

FACILITIES AND PATIENT CARE ENVIRONMENT RISK ASSESSMENT TOOL

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DESCRIPTION

Facilities and infrastructures collaborate with patient safety, or with failure modes. There is an important relationship between knowing risks in the hospital environment, and the level of security required. When reviewing the literature, tools were developed for the identification and analysis of risks, but none established specific results or are from an easy understanding to health managers.

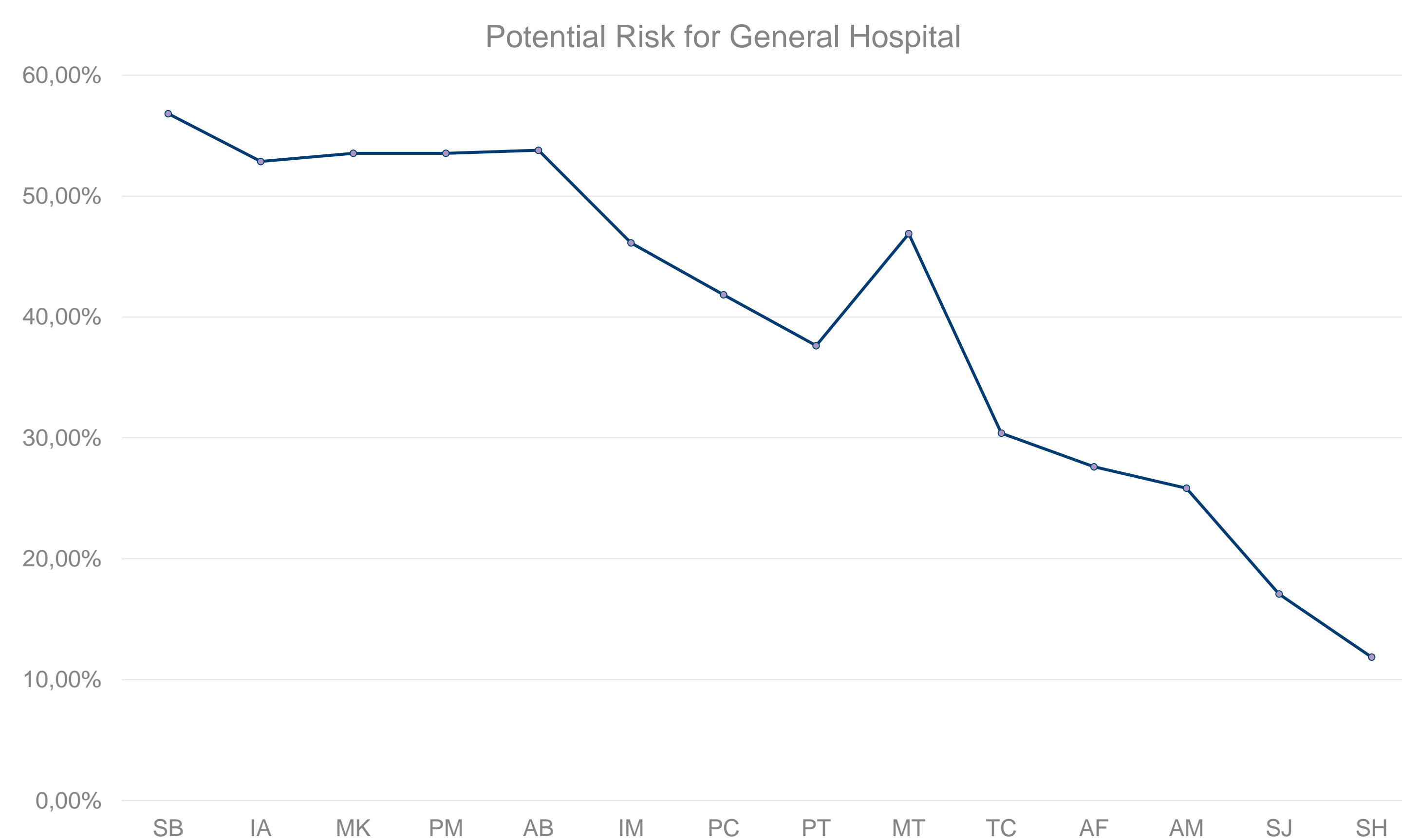
This study presents the application of the developed tool in 14 accredited hospitals, distributed in Brazil, listing 11 main risks: judicialization (FERA 1); methodological (FERA 2); Operational Management (FERA 3); Facilities Safety (FERA 4); Health products and Waste (FERA 5); Continuity of care (FERA 6); Fire safety (FERA 7); Medical Technology (FERA 8); Utilities Systems (FERA 9); Quality and Safety Management (FERA 10); Safety Education (FERA 11).

OUR AIM

Develop a tool for understanding and prioritizing the risk management of hospital facilities and environments.

ACTIONS TAKEN

Requirements were defined to be evaluated for the eleven risks listed as priorities, and a methodology with high reproductability and easy interpretation of results was established. The tool was applied to the hospitals in the study, to identify risks that still needed to be prioritized in the allocation and management of resources.



SUMMARY OF RESULTS

The graphs present the results of the environmental and structural risk of the hospitals when evaluated with the tool. The tool enables an integrated and comprehensive view of the safety of facilities and the environment, from the technical, administrative, and care settings. Facilities that are not safe compromise the end result of patient care.

From the 14 hospitals evaluated by the tool, we present those that have reached more than 40% of the specific risk: 07-judicialization; 05-methodological; 06-operational management; 11-Facilities Safety; 11-health products and Waste; 6-continuity of care; 07-fire; 01-medical technology; 07-Utilities Systems; 09-quality

and safety management; and 05-Safety Education.

H. U.	FERA.1	FERA.2	FERA.3	FERA.4	FERA.5	FERA.6	FERA.7	FERA.8	FERA.9	FERA.10	FERA.11	Average Hospital
SB	61,11%	44,44%	57,41%	64,81%	62,96%	64,81%	68,52%	21,30%	68,52%	57,41%	53,70%	56,82%
IA	61,11%	61,11%	59,26%	64,81%	62,96%	64,81%	68,52%	38,89%	5,56%	57,41%	37,04%	52,86%
MK	61,11%	38,89%	40,74%	64,81%	62,96%	66,67%	53,70%	23,15%	64,81%	57,41%	54,63%	53,54%
PM	61,11%	38,89%	40,74%	64,81%	62,96%	66,67%	53,70%	23,15%	64,81%	57,41%	54,63%	53,54%
AB	59,26%	55,56%	37,04%	64,81%	62,96%	64,81%	68,52%	22,22%	61,11%	40,74%	54,63%	53,79%
IM	59,26%	54,63%	53,70%	56,48%	62,96%	39,81%	46,30%	37,96%	22,22%	36,11%	37,96%	46,13%
PC	54,63%	55,56%	37,04%	48,15%	46,30%	6,48%	31,48%	55,56%	46,30%	40,74%	37,96%	41,84%
PT	3,70%	38,89%	37,04%	64,81%	46,30%	38,89%	35,19%	22,22%	48,15%	40,74%	37,96%	37,63%
MT	3,70%	37,96%	53,70%	56,48%	46,30%	59,26%	62,96%	38,89%	61,11%	40,74%	54,63%	46,89%
TC	3,70%	38,89%	37,04%	46,30%	29,63%	3,70%	35,19%	22,22%	38,89%	40,74%	37,96%	30,39%
AF	3,70%	38,89%	37,04%	39,81%	46,30%	3,70%	29,63%	22,22%	38,89%	24,07%	19,44%	27,61%
AM	3,70%	37,96%	37,04%	56,48%	29,63%	3,70%	22,22%	27,78%	22,22%	24,07%	19,44%	25,84%
SJ	3,70%	3,70%	2,78%	39,81%	46,30%	4,63%	37,04%	5,56%	5,56%	19,44%	19,44%	17,09%
SH	2,78%	37,04%	2,78%	38,89%	2,78%	3,70%	12,96%	21,30%	2,78%	2,78%	2,78%	11,87%
Average Risk	31,61%	41,60%	38,10%	55,09%	47,95%	35,12%	44,71%	27,31%	39,35%	38,56%	37,30%	39,70%
Potential Risk	31,83%	46,58%	33,38%	52,93%	37,90%	34,55%	42,06%	29,17%	36,88%	32,91%	25,71%	36,13%

The results obtained in requirements 1, 2, 3, and 10 highlight the need to improve the management of facilities safety. To improve the risk detection capacity through management, establishing methodology that classifies and prioritizes its weaknesses: recognize the risk or a near miss and develop mechanisms to reverse the process. Promote projects for the hospital environment with safe facilities and layout, enabling all patient care operations. These factors impact on the result of requirement 4, which evaluates the management applied in the hospital's operational routine. This result presents the highest average percentage among all the requirements. It shows the need to ensure a safe environment for the patient and other occupants. It reflects the lack of a routine where a security scenario and a culture of risk and event notifications are present throughout the team.

Requirements 5 through 9 evaluate specific and critical processes present in the hospital routine. Each result allows you to measure the risk of each process and the ability to mitigate risks and reduce damage before an event or occurrence.

Based on data from requirement 11, it is possible to evaluate the vulnerability of these hospitals to the internal and external response capacity of the team, to reduce damages and to recover the patient care process in the shortest possible time.

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