ESA2016: Safety in Anaesthesiology and Intensive Care a Key Theme

Safety of both patients and doctors was a key theme of Euroanaesthesia 2016, meeting in London. The Sir Robert Macintosh lecture, named after the first professor of anaesthetics outside the United States, was delivered by Sven Erik Gisvold (pictured), Professor of Anaesthesia & Intensive Care Medicine, from St Olavs Hospital, Trondheim, Norway. Departments should not neglect the impact on the health professional who is responsible for an adverse event, said Gisvold. "Problems happen to good people, and you are really tested after something serious has happened. There is room for improvement in supporting colleagues involved in serious events," he added.

Patients and relatives want honest disclosure and truth after a serious event. However, they may have different perceptions of events than doctors. Truth and reality is very personal. However, you do not admit guilt just by telling exactly what happened, said Gisvold. There are positive effects of honest disclosure, said Gisvold. You meet the patients's needs and take care of your own self-respect. "You may even be forgiven and respected", he added.

Gisvold outlined his experience of what was important for a quality and safety culture at the department level. Checklists are important, he said, and seniors must also report their adverse events. There should be regular problem meetings, looking both at individual cases and at trends.

"It is often said that the study of such intermediate/surrogate outcomes are of limited interest. I disagree: let us record and discuss what matters most, the everyday events that happen on the clinical floor at the sharp end, with the potential to develop into disasters," he told delegates.

At his own hospital, St Olavs in Trondheim they successfully run a preoperative clinic, a joint venture between anaesthesia and surgery which meets prior to elective surgery. This has meant that patients and doctors are better prepared, there are fewer cancellations due to inadequate preoperative preparation and more same day admissions.

The key elements of a safety culture mean a focus on the clinical unit level, a bottom up approach. Psychological safety and an environment of trust and fairness come first. There should be a learning system and honest disclosure and colleagues need to take care of each other, concluded Gisvold.

See Also: Standards for Healthy Critical Care Work Environments Updated

Safety and Quality

Safety and quality are intimately connected, and cannot be separated, according to Prof. Hans Flaatten, the current Chair of the European Society of Intensive Care Medicine (ESICM) Section on Health Services Research & Outcome, speaking at a symposium organised by ESICM at Euroanaesthesia 2016 in London. However, quality indicators alone do not improve safety. Improving safety in the ICU requires change according to input from various sources, often but not only quality indicators, he said.

Flaatten cautioned that it is not possible to have a unified, all inclusive definition of quality in the clinical sense. Depending on one's perspective, quality will take different forms and shapes. Quality means different things to a CEO than to a patient, for example. Quality is best recognised when it is absent, he added.

A simple description of quality in healthcare encompasses structure, process and outcome, described by standards, guidelines and indicators respectively. Quality indicator selection is variable across Europe, however, said Flaatten, adding: "We left patients or relatives completely out of the picture when we created quality indicators."

See Also: ICU Management & Practice's Cover Story on Safety

The ESICM's 9 quality indicators were published in 2012 (Rhodes et al. 2012). Flaatten explored their potential link to safety.

1. ICU fulfils national requirements to provide intensive care
If there is a national requirement, this may lead to improved care in the ICU because national requirements will cover education, equipment standards, hygiene issues and reporting. But not all countries have requirements, for example his own country, Norway.

2. 24-hour availability of a consultant-level intensivist

Very few European countries have intensive care medicine as a specialty, so 24/7 availability of an intensivist should relate to the requirements of calling oneself an intensivist, suggested Flaatten.

3. Adverse event reporting system
Even if there is an adverse event reporting system in place, merely reporting events does not in itself make the ICU a safe place.

4. Presence of routine multidisci[plinary clinical ward rounds

5. Standardised handover procedure for discharging patients
Flaatten observed that having a standardised handover procedure is probably the strongest direct link to safety, as a lot of information is lost in this process, particularly about drugs.

6. Reporting and analyis of standardised mortality ratio (SMR)
This is best used as a local comparison, said Flaatten, as it is difficult to compare SMR against another ICU.

7. ICU re-admission rate within 48 hours of ICU discharge
The rationale is that readmitted patients have a higher mortality in general, but what if we did not readmit them, asked Flaatten.

8. The rate of central venous catheter-related bloodstream infection
Just to report your rate does not in itself make your ICU a safe place, and it is possible to 'manipulate' both nominator and denominator, said Flaatten.

9. The rate of unplanned endotracheal extubations.
Intuitively there is a direct link to safety, but if the patient is promptly reintubated, what then, said Flaatten.

Analysis is the key word that links quality to safety, emphasised Flaatten. To transform results from quality indicators to increase safety, we must change, he added. Barriers to change include resistance to change, the ICU culture, stakeholders, insufficient leaders, lack of 'change-pilots', lack of resources and resistance to technology. He recommended the NHS Institute for Innovation and Improvement's resource on overcoming resistance to change, which delineates levels of resistance and how to overcome them. For example, for "Level 2" resistance as described by the NHS, which is an emotional and physiological reaction to change based on fear of loss, incompetence or abandonment the best response is to discuss and fully explore the idea with staff - listening and meaningful dialogue are essential.

Claire Pillar
Managing editor, ICU Management & Practice

Image credit: European Society of Anaesthesiology

Published on : Thu, 2 Jun 2016