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NOTE PREVIEW ARTICLE

USING THE GLOBAL TRIGGER TOOL TO TRACK ADVERSE EVENTS IN AN INPATIENT PEDIATRIC UNIT

USO DA GLOBAL TRIGGER TOOL PARA RASTREAR EVENTOS ADVERSOS EM UMA UNIDADE DE INTERNAÇÃO PEDIÁTRICA

UTILIZANDO LA HERRAMIENTA TRIGGER TOOL PARA SEGUIMIENTO DE EVENTOS ADVERSOS EN UNA UNIDAD DE HOSPITALIZACIÓN PEDIÁTRICA

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ABSTRACT

Objective: tracking the occurrence of adverse events using the Global Trigger Tool proposed by the Institute for Healthcare Improvement (IHI) in a Pediatric Inpatient Unit. **Method:** a study of cross-sectional and analytical approach, of retrospective type. Data collection will be conducted by the methodology proposed by the Institute for Healthcare Improvement (IHI), then will be built a database into an Excel spreadsheet and being analyzed using SPSS software version 21.0. The research project was approved by the Research Ethics Committee, CAAE: 25473713.6.0000.5344. **Expected results:** identifying by tracing through triggers, adverse events that affected children during their hospitalization, trying to propose strategies for improving the safety of pediatric patients. It is hoped that this research will bring benefits to qualify the safety of pediatric patients. **Descriptors:** Patient Safety; Quality of Health Care; Inexpertness; Child Health.

RESUMO

Objetivo: rastrear a ocorrência de eventos adversos utilizando a ferramenta *Global Trigger Tool* proposta pelo *Institute for Healthcare Improvement* (IHI) em uma Unidade de Internação Pediátrica. **Método:** estudo de abordagem transversal e analítico, de modo retrospectivo. A coleta dos dados será realizada pela metodologia proposta pelo *Institute for Healthcare Improvement* (IHI), em seguida, será construído um banco de dados em planilha Excel e analisados pelo software SPSS versão 21.0. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE: 25473713.6.0000.5344. **Resultados esperados:** identificar pelo rastreamento, por meio de gatilhos, os eventos adversos que acometeram crianças durante sua hospitalização buscando propor estratégias voltadas para a melhoria da segurança dos pacientes pediátricos. Espera-se que esta pesquisa traga subsídios para qualificar a segurança do paciente pediátrico. **Descritores:** Segurança do Paciente; Qualidade dos Cuidados à Saúde; Imperícia; Saúde da Criança.

RESUMEN

Objetivo: rastrear la ocurrencia de eventos adversos con la herramienta *Global Trigger Tool* propuesta por el *Institute for Healthcare Improvement* (IHI) en una Unidad de Hospitalización Pediátrica. **Método:** estudio de enfoque analítico transversal, de forma retrospectiva. La recogida de datos se llevará a cabo mediante la metodología propuesta por el *Institute for Healthcare Improvement* (IHI), a continuación, se construirá una base de datos en una hoja de cálculo Excel y analizados con el programa SPSS versión 21.0. El proyecto de investigación fue aprobado por el Comité de Ética en Investigación, CAAE: 25473713.6.0000.5344. **Resultados esperados:** identificar mediante el trazado a través de disparadores, eventos adversos que afectaron niños durante su hospitalización tratando de proponer estrategias para mejorar la seguridad de los pacientes pediátricos. Se espera que esta investigación traiga beneficios para calificar la seguridad de los pacientes pediátricos. **Descriptor:** Seguridad del Paciente; Calidad de la Atención de la Salud; Inexperiencia; Salud Infantil.

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INTRODUCTION

The report by the Institute of Medicine of the United States, titled "Making mistakes is Human: building a safer health care system" published in the late 1999 raised discussions about the need to rethinking health care practices. This report revealed that approximately 44 to 98 million people died in the United States of America/USA due to errors related to health services.¹

Patient safety is defined as the reduction of unnecessary risk to an acceptable minimum damage during health care and security incident; in turn, it is an event or circumstance that could have resulted, or resulting in unnecessary damage to patient.² Under the aspect of patient safety in child, adolescent and family health, the hospitalization process just provides numerous confrontations for it and its family, leaving them more vulnerable to adverse events. Patient safety has become prominent in discussions of patient care and thus health policy organizations have invested in awareness of professionals.³

Hospital organizations have sought to serve its customers with more quality in order to reducing costs and seek satisfaction. With increased competition in the health sector, aligned to customer's requirements and processes of evaluation of health services, these organizations must be increasingly alert to the issues surrounding the quality and patient safety.

Given the theme, there are listed two lines of action, one with capitalist focus toward risk management in which subsidies to developing standards of care are in the use of hospital accreditation systems and the other focusing on patient facing forward discussions on best practices developed by health professionals. Along the trajectory of the author, as a nurse in the field of child, adolescent and family have experienced several situations related to

safety of pediatric patients. Some are related to health practices developed by professionals, others are related to the safety culture in the hospitals and the mobilizations for patient safety become more evident during the process of hospital accreditation.

There is a "recovery" related to professionals involved, so that all processes are in compliance with the requirements of the agencies responsible for evaluation, often unknown by most of the professionals who end up becoming programmed machines to developing its activities in day and certain time, but what happens after this process ends or maybe what should happen before it started? Maybe hospitals are increasingly concerned with the capitalist part of patient safety than with the patients themselves, forgetting all matters involving the humanization of health care relevant for guiding health practices.

Given the concern to the theme in question and the need to developing proactive actions for patient safety, especially regarding child, adolescent and family health, requiring strategies for safe care, because their particularities and how we can, by the use of tools to identifying the most obvious problems and developing actions for this operation scenario, I bring some justifications:

a) The culture of safety in the hospital must be instituted in the health service as something implicit to secure care, and not only appear at times when the service needs the collaboration of all.

b) Health professionals not literally understand the role of the adverse event reporting system instituted. Thus, it becomes important because of the major limitations on the notification be underreporting, limiting the institution and its staff and managers with a broader knowledge of their adverse events as well as the use of trackers has advocated internationally to seek improvements culture of patient safety.

OBJECTIVE

- Tracking the occurrence of adverse events using the Global Trigger Tool proposed by the Institute for Healthcare Improvement (IHI) in a Pediatric Inpatient Unit.

METHOD

A cross and analytical approach study, of retrospective type, to be held in a Pediatric Inpatient Unit of the Hospital São Lucas, Pontifical Catholic University of Rio Grande do Sul.

Data collection will be conducted by the methodology proposed by the Institute for Healthcare Improvement (IHI),⁴ in which the triggers according to the module of care in the found information of medical records and the results will be ready in three analytical tools that will be identified one data collection forms to identify the crawlers of care modules; collection of possible adverse events and classifying adverse events plug.

The sample will be selected following the methodology recommended by the IHI and will consist of 209 records according to the sample size calculation performed, which will be selected by stratified proportional random and 20 charts per month. Every two weeks a cutoff occur, 10 from the first day to the 15th, and 10 on the 16th day to 31th day, to complete the sample size.

A small sampling in the month is justified because it provides greater accuracy over time, making useful information on trends and special causes of variation damage. Later will be built a database into an Excel spreadsheet and the data will be analyzed by SPSS software version 21.0.

The research project was approved by the Research Ethics Committee of the University of the Vale dos Sinos / UNISONOS, under CAAE: 25473713.6.0000.5344.

EXPECTED RESULTS

Identifying by tracing through triggers, adverse events that affected children during hospitalization, seeking to propose strategies for improving the safety of pediatric patients; It is hoped that this research bring subsidies to enlarging the vision before patient safety for children, seeking a qualified care.

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