第2週	9/21	醫院的病人安全管理架構	鄭之勛醫師
第3週	9/28	品質改善的實務流程(一)	鄭之勛醫師
第4週	10/5	個案學習(一)	洪冠予醫師
第5週	10/12	品質改善的實務流程(二)	黃嗣棻督導長
第6週	10/19	個案學習(二)	黃嗣棻督導長
第7週	10/26	異常事件通報與根本原因分析(RCA)	呂立醫師
第8週	11/2	個案學習(四)	呂立醫師
第9週	11/9	用藥安全流程與實務	林美淑藥師

醫學系四年級課程大綱(2/2)

週次	日期	單元主題	授課老師
第10週	11/16	從「顧客意見」到「品質改善」	梁蕙雯醫師
第11週	11/23	個案學習(五)	梁蕙雯醫師
第12週	11/30	品質管理指標與持續改善(PDCA)	鄭之勛醫師
第13週	12/7	個案學習(六)	鄭之勛醫師
第14週	12/14	病人安全文化的塑造	朱家瑜醫師
第15週	12/21	品質管理競賽與標竿學習	洪冠予醫師
第16週	12/28	實證醫學與臨床路徑	姜至剛醫師
第17週	1/4	醫療團隊資源管理(TRM)	劉越萍醫師
第18週	1/11	期末考	洪冠予醫師

Q6. 如何建構醫院的 Patient Safety Culture …？

Q7. What Do Your Incident Reporting System Look like?