RETE CURE SICURE FVG

ASU FC
Azienda sanitaria universitaria Friuli Centrale

REGIONE AUTONOMA FRIULI VENEZIA GIULIA

GIORNATA REGIONALE DELLA SICUREZZA E QUALITÀ DELLE CURE 2022

Udine
13 Dicembre 2022

Palazzo della Regione
Auditorium "A. Comelli"

Giornata regionale della sicurezza e qualità delle cure

Friuli Venezia Giulia
13 dicembre 2022

La relazione tra empowerment del cittadino e rischio clinico: le evidenze scientifiche

Sara Albolino – PhD, Responsabile Organizzazione Sviluppo e Qualità
Azienda Ospedaliero Universitaria Policlinico Umberto I

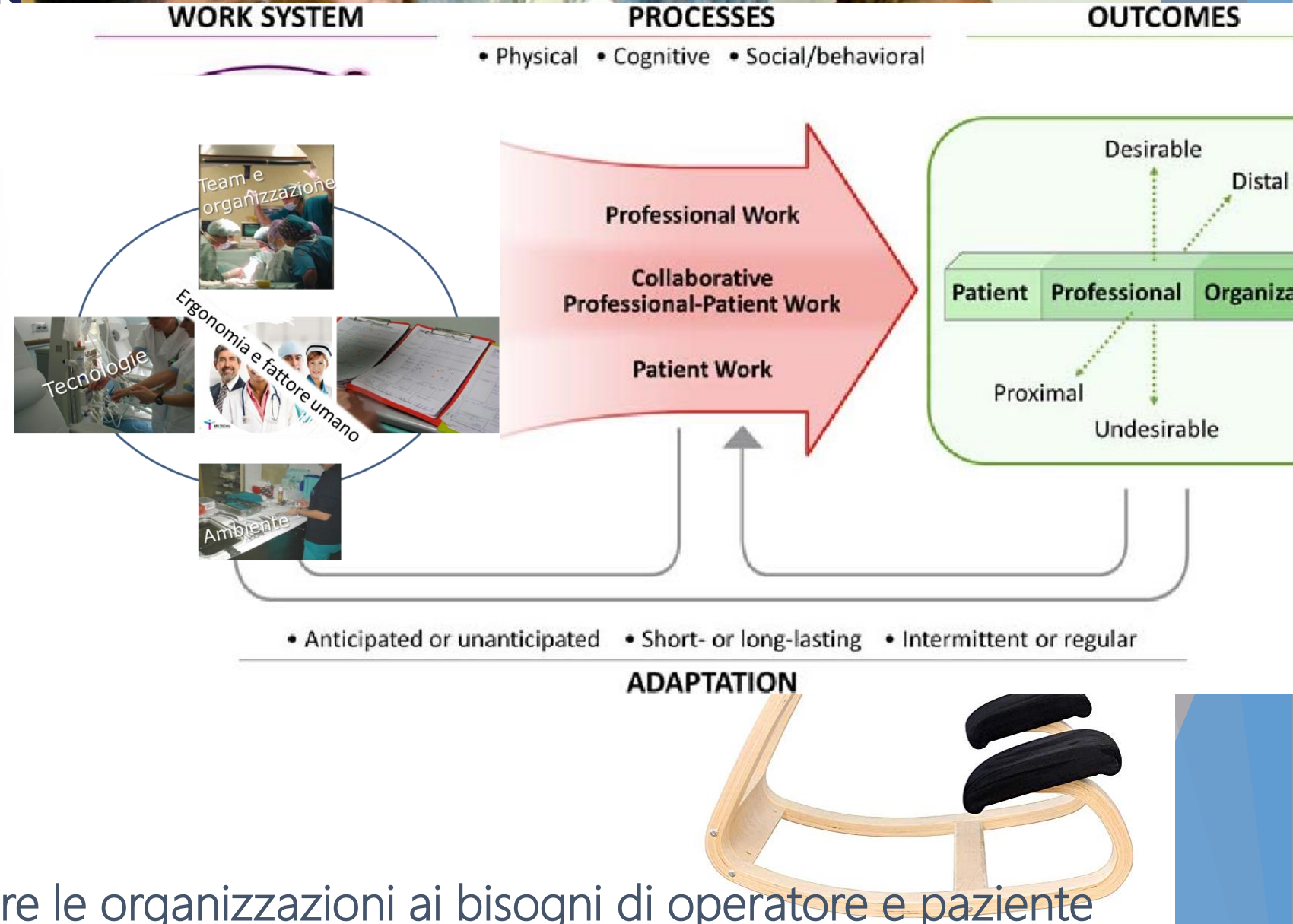
In collaborazione con Elena Beleffi – Centro GRC

GRC
Centro Regionale
Gestione Rischio Clinico
e Sicurezza del Paziente

SISTEMA SANITARIO REGIONALE
AZIENDA OSPEDALIERO-UNIVERSITARIA
POLICLINICO UMBERTO I

SAPIENZA
UNIVERSITÀ DI ROMA

Ergono



Adattare le organizzazioni ai bisogni di operatore e paziente

Il paziente e la famiglia al centro delle cure

"è uno dei **valori** fondamentali di una organizzazione che guida la **programmazione**, lo **svolgimento** e la **valutazione** dei servizi sanitari che eroga, e si fonda su un'**alleanza reciproca che porta benefici** ai professionisti sanitari, ai pazienti, alle loro famiglie"

«Safety is Personal: Partnering with Patients and Families for the Safest Care», NPSF

siamo tutti pazienti

Migliorare i risultati dell'assistenza sanitaria

Migliorare l'esperienza delle cure

Migliorare l'esperienza lavorativa di chi cura

Migliorare i risultati delle cure per tutti i pazienti

PATIENT SAFETY 2030

I quattro pilastri per la sicurezza

- Approccio sistemico alla riduzione del danno
- Sviluppo della cultura della sicurezza
- **Coinvolgimento dei pazienti come partner nel campo della sicurezza**
- Prendere decisioni sulla base di evidenze e ragionamenti motivati e non rimanere inattivi nei confronti dei problemi aperti

NIHR Patient Safety Transnational Research Centre at Imperial College

WHO GLOBAL SAFETY ACTION PLAN (2021-2030)

4 Patient and family engagement

- 4.1 Co-development of policies and programmes with patients
- 4.2 Learning from patient experience for safety improvement
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- 4.4 Patient safety incident disclosure to victims
- 4.5 Information and education to patients and families

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I «campioni»


عربي | 中文 | English | Français | Русский | Español
World Health Organization
Health topics
Data and statistics
Media centre
Publications
Countries
Programmes and projects
About WHO
Search
Advanced search
Patient safety
Patient safety
Research
Campaigns
Education & training
Implementing change
Patient engagement
Information centre
News and events
Patients for Patient Safety
Patients for Patient Safety (PFPS) emphasizes the central role patients and consumers can play in efforts to improve the quality and safety of health care around the world. PFPS works with a global network of patients, consumers, caregivers, and consumer organizations to support patient involvement in patient safety programmes, both within countries and in the global programmes of WHO Patient Safety. The ultimate purpose is to improve health-care safety in all health-care settings throughout the world by involving consumers and patients as partners.
Patients for Patient Safety Champions
Our latest PFPS Initiative
New WHO Patient Safety tool for mothers and babies
The Patients for Patient Safety team of WHO Patient Safety, in collaboration with WHO Reproductive Health Research, is creating a patient-held safety tool that will help increase safety for mothers and their newborn babies during the first seven days after birth,
About us
WHO Patient Safety
The PFPS team
Background
How patient engagement became a priority
Frequently asked questions
PFPS News
PFPS News - November 2010
pdf, 571kb
More news
More newsletters

Le origini

aumentare la consapevolezza dell'importanza del coinvolgimento del paziente e dell'empowerment per il miglioramento della sicurezza dei farmaci

condividere le esperienze dei pazienti e delle famiglie di tutto il mondo

impegnarsi attivamente per promuovere il coinvolgimento del paziente e della famiglia nell'ambito della sicurezza dei farmaci

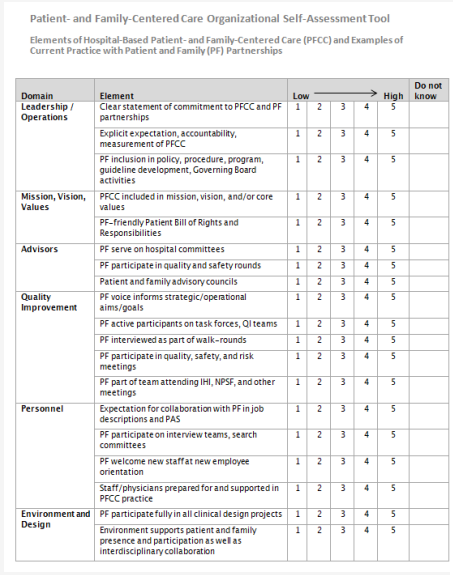
PFPS WORLD HEALTH ASSEMBLY 2013, Australia - Engaging Patients in Medication Safety

IHI

Le storie e la voce dei pazienti e familiari

La partecipazione dei pazienti alle visite multidisciplinari

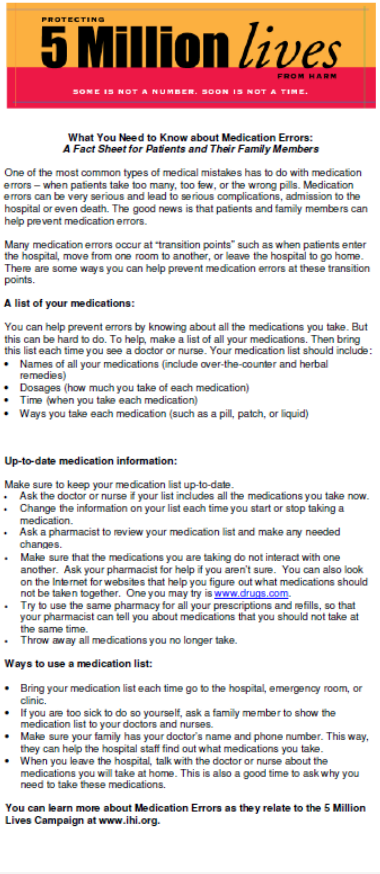
L'alleanza con i pazienti, le famiglie, le comunità



Patient- and Family-Centered Care Organizational Self-Assessment Tool

Elements of Hospital-Based Patient- and Family-Centered Care (PFCC) and Examples of Current Practice with Patient and Family (PF) Partnerships

Domain	Element	Low → High					Do not know
Leadership / Operations	Clear statement of commitment to PFCC and PF partnerships	1	2	3	4	5	
	Explicit expectation, accountability, measurement of PFCC	1	2	3	4	5	
	PF inclusion in policy, procedure, program, guideline development, Governing Board activities	1	2	3	4	5	
Mission, Vision, Values	PFCC included in mission, vision, and/or core values	1	2	3	4	5	
	PF-friendly Patient Bill of Rights and Responsibilities	1	2	3	4	5	
Advisors	PF serve on hospital committees	1	2	3	4	5	
	PF participate in quality and safety rounds	1	2	3	4	5	
	Patient and family advisory councils	1	2	3	4	5	
Quality Improvement	PF voice informs strategic/operational aims/goals	1	2	3	4	5	
	PF active participants on task forces, QI teams	1	2	3	4	5	
	PF interviewed as part of walk--rounds	1	2	3	4	5	
	PF participate in quality, safety, and risk meetings	1	2	3	4	5	
	PF part of team attending IHI, NPSF, and other meetings	1	2	3	4	5	
Personnel	Expectation for collaboration with PF in job descriptions and PAS	1	2	3	4	5	
	PF participate on interview teams, search committees	1	2	3	4	5	
	PF welcome new staff at new employee orientation	1	2	3	4	5	
	Staff/physicians prepared for and supported in PFCC practice	1	2	3	4	5	
Environment and Design	PF participate fully in all clinical design projects	1	2	3	4	5	
	Environment supports patient and family presence and participation as well as interdisciplinary collaboration	1	2	3	4	5	



PROTECTING 5 Million lives FROM HARM

SOME IS NOT A NUMBER. SOON IS NOT A TIME.

What You Need to Know about Medication Errors:
A Fact Sheet for Patients and Their Family Members

One of the most common types of medical mistakes has to do with medication errors – when patients take too many, too few, or the wrong pills. Medication errors can be very serious and lead to serious complications, admission to the hospital or even death. The good news is that patients and family members can help prevent medication errors.

Many medication errors occur at "transition points" such as when patients enter the hospital, move from one room to another, or leave the hospital to go home. There are some ways you can help prevent medication errors at these transition points.

A list of your medications:

You can help prevent errors by knowing about all the medications you take. But this can be hard to do. To help, make a list of all your medications. Then bring this list each time you see a doctor or nurse. Your medication list should include:

- Names of all your medications (include over-the-counter and herbal remedies)
- Dosages (how much you take of each medication)
- Time (when you take each medication)
- Ways you take each medication (such as a pill, patch, or liquid)

Up-to-date medication information:

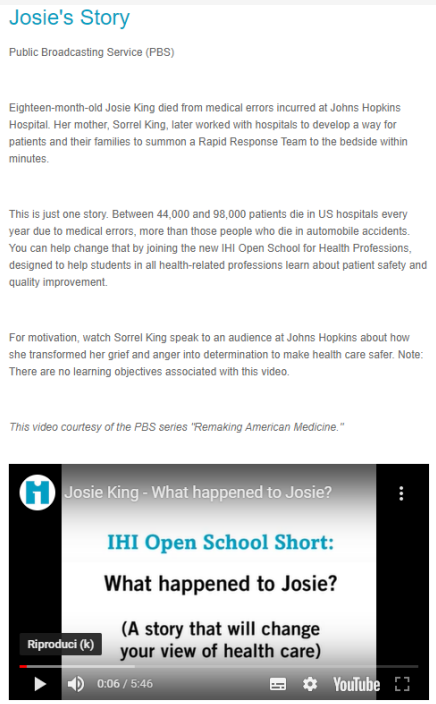
Make sure to keep your medication list up-to-date.

- Ask the doctor or nurse if your list includes all the medications you take now.
- Change the information on your list each time you start or stop taking a medication.
- Ask a pharmacist to review your medication list and make any needed changes.
- Make sure that the medications you are taking do not interact with one another. Ask your pharmacist for help if you aren't sure. You can also look on the Internet for websites that help you figure out what medications should not be taken together. One you may try is www.drugs.com.
- Try to use the same pharmacy for all your prescriptions and refills, so that your pharmacist can tell you about medications that you should not take at the same time.
- Throw away all medications you no longer take.

Ways to use a medication list:

- Bring your medication list each time go to the hospital, emergency room, or clinic.
- If you are too sick to do so yourself, ask a family member to show the medication list to your doctors and nurses.
- Make sure your family has your doctor's name and phone number. This way, they can help the hospital staff find out what medications you take.
- When you leave the hospital, talk with the doctor or nurse about the medications you will take at home. This is also a good time to ask why you need to take these medications.

You can learn more about Medication Errors as they relate to the 5 Million Lives Campaign at www.ihi.org.



Josie's Story

Public Broadcasting Service (PBS)

Eighteen-month-old Josie King died from medical errors incurred at Johns Hopkins Hospital. Her mother, Sorrel King, later worked with hospitals to develop a way for patients and their families to summon a Rapid Response Team to the bedside within minutes.

This is just one story. Between 44,000 and 98,000 patients die in US hospitals every year due to medical errors, more than those people who die in automobile accidents. You can help change that by joining the new IHI Open School for Health Professions, designed to help students in all health-related professions learn about patient safety and quality improvement.

For motivation, watch Sorrel King speak to an audience at Johns Hopkins about how she transformed her grief and anger into determination to make health care safer. Note: There are no learning objectives associated with this video.

This video courtesy of the PBS series "Remaking American Medicine."

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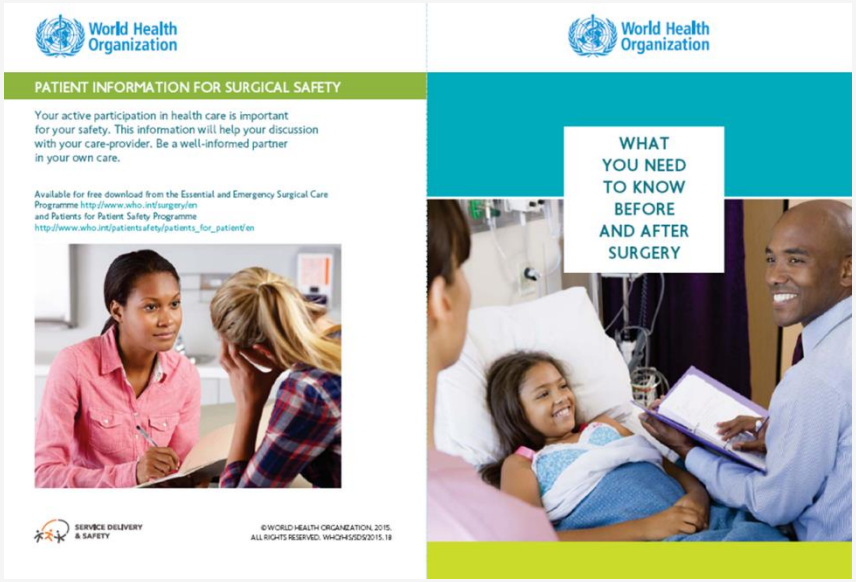
Strumenti



World Health Organization

PATIENT INFORMATION FOR SURGICAL SAFETY

Your active participation in health care is important for your safety. This information will help your discussion with your care-provider. Be a well-informed partner in your own care.

Available for free download from the Essential and Emergency Surgical Care Programme http://www.who.int/surgery/en and Patients for Patient Safety Programme http://www.who.int/patientsafety/patients_for_patient/en

SERVICE DELIVERY & SAFETY

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World Health Organization

WHAT YOU NEED TO KNOW BEFORE AND AFTER SURGERY

WHAT YOU NEED TO KNOW BEFORE AND AFTER SURGERY

If you or your child is undergoing a surgical procedure, be sure to communicate the following to your health-care provider

BEFORE SURGERY

1. Tell them about your previous surgeries, anesthesia and current medications, including herbal remedies
2. Tell them if you are pregnant or breast-feeding
3. Tell them about your health conditions (allergies, diabetes, breathing problems, high blood pressure, anxiety, etc.)
4. Ask about the expected length of your hospital stay
5. Ask for personal hygiene instructions
6. Ask them how your pain will be treated
7. Ask about fluid or food restrictions
8. Ask what you should avoid doing before surgery
9. Make sure that the correct site of your surgery is clearly marked on your body

AFTER SURGERY

1. Tell them about any bleeding, difficulty breathing, pain, fever, dizziness, vomiting or unexpected reactions
2. Ask them how you can minimize infections
3. Ask them when you can eat food and drink fluids
4. Ask when you can resume normal activity (e.g. walking, bathing, lifting heavy objects, driving, sexual activity, etc.)
5. Ask what, if anything, you should avoid doing after surgery
6. Ask about the removal of stitches and plasters
7. Ask about any potential side effects of prescribed medications
8. Ask when you should come back for a check-up

SISTEMA SANITARIO REGIONALE
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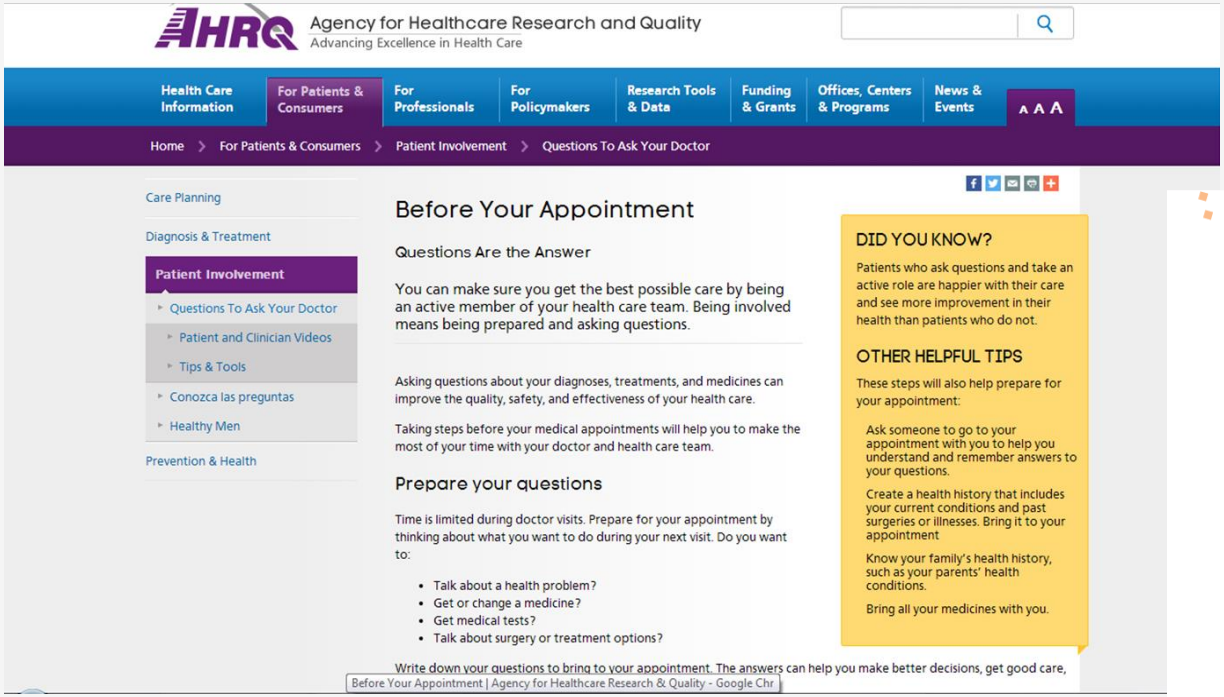
SAPIENZA UNIVERSITÀ DI ROMA

Informare per supportare



My Medicine List

(As of _____)

My **Allergies** to Medicines _____

My **Regular** Medicines **(Bring this form to your next appointment.)**
Remember to include any over-the-counter medicines, vitamins, or supplements on the list.

Name (brand and generic)	Why do I take it?	Who prescribed this medicine?	When did I start taking this medicine?	How much do I take?	When do I take it?	Notes

Medicines I Need to Stop Taking

Name (brand and generic)	Why did I take it?	Why was it stopped?

Sicurezza del farmaco

Readability
Revisione contenuti con i Clinical Risk Manager SST
Revisione comprensibilità con i cittadini esperti

video promo
website
social network

Formare la comunità

Creare una comunità che promuove una cultura della sicurezza trasversale

Un'Accademia del cittadino

Migliorare insieme la qualità e la sicurezza delle cure

2009 - I° edizione

Informarsi, valutare e agire per il cambiamento

2012 - II° edizione

Formarsi per praticare il diritto alla salute delle cure

2017 - III° edizione

I cartoon per la sicurezza del paziente

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Ministero della Salute

Uniti per la sicurezza - Dieci Guide per una assistenza sanitaria più sicura

Uniti per la sicurezza - Dieci Guide per una assistenza sanitaria più sicura

A cura di Ministero della Salute

Download

- Guida Strutture Sanitarie (pdf, 2 Mb) (PDF 2.06 Mb)
- Guida per gli operatori (PDF 0.94 Mb)
- Guida per i cittadini (PDF 1.01 Mb)
- Guida per i familiari (PDF 1.00 Mb)
- Guida per i volontari (PDF 0.96 Mb)
- Guida per i pazienti degli studi odontoiatrici (PDF 0.84 Mb)
- Guida per l'uso sicuro dei farmaci (PDF 1.01 Mb)
- Guida per l'assistenza a casa (PDF 0.87 Mb)
- Guida per gli operatori che assistono a domicilio (PDF 0.84 Mb)
- Guida per i pazienti oncologici (PDF 0.75 Mb)

Ministero della Salute

DIPARTIMENTO DELLA QUALITÀ

DIREZIONE GENERALE DELLA PROGRAMMAZIONE SANITARIA, DEI LIVELLI DI ASSISTENZA E DEI PRINCIPI ETICI DI SISTEMA

UFFICIO III

RACCOMANDAZIONE PER LA COMUNICAZIONE AI PAZIENTI DEGLI EVENTI AVVERSI

È essenziale una comunicazione

trasparente e onesta degli eventi avversi

La comunicazione trasparente e onesta degli eventi avversi rappresenta un pilastro fondamentale per la gestione del rischio clinico e per mantenere il rapporto di fiducia tra il sistema sanitario, i cittadini ed i pazienti.

Al verificarsi di un evento avverso è necessario che gli operatori sanitari esprimano rincrescimento per l'accaduto ai pazienti o ai loro familiari.

Aprile 2011

Cosa chiedono i pazienti lesi e i loro familiari

- Comunicazione onesta, chiara e trasparente (Hobgood C. Et al., 2002)
- Spiegazioni e scuse (Schappach D, 2004)
- Attenzione alla relazione e agli aspetti emotivi (Kathleen M. Et al., 2005)
- Rispetto e ascolto del paziente e del suo punto di vista (Duclos C et al., 2005)
- Risarcimento adeguato e supporto al paziente (Clinton, Obama, 2006)
- Informazione e conoscenza (Gallagher T. Et al., 2007)
- Partecipazione e collaborazione nell'analisi e nella gestione degli eventi avversi (Accademia del Cittadino, 2010)

Cosa vogliono i pazienti lesi e i loro familiari

Essere aperti al dialogo e all'interazione con i pazienti può **mitigare la reazione dei pazienti** e promuovere un clima di fiducia

La mancanza di spiegazioni e l'assenza di scuse sono i motivi principali che incentivano **l'azione legale**

(Vincent C., 2007)

Institute for Healthcare Improvement Open School

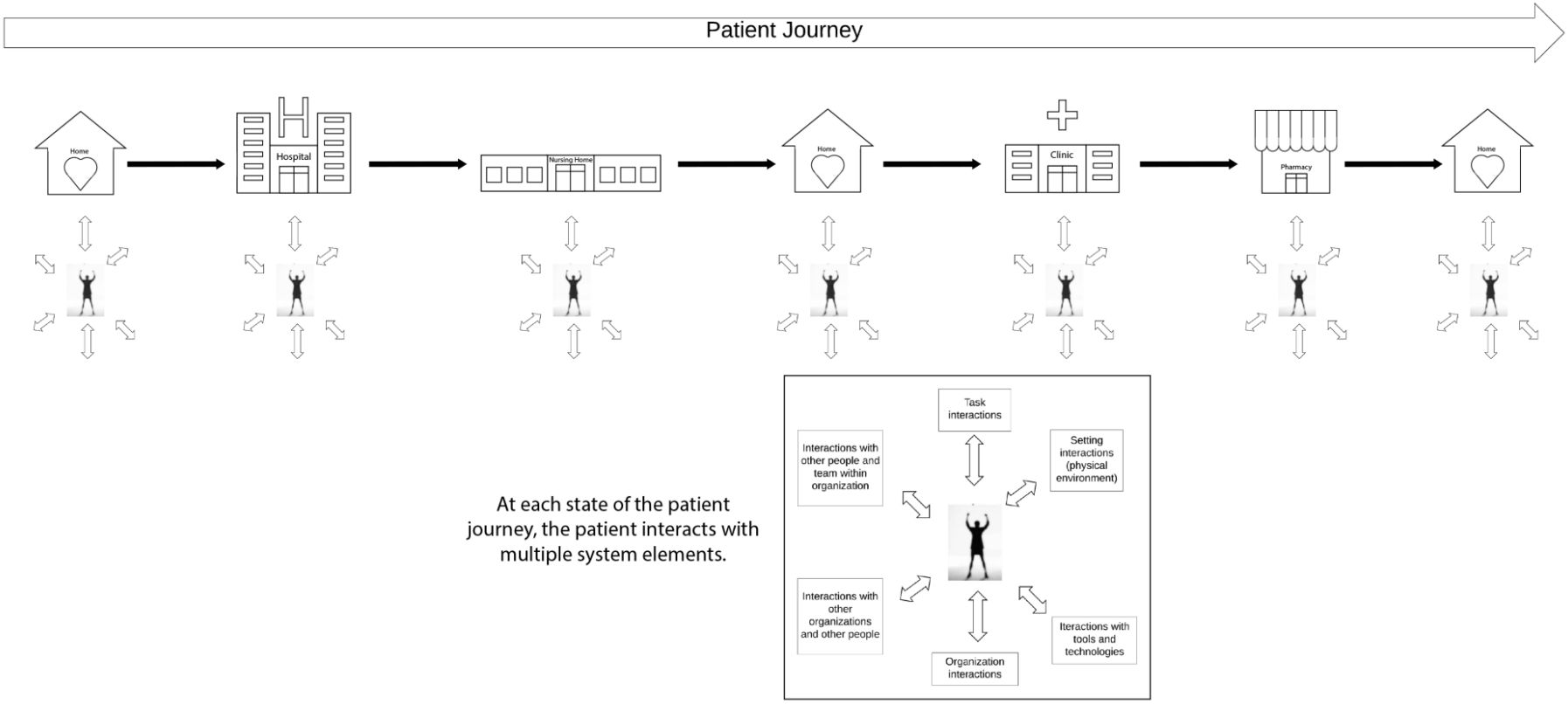
Patient Safety 105: Communicating with Patients after Adverse Events
Summary Sheet

Lesson 1: The Importance of Communication when Things Go Wrong

- There are a number of reasons for not communicating when something bad happens:
  - A psychologically reactive need to preserve a sense of self
  - Fear of admitting responsibility for making an error that may have hurt someone
  - Fear of anger from the patient and/or someone in authority
  - Fear of loss of job or position
  - Threat of censure
  - Threat of medical malpractice claims
  - Fear of colleague disapproval
  - Fear of negative publicity
- Disclosure and communication should not be used interchangeably
  - **Disclosure:** The discussion of clinically significant facts between providers and/or other personnel and patients or their representatives about the occurrence of an adverse event that could reasonably be anticipated to result in harm in the foreseeable future.
  - **Communication:** This conveys "a sense of openness and reciprocity" and implies a continual dialogue.
- Communicating with a patient after an adverse event does not eliminate the risk of a lawsuit.
  - However, good communication has been show to lower your risk of being sued.

WHO GLOBAL SAFETY ACTION PLAN (2021-2030)

PATIENT JOURNEY e PDTA



Carayon P, Wooldridge AR. Improving Patient Safety in the Patient Journey: Contributions from Human Factors Engineering, 2019


Centro Senologico Integrato
(BREAST UNIT)
il Policlinico Umberto I
Per la donna con Tumore al seno:
Centro Senologico Integrato
Centro Senologico Integrato
BREAST UNIT

Insieme a

aimac
associazione italiana malati di cancro, parenti e amici

ANDOS
Associazione Nazionale Donne Operate al Seno

Filofeso

LILT
Lega Italiana per la Lotta contro i Tumori

Pagaie Rosa

Con la collaborazione

Centro Servizi SapienzaSport

Sport

Servizio OneDay OneSite

Percorso unico e facilitato

Call Center unico Centro di Senologia

Servizi ROSA e councelling di percorso

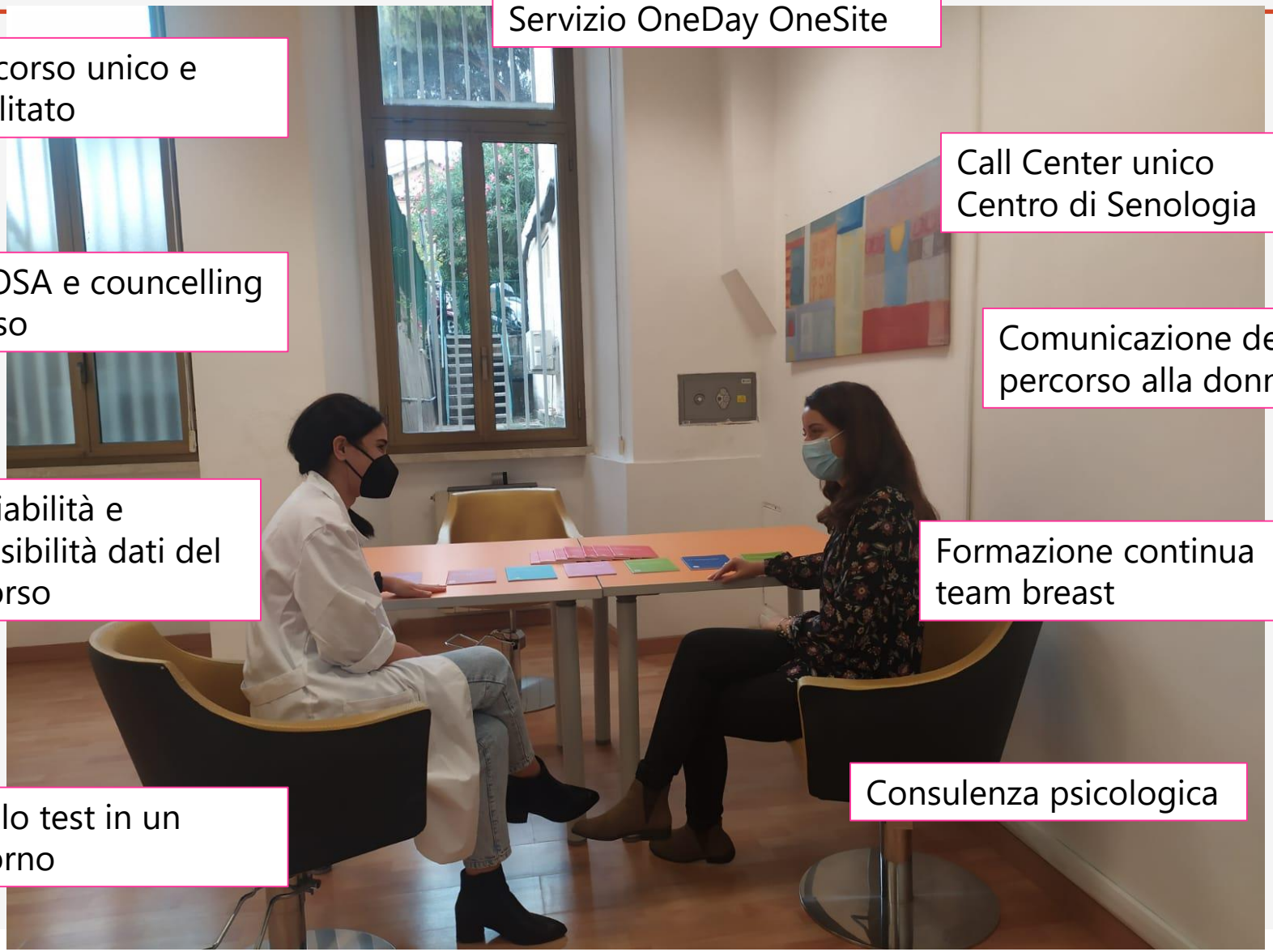
Comunicazione del percorso alla donna

Tracciabilità e accessibilità dati del percorso

Formazione continua team breast

Consulenza psicologica

Triplo test in un giorno



Le barriere al coinvolgimento del paziente

[sistema sanitario]

Un sistema frammentato

Carenza di una leadership organizzativa

Cultura dei professionisti sanitari

Mancanza di strumenti efficaci per coinvolgere i pazienti

Elementi di successo per la partecipazione

la partecipazione deve essere competente

partecipanti **rappresentativi**
del pubblico a cui ci riferiamo

momento in cui i cittadini sono coinvolti,
sufficientemente in tempo per avere un effetto sulla decisione

la **reale influenza** che la voce dei cittadini
può avere sulle decisioni

[Susan Sheridan, WHO Global consultation on Patient Safety 2016, Florence]

grazie per l'attenzione

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L'albero della vita – Gustav Klimt