Fewer adverse events with the SAFE or SORRY? programme: a cluster randomised trial

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Problem

Patients are at risk for the development of, often preventable adverse events, which compromise patient safety. Part of these events can often be linked directly to suboptimal nursing care. Many guidelines for the improvement of care are available. Organisations must translate each guideline to their own target group, and develop and organise their own information and education = a time-consuming process. It is difficult to implement all available guidelines necessary for good quality nursing care. Typically, care guidelines are implemented one at a time.

Measurement

A cluster randomised trial in the Netherlands:
- 4 hospitals: 4 internal medicine + 6 surgical wards
- 6 nursing homes: 7 wards for patients with physical impairments (no dementia) + 3 rehabilitation wards

Randomisation was stratified for centre and type of ward.

A patient safety programme to implement multiple guidelines simultaneously:
- Pressure ulcers (PUs)
- Urinary tract infections (UTIs)
- Falls

A multifaceted implementation strategy:
- Educational activities
- Educational meetings
- A CD-ROM
- Case discussions
- Patient involvement
- Folders
- A registration and feedback system

Effect

The incidence of the three adverse events:

Results from multilevel analyses, after correction for ward, institute and results from baseline:

Hospitals: 43% less adverse events
Nursing homes: 33% less adverse events

Message for others

Implementing multiple guidelines simultaneously is possible.

The patient safety programme may facilitate guideline use and thus improve patient safety