410: 'Safe patient, safe hospital' Project: A prelude to a culture of safety in Polish hospitals

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Objective:
To describe the views of doctors and nurses, from the post communist accession country, on the development of an adverse events reporting system in the project, which precedes the development and implementation of national patient safety programs in Poland.

Methods:
Patient safety, understood as preventing the adverse events and errors on clinical wards is an underestimated issue in European hospitals. Poland is the first post-communist accession country to facilitate the development of a safer health care system by initiating the National Patient Safety Program. The 'Safe patient, safe hospital' project is a preliminary to the program and the initiative of the Polish Society for Quality Promotion in Healthcare (TPJ). Key components of the project include:

- Diagnosis (developing an Adverse Events Questionnaire: cooperation with the Danish Patient Safety Project; conducting the survey; analysis of results: November 2003-January 2004);
- Focus groups (identification of categories and types of adverse events to be reported; designing the scheme of the reporting system: February - May 2004);
- Pilot studies in the selected district, provincial and teaching hospitals (staff education; implementation of the system; monitoring the reporting; evaluation of results: June – October 2004);
- Publishing the final project report: November 2004.

Simultaneously, dissemination of information on patient safety culture based on literature reviews and educational activities (workshops; conference on Risk Management and Patient Safety planned in April 26th, 2004) will enhance the conscience and knowledge of patient safety among healthcare professionals; healthcare managers; insurers and payers. Program related activities also include forming the Coalition for Patient Safety, representing the main stakeholders (key medical organisations and associations; MoH; insurance companies; payers). Proposals of the new legislation that enables reporting of adverse events will be the result of focus groups comprising lawyers. Questionnaires on Adverse Events were aimed at collecting information on staff behavior when an adverse event occurs; the most acceptable model of the reporting system and the opinions of adverse events (5-point Likert scale). The self-administered questionnaire was sent to heads of the randomly selected departments (both doctors and nurses) of general surgery; orthopedics; neurosurgery, internal medicine, accredited for specialty training. The survey was anonymous; 246 questionnaires were analysed.

Results:
In the group of respondents consisting of doctors (40%) and nurses (60%), 78% admit to participating in adverse events. Almost 96% of respondents are of the opinion that patients should be informed about complications in surgery; 91% would definitely disclose if they had mistaken 2 drugs producing contrary effects (e.g. Nimbex and Narcan). Nurses, more than doctors, are afraid of reprimand from superiors (43% and 25.3%; $p<0.05$) but both groups would definitely inform the superiors about conducting an error. Doctors (89%) are more willing than nurses (55%) to talk about adverse events with their peers ($p<0.05$). The preferred model of reporting is conditionally confidential (chosen by 6/10 respondents); only every 3rd respondent chooses the confidential model and there is no acceptance for the anonymous model. 84% of respondents point to their medical profession representative as a recipient.

Conclusions:
Since the project is the first attempt to tackle the issue of patient safety in Polish healthcare, the questionnaire provided invaluable information; on the attitudes and opinions of medical professionals relating to adverse events; preferences and criteria for future reporting systems and justification of further implementation of the project, in attempting to introduce a culture of safety into Polish hospitals.

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