



Intrahospital transport for critically ill children

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Intra-hospital transport (IHT) for critically ill children

- ▶ Introduction
- ▶ Patient safety incidents during IHT:
 - ▶ Serious adverse events (SAEs) vs High risk events (HREs)
 - ▶ Which patients and situations face an increased risk of adverse events during transport, and why?
 - ▶ What should be done before transport to minimize the risk of critical events during transport?
- ▶ Planning phase of IHT
- ▶ Conduct the IHT
- ▶ Evaluation and CQI



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- ▶ **Transportation of a critically ill patient requires the ongoing delivery of organ support in an unfavorable environment.**
- ▶ **Failure to prepare both the patient and the transport team may lead to sub-optimal delivery of care to the patient.**
- ▶ **The principles of transport are identical for pre-hospital, inter-hospital or intrahospital setting. It is particularly important that the expected benefits of the transfer for the patient are identified.**

Patient safety concepts and practice

Recognition of preventable adverse events



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Shaping the Future for Health

TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM

Health care in the United States is not as safe as it should be—and can be. At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS.

Medical errors can be defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Among the problems that commonly occur during the course of providing health care are adverse drug events and improper transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries or death, falls, burns, pressure ulcers, and mistaken patient identities. High error rates with serious consequences are most likely to occur in intensive care units, operating rooms, and emergency departments.

Beyond their cost in human lives, preventable medical errors exact other significant tolls. They have been estimated to result in total costs (including the expense of additional care necessitated by the errors, lost income and household productivity, and disability) of between \$17 billion and \$29 billion per year in hospitals nationwide. Errors also are costly in terms of loss of trust in the health care system by patients and diminished satisfaction by both patients and health professionals. Patients who experience a long hospital stay or disability as a result of errors pay with physical and psychological discomfort. Health professionals pay with loss of morale and frustration at not being able to provide the best care possible. Society bears the cost of errors as well, in terms of lost worker productivity, reduced school attendance by children, and lower levels of population health status.

A variety of factors have contributed to the nation's epidemic of medical errors. One oft-cited problem arises from the decentralized and fragmented nature of the health care delivery system—or “nonsystem,” to some observers. When patients see multiple providers in different settings, none of whom has access to complete information, it becomes easier for things to go



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Medical Errors หรือ ความผิดพลาดทาง การแพทย์