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Perinatal Dönemde Hasta Güvenliği

Patient Safety in the Perinatal Period

Tunçay PALTEKİ[1]

Abstract

Patient safety is the redesign of the entire system in order to prevent healthcare-related errors and to eliminate injuries and deaths caused by these errors. The concept of patient safety makes its importance felt more and more every day in every field of healthcare.

Patient safety is the most important part of optimal healthcare for mother and baby. The aim is to ensure that the baby and mother receive care in the safest possible environment during pregnancy, delivery and afterwards, and to prevent maternal and infant deaths.

By the millennium, it has been observed that many hospitals and healthcare systems that have developed programs focusing on various strategies to avoid preventable harm associated with mothers and babies are turning towards perinatal patient safety and quality.

In this article, patient safety problems and solutions related to the perinatal period are included.

Key words: Patient safety, Perinatal period, Medical error(s)

[1]Emergency and Disaster Management Department, Health Sciences Faculty, Biruni University, Assistant Professor

Patient safety can be defined as a redesign of the entire system in order to prevent healthcare-related errors and to eliminate injuries and deaths caused by these errors (Sur, 2019). In other words, it is to protect patients from potentially preventable complication, medical errors, accidental injuries or undesirable situations arising from care processes (AHRQ, 2003).

Although the concept of patient safety drew the attention of professionals towards the end of the last century, it has existed throughout history. The saying "First, do no harm", which was uttered by Galen of Bergama (Galenos, 129-216 AD) expresses the past interest in patient safety very well. More recently, Ignaz Philipp Semmelweis (1818-1865), known as the "saviour of mothers", discovered the relationship between the incidence of postpartum fever and handwashing habits in maternity clinics (Bodur, 2013). Along these pioneering studies achieved in the past, today's patient safety understanding emerged with the report prepared by the Institute of Medicine at the end of the last century.

The concept of patient safety makes its importance felt more and more every day in every field of healthcare. While there was a general safety approach used in all fields of medicine in the past, branch-based studies have come to the fore recently (Monson et al., 2008; Simpson, 2011). One of these fields is the obstetrics area. In a study conducted by Bodur et al. (2012) on "the attitude of senior midwifery and nursing students towards patient safety and medical errors"; The midwives and nurse candidates stated that 37% of them made medical errors during their internships, more than half (59%) had medication errors, 12% of the errors made caused harm, but mostly (71%) did not report on errors. They reported these rates to be higher for their internship colleagues.

Patient safety is an essential part of optimal healthcare for mothers and babies. The goal is to ensure that the baby and the mother receive care in the safest possible environment during pregnancy, delivery and afterwards, also to prevent maternal and infant deaths.

With the millennium, it has been observed that many hospitals and healthcare systems that have developed programs focusing on various strategies to avoid preventable harm associated with mothers and babies are turning towards perinatal patient safety and quality. In this context, clinical topics that may lead to frequently encountered problems related to patient safety can be listed as; drug safety (oxytocin, misoprostol, magnesium sulfate), the timing of elective deliveries, labour induction, tachysystole avoidance and treatment, intrauterine resuscitation, minimizing the risk of cesarean delivery, second-level labour care, interventional vaginal delivery, avoidance of routine episiotomy, management of shoulder dystocia, minimizing the risk of birth trauma, caring for women who have a vaginal delivery after c-

section, minimizing maternal mortality risk, postpartum haemorrhage management, surgical safety, neuroprotection through maternal magnesium sulfate administration for newborns, neonatal resuscitation at birth, neonatal oxygen therapy and therapeutic neonatal hypothermia for perinatal asphyxia as pain relief measures for neonatal interventions including circumcision (Simpson, 2011). However, in order to improve professional competence, issues such as teamwork, communication, training and simulation (including NST training and certification), safety culture, management support, and the adequacy of the number of health professionals should also be addressed.

The US National Patient Safety Goals of the Joint Commission were first established in 2002 to support accredited organizations. Joint International Commission later published the International Patient Safety Goals. These goals include; correct identification of patients, effective communication, the safety of high-alert medications, safe surgery, reducing the risk of healthcare-associated infections, and reducing the risk of patient harm resulting from falls (JCI, 2017).

Identify Patients Correctly

Verification of the identity of the patient who is going to receive healthcare is the basis of patient safety. The mother's bracelet should be changed with the birth. The situations in which the identity verification should be done can be listed as; before drug administration, in sampling for laboratory tests, before treatment application, before side marking, before the patient's transfer from the clinic to the operating room, before the patient's admission to the operating room, before the surgery, just before the anaesthesia, during the delivery of the patient from the operating room, before any imaging and interventional procedure and before the transfusion of blood and blood products. During delivery, a pink bracelet should be used for female babies and blue-coloured wristbands for male babies. A bracelet with the same serial number should be used both for the mother and the baby. At least the mother's name and surname, the baby's date of birth and the mother's / baby's protocol number must be on the wristband of the baby.

Improve Effective Communication

Communication is crucial in a way that, when ineffective, it directly causes medical errors that frequently occur in the provision of health services. Many factors hinder communication in hospitals. It poses a risk in terms of patient safety especially in the consultation processes between physicians, in the verbal request process between nurse/midwife and physician, and the delivery of shifts between nurse/midwife to

nurse/midwife. Verbal/telephone requests applications, use of abbreviations and symbols, the transmission of critical test results are frequently encountered among the sources of communication-related errors in hospitals.

Improve the Safety of High-Alert Medications

The "10 Rights of Drug Administration Principle" is a safe drug administration method that has been widely accepted in our country. These principles are (Berman, Snyder, & Frandsen, 2016); The right medication, the right patient, the right patient education, the right dose, the right way, the right time, the right rejection, the right registration, the right effect and the right evaluation.

Oxytocin, used for induction of labor, was included in the high-risk medications group by the Institute for Safe Medication Practices (ISMP) in 2007. Thus, as with all high-risk medications, it has become a rule to use the lowest possible dose for oxytocin to achieve the intended clinical effect, careful monitoring and timely detection and intervention for possible adverse effects. For this reason, hospitals and health systems have developed various algorithms and standards for the correct application of the process. Similarly, protocols have also been created for Magnesium Sulphate (Simpson, 2011).

Ensure Safe Surgery

"Safe Surgery Saves Lives" project was initiated by the World Health Organization (WHO) in 2008. Within the scope of the project, the Surgical Safety Checklist has been used in more than 3000 hospitals in 25 countries. In our country, the Ministry of Health modified the checklist created by WHO in 2009 and made it available as a "Safe Surgery Checklist". In a study conducted by the Safe Surgery Saves Lives Working Group, it was observed that the mortality rate decreased from 1.5% to 0.8% after the application of the Surgical Checklist, and the complication rate also fell from 11% to 7% (Haynes et al., 2009).

Reduce the Risk of Healthcare-Associated Infections

A well-organized infection control program must be carried out in every hospital in order to provide quality healthcare and to prevent hospital infections. This program is carried out by Infection Control Committees, which are also defined by the legislation in our country.

Reduce the Risk of Patient Harm Resulting from Falls

Newborn falls in the postpartum period pose a safety risk and are often associated with tired mothers who fall asleep while holding their babies. Promoting breastfeeding as a result of the Baby-Friendly Hospital Initiative; increases the baby's stay in the room with the mother and

jeopardizes the mother's uninterrupted resting opportunity. It is stated that this may increase the risk of neonatal fall. In a study conducted by Monson et al. (2008), when the three-year data of a chain hospital group were examined, it was observed that 14 newborns fell. In the hospital group, the newborn drop rate was 1.6 per ten thousand births on average.

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