



**Coimbra
Health School**
Polytechnic of Coimbra

AM001

Patient Safety in Primary Care

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ANNUAL MEETING
2020 | 25-27 junho

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- 2) *Center for Innovative Care and Health Technology (ciTechCare)*



INTRODUCTION

Patient safety and the development of Quality Safety processes have been gaining prominence in business management in the public and political sector, particularly in Europe, after the Quality and Safety in European Hospitals project was driven by the support of the Lisbon strategy agenda.

The Scientific research has also followed this trend.

However, the study of patient safety management and methods are still scarce, specially in Primary HealthCare (PHC).

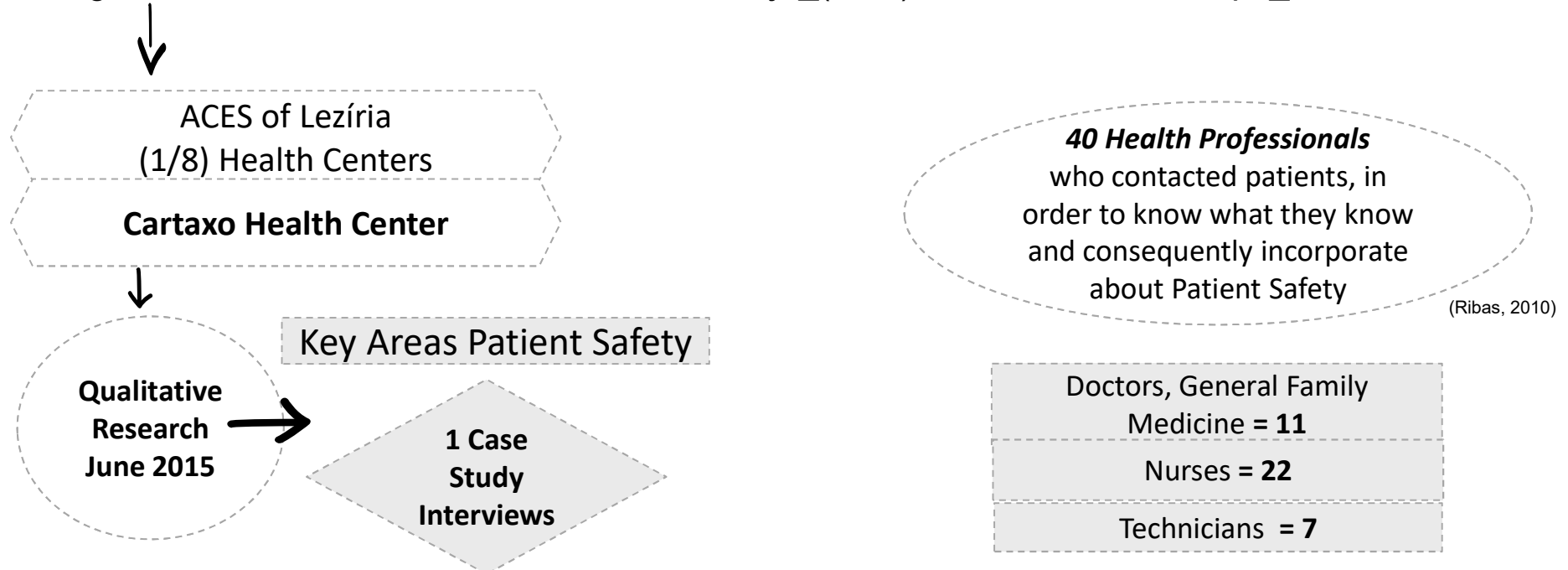
Key Words

Primary Health Care; Quality in Patient Safety; Adverse Events

OBJETIVES & METHODOLOGY

Resorting to **Cartaxo Health Centre**, the research contributes to the analysis of the proposition that there is **not only a lack of knowledge** of the professionals who directly contact the patient about the patients safety in primary health care, but also **that the methods used in practice are very intuitive and individualised by the absence of formal and institutional coordinated orientation.**

Regional Health Administration Lisboa Vale Tejo_(1/15) Health Center Groups_ACES of Lezíria

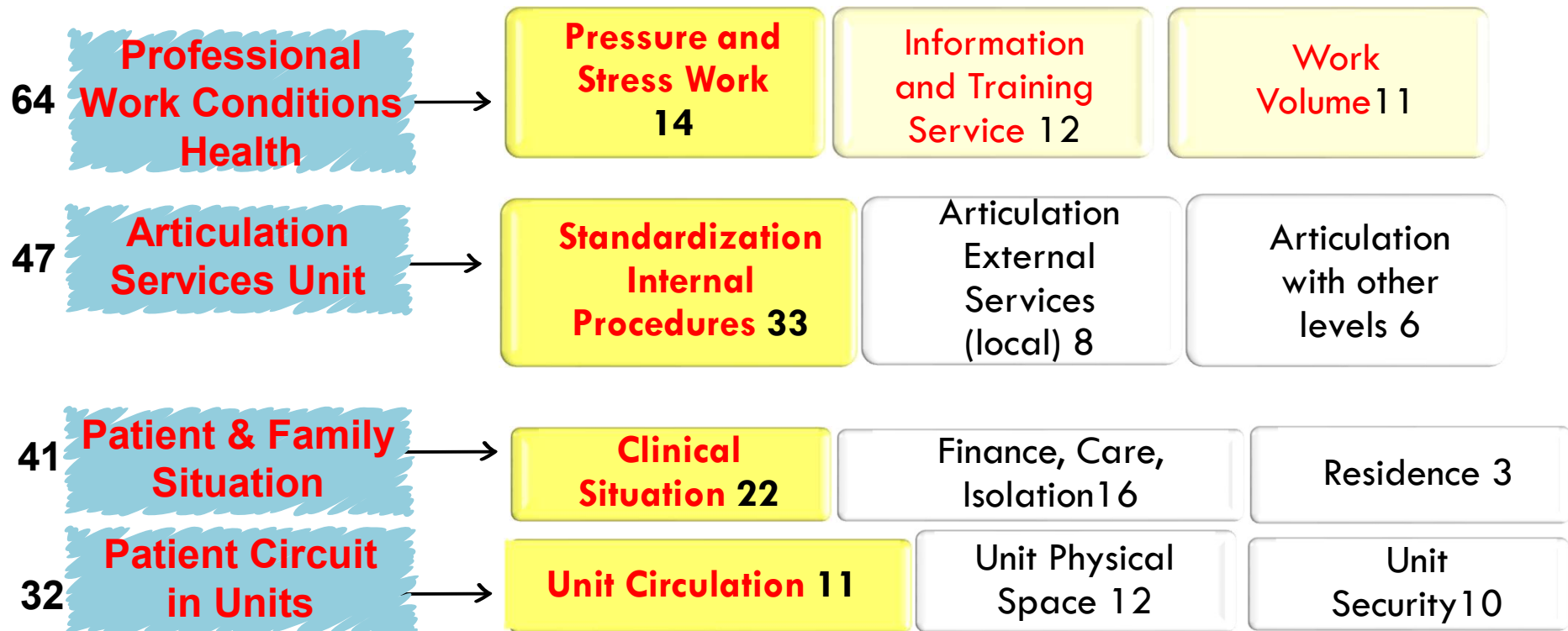


RESULTS/CONCLUSIONS

1. Looking about 75% of the data, the complexity of the context impacts on the nature and dimension of adverse events due to **stress, workload and organization** (main causes of adverse events in primary health care).
2. Observing in detail the causes of adverse events at the Cartaxo Health Center, it was found that main causes are: **organization; patient & Health system; training & health unit conditions.**
3. We confirmed several discrepancies between functional units.
4. It was clarified that in residence the knowledge is scarcer.

RESULTS/CONCLUSIONS

(244 Causes Adverse Events PHC)

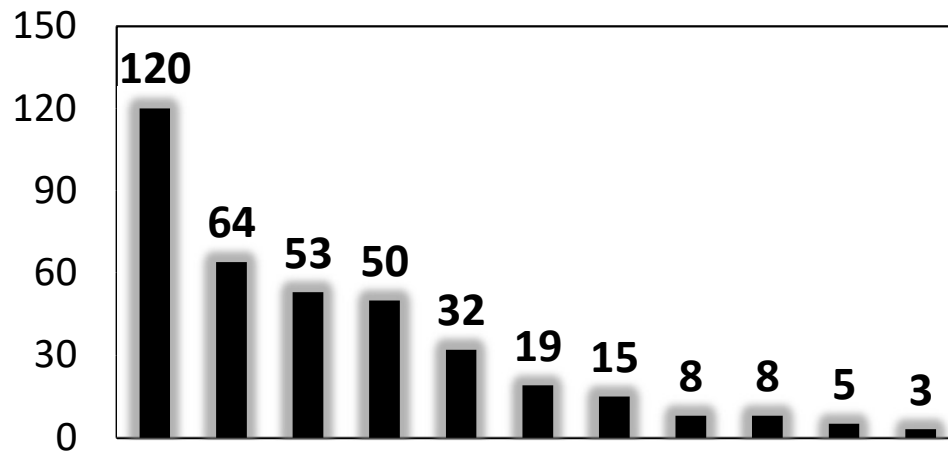


RESULTS/CONCLUSIONS

5. We have delimited factors that do not ensure a reliable environment and culture, to be improved with a **training plan** & 1 institutional coordination that supports **notification**.
6. With this knowledge 1 Taxonomy of Adverse Events was constructed and its path from the source to the solution was mapped. It's our intention to share this Taxonomy with the professionals, with a strong expectation that will improve Quality and Safety in Portuguese Primary Care.

RESULTS/CONCLUSIONS

(377 Causes Adverse Events in Cartaxo Health Center)



120 » **Organization**

64 » Patient & The Health System

53 » Training

50 » Health units conditions

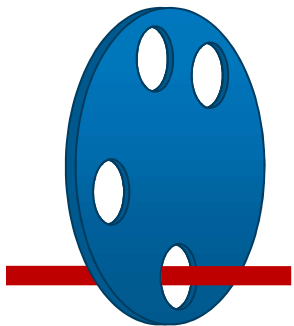
TAXONOMY

Path Source to Solution
Organization

Lack of standardized procedures
for all interventions since Patient
entry to exit in the Health care
System

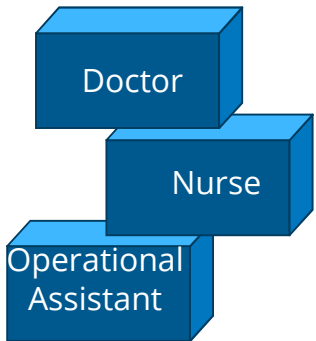
Organization
problems
Impacting Patient
Safety

Lack of standardized procedures for all interventions since Patient entry to exit in the Health care System



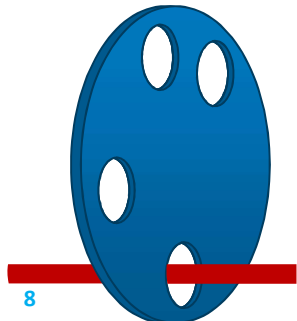
SOURCE

High professional / patient ratio / increasing



SOURCE

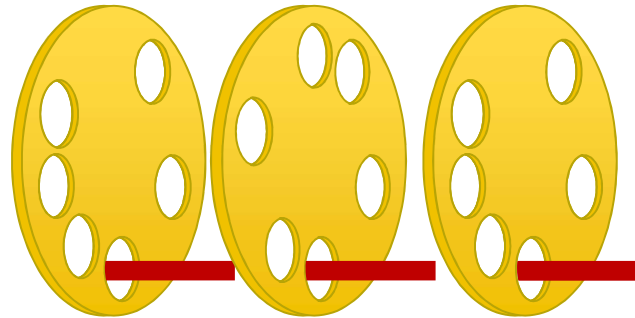
Little no ongoing training



BARRIERS TO KNOWN EXPOSURE

**Define priority tasks
secure files without
family doctor/nurse**

**Define /xtend
minimum
services
all CS functional
units**



**Continuing training on
safety, cleaning, sick,
various hygiene procedures**

BARRIERS TO KNOWN EXPOSURE

SOLUTIONS

Review indicators /available time attendance /consultation; ratio geographic area all Functional Units

Establish adverse events/sick circuit assessment and prevention procedures within the system

Build a good practice manual in all / between all Functional Units

Hold team meetings (periodicity adjusts) within, between functional units and levels

Test procedures simulation cases and procedures; periodically incorporate safe techniques / recent scientific knowledge within system and outside system

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