

Quality improvement in the processes of the Medical Emergency Dispatch Centre 118 of Verona Province, Italy

Schönsberg A°, Cipolotti G°,
Zerman T°, Romano G°, Pascu D°

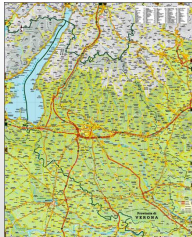
° Verona Healthcare Trust 20
°° Department of Medicine and Public Health,
University of Verona

Objective

Point out: the emergency interventions are time and space defined and focalized on just-in-time patient management

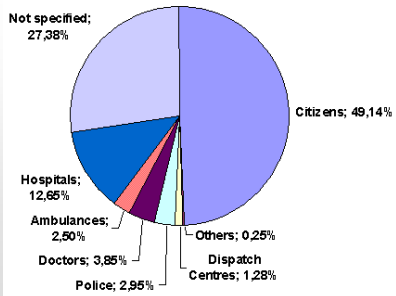
The aim of this study was to identify and analyze the potential risks in processes and subprocesses carried out by the Medical Emergency Dispatch Centre of Verona in order to improve service quality and patient safety

Context



- Inhabitants 900.000
- Surface 3.121 km²
- Density 291,1 inhabitants/km²
- Increase of the density for tourist influx
- 98 Municipalities
- 1 Emergency Dispatch Centre
- 135.000 calls every year

Context: origin of 135,000 calls



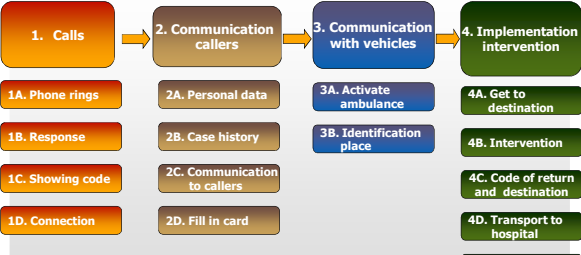
Origin	Percentage
Citizens	49,14%
Hospitals	12,65%
Not specified	27,38%
Police	2,95%
Doctors	3,85%
Ambulances	2,50%
Dispatch Centres	1,28%
Others	0,25%

Methods

- Whole staff involved (3 doctors and 21 nurses)
- A series of meetings for the duration of 3 months (April – June 2008)

- **First step:** the staff identified processes most at risk analyzing all operational phases, from the arriving call to the hospital admission using HFMEA
- **Second step:** the staff participated in focus group to bring up to the light critical points of the service and the perceived risks for patients


Results



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graph LR
    1[1. Calls] --> 2[2. Communication callers]
    2 --> 3[3. Communication with vehicles]
    3 --> 4[4. Implementation intervention]
  
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Assign a score according to seriousness and probability of error




Results

The staff of Medical Emergency Dispatch Centre participated in focus group. Group was heterogeneous for age, experience, roles and activities.


CRITICAL POINTS IDENTIFIED

- Quality and quantity of services differ in terms of resources
- High requests
- Complexity of protocols
- Poor dialogue among professionals
- Stress and burnout






Results

	BIBLIOGRAPHY	HFMEA	FOCUS GROUP
Communication	✓	✓	✓
Education	✓	✓	✓
Dispatch and new technologies	✓	✓	✓
"Experience"	✓	✓	✓
Territorial differences in terms of resources		✓	✓
Stress and burnout	✓	Not considered	✓
Changeability of the situation			✓
Team communication			✓
Protocols	✓		✓





Undertaken improvement actions

- Educational campaign
- Introduction of Incident Reporting (Database)
- Psychological support: meetings "Care for caregivers"
- Standardization and simplification of protocols and online deployment



Improvement actions in progress

- Use of handhelds to keep in touch ambulances and hospitals
- Uniformation of the resources throughout the territory
- Accreditation of the Emergency Services


Impacts of the project

- Reduction of the risk for patients
- Appropriateness of requests
- Staff well-being
- Improvement of processes with the aim to guarantee better quality of care for the patients in this area
- Assessment of tools (HFMEA vs FG) in Emergency Area

Conclusions

This study has allowed to evaluate the sense of affiliation to organization, the will of improvement, the great sensitivity and expertise of the team. The positive organizational climate and the involvement of the staff represent a starting point to solve critical processes.





QUESTIONS?