Booked Sessions

Thu		Thu
08:15 - 08:45	Forum	En7: Translating the Evidence Base for Patient and
09:00 - 09:30	Hall 11	Opening Ceremony
09:30 - 10:30	Hall 11	K1: Keynote 1: How to move from fixed to growth mi
11:00 - 12:15	Poster Stage (Exhibition Hall)	Poster Stage Session - Quality, Cost, Value
13:15 - 14:30	Emerald	B4: Antimicrobial resistance in healthcare? Everyo
15:00 - 16:00	Poster Stage 2 (Exhibition Hall)	Poster Stage Session - Population and Public Healt
16:15 - 17:00	Hall 11	K2: Keynote: Creating moments that matter
19:00 - 21:00	Beach Bar	Night Forum - Amsterdam Treasure Hunt
Fri		Fri
08:00 - 09:00	Elicium 2	BR2: Friends of IHI and Global Initiatives - What'
09:15 - 09:30	Hall 11	Opening Ceremony
09:30 - 10:30	Hall 11	K3: Keynote: Caitlyn Jenner
11:00 - 12:15	Poster Stage (Exhibition Hall)	Poster Stage Session - Work in Progress
12:30 - 13:00	Elicium 1	L1: 2019-20 Harkness Fellowships in Health Care Po
13:15 - 14:30	Emerald	E2: Infection control: two international approache
15:00 - 16:00	Auditorium	F1: Leadership Lessons from the Field: From Sports
16:15 - 17:00	Hall 11	K4: Keynote: Quality Goes Global at Last: Three Gu

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International Forum on QUALITY&SAFETY in HEALTHCARE
2 - 4 May 2018 | Amsterdam

Firoozeh
Bairamikuzehkanan

Health Policy PhD Candidate

Department of Health Management and Economics, School of Public Health, Tehran University of Medical Sciences (TUMS),

Iran, Islamic Republic of

Institute for Healthcare Improvement

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International Forum on Quality and Safety in Healthcare

Abstract Proposal for Poster Display

- **Abstracts must be submitted in English**
- **Abstracts must not exceed 700 words (not including the template text)**
- **All information (including tables) must be included in a single document**
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- ***If you are submitting an abstract to the Improvement Science and Research category, please only complete the relevant sections. Please do not complete section 3A or section 5. Please ensure to complete section 3B.***

1) Background:

- This cross-sectional study was conducted in a paediatric reference hospital which included all clinical departments.
- We observed nurses activities towards medical error reporting and changed their attitude in this regard.
- In this study Patients are indirectly affected by the intervention.

2) Problem:

- Medical error is a common problem that makes a massive burden on health care systems and patients which most of them are often avoidable.
- To address such errors the patient safety team should know about the frequency, severity, and causes of medical errors and this would be possible through reporting.
- In spite of universal action to persuade people working in hospitals that reporting errors is the first step toward controlling them, yet the rate of medical error reporting is very low.

3A) - *(All categories EXCEPT Improvement Science and Research)* Assessment of problem and analysis of its causes:

- · Health Care Workers (HCWs) should be informed about what happens as the harm or near miss errors in hospital by their peers but they fear to report their errors due to further feedbacks of their peers and managers including reprimand, legal actions, and deterioration of their professional image at work.
- The result of not reporting the errors leads to more errors happen and more errors can lead to more morbidity and mortality.
- Thus to prevent and reduce medical errors we need to improve the rate of reporting medical errors.

3B) - *(Only complete if submitting to Improvement Science and Research category)* Your Improvement-related question

· State clearly the research question the study was designed to answer and what is novel about the research conducted

4) Intervention:

- We hypothesized that improving the culture of error reporting can be helpful through a change agent. Therefore we employed a new staff in a reference paediatric hospital as a change agent.
- The girl was taught to be active, patient and run every ward in a day

5) Strategy for change *(please ignore if submitting to Improvement Science and Research category)*:

- All the nursing staff were informed that a new staff will run their ward every day and will ask them about their errors.
- The girl was taught to ask if there has been any error (even any minor ones) in the last 24 hours.
- If their response was no, then she would give them options of some possible errors with using a self-constructed medical error form, like “didn’t you have any fall, medication error or a bad phlebotomy in the last 24 hrs?” and through this discussion she could obtain some error reports.

6) Measurement of improvement:

- She then recorded any error or near miss in her checklist in an excel sheet.
- She had an excel sheet for every month. Each excel sheet included a cross sectional table which was divided to wards and days.
- So she could able to report data (errors) by the ward and day in which they had happened.

7) Effects of changes:

- This method was conducted for one month. During this period the reporting increased from monthly average of 11 error reports before the start of intervention to 34 in the first intervention month.
- After the first month the change agent asked from HCWs to bring their error reports to her office and she also run wards every week to make sure there is no hidden error in wards.
- In second month the number of reports was increased to 54. We observed the rate of error reports for 15 months with this method and the results showed that after month four when the HCWs saw managerial supports, lessons learnt from reported medical errors and practiced root cause analysis, the rate became steady with average of 55 medical error reports for every month.

8) Lessons learnt:

- A change agent can perform like a trigger to change the attitude and culture of an organization.

9) Messages for others:

- Setting a change agent which can be a person or software can be helpful in improving medical error reporting.

10) Please describe how you have involved patients, carers or family members in the project:

- We held a meeting for nurses and described the magnitude of problem for them. Then to solve the problem we asked them to collaborate with the new staff. We made sure that we won't record any name

11) Please declare any conflicts of interest below None declared.

12) Ethics Approval: Not required.

Firoozeh Bairamikuzehkanan
Department of Health Management and Economics, School of Public Health, Tehran University of Medical Sciences, Tehran, Iran