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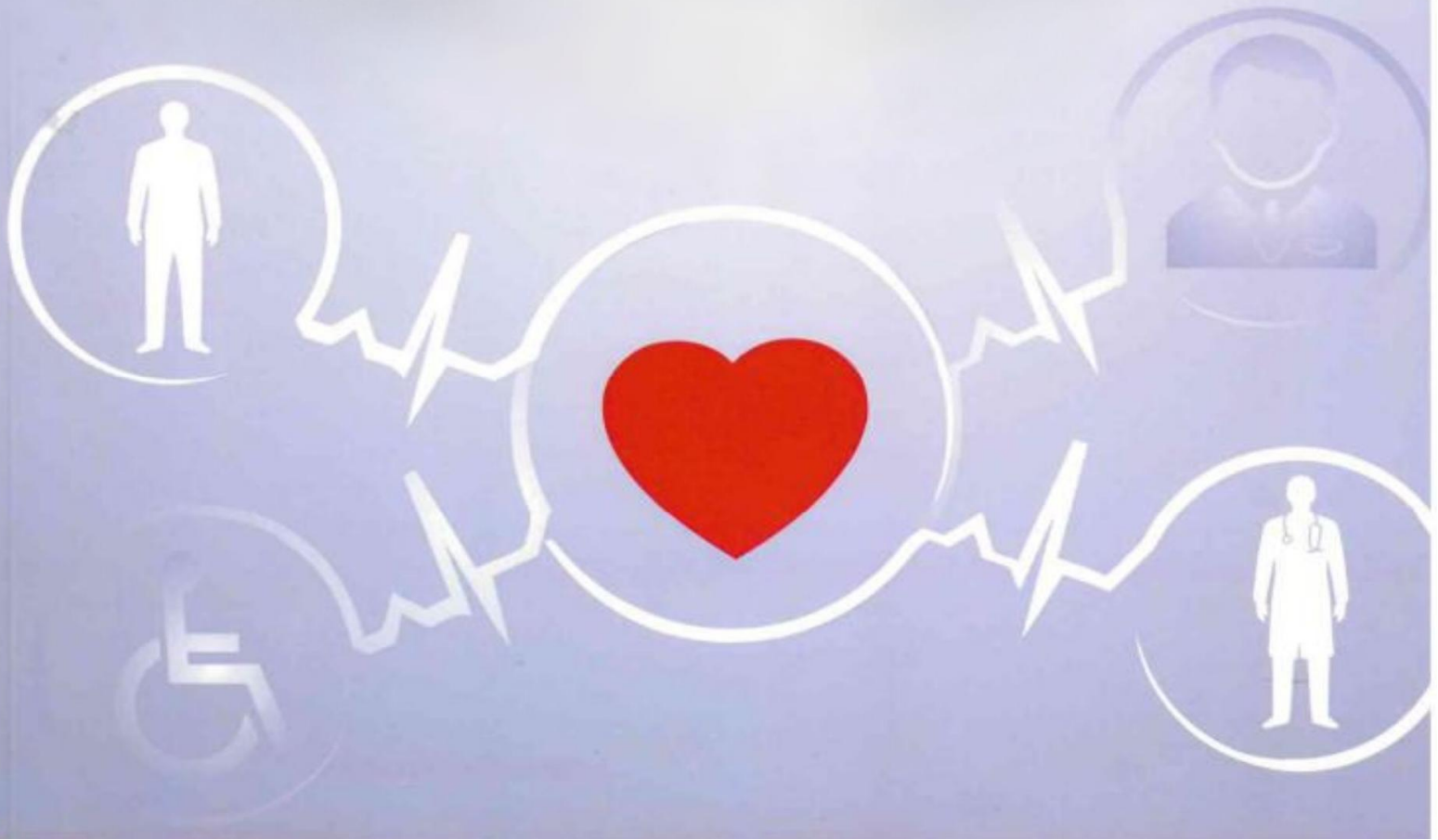
"Sağlıkta Kalite, Akreditasyon ve Hasta Güvenliği ile Sağlık Yönetiminde Güncel Yaklaşımlar"



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Derleme / Review Article

Kazakistan'da Sağlık Hizmetlerinde Akreditasyon; Metodoloji ve Etkiler

Healthcare Accreditation in Kazakhstan: Methods and Impact

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ÖZET

Günümüzde sağlık arenasında sağlık hizmeti kullanıcıları ya da medya tarafından sağlık alanında farklı tartışmalar gündeme getirilmektedir. İster sağlık hizmeti sunan, ister hizmet kullanıcısı ya da hizmeti sağlayan kurum olsun hepsinin de ortak amacı sağlık çıktılarının doğru bir biçimde ölçülmesi, raporlanması dolayısıyla kanıta dayalı bu çabalarla hizmetin iyileştirilmesidir. Bu alanda yıllardır Dünya Sağlık Örgütü kalite değerlendirme, performans iyileştirme ve çıktı değerlendirmeleri ile ilgili sayısız aktiviteler yerine getirirken, son yıllarda pek çok ülke ve kuruluşlarda bu çabalara ortak olmakta ve sağlık hizmetlerinde kaliteyi objektif olarak değerlendirmeye uğraşmaktadırlar.Bu bağlamda karşımıza tüm bunları gerçekleştirmede anahtar oluşumların sertifikasyon, ruhsatlandırma ve akreditasyon olduğu gerçeği çıkmaktadır.

Bu makalede sağlık hizmetlerinde kalite yaklaşımı, kavramlar, tarihçesi ve sağlık kuruluşlarında uygulanan akreditasyon çalışmaları tartışılacaktır. Sağlık hizmetlerinde akreditasyon ve bazı akreditasyon modelleri Kazakistanda kurulan sağlık hizmetlerinde akreditasyon sistemi örnek alınarak detaylarıyla tartışılacaktır.

ABSTRACT

In today's health care arena, a number of issues are being raised that have received more attention either from the health care consumers or the media. Whether as a provider, a consumer or a purchaser, each was looking for ways to satisfy the other through measuring and reporting on care outcomes. All of these activities were done in the effort to measure performance. WHO organized and facilitated a number of activities related to quality assessment, performance improvement and outcome measurement. A large number of countries and institutions participated in these activities and initiatives. And at the end, all agreed that there had to be an organized mechanism to account for quality, continuous measurement and improved performance in health care organizations. In order to do this a mechanism for certification, licensure or accreditation should be put in place.

In this article we will discuss the importance and the components of quality in health care and accreditation. A detailed exploration of accreditation will take the majority of discussion of this article. The process and the methodology of accreditation will be discussed and a system for its implementation is presented as a case study of Republic of Kazakhstan.

INTRODUCTION AND BACKGROUND

Health facilities and Healthcare professionals are dedicated organizations and individuals who require minimal direction and supervision to perform their duties. Healthcare organizations are comprised of true professionals. These professionals are bound to their code of ethics and their fiduciary responsibility to perform well and render quality services to their clients. Care providers are the type of professionals that embody such beliefs and such behavior. Motivation in any form combined with other methods to improve performance or maintain certain level of accomplishment are paramount. Healthcare professionals are self-dependent but thrive on encouragements and would perform even better in a culture of constant appraise that rewards positive outcomes and excellent performance.

It is a widely accepted belief that accreditation, as a system and mechanism, has the ability to improve process and outcome. Several studies have documented the impact of accreditation on organizations and their clients. Organizations that participate in accreditation have shown improved patient and environmental safety as well as a more satisfied patients and staff. Accreditation fosters "an ongoing improvement process that continually stimulates vital educational efforts through a process of self-regulation. In seeking

accreditation organizations must meet rigorous organizational and training standards, which are considered essential for quality education. Accreditation ensures that the training organization has undergone a self-study and validation process with a third party accrediting agency."

http://accreditationtrainingadvisors.com/knowledge_base/what_is_accreditation.html (2015)

According to Alion (a United States highly regarded government sponsored laboratory), accreditation is a tools to achieve; Recognition, Confidence, Preparedness, Sponsorship, Collaboration, Recruitment, Improvement (Alion, 2015). For healthcare organizations, participation in accreditation will promote a quality and safety culture. One that crosses departmental borders and leaps outside organizational boundaries. Motivated organizations that seek accreditation must have a motivated workers. Knowledge about worker motivation can help in promoting learning, interdisciplinary teambuilding and service improvement (Greenfield et al., 2011).

The International Society of Quality in Health Care (1998) defines accreditation as:

"…self-assessment and external peer review process used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system. Quality standards and the external peer review process are directed by nationally recognized autonomous, independent accrediting agencies with a commitment to improve the quality of health care for the public".

Accreditation is a rigorous and comprehensive evaluation process through which an external accrediting body assesses the quality of the key systems and processes that make up a healthcare organization. Accreditation includes an assessment of the care and services that healthcare organizations are delivering in important areas such as preventive services and client satisfaction. Accreditation was developed in response to the need for standardized, objective information about the quality of healthcare organizations. Almost all accreditation programs are voluntary. Organizations seek accreditation for different reasons but most do so in an effort to increase market share and to win customer satisfaction and professional reputation.

Each health service organization's performance is assessed against a set of national (or international) standards developed by the accrediting organization in collaboration with key players in the healthcare system and related stakeholders. The assessment is designed to address processes, outcomes and structures, with the focus on continuous improvement within the health service delivery system.

The value of accreditation is in the internal self-assessment that an organization undergoes in preparation for the survey visit and in the consultative peer review process which is part of the on-site survey visit. The principle of self-assessment is the fundamental basis of accreditation. It serves as the mechanism by which an organization can assess its own performance, on an ongoing basis, against the national or international accreditationstandards.

For more than six decades, accreditation has been the highest form of public recognition a health care organization could receive for the quality of care it provides. Accreditation offers quantitative as well as intangible benefits to a healthcare organization besides public recognition.

Healthcare consumers are becoming increasingly aware of the different requirements a healthcare organization must meet in order to be considered a quality organization. They are also becoming interested in learning about the status of care provided by an organization judged by its peers or professional experts. Accreditation provides just the answers and the assurances for which health consumers are asking. Accreditation provides for a mechanism for an objective unbiased peer review of a health organization. It provides the consumer a set of measures by which they can judge a healthcare organization in comparison with similar organizations. With the seal of approval, accreditation provides the consumer a level of comfort ensuring that a healthcare organization has been checked and is considered a quality organization since it has passed a rigorous set of evaluation processes and is complying to a set of high industry standards. In essence, accreditation could be defined as the process of assessing the quality of an organization for the purpose of providing comparative information to the customer.

As such, accreditation provides a mechanism for comparison between healthcare organizations. Those organizations that have achieved accreditation, especially "commendation" or "excellent" status, will have a positive image and will use that distinction to market their services accordingly. Accreditation can therefore be used as a tool for positive marketing and as a tool that enhances positive competition between health care organizations. Competition can be based on price or other factors. Competition based on quality as exemplified by the attainment of accreditation is a form of non-price competition and is a form of positive competition. This type of accreditation is in contrast with the type of competition exhibited by and between political candidates where they each try to find

weaknesses in each other's performance or character to attack and "win". Positive competition on the other hand encourages benchmarking and identifying the positive attributes of your competitor in order for you to achieve even a better level of these attributes in your organization. It is a process of a continuous search for excellence and a mechanism for emulating that excellence in one's own systems. Accreditation facilitates this process and encourages it.

As stated earlier, achieving accreditation by a healthcare organization requires a rigorous and demanding process of enhancing performance and care processes and receiving it is equivalent to receiving a quality award. It is basically a seal of approval on the quality of one's own organization. This recognition certificate is usually worthy of announcement and heavy marketing to promote it. It is both rewarding and beneficial to an organization and its employees. Accreditation can also be used as the mechanism for rewarding individuals who have worked hard in order for the organization to achieve it. It is another method of recognition among peer organizations and a proof of quality and safety.

Quality has many dimensions. Two of these dimensions are related to the ability of an organization to attain its objectives in a timely and cost-beneficial manner. Therefore the ability of an organization to use its resources in the optimum way is one of the important dimensions of quality. Similarly, an organization that can demonstrate its ability to achieve its goals and objectives in a timely manner is considered an effective organization and therefore has met another dimension of quality. Accreditation is somewhat similar to what quality is all about. Accreditation requires an organization to be effective and to use its resources most efficiently. In order for the healthcare organization to achieve accreditation it has to demonstrate its effectiveness and its efficiency through completed projects and noted accomplishments related to their mission, their objectives and their goals. Efficiency and effectiveness must be practiced and proof must be documented in order for an organization to receive accreditation.

BENEFITS OF ACCREDITATION

Here are some of the benefits of accreditation according to TJC (2014), NCQA (2014) and AAAHC (2014). Accreditationof a healthcare organization:

1. Strengthens overall performance (clinical and managerial)
2. Improves patient, medication and facility safety in all units and departments
3. Enhances community trust and confidence in the organization
4. Provides a report card for the public to compare between organizations
5. Offers an objective evaluation of the organization's performance
6. Stimulates the organization's quality improvement efforts
7. Aids in professional staff recruitment and retention
8. Provides educational and training outlets for staff
9. May be used to meet certain government certification requirements
10. Expedites third-party (insurance and government) payment
11. Often fulfils licensure requirements
12. May favourably influence liability insurance premiums
13. Favourably influences employers' contract decisions
14. Finds new ways to improve the care and services they offer
15. Increases the organization's efficiency and reduces costs
16. Provides a mechanism for sustainable documentation of processes and services
17. Develops better risk management programs
18. Motivates staff and instils pride and loyalty
19. Strengthens public relations and marketing efforts
20. Develops alliances with other provider groups and health care organizations

From the above we can conclude that accreditation enhances quality improvement efforts by the healthcare organization. These improvements will have a positive impact on the patient and his/her family. It will most probably lead to increased customer satisfaction enhancing their trust and loyalty to the organization.

WHO IS RESPONSIBLE FOR ACCREDITATION?

Accreditation is an external assessment program based on a set of standards. The program itself is coordinated by an accreditation agency. This agency is usually private independent organization but can also be a governmental agency related to the nation's ministry of health. This agency will be responsible for overseeing the overall accreditation program in that country.

Internationally however, there are a number of accrediting organizations that have been established for the same purpose of healthcare organizations' assessment and improvement. As explained above, some of these organizations are sponsored by the government

of a specific country while others are primarily private not-for-profit organizations that have the support of their national government and key health care players in that country. In the US, there are several major accrediting agencies; each is independent and each has a specific emphasis. For example, hospitals in the US are accredited by one of three agencies; The Joint Commission (TJC), DNV Global and Health Facilities Accreditation Program (HFAP); while ambulatory care organizations are accredited by either the Accrediting Association for Ambulatory Health Care (AAAHC), or by Utilization Review Accrediting Commission (URAC) or yet by TJC. Managed Care organizations are accredited by such organizations as the National Committee on Quality Assurance (NCQA) or by any of the other three agencies, TJC, AAAHC or URAC. Rehabilitation facilities on the other hand has their own accrediting agency, the Commission on Accreditation of Rehabilitation Facilities, CARF. In all of those cases, accreditation is a separate process and system from licensure which is usually handled by government at the level of States rather than at the level of the Federal government.

Similarly in Europe accreditation and licensure are separate and never crossed paths. These are run by two separate organizations or systems albeit in some countries both systems are run by the government. Some countries in Europe however opted to pursue and enforce "certifications" at least for safety in their healthcare organizations. An example is France and Ireland (Serbia is contemplating it) where they made it mandatory for healthcare organization to meet safety standards and achieve certification by ISO. Also, in the Republic of South Africa, there is a requirement for registration and licensure of private healthcare organization in order to operate in the country but this requirement has not been extended to governmental organizations. It is worth noting that in Europe the number of accrediting organization has doubled every five years since 1990. Most have been backed by "statuary" mandates by their government and most new programs are run by the government. Once operating and smoothly running they all tend to evolve from a voluntary accreditation system that is for the sake of self-development to a more regulatory instrument for accountability by the public. Transparency on the other hand has been slowly evolving of such programs in Europe. Although most have their standards available and accessible to the public including aggregate accreditation reports, some are reluctant to share "all" with the public guarding their intellectual property and their investment especially at the development stage. This is true for European accrediting bodies where funding is an issue but most have secured if not political, financial support of their government even if they have been operating as private or quasi private organizations.

Other issues to consider is the cost and benefits of such programs. Unlike the US, in Europe almost all accreditation standards are either available free to healthcare organizations or are offered to them with very low cost. Most such programs and agencies proclaim lots of benefits to the patient population or to the healthcare organization itself towards efficiency and cost savings, there is not much evidence to unequivocally support that.

In other countries, accreditation is handled primarily by a government agency or a quasi-government agency such as Accreditation Canada or its Australian, Japanese, Indonesian, Turkish, Austrian, Jordanian or Saudi counterparts. In all cases however, these accrediting organizations are governed by a board comprised of experts as well as independent agencies that represent other sectors in the healthcare system in that country such as the private sector and academia.

In Kazakhstan, the Ministry of Health created the accreditation program for healthcare organizations. A unit within the Ministry was created and called the National Healthcare Accreditation Center with a governing board comprised of MOH leaders. The Center is hosted at the MOH and several professionals were assigned to administer and operate the Center. So since its inception, the Center worked hard to develop several sets of accreditation standards (for hospitals, emergency care and rehabilitation organizations) and had those standards approved by the MOH and further accredited by the International Society of Quality in Healthcare (as explained below). The Center further worked on identifying, selecting and training a large number of healthcare professionals to act in the role of accreditation surveyors. These individuals were recently gathered and retrained on a set of new accreditation methodologies and then certified to take the role of national accreditation surveyors. The Center is now preparing for the accreditation of its structure by ISQua as an accredited national accreditation organization fulfilling the stringent requirements of that international body.

The main functions of the accreditation agency are:

- Creating and maintaining of the register of accredited organizations and the register of accreditation personnel;
- Representing Kazakhstan and participating in all relevant international, European and regional organization and meetings on accreditation;
- Drafting and executing related international and national agreements on cooperation and mutual recognition of accreditation;

- Seeking, achieving and complying with international accreditation standards (e.g. ISQua) and become an accredited organization for the granting of accreditation of healthcare organization in Kazakhstan;
- Development and delivery of training of accreditation personnel and empower them to carry out accreditation activities according to the set requirements;
- Provide educational and awareness material to providers and the public on issues related to accreditation and the associated standards;
- Develop and regularly update the pertinent accreditation standards for the different healthcare organizations in the country;
- Identify, select, train and certify qualified healthcare professionals to fulfill the role of national accreditation surveyors and assessors;
- Assess compliance of healthcare organizations to accreditation standards through triennial site visits and periodic as needed surveys to sustain such conformity to the standards;
- Make decisions as to the degree of compliance of healthcare organizations to the accreditation standards and decide on the awards of accreditation to such facilities or the revocation of such awards for non-complying organizations;
- Development of policies, procedure and related guidelines on the preparation for site visits and the delivery of such visits to healthcare organizations nation-wide;
- Develop guidelines and train surveyors on the on-site survey assessment methodology (e.g. clinical and system tracers) and procedures for conducting the site visits, the scoring of the standards, and on the reporting of the findings;
- Assess and collect surveying fees and related financial requirements to operate and sustain an effective and objective national accreditation program
- Creation of technical accreditation committees and approval of their provisions (e.g. standards development);
- Provide a set of guidelines and policies on accreditation decisions appeals and grievance procedures;
- Organize and deliver seminars, workshops and training avenues on the accreditation standards to healthcare professionals and their organizations;
- Organize and administer an annual consensus national conference on accreditation process, standards and related outcomes;
- Provide a national "help-line" and mechanism to provide logistical and expert support to healthcare organizations as they prepare for their accreditation award;
- Provide comparative information to select national regulatory agencies and the public on healthcare organizations performance and patient related outcomes and;
- Assist in enhancing nation-wide awareness on patient rights and safety and on providers' responsibilities and ethical behavior

ACCOUNTABILITY OF ACCREDITATION ORGANIZATIONS

Apart from ISO certification (www.iso.org), the International Society for Quality in Healthcare (ISQua) is the only organization that has the standards, process and resources to "accredit the accreditors". According to ISQua's website (www.isqua.org); "ISQua is…a global organization dating back to 1984. Its mission is to inspire, promote and support continuous improvement in the safety and quality of health care worldwide".

ISQua's "International Accreditation Program (IAP) is the leading International Health Care external evaluation program of its kind". It Accredits the Accreditors through three unique programs:

1. Accreditation of health care and social care standards
2. Accreditation of external evaluation organizations and
3. Accreditation of surveyor training programs

The Kazakhstan accreditation standards have already been accredited by ISQua and once the Accreditation Center is further strengthened and perhaps re-organized,ISQua accreditation of the Center can be sought and achieved.

To achieve such status and achieve international recognition and accountability, the Kazakhstan National Healthcare Accreditation Center will have to comply with ISQua's accreditation standards that are required for similar organizations. ISQua further publishes a "checklist" for the development and accreditation of new accreditation programs consisting of the following items:

1. A clear definition of the purpose of the accreditation program which should include but not limited to; performance improvement, enhance public and patient safety, improve public confidence and increase accountability through objectivity and transparency.

2. Define accreditation vis a vis quality nationally; with a clear definition of the role of the Ministry of Health, clearly stating it is not a licensing organization and that it is fully independent.
3. Getting full support and participation of the major national stakeholders including other related government agencies, insurance, academe, private sector, professional associations including those for hospitals and healthcare professionals as well as individual hospitals and healthcare professionals.
4. Establish an advisory inclusive Board or committee
5. Develop a supervisory and governance Board and draft its mission, vision, values and ethics.
6. Secure adequate funding for its set up and operation for at least the first 5 years of operation
7. Insure objectivity in operation and decision making and acquire support and true commitment of major stakeholders and establish a fair and transparent appeals process.
8. Selection and training of national accreditation surveyors and develop a full program for their orientation and training and periodic retraining. Make sure each training program delivered is evaluated for its effectiveness and eventually get it accredited.
9. Development of appropriate indicators and performance measures in order to evaluate the accreditation program and the satisfaction of its beneficiaries with the standards, the process, the surveying process, the surveyors and with the impact on care processes and patient outcomes.

ACCREDITATION STANDARDS

According the Webster dictionary (2015), standards are defined as: "a level of quality, achievement, etc., that is considered acceptable or desirable" and that standards are "ideas about morally correct and acceptable behavior" or it is "something that is very good and that is used to make judgments about the quality of other things". Therefore standards are developed to help gauge certain performance and to compare one object with another. In quality, we develop standards to express what we believe this quality to be. They are the expectations, the attributes and the language for which quality is meant to be. They include expectations of what we believe a quality system (or organization) is. They are therefore a form of a yardstick of we expect the unit's structure or its processes or even its outcomes are.

Accreditationstandards are developed to be as quantifiable as possible. Each standard is further stated in the form that will allow its measurement. Such measurable forms of the standards are often called indicators or depending on the accrediting organization may be referred to as measurable elements, evidences of performance, criteria or the like. These standards follow the various functions and units health care organizations perform and possess. Standards are developed and are updated annually by a group of experts that are related directly to the process of care and to the structure of services rendered by the health care organization. These standards are therefore developed to measure the performance of the health care organization in the aspects of care and services it claims to provide. Compliance with these standards is a proxy measure of the performance of such an organization. Of course compliance may have to be substantial for the health care organization to receive the seal of approval from the accrediting organization. In this way accreditation can work as a measure of the performance of the organization, especially in such areas as structure and process.

So, one of the main activities of accreditation is to set standards that a healthcare organization must meet. Experts usually rigorously develop these standards. It is with these standards that the accreditation agency is able to measure the quality of the health care organization they want to evaluate for accreditation. These standards soon become the measuring guide by which performance is measured and accreditation is achieved. Standardization is important in order that objectivity can be assured in the evaluation process. It is also a mechanism for controlling outcomes and comparing performances. Meeting certain standards will render the healthcare organization "accredit-able" and will decrease variation between its current performance and the desired performance. Standardization is also useful in controlling cost by controlling expectations, predicting outcomes and facilitating effective budgeting.

Every accreditation program must develop its own standards. Understandably, these standards must comply with nationally and internationally accepted norms. The accreditation agency (in Kazakhstan it is the National Healthcare Accreditation Center within the Ministry of Health) is responsible for the setting and continuously updating the accreditation standards of healthcare organizations operating in the country. They must also develop the scoring guidelines for measuring compliance to the standards. Specifically, this agency will be responsible for;

Developing the standards manuals for the different settings and organizations (e.g. hospital, diagnostic centers, clinics, laboratory, rehabilitation facilities, etc.);

Each manual will then be organized into domains or chapters/sections that represent the focus areas of a healthcare organization (e.g. safety, care, patient

assessment, communications, quality improvement, infection control, etc.);

Each domain or section will then be comprised of a number of standards and each of which will have a list of related measures or criteria;

The agency will also be responsible for identifying the documentation requirements for evaluating healthcare organizations' compliance to these standards;

Establishing scoring guidelines for the degree of compliance to each standard and related criteria or measurable elements and;

Organizing and updating the standards manuals periodically and insuring its applicability, timeliness and adaptability to the different healthcare settings and organizations.

In its effort to continuously update and upgrade standards, this unit will be responsible for identifying related experts from the healthcare community at large and assign them to different teams. These teams will be responsible for developing, revising and/or updating standards. So there may be a team for patient safety, another for care processes, and yet another for infection control and medication management. Once these teams complete their work, new standards are developed or old ones revised and a new edition of the standards manual is published. Thus this manual becomes the guide for both organizations and surveyors to gauge accreditation eligibility and organizations must strive to achieve as many of these standards as possible to achieve the acceptable "score" for winning accreditation. Once accredited, organizations will still have to maintain (on a continuous basis) the level of performance associated with those standards and will have to undergo another accreditation cycle every three years.

CONCLUSION

Accreditation has played a major role in the monitoring of health service organizations for over 40 years. The success of accreditation rests with the recognition of it as a voluntary, objective peer review process with self-assessment at its core. Its success also rests with the on-going participation of the multitude of professional groups who all work collectively and collaboratively to ensure that accreditation reflects the common goal of delivery of consistent, high quality care.

It is a process that has the potential of insuring continuous improvement, and institutionalization of quality. Sustaining quality activities are enhanced with certain incentives and accreditation is an example of such incentives. In this era of performance measurements and accountability, a mechanism that encourages compliance to standards such as accreditation is exactly what this era needs. It is no wonder that countries around the world are becoming increasingly and seriously interested in such an activity.

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Kısa Derleme / Mini Review

Doğum sonrası ağrının rahatlaması ve ruh sağlığı üzerine vajinal doğum eylemi esnasında uygulanan müzik terapinin etkisi

The effect of music therapy during vaginal delivery on postpartum pain relief and mental health

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ÖZET

Kadınlar doğum sonrası dönemde psikiyatrik hastalıklara daha fazla maruz kalırlar. Birçok kadın, hamilelik ve doğum sırasında meydana gelen fizyolojik ve psikolojik değişikliklerle karşı karşıya kaldıklarında ciddi stres yaşamaktadırlar. Doğum kadınların hayatında önemli bir deneyimdir. Olumsuz doğum deneyimlerinin postpartum psikiyatrik belirtileri, cinsel işlevleri, gelecek doğum hakkındaki beklentileri ve anne-bebek arasındaki ilişkileri olumsuz şekilde etkilediği gösterilmiştir. Doğum sonrası annede yaşanan hüznün, doğum ağrısının neden olduğu strese karşı bir reaksiyon olabileceği ifade edilmiştir. Erken postpartum dönemde doğum ağrısının yoğunluğu ile duygu durum bozuklukları arasında güçlü bir ilişkinin bulunduğu belirtilmiştir. Doğum ağrısı duygu durum bozukluklarına kadar giden duygusal kontrolün kaybına neden olabilir. Eğer müzik terapi doğum ile ilişkili ağrıyı azaltabiliyorsa, doğum sonrası depresyonu da azaltabileceği varsayılmıştır. Bu derlemede doğum sonrası ağrı ve ruh sağlığı üzerine müzik terapinin olumlu etkilerinin neler olduğu değerlendirilmiş ve bu etkiler ile ilgili yapılmış olan çalışmalar tartışılmıştır. Literatürü gözden geçirdiğimizde müzik terapinin ameliyat sonrası ağrı üzerine analjezik olarak etki gösterdiğinin ifade edildiğini tespit ettik. Sonuç olarak doğum sonrası ağrı giderme açısından müzik terapi alternatif, güvenli, kolay bir yöntem olarak tavsiye edilebilir ve umut verici bir farmakolojik olmayan müdahaledir.

ABSTRACT

Women are more exposed to psychiatric illnesses during the postpartum period. Many women suffer from severe stress when faced with physiological and psychological changes that occur during pregnancy and childbirth. Childbirth is an important experience in a woman's life. It was shown that negative birth experiences affect negatively postpartum psychiatric symptoms, sexual functioning, expectations about future births and the relationship between mother and infant. It was stated that maternity blues could be a reaction to stress caused by childbirth pain. It was indicated that a strong association was found between the intensity of labor pain and mood disorders in early postpartum period. Labor pain can cause loss of emotional control leading to the mood disorders. It is assumed that "If music therapy reduces the pain associated with childbirth, it can reduce postpartum depression, too". In this review, the positive effects of music therapy in pain after vaginal delivery and postpartum mental health are evaluated. In addition, the studies related these effects are discussed. When we review the literature, we found that reported as music therapy effect on postoperative pain as an analgesic. As a result, music therapy can be recommended as an alternative, safe and simple method for postpartum pain relieving. It is a promising non-pharmacological interventions.

GİRİŞ

Kadınlar doğum sonrası dönemde psikiyatrik hastalıklara daha fazla maruz kalırlar. Doğum sonrası ilk 3 ay içerisinde çoğunlukla psikoz ve depresif hastalıkların ortaya çıkması nedeniyle, psikiyatrik yatış oranı doğum sonrası artmaktadır (Kendell, 1976:6). Birçok kadın, hamilelik ve doğum sırasında meydana gelen fizyolojik ve psikolojik değişikliklerle karşı karşıya kaldıklarında ciddi stres yaşamaktadırlar (Matas, 1997:10; Turner, 2004:112). Doğum kadınların hayatında önemli bir deneyimdir ve bu deneyim kısa ve uzun dönemlere etki etmektedir. Olumsuz doğum deneyimlerinin postpartum psikiyatrik belirtileri, cinsel işlevleri, gelecek doğum hakkındaki beklentileri ve anne-bebek arasındaki ilişkileri olumsuz şekilde etkilediği gösterilmiştir (Goodman, 2004:46). Kadınların özellikle hem yenidoğan hem de anneyi olumsuz etkileyebilen ilk doğumlar nedeniyle doğum sırasında anksiyete ve ağrı artışıyla karşılaşabildiği ifade edilmiştir. Devamlı yaşanan şiddetli doğum ağrısının hem annede hem de bebek üzerinde zararlı etki oluşturabileceği belirtilmiştir (Phumdoung, 2003:4). Doğum ağrısı şiddeti ve doğum sonrası yaşanan hüzün arasındaki ilişki araştırılmış

ve doğum ağrısının yoğunluğunun erken postpartum dönemde duygu durum bozukluğu ile ilişkili olduğu gösterilmiştir. Doğum sonrası annede yaşanan hüznün, doğum ağrısının neden olduğu strese karşı bir reaksiyon olabileceği ifade edilmiştir. Ayrıca, ağrı doğum sancısı yaşamadan doğum yapacağına kendini hazırlamış olan kadınlar için doğum aşamasında bir başarısızlık yaşadıklarını hissetmelerine neden olabilir. Aslında, doğum eğitimi alarak hazırlanmış olan kadınlar fiziksel ve zihinsel eğitim yoluyla ağrının üstesinden gelme becerisini taklit ederek uygular. Ağrıyla başa çıkma sorumluluğu ağırdır. Eğer bu kadınlar başarısız olurlarsa kendilerini suçlu hissedebilirler. Ağrı büyük bir hayal kırıklığından kaynaklanıyor olabilir. Erken postpartum dönemde doğum ağrısının yoğunluğu ile duygu durum bozuklukları arasında güçlü bir ilişkinin bulunduğu belirtilmiştir. Ayrıca doğum sonrası hüznün yoğunluğu doğum sonrası depresyonun en iyi belirleyicisi olduğu düşünülmektedir (Boudou, 2007:33). Doğum ağrısı duygu durum bozukluklarına kadar giden duygusal kontrolün kaybına neden olabilir (Phumdoung, 2003:4). Eğer müzik terapi doğum ile ilişkili ağrıyı azaltabiliyorsa, doğum sonrası depresyonu da azaltabileceği varsayılmıştır (Simavli, 2014:156).

Bu derlemede doğum sonrası ağrı ve ruh sağlığı üzerine müzik terapinin olumlu etkilerinin neler olduğu ve bu etkiler ile ilgili yapılmış çalışmalar değerlendirilmiş ve tartışılmıştır.

Müzik terapi düzenli farmakolojik sedasyon dozları azaltılarak, anksiyete ve ağrı üzerinde etkisi olması nedeniyle güvenli, ucuz ve etkili bir non-farmakolojik , anksiyolitik ajan olarak kabul edilmiştir (Ovayolu, 2006:12). Müzik terapinin hastalarda fiziksel belirtileri iyileştirdiği, stres hormonlarını azalttığı, kanser ağrısı ve kronik ağrıları azalttığı, ameliyat sonrası ağrıları, analjezi tüketimini ve anksiyeteyi azalttığı ve vital bulguları stabilize ettiği gösterilmiştir (Hoffman, 1997:60; Kendell, 1976:6; Lopez-Cepero Andrada, 2004:16; Sen, 2010:22; Siedliecki, 2006:54; Zimmerman, 1989:11). Ayrıca önceki çalışmalarda müzik terapinin, kanser ağrısı ve kronik ağrılarda, ameliyat sonrası analjezi tüketiminin ve anksiyetenin azaltılmasında etkili olduğu bulunmuştur.

236 Tayvanlı hamile kadında stres, kaygı ve depresyon üzerine müzik terapinin etkisi incelenmiştir. Müzik terapi grubu iki hafta 4 çeşit rahatlatıcı müzik almıştır. Kontrol grubu ise sadece genel doğum öncesi bakım almıştır. Deney grubundaki katılımcılara önceden kaydedilmiş olan CD verilmiş ve iki hafta boyunca günde herhangi bir zamanda, en az 30 dakika dinlemesi söylenmiştir. Hamilelik sırasında müzik terapinin 2 hafta boyunca ölçülebilir psikolojik yararlar sağladığı gösterilmiştir (Chang, 2015:23; Chang, 2008:17).

30 doğum yapmış kadında doğum sonrası hüzün ve loğusalıkta annelik duygusu üzerine müzik terapinin etkileri incelenmiştir. Sekiz gün boyunca günde bir kez 40 dakika müzik terapi verilmiştir. Ardından doğum sonrası hüzün ve kontrol grubu için anne bağlılığı sekizinci gün ölçülmüştür. Müzik terapinin doğum sonrası hüznü azaltmada ve loğusada anne bağlılığını artırmada olumlu etkilerinin olduğu gösterilmiştir (Lee, 2010:40).

Eğer müzik terapi doğum öncesi depresyon oranını azaltırsa doğum sonrası depresyonu da azaltabilir. 161 ilk gebeliği olan amile kadında doğum sonrası ağrı, anksiyete, depresyon, vajinal doğum sırasındaki memnuniyet üzerine müzik terapinin etkileri incelenmiş ve bunların hepsi üzerine müzik terapinin yararlı etkilerinin olduğu gösterilmiştir (Simavli, 2014:156).

TARTIŞMA

Doğum sırasındaki müzik terapi rahatlatıcı tekniklerden birisidir ve yıllardır yararlı etkileri kabul edilegelmiştir. Klinik çalışmaların sonuçları, müzik dinlemenin psikolojik ve fizyolojik koşullar üzerinde olumlu etkisinin olduğunu ve bu nedenle müzik terapinin stresle ilişkili müdahalelerde bir anksiyolitik olarak kullanılabileceğini önermektedir (Angioli, 2014:21; Lee, 2002;55; Lee, 2010:40; Ovayolu, 2006:12).

Literatürü gözden geçirdiğimizde müzik terapinin ameliyat sonrası ağrı üzerine analjezik olarak etki gösterdiğinin ifade edildiğini tespit ettik (Ebneshahidi, 2008:14; Good, 2002:3; Sen, 2010:22).

İşitsel uyaranlar, stres, rahatsız edici bir ortam, kontrol kaybı, korku insanın cevabını etkileyebilir. Bu yanıt müziğin rahatlatıcı etkisi ile azaltılabilir. Ağrı ve işitme yollarının birbirini inhibe ettikleri öne sürülmüştür. Bu şekilde kulak yolunun aktivasyonu, ağrılı uyaranların merkezi yayın engellemesinde önemli rol oynayabilir (Ebneshahidi, 2008:14).

Müzik terapinin sezeryan ameliyatı sonrası dönemde ameliyat sonrası ağrı ve analjezik ihtiyacını azalttığı gösterilmiştir (Ebneshahidi, 2008:14; Sen, 2010:22).

Doğum sancısı esnasında müzik dinletme sonucunda doğum sonrası anne iyileşmesi üzerinde pozitif etki gösterilmiştir. Müzik terapi doğum sonrası ağrı ve anksiyeteyi azaltma ve iyileştirme için etkili bir yöntemdir. Annenin çocuk doğurma ile ilgili memnuniyetini arttırır. Erken dönemdeki doğum sonrası depresyon oranında azalma sağladığı görülmüştür (Simavli, 2014:156). Sonuç olarak müzik terapi, doğum sonrası ağrı giderme ve mental sağlık açısından bilinen bir yan etkisi olmayan alternatif, güvenli, kolay bir yöntem olarak tavsiye edilebilir ve umut verici bir farmakolojik olmayan müdahaledir.

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Editöre Mektup / Letter to the Editor

Çocuklarda endoskopi araştırması

Endoscopy in children for research

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This letter is a continuation of preceding reviews on invasive methods applied with questionable clinical indications, also for research [1-3], in particular, the use of bronchoscopy in bronchial asthma, in spite of the prevailing opinion that it has not much benefit [4]. In the literature, no particular role of bronchoscopy in the diagnostics and treatment of asthma has been specified, while asthmatics are regarded to be at risk for complications [4]. Among indications for bronchoscopy are persistent wheeze unresponsive to bronchodilators and other therapy [5,6]. While there are other diagnostic tests, the most common indication for bronchoscopy in asthma is a search for an alternative condition causing the symptoms [5]. Removal of mucus plugs by lavaging of bronchi was recommended in severe asthma under certain conditions [7,8]. Exacter formulations are avoided here because this letter is not an instructive publication. The newest Russian-language textbooks are largely based on the international literature. However, earlier textbooks and manuals contained recommendations that were at variance with international practice. In asthmatics, the purpose of bronchoscopy was stated to be a search for signs of infection; examination of lavage fluid was recommended for the same purpose [9,10]. Abundant secretion or mucopurulent sputum in children was presented as indication for bronchoscopy "for evaluation of endobronchial inflammation" [11]. Asthma, tuberculosis and bronchitis (in particular, "atrophic bronchitis") were generally presented as indications for bronchoscopy [12,13]. Laser treatment via bronchoscope was applied in children in chronic pneumonia, asthma and bronchitis [14,15], also in the presence of "pronounced atrophy of bronchial mucosa" [16]. Note that, similarly to other forms of electromagnetic radiation, laser at lower power densities causes warming and at higher energy – damage of tissues. From the viewpoint of general pathology, atrophy may progress due to additional damage. Bronchial biopsies were collected for research from patients with "chronic atrophic bronchitis" and "primary atrophic bronchopathy" including that supposedly caused by ionizing radiation, whereas histological specimens shown as illustrations were thick [17]. Not only flexible but also rigid bronchoscopes have been used [18]. For acute pneumonia in children, bronchoscopy was recommended to determine the type of inflammation in bronchi (catarrhal or purulent), for chronic pneumonia - to exclude tuberculosis and congenital anomalies. Primary tuberculosis in children was regarded to be an indication for bronchoscopy [9], although this method is no more sensitive for culture of Mycobacteria than gastric aspiration [5,6]. In destructive tuberculosis, therapeutic bronchoscopy (1-2 weekly during 2-4 months) was officially recommended by the Health Ministry [19] and applied in spite of sometimes suboptimal procedural quality assurance; while the principle of informed consent was not always observed [20]. Among others, these conditions have been caused by partial isolation from the international scientific community and limited access to the foreign literature [21].

As mentioned above, bronchial biopsy specimens were used for research, whereas some morphological illustrations were hardly informative, morphometric and other quantitative indices uniformly improving after medical or surgical treatment of asthma [17,22,23], surgery being consistently more efficient [24]. Based

on corresponding experience [25], some datasets appear suspicious of trimming. Certain morphological descriptions were doubtful e.g. "atrophic processes" in bronchi of asthmatic children advancing with time: atrophy or subatrophy of bronchial mucosa was found in 79.5% of asthmatic children older than 12 years [18]. Furthermore, broncho- and gastrodoudenoscopy were used as a second phase of screening e.g. in children with "chronic non-specific pulmonary diseases" (including asthma and chronic bronchitis) found in 4.08 % of children residing in industrially contaminated areas of Moscow and the suburbs [26]. Bronchoscopy was used as a screening method in young (mean age 19.5 years) individuals diagnosed with community-acquired pneumonia (1478 bronchoscopies in 977 patients), while the most frequent finding was mucopurulent bronchitis [27]. Biopsies were taken for research from large bronchi of patients with known lung cancer whereas histological sections presented as illustrations were thick and uninformative [23]. Admittedly, as far as it can be perceived from the literature, bronchoscopy is less frequently used in children for research today. For example, in the study [28], bronchoscopy was applied in children 5-15 years of age with moderate to severe asthma, while informed consent was obtained from parents.

In the pediatric clinic of I.M. Sechenov Medical University (a leading institution where textbooks have been issued [9]) endoscopic methods have been widely used for diagnostic, therapeutic and research purposes since the 1960s also in newborn infants [29]. At the same time, complications in children were noticed [30]. Bronchoscopy was applied in children with pneumonia, chronic bronchitis and asthma [30-32]. Besides, upper gastrointestinal endoscopy with biopsies used for research was applied in children with rheumatoid arthritis, dermatomyositis, scleroderma, systemic lupus erythematosus, respiratory and hepatobiliary diseases [26,33-38]. Gastroscopy was used as a screening method in children of mothers with bronchial asthma [39]. Informed consent was mentioned only in recent papers [28,40,41].

Numerous bronchoscopic methods applied in children and adults for diagnostics and therapy have been patented; here follow several examples. Monitoring of treatment efficiency of chronic catarrhal bronchitis by means of repeated examinations of bronchial washings obtained by bronchoscopies performed every other day during the whole period of treatment [42]; laser treatment via bronchoscope of "atrophic bronchitis deformans" (the term was used in the former SU having no clear radiological signs) [43]; bronchitis diagnostics in children [44] and adults [45], treatment of pulmonary tuberculosis by endobronchial instillations of surfactant preparations produced from bovine lung or human amniotic fluid every other day during 3-8 weeks [46] discussed in [1,47].

In conclusion, the purpose of this letter was to overview some endoscopic procedures with questionable indications used in the past, and to remind that the risk-to-benefit ratio should be kept as low as possible. When a child is able to give assent to decisions about participation in research, the investigator must obtain it in addition to the consent of parents or legally authorized representatives. Adolescents are in a sense between children, who are to be treated according to their best interests represented by parents or legally authorized persons, and independent adults, who are to be treated according to their wishes [48]. Consent of human subjects for participation in research requires that they fully understand their role and risks, and can withdraw at any time without being punished. Children require additional protection [49,50]. In the author's opinion, endoscopy for research and screening (bronchoscopy in particular) should not exist as such in children and adolescents; it should always be performed according to clinical indications. If a patient gives informed consent to research on endoscopic biopsy specimens obtained for diagnostic purposes, it can be done, provided that enough tissue remains for the diagnostics, if non-morphological or otherwise suboptimal for the diagnosis research methods, consuming the tissue, are applied [51]. Finally, significance of the procedural quality assurance in endoscopy should be stressed, especially the training methods not involving patients e.g. using anatomic models and video technologies as well as selection of capable trainees [5].

CONFLICT OF INTEREST

The author declares that there are no conflicts of interest.

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Araştırma / Research Article

Sudan'da rahim ağzı kanserinde palyatif bakıma yönelik hemşirelik öğrencilerinin algısı

Perception of Nursing Students towards palliative care of cervical cancer in Sudan

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Anahtar Kelimeler:
Rahim ağzı kanseri, hemşirelik öğrencileri, farkındalık, Sudan

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ÖZET

Amaç: Temel amaç, farkındalığı, konuya karşı sergilenen tutumu ve hemşirelik lisans öğrencilerinin rahim ağzı kanserini önleme ve tedavi etmeye yönelik uygulamalarını saptamaktı.İkincil amaç,palyatif bakım konusunda olduğu kadar hemşirelik öğrencilerinin farkındalığı artırma noktasındaki iştirakını , medikal görüntülemeyi , prekanseröz durumu¸ yönetimini ve invazif rahim ağzı kanserini koruma altına almaktı. **Gereç ve Yöntem :** Tanım-Khartoum Devlet Üniversitesitesindeki Hemşirelik Okullarında enlemesine araştırma yürütüldü. Toplamada 246 kadın lisans öğrencisi basit rasgele örneklerce seçilerek göüşmeler yapıldı.Çalışmanın hükmünü gerçekleştirmek amacıyla 10 öğrenciye ön sınav uygulandı.Palyatif bakım ve rahim ağzı kanserini tedavi konusundaki bilgi ve uygulaması,kesin ölçeklere,iyi ,adil ve doğru ürün temelinde yetersiz olmasına göre tanımlanmıştır. **Sonuç :** Çoğu öğrenci rahim ağzı kanserinin getirdiği zorluklar ve bu hastalığın Sudan'daki güncel durumu konusunda çok az bir bilgiye sahip. Öğrenciler prekanseröz durumu yönetiminde de oldukça az bilgiye sahip ve bu açıdan öğrenciler arasında anlamlı bir fark bulunuyor,ayrıca yanıtlayanların yarıdan azı hafifletici bakıma aşina değil.Yanıtlayanların neredeyse üçte biri,edindikleri bilgiyi genel olarak kitle iletişim araçlarından ediniyolar.Çoğu öğrenci palyatif bakımın bileşenlerini ve ilerlemekte olan hastalığın artan belirtilerini aşmak için nasıl destek sağlayacaklarını bilmiyorlar.

ABSTRACT

Objective: The primary objective was to determine awareness, attitude, and practice of undergraduate nursing students towards prevention and treatment of cervical cancer. The Secondary objective was to ensure their participation in raising awareness, screening, management of precancel conditions, and invasive cervical cancer, as well as palliative care. **Material and Method:** A descriptive - cross sectional study was carried out in the nursing colleges at Khartoum state universities. A total of 246 female undergraduate students, selected through simple random sample were interviewed. A pre test was done among 10 students to ensure validity of the study. The knowledge, and practice towards treatment of cervical cancer and palliative care were identified according to a certain scale, being as good, fair, and poor on the basis of correct items. **Result:** Most of the students has poor information about the burden of cervical cancer and current situation of disease in Sudan. Students have poor information about the management of precancerous conditions, with significant difference between students in this aspect (P 0.000) and less than half (40.7%) of the respondents were not familiar with palliative care (P 0.012). Nearly one third of the respondents received their information mainly from the mass media p (0.000). Most of the students did not know the component of palliative care and how to provide relief a rise symptoms of advancing disease.

GİRİŞ

Cervical cancer is the second most common women cancer worldwide, representing 13% of female cancers. It ranks as the second most frequent cancer among women after breast cancer in Sudan. The majority of cases present with advanced stage when the treatment either by surgery or radiotherapy is expensive and not always available. Breast and Cervical Cancer account for about 50% of all cancers in Sudanese women Therefore, there is an urgent need for better early detection of cancer in Sudan to make treatment more effective, less costly, less invasive, more accessible and acceptable to patients [1, 2]. Cervical cancer is potentially preventable, and curable, effective screening programs can lead to significant reduction in morbidity and mortality related to cervical cancer and eradicating a pre-invasive disease as shown by studies done in high income countries [3]. Studies have shown sensitivity and specificity of Pap smear screening to be 50-75% and 98-99% respectively. Nurses in high income countries play a role in cancer prevention and participates in cervical cancer screening by carrying out Pap smear tests[4]. Since survival rates for cervical cancer are over 90% if it is detected early and properly managed Its crucial that women of all ages should be armed with a strong knowledge base of HPV, including its acquisition, it's potentially serious consequences and prevention strategies to make informed decisions for their own health and wellness[5].

Most countries which have significantly reduced morbidity and mortality rate have attributed it to

effective cervical cancer screening program and early treatment. All women who were, or who have had been sexually active and between age 20-65 years old are recommended to undergo Pap smear screening. Screening every three years is recommended if the first two consecutive screenings are negative[6].

The vast majority of women who suffer from cervical cancer in Sub-Saharan Africa present with disease that is advanced far beyond the capacity of surgery or other treatment modalities to offer a cure. Palliative care services are very poorly developed and therefore these unfortunate women are sentenced to a miserable end of life[7]. The Palliative care nurse practitioner offers training to the family members in care-giving and controls at least once a week. Moreover, the nurse managed drug supply, including morphine in the absence of the physician following his advice. Hospital-at home nurses have great importance in developing countries[8]. In Uganda, a network of trained palliative care nurses, licensed to prescribe liquid oral morphine. Knowledge about palliative care, including pain relief, as a way of providing clinical and psycho social support for terminally ill patients was generally poor among most providers, and cervical cancer issues were not included in the theoretical or practical training of nurses[9]. British palliative care nurse Esther Walker has developed the palliative care in Sudan 2010. It launched with a nine-bedded palliative care ward and a clinic that opens daily at Radio Isotope Center, Khartoum (RICK) Patients who were being cared at RICK have great advantages of a dedicated palliative care team and access to opiates is being promoted. The palliative care team consists of nurses, a registrar, medical officers, psychologists and volunteers. In 2010 a three-day workshop – 'Palliative Care in Practice' was held at the University Hospital (SUH). It considered that the main barriers to palliative care in Sudan were lack of trained human resources and infrastructure[8]. Research suggests that nurses may not be adequately prepared for working with individuals at the end of life and strongly supports the integration of palliative care into the undergraduate curriculum [10]. Barrie et al. (2008) identified that nursing student's attitudes toward care of the dying was positively influenced by the integration of palliative care into the undergraduate nursing program.

Although, exploration was based on the use of an end of life education package designed within the United States of America the significance of changing student's attitudes by the integration of palliative education into curriculum cannot be discounted[9]. In a workshop conducted in Sudan participants agreed on recommendations to introduce palliative care in undergraduate medical schools and postgraduate training curriculum as was suggested by Stannebergerr in his review article[8].

Methods This is a cross sectional descriptive study, which targeted final year undergraduate nursing students for assessment of their knowledge, attitudes, and practice in relation to use of palliative care in cervical cancer. A study conducted in nursing colleges at all universities in Khartoum had final year undergraduate students. Non-probability sampling technique was an appropriate method to select 246 students from selected universities for the study. Data collection was done through a self structured interview questionnaire, with closed-ended questions. The purpose and importance of the study were explained to participants before filling the questionnaire. Nurses who assisted in data collection received two days additional training. Names were not used for identification, but coding numbers were used instead.

The pretest study is the collection of data before the basic study is executed, the rationale for the pretest study was to determine whether the survey instrument was clearly stated. The total score for each respondent was obtained by summing the correct number of responses, then categorizing the samples according to respondents knowledge score, and graded as poor, satisfactory, and good. A higher score indicated better knowledge and Scores were expressed as percentages the total. The interpretation of knowledge score was done as poor

(0-33.3% satisfactory (33.4-66.7%) and good (66.7%). The study approval was taken from the Research and Ethical Committee of AlneealinUniversity, Faculty of Medicine & Health Sciences. And Permission obtained from them to carry out the study.

Statistical analysis

was performed with Statistical Package for Social Sciences software (SPSS) version 11. Chi square test (X2) was used to determine the association between variables. The level of significance was set at p = 0.05.

RESULT

Table1. Knowledge of Cervical Cancer Side effect After Treatment

Sexual Dysfunction after Radiotherapy			
Poor	100	40.7%	
Satisfactory	84	34.1%	0.012
Good	62	25.2%	

Table 2. Knowledge of Palliative Care

Palliative Care Component			
Poor	124	50.4%	
Satisfactory	65	26.4%	0.0004
Good	57	23.2%	

Table3. Relation between and How to Relive Bad Smell from Cervical Cancer Woman

Variable	Category		How to relive the bad smell			Total
			Poor	Satisfactory	Good	
Total knowledge of Treatment	Poor	168 % 68.3	58 80.6%	13 18.1%	1 1.4%	72 100.0%
	Satisfactory	50 %20.3	72 52.6%	51 37.2%	14 10.2%	137 100.0%
	Good11.4	28 11.4 %	4 21.6%	14 37.8%	15 40.5%	37 100.0%
	Total	246 100.0%	138 56.1%	78 31.7%	30 12.2%	246 100.0%

(2), = 53.521[a], p = 0.0004

Approximately one quarter (25.2%) of the respondents were aware about that, sexual dysfunction occurs after radiotherapy treatment, there was a significant association between groups (P= (0.012). About half of the respondents (50.4%) were not oriented about the component of palliative care with significant differences between groups among universities (P=0.0004).

Only 68.3% of the students, have an awareness of the treatment of cervical cancer.

DISCUSSION

Palliative care supports patient with advanced disease and those who do not respond to curative treatment, especially in developing countries, as the majority of the cases present in advanced stages. The idea is to manage these cases in a special hospice under the care of trained personnel. The true fact is that hospice care is not always available in low- resource setting, therefore women with cervical cancer usually cared for at home by family members, and that is a big burden especially many of them are working personnel. Less than half of the respondents in our study were not well aware about the component of palliative care and how to deal with women in advance stage of the disease (P=0.0012). Palliative care should be part of the training program for nurses because it is an important component of cervical cancer treatment and it is not available in our country[8]. In Uganda, a network of trained palliative care nurses, licensed to prescribe liquid oral morphine, has demonstrated how palliative care can be provided safely and effectively in the community without access to a large number of doctors. As the result of Stephan Tanneberger in his review article, that workshop conducted in Sudan, participants had agreed on recommendations that to introduce palliative care in undergraduate medical schools and postgraduate training curriculum, that have been adopted by WHO-EMRO as guidelines for Ministers of Health[8]. An advanced stage of cervical cancer is a situation that usually associates with adverse clinical presentation, such as foul-smelling vaginal discharge, a palliative nurse manages these symptoms through simple procedure such as Periodic packing of the vagina with clean gauze soaked with a solution of Soda bicarbonate powder, dilute vinegar or metronidazole solution[11]. Most of our respondents demonstrate good practice to relive the bad smell from cervical cancer woman. We find association between students knowledge of treatment and the ability of the students to relive the bad smell from women affected with cervical cancer. From a researchers point of view, we appreciated this finding because the bad smell becomes dominant barriers for nurses to work with cervical cancer woman (p= 0.000). Less than half of students (41.5%) were satisfied with cervical cancer curricula and considered it to be complete and informative, the rest of students consider it incomplete and non- informative. Nganwai et al. conducted a study, which showed that most nurses requested extra information about cervical cancer; this is similar to our finding when 93.5% of respondents also showed interest in extra information regarding cervical cancer prevention and treatment [12, 4]. In spite of the poor knowledge in our present study, approximately all respondents demonstrated great interest to work in cervical cancer prevention program area and in oncology hospital after graduation. Involvement of the nurses in awareness raising of treatment of cervical cancer as well as participating in palliative care. Nursing college curricula should include modules for better training of nurses in all aspects of palliative care and patient end of life. Media in all kinds is very important in promoting awareness about prevention and treatment of cervical cancer, therefore involvement of the media in the development and implementation of the program was important. Palliative care education is gradually being incorporated into preregistration nurse training programs. Palliative care an important component

of cervical cancer treatment needs more evaluation, analysis, and structured quantitative research.

CONCLUSION

Most of the students did not know the component of palliative care and how to relieve the arising symptoms of advancing disease such as bad smell which is the dominant reason preventing nurses from working in a palliative care area as well as end of life patient.

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Kısa Derleme / Mini Review

Klinik dokümantasyon iyileştirme programı konusunda bir rehber

A primer on Clinical Documentation Improvement Program

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ÖZET

Klinik Belgelemenin alanı hekimlerin belgelerinden daha fazlasını kapsamak amacıyla geliştirildi.Şu an Klinik Belgeleme laboratuvar raporlarını,teknisyen belgelerini , bakım belgelerini vb.içeriyor.Ayrıca Klinik Belgeleme , hastaya sunulan bakımla diğer bakım ekibinin üyeleri arasındaki iletişimi kurar.Şu aralar tedarikçi kurumlar,teknoloji sağlayıcılar,kamusal düzenleyiciler ve muhataplar gibi diğer paydaşlar doğrudan hasta bakımının haricinde Klinik Belgeleme sürecindeki ek gereksinimlerdeki yerlerini aldı.Klinik Belgeleme Gelişim Programının amacı Klinik Belgeleme kalitesini artırmak ve bu belgelemeye hasta bakımı gelişimi konusunda çok daha fazla verim kazandırmaktır.

ABSTRACT

The domain of Clinical Documentation (CD) has grown to encompass more than just physician notes. Now CD includes Laboratory reports, Operative notes, Nursing notes, etc.CD is also to communicate the care given to the patient to other members of the care team. Now other stakeholders like provider institutions, technology vendors, government regulators and payers have placed additional requirements on the CD process for purposes other than direct care of the patient. The aim of CD improvement program is to improve the quality of CD and to better use this documentation to improve patient care.

INTRODUCTION

Sir William Osler said, "Observe, record, tabulate, communicate"[1]. This was long before Clinical Documentation Improvement (CDI) programs came into being. Over the years, the domain of Clinical Documentation (CD) has grown to encompass more than just physician notes. Now CD includes Laboratory reports, Operative notes, Nursing notes, etc.

Each patient is unique. For instance, no two Community Acquired Pneumonia patients are the same. One may be associated with urinary incontinence; the other with acute renal failure. They belong to two separate Disease Related Groups (DRGs).The latter has more Case Weight (CW) than the former. So, health care facilities have standardized this data for comparison. This is done by converting CD into codes such as ICD-10-CM, CPT, PCS, etc.

The focus of CDI programs is on improving the quality of care given to patients regardless of revenue generated. A CDI program is for facilitating an accurate representation of healthcare services through 4C's -Clear, Concise, Complete and Compliant - and accurate documentation of diagnoses and procedures. CDI is for better patient care not just about revenue, which anyway follows. Cooperation is needed among industry health care providers, health care systems, government and insurers to continue to improve the documentation[2.

Individuals qualified to serve as a CDI specialist include, but are not limited to, physicians, health information management professionals, coding professionals, nurses,

and other professionals with a clinical and/or coding background[3] . There is need for physician partnerships to sustain the program and achieve results [4]. Creating a new position of Coding/Documentation Specialist, working at the point of care as a regulatory interpreter and coding expert, was found to be key to cementing the successful team approach to documentation quality [4].

Clinical documentation, an essential process within electronic health records (EHRs), takes a significant amount of clinician time [5]. Physicians who dictated their notes appeared to have worse quality of care than physicians who used structured EHR documentation[6]. The use of standardized documentation improves quality documentation and retrieval of data from EHR [7].

THE VALUE OF CDI PROGRAMS

It is a myth that CDI programs are meant for revenue and reimbursement. In fact CDI is meant for improving quality and continuity of care given to patients. Accurate clinical documentation is necessary for healthcare organizations to achieve quality improvement and accurate payment [8]. Clear, complete, timely and accurate documentation serves the following purposes:

1. Proof of quality of care given.
2. Profiling of hospital physician data.
3. Data for tumor registry mortality, etc.
4. Compliance for reimbursement.
5. Protection in the event of litigation.

Physician buy-in is essential to a successful clinical documentation improvement program [8].

Clinicians, provider institutions, technology vendors, government regulators, payers, and other interested groups should improve the quality and value of clinical documentation and to better use this documentation to improve care[2].The program should not focus on revenue enhancement or a particular tool, but should encourage critical thinking by physicians [8].

CERTIFICATIONS

Numerous industry trends, such as the increased adoption of electronic health records (EHRs), an increase in health insurance fraud, and the need for complete and accurate documentation to support the requirements of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), all suggest the need for a highly qualified, specialized set of documentation improvement specialists who meet stringent professional guidelines [9]. It is projected that fraud and abuse account for between 3 to 15 percent of annual expenditures for healthcare in the United States [10]. Because clinical documentation specialists have expertise in clinical care, coding guidelines, and reimbursement methodologies, a nationally recognized CDI-related credential would distinguish those practitioners as competent to provide direction relative to clinical documentation in the patient's health record [11].

1. Certified Documentation Improvement Practitioner (CDIP):

In response to industry demand, the Commission on Certification for Health Informatics and Information Management (CCHIIM) developed the CDIP credential. The American Health Information Management Association (AHIMA) conducts the examination and awards CDIP certification.

2. Certified Clinical Documentation Specialist (CCDS):

Applicants who pass the certifying examination conducted by Association of Clinical Documentation Improvement Specialists (ACDIS) receive the designation CCDS.

SKILLS AND KNOWLEDGE NEEDED FOR THE CDI SPECIALIST

Clinical documentation specialists should have knowledge of official medical coding guidelines, CMS, and private payer regulations related to the Inpatient Prospective Payment System; an ability to analyze and interpret medical record documentation and formulate appropriate physician queries; and ability to benchmark and analyze clinical documentation program performance. Proficiency in medical record review; communication and physician query techniques; CMS quality programs and reportable diagnoses that impact quality metrics, and data mining and reporting functions are also needed.

Evaluation and management (E&M) CPT codes seem to be one area where documentation and coding issues are prevalent 10. Educational and training programs focused on CPT codes should emphasize the importance of documentation to support time spent examining the patient [10].

The following is a partial list of skills needed:

1. To differentiate between Present on Admission (POA) and Hospital Acquired Conditions (HACs) .
2. To improve continuity of care for the patient.
3. To identify and clarify any missing information in the

health record and provide accurate representation of patient severity.

4. To know state requirements for coding, documentation and reporting e.g. CMS, COP.
5. To educate coding staff members to increase their clinical knowledge.
6. To enhance communication between members of the CDI team and the medical staff.

CDI TERMINOLOGY

DRG: An inpatient classification scheme that categorizes patients who share similar clinical characteristics.

SOI: Severity Of Illness.

ROM: Risk Of Mortality

MS-DRGs : Medicare Severity Diagnosis-Related Groups .

POA : Present On Admission.

HAC: Hospital Acquired Condition.

CC : Complications or Co-morbidities.

MCC: Major Complications or Co-morbidities.

CONCLUSION

The CDI programs are meant for improving the quality of clinical documentation . CDI is for better patient care regardless of its effects on bottom-line of the health care facility. A CDI program is for facilitating an accurate representation of healthcare services through 4C's -Clear, Concise, Complete and Compliant - and accurate documentation of diagnoses and procedures. The aim is to improve the quality of CD and to better use this documentation to improve patient care.

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CONFLICT OF INTEREST

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ETHICAL APPROVAL

Not required.

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Kısa Araştırma Raporu / Short Communication

Kalite akreditasyon programlarının hemşirelik hizmetlerinde hasta güvenliği deneyimlerine etkisi

The effect of quality accreditation programs on patient safety experiences in nursing services

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Anahtar Kelimeler:
Hasta Güvenliği, Hasta Güvenliği Deneyimi, Hemşirelik Hizmetleri, Kalite

Key Words:
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ÖZET

Giriş: Sağlık Bakanlığının 2003 yılında Sağlıkta Dönüşüm Projesi ile başlattığı ve özellikle son 10 yılda büyük bir ivme kazanan Kalite Akreditasyon çalışmaları ile oluşturduğu Kalite Akreditasyon Programları (Sağlıkta Kalite Standartları, bağlı rehberler) tüm sağlık kurum ve kuruluşlarında uygulanmaktadır. Sağlıkta Kalite Standartlarının ortaya koyduğu ölçütleri uygulamadaki başarı durumunu; kurum ve kuruluşların fiziki konumları, teknik olanakları ve personelin bilgi düzeyleri ile deneyimleri önemli ölçüde etkilemektedir. **Amaç:** Bu çalışma, Kalite Akreditasyon Program'larının, hemşirelik hizmetlerinde hasta güvenliği bilgi ve uygulamalarına katkılarını değerlendirmek ve farklı değişkenlerin bu uygulamalara etkilerini ölçmek amacıyla yapılmıştır. **Yöntem:** Çalışma farklı yaş gruplarında, farklı eğitim düzeylerinde, hastane kliniklerinde çalışan ve farklı iş deneyim sürelerine sahip 175 hemşireyle gerçekleştirilmiştir. Veriler 12 sorudan oluşan bir anket yoluyla elde edilmiştir (iki sorunun alt açılımları mevcuttur). Verilerin analizinde tanımlayıcı istatistik yöntemleri ve gerekli alt grup analizlerinde ki kare testi kullanılmıştır. **Bulgular:** Katılımcıların yarısı 25-34 yaş aralığında idi. Hemşirelerin %98.9 hasta güvenliği eğitimi aldığını bildirdi. %90.9 katılımcı bu eğitimlerin yeterli olduğunu düşünüyordu. Bu konuda eğitime ihtiyaç duyduklarını belirtenlerin oranı %22.3'tü. Hasta güvenliği konusunda raporlama yapan katılımcı oranı ise %78.3 olarak saptandı. 25-34 yaş grubu arasında bu konuda raporlama yapan hemşire oranı anlamlı derecede yüksek bulundu (p=0.012). Bir yıldan az çalışma süresi olan hemşirelerde eğitim alma oranı düşüktü (p=0.038). Hasta güvenliği konusunda raporlama yapma oranı, bir yıldan az ve 10 yıldan fazla çalışma süresi olan katılımcılarda anlamlı derecede düşüktü (p=0.049). **Sonuç:** Hasta güvenliği konusunda eğitim alma oranının yüksekliğine karşın pratik uygulamada bu konuda raporlama yapan katılımcı oranının düşük olması, eğitimin her zaman tutum değiştirmede tam etkili olmadığını düşündürmüştür. Kısa sureli hatırlatma eğitimlerinin uygulanmasının yararlı olabileceğini düşünüyoruz.

ABSTRACT

Introduction: Ministry of Health has initiated Quality Accreditation studies with Transformation Project in Health in 2003. These studies have gained extensive momentum especially in the last decade, and have composed Quality Accreditation Programs (Quality Standards in Healthcare, associated guidelines), which are applied in all healthcare institutions and institutes. The status of achievement in applying the criteria, laid down by Quality Standards in Healthcare, is significantly affected by physical locations of institutions and institutes, technical facilities, and knowledge levels and experiences of personnel. **Purpose:** This study has been conducted to assess the contributions of Quality Accreditation Programs to patient safety knowledge and practices in nursing services and to measure the effects of different variables on these practices. **Method:** The study has been conducted with 175 nurses in different age groups, at different educational levels, and working in hospital clinics, and having different durations of work experience. Data has been obtained by a questionnaire of 12 questions (two questions have sub-questions). Descriptive statistical methods have been used in data analysis, and Chi square test has been used in required sub-group analysis. **Findings:** The half of the participants was in the age group of 25-34 years. 98.9% of nurses stated that they received patient safety training. 90.9% of participants thought that these trainings were sufficient. The ratio of the ones, indicating that they needed training on this subject, was 22.3%. The ratio of the participants, reporting on patient safety, was detected as 78.3%. The ratio of nurses, reporting on this subject, was found significantly high in the age group of 25-34 years (p=0.012). The rate of receiving training was low in nurses with work experience of less than one year (p=0.038). The rate of reporting on patient safety was significantly low in participants with work experience of less than one year and with work experience of more than 10 years (p=0.049). **Conclusion:** Although the rate of receiving training on patient safety is high, the rate of participants, practically reporting on this subject, is low. This has led to the thought that training is not always fully effective in attitude change. We think that the implementation of short-term reminder trainings may be useful.

GİRİŞ

Sağlık Bakanlığının 2003 yılında Sağlıkta Dönüşüm Projesi ile başlattığı ve özellikle son 10 yılda büyük bir ivme kazanan Kalite Akreditasyon çalışmaları ile oluşturduğu Kalite Akreditasyon Programları (Sağlıkta Kalite Standartları, bağlı rehberler) tüm sağlık kurum ve kuruluşlarında uygulanmaktadır. Sağlıkta Kalite Standartlarının ortaya koyduğu ölçütleri uygulamadaki başarı durumunu; kurum ve kuruluşların fiziki konumları, teknik olanakları ve personelin bilgi düzeyleri ile deneyimleri önemli ölçüde etkilemektedir.

Personelin bilgi düzeyleri özellikle de bilgilerini deneyimlerine yansıtmaları önemlidir. Sağlık hizmetlerinde kalite programlarının en önemli

konularından birisini hasta güvenliği oluşturmaktadır Hasta güvenliği, sağlık bakım hizmetlerinin kişilere vereceği zararı önlemek amacıyla sağlık kuruluşları ve kuruluşlardaki çalışanlar tarafından alınan önlemlerin tamamıdır ve nitelikli sağlık hizmetinin birincil ve vazgeçilmez koşulunu oluşturmaktadır. Hasta güvenliğinde amaç, hasta ve hasta yakınlarını, hastane çalışanlarını fiziki ve psikolojik olarak olumlu etkileyecek bir ortam yaratarak güvenliği sağlamaktır. Burada temel hedef, hizmet sunumu sırasında hata oluşmasını engelleyecek, hatalar nedeniyle hastayı olası zararlardan koruyacak, hata olasılığını ortadan kaldıracaktır.

Hasta güvenliği konusu sağlık hizmetlerinde çalışan tüm personelin sahiplenmesi gereken bir konudur (Dursun ve ark., 2010). Sağlık çalışanlarının sağlık hizmetleri verirken neden oldukları tıbbi hataları sıfıra indirmek mümkün olmasa da hastanelerde hasta güvenliği kültürünün yerleştirilip geliştirilmesi ve aynı zamanda tüm çalışanlar tarafından benimsenmesi ile bu hata ve risklerin en az sayıya indirilebileceği görülmektedir. Hasta güvenliğinin sağlanmasında ilk hedef, riskleri azaltmak olmalıdır

Hasta güvenliği kültürünün gelişmesi deneyimlere de önemli ölçüde olumlu yansıyacaktır bunun içindir ki; hastaları zararlardan korumak ve organizasyon içinde hasta güvenliğini oluşturmak ve geliştirmek personel deneyimlerinin artırılması ile mümkün olacaktır.

Hasta güvenliği ile ilgili olaylar hastanede yatan hastalar için zararlı sonuçlar doğurmakla beraber hastaneye ek bir maliyet de getirebilmektedir. Hastanın yaşadığı zarar ciddi yaralanmalara, hastanede kalış süresinin uzamasına, sakatlığa, hatta kişinin ölümüne neden olabilmektedir. Yorgunluk, yetersiz eğitim, iletişim sorunları, zamansızlık, yanlış karar, tartışmacı kişilik gibi insan kaynaklı sorunlar tıbbi hatalara neden olabilmektedir. İşyeri yapısı, takip edilen politikalar, idari yapı, personelin yanlış dağılımı, sorunlara çözüm konusunda yetersizlik gibi nedenler kurumsal kaynaklı sorunları oluşturmaktadır. Yetersiz otomasyon, yetersiz cihaz ve eksik cihaz gibi teknik faktörler de personel deneyimlerini etkilemekte, tıbbi hata nedeni olabilmektedir (Akalın, 2008; Ertem ve ark., 2009; Karataş ve Yakıncı, 2010).

Sağlık hizmetlerinde olay raporlama faaliyetinin uygulanması, organizasyona dâhil olan iş görenin eksik yanlarının görülmesi, güçlü yanlarının farkına varılması, yaratıcılığının geliştirilmesi, organizasyon içinde verilecek sorumluluk ve görevin belirlenmesinde yol gösterici bir araç olmakla beraber performansı yüksek bir örgüt ortaya çıkararak hasta için daha iyi hizmet sunmaktadır (Kohn ve ark., 2000; Dursun ve ark., 2010; Altındiş ve Kunt 2010).

Hata raporlamanın en temel amaçları, epidemiyelojik verilerin toplanmasının yanında öğrenmenin gelişmesi için kullanılabilen niteliksel bilgiyi toplamaktır. Çünkü burada amaç, kişilerin yaşadığı hata ve istenmeyen olaylar konusundaki deneyimlerinden organizasyonun tümünün öğrenebilmesinin sağlanmasıdır.

Hasta güvenliği sürecinde hasta bakım aşamasının ve tıbbi faaliyetlerin büyük bir kısmını hemşireler yürütmektedir. Hemşirelerin sayıca yoğun ve hasta ile en fazla muhatap olan sağlık personeli grubu olmaları nedeniyle hemşirelik uygulamalarında hasta güvenliği kültürünün oluşturulması büyük öneme sahiptir (Mitchell, 2008; Çırpı, 2009; Korkmaz, 2012; Cebeci ve ark., 2012). Hemşireler, bakımın her alanında hasta güvenliği ile iç içe bulunmaktadır. Bir kurumda hasta güvenliği kültüründen söz edebilmek için hasta güvenliği uygulamalarının hemşireler tarafından benimsenmesi ve sürekliliğinin sağlanması ve hasta güvenliği deneyimlerinin artırılması gerekmektedir.

AMAÇ

Bu çalışma, Kalite Akreditasyon programlarının, hemşirelik hizmetlerinde hasta güvenliği bilgi ve uygulamalarına katkılarını değerlendirmek ve farklı değişkenlerin bu uygulamalara etkilerini ölçmek amacıyla yapılmıştır.

Araştırma Soruları:

- Hasta güvenliğine yönelik eğitim alma durumları nedir? Hangi konularda eğitim gereksinimleri vardır?
- Hemşirelerin hasta güvenliği ile ilgili yaşadığı olayları raporlama durumu nedir?
- Hemşirelerin hasta güvenliği eğitimi alma durumları ile kurumdaki hasta güvenliği uygulamaları arasında ilişki var mıdır?

YÖNTEM

Araştırmanın Tipi

Çalışma, tanımlayıcı tasarımda gerçekleştirilmiştir.

Araştırmanın Örneklemi

Çalışma farklı yaş gruplarında, farklı eğitim düzeylerinde, hastane kliniklerinde çalışan ve farklı iş deneyim sürelerine sahip 175 hemşireyle gerçekleştirilmiştir.

Veri Toplama Araçları

Araştırma verilerinin toplanmasında "Anket Formu" kullanılmıştır. Veriler 12 sorudan oluşan bir anket yoluyla elde edilmiştir (iki sorunun alt açılımları mevcuttur).

Verilerin Toplanması

Araştırma, Nisan 2016 tarihinde gerçekleştirilmiştir.

Anket formları, araştırmacı tarafından hemşirelere gerekli açıklamalar yapıldıktan sonra elden dağıtılmıştır. Hemşirelerin formları doldurabilmesi için 3 gün süre verilmiş ve bu süre sonrasında anketler tekrar gidilerek elden toplanmıştır.

Verilerin Analizi

Araştırmaya katılan hemşirelerden elde edilen veriler bilgisayar ortamına aktarılmış ve SPSS 16.0 programında değerlendirilmiştir. Verilerin analizinde tanımlayıcı istatistik yöntemleri ve gerekli alt grup analizlerinde ki kare testi kullanılmıştır. Analiz CO Tıbbi Araştırma Danışmanlık Şirketi tarafından yapılmıştır.

BULGULAR

Çalışmamızda hemşirelerin kişisel ve mesleki özelliklerine göre dağılımı incelendiğinde (Tablo 1);

Tablo 1. Hemşirelerin Kişisel ve Mesleki Özellikleri (n=175)

	Sıklık	%
Yaş		
20-24	11	6,3
25-29	44	25,1
30-34	42	24,0
35-40	36	20,6
Eğitim		
Lise	11	6,3
Ön lisans	82	46,9
Lisans	77	44,0
Lisans üstü	5	2,9
Çalıştığı bölüm		
Acil	16	9,1
Ameliyathane	14	8,0
Kardiyoloji	13	7,4
Enfeksiyon Servisi	12	6,9
Nöroloji	11	6,3
Dahiliye	10	5,7
Genel Cerrahi	10	5,7
KBB- Göz	10	5,7
Göğüs Hst.	9	5,1
Ortopedi	9	5,1
Genel yoğun bakım	8	4,6
Hemodiyaliz	8	4,6
Kadın Doğum	7	4,0
Plastik Cerrahi	5	2,9
Diğer*	33	18,9
Kurumda Toplam Çalışma Süresi		
1 yıldan az	6	3,4
2-5 yıl	72	41,1
6-10 yıl	44	25,1
10 yıl üzeri	53	30,3

*Çocuk servisi, yeni doğan yoğun bakım, ayaktan tedavi unitesi, cocuk acil, cocuk cerrahi, koroner yoğun bakım, noroloji yoğun bakım, diyabet eğitimi, ekk hemşiresi, kalite birimi, psikiyatri, diyaliz, eğitim.

% 49.1'inin 25-34 yaş aralığında, %90.9' unun ön lisans ve Lisans mezunu, % 41.1' inin 2-5 yıl kurumda çalışma süresi olduğu tespit edilmiştir. Bir yıldan az çalışma süresi olan hemşirelerde eğitim alma oranı düşüktü (p=0.038). Hasta güvenliği konusunda raporlama yapma oranı, bir yıldan az ve 10 yıldan fazla çalışma süresi olan katılımcılarda anlamlı derecede düşüktü (p=0.049).

Hemşirelerin hasta güvenliğine ilişkin bulguları değerlendirildiğinde (Tablo 2); Hemşirelerin %98.9 hasta güvenliği eğitimi aldığını bildirdi. %90.9 katılımcı bu eğitimlerin yeterli olduğunu düşünüyordu. Bu konuda eğitime ihtiyaç duyduklarını belirtenlerin oranı %22.3'tü. Eğitim ihtiyacı olduğunu belirtenlerin %14.3 (n=25) Radyasyon Güvenliği, %8.6 (n=15) Tıbbi cihaz güvenliği eğitimine ihtiyaç duyduklarını ifade etmiştir. Hasta güvenliği konusunda raporlama yapan katılımcı oranı ise %78.3 olarak saptandı. Raporlama yaptığını belirtenlerin ise %62.9' unun (n=110) "düşme" konusunda raporlama yaptıklarını söyledikleri saptanmıştır. 25-34 yaş grubu arasında bu konuda raporlama yapan hemşire oranı anlamlı derecede yüksek bulundu (p=0.012). Araştırmada, hemşirelerin %76.0'sı hasta güvenliğine yönelik uygulamaların yeterli olduğunu ve %79,4 ü Kalite programlarının Hasta Güvenliği Konusunda deneyimlerine katkı sağladığını belirtmişlerdir.

TARTIŞMA

Bu araştırma, hastanenin hemşirelik hizmetlerindeki hasta güvenliği deneyimleri değerlendirerek etkileyen faktörleri belirlemek amacıyla tanımlayıcı tasarımda gerçekleştirilmiştir.

Hemşirelerin kişisel ve mesleki özelliklerine göre dağılımı inçelendiğinde % 49.1'inin 25-34 yaş aralığında, %90.9' unun ön lisans ve Lisans mezunu, % 41.1' inin 2-5 yıl kurumda çalışma süresi olduğu tespit edilmiştir. Bir yıldan az çalışma süresi olan hemşirelerde eğitim alma oranı düşüktü (p=0.038). Hasta güvenliği konusunda raporlama yapma oranı, bir yıldan az ve 10 yıldan fazla çalışma süresi olan katılımcılarda anlamlı derecede düşüktü (p=0.049).

Hemşirelerin %98.9'unun hasta güvenliğiyle ilgili eğitim aldıklarını belirttiği, eğitim alanlardan %%90.9'ünün alınan bu eğitimleri yeterli gördüğü saptanmıştır. Çalışanların hasta güvenliğine yönelik eğitim ihtiyacı ise %22.3 olup en fazla ve aynı oranda (%22.9) Radyasyon Güvenliği, ve tıbbi cihaz güvenliği ile ilgili konularda eğitime ihtiyaçları oldukları belirlenmiştir. Bu bulgular, araştırma yapılan hastanede hemşirelere hasta güvenliğine yönelik eğitimlerin verildiğini ancak bazı konularda eğitim ihtiyaçlarının hala olabileceğini göstermektedir. Bu bulgular doğrultusunda yönetici

Tablo 2. Hemşirelerin Hasta Güvenliğiyle İlişkili Durumlarının Dağılımı (N=175)

Hasta güvenliği ile ilgili eğitim aldınız mı?	Evet	173	98,9
Hasta güvenliği ile ilgili aldığınız eğitim sizce yeterli mi?	Evet	159	90,9
Hasta güvenliği ile ilgili eğitime ihtiyacınız var mı?	Evet	39	22,3
Hangi konularda eğitime ihtiyacınız var?			
Güvenli ilaç uygulamaları		11	6,3
Transfüzyon güvenliği		11	6,3
Güvenli cerrahi uygulamaları		10	5,7
Düşmelerden kaynaklanan risklerin azaltılması		8	4,6
İletişim		14	8,0
Radyasyon güvenliği		25	14,3
Tıbbi cihaz güvenliği		15	8,6
Hastaların doğru kimliklendirilmesi		6	3,4
Hasta güvenliği uygulamalarına yönelik raporlama yapıyor musunuz?	Evet	137	78,3
Hangi konularda raporlama yapıyorsunuz?			
Kimliklendirme		104	59,4
Düşme		110	62,9
İlaç Güvenliği		103	58,9
Cerrahi Güvenliği		103	58,9
Transfüzyon Güvenliği		106	60,6
Kalite programlarının Hasta Güvenliği Konusunda deneyimlerinize katkı sağladığını düşünüyor musunuz?	Evet	139	79,4
	Hayır	5	2,9
	Kısmen	31	17,7
Hasta güvenliği uygulamaları sizce yeterli mi?	Evet	133	76,0
	Hayır	12	6,9
	Kısmen	30	17,1

hemşirelerin, hemşirelerin eğitim ihtiyaçlarının belirli aralıklarla değerlendirilerek bu doğrultuda eğitim programlarını düzenlemesi ve yapılan eğitimleri tekrarlaması gerekmektedir.

Çalışmada, hasta güvenliği uygulamalarına yönelik raporlama oranının düşük olması (%78.3) ve en fazla düşme konusunda raporlamanın yapıldığı bildirilmesi, 25-34 yaş grubu arasında bu konuda raporlama yapan hemşire oranı anlamlı derecede yüksek bulunması (p=0.012) ve raporlama yapan çalışanların bir yıldan az ve 10 yıldan fazla çalışma süresi olan katılımcılarda anlamlı derecede düşük (p=0.049) çıkması. üzerinde durulması gereken bir konu olmaktadır. Hataların raporlanması, bir kurumda hasta güvenliği kültürüne yönelik en önemli göstergelerden biri olarak kabul edilmektedir. Hemşirelerin hasta güvenliği uygulamaları ile ilgili eğitim alma oranı yüksek olmasına rağmen raporlama oranı düşük bulunmuştur. Bu durum bize hemşirelerin güvenlik raporlama sistemi ile ilgili tutum ve davranışlarında yetersizliğin veya sorunların olduğunu göstermektedir. Kurum yöneticilerinin bu konuya dikkat ederek, güvenlik raporlama sistemiyle ilgili rutin eğitimlerin dışında kısa süreli hatırlatma eğitimleri düzenlemeleri, çalışanları bilinçlendirmeleri ve uygulamada yaşanan sorunlara yönelik çözümler üretmeleri, verilen eğitimlerin uygulamaya yansıtılması için çaba göstermeleri gerekmektedir. Araştırmada, hemşirelerin %76.0'sının hasta güvenliğine yönelik uygulamaların yeterli olduğunu ve %79,4 ünün Kalite programlarının Hasta Güvenliği Konusunda deneyimlerine katkı sağladığını düşündüklerini belirtmiş olmalarına karşın raporlamanın yeterli düzeyde yapılmaması hasta güvenliği kültürünün yeterince gelişmediğini ve bu konuda çalışmaların yapılması gerektiğini düşündürmektedir

SONUÇ VE ÖNERİLER

Bu çalışmada hemşirelerin % 49.1'inin 25-34 yaş aralığında, %90.9' unun ön lisans ve Lisans mezunu, % 41.1' inin 2-5 yıl kurumda çalışma süresi olduğu, %98.9 hasta güvenliği eğitimi aldığını bildirdi. %90.9 katılımcının bu eğitimlerin yeterli gördüğü belirlenmiştir. Ayrıca bu konuda eğitime ihtiyaç duyduklarını belirtenlerin oranı %22.3 olarak belirlenmiştir. Çalışmada hasta güvenliği konusunda raporlama %78.3 oranında bulunmuş ve en fazla düşme konusunda raporlamanın yapıldığı bildirilmiştir. Bir yıldan az çalışma süresi olan hemşirelerde eğitim alma

oranının düşük (p=0.038) olduğu ve Hasta güvenliği konusunda raporlama yapma oranı, bir yıldan az ve 10 yıldan fazla çalışma süresi olan katılımcılarda anlamlı derecede düşük (p=0.049).olduğu belirlenmiştir.

Sonuçta;

Hasta güvenliği konusunda eğitim alma oranının yüksekliğine karşın pratik uygulamada bu konuda raporlama yapan katılımcı oranının düşük olması, eğitimin her zaman tutum değiştirmede tam etkili olmadığını düşündürmüştür.

Kısa süreli hatırlatma eğitimlerinin uygulanmasının yararlı olabileceğini düşünüyoruz.

Araştırma sonucunda elde edilen bulgular doğrultusunda;

- Kurumlarda hasta güvenliği deneyimlerine ilişkin düzenli kontrol takiplerinin yapılarak mevcut durumun değerlendirilmesi ve iyileştirmelerin bu yönde gerçekleşmesi,
- Bu durum değerlendirmeleri sonucunda elde edilen sorunlar doğrultusunda eğitim programlarının düzenlenmesi ve çalışanların bilinçlendirilmesi,
- Hasta güvenliğine yönelik her konuda raporlamanın yapılabilmesi için verilen eğitimlerde, hata raporlamanın çalışanı cezalandırma olarak görülmeyip sistemin önemli bir parçası olarak değerlendirilmesi gerektiğinin vurgulanması,
- Kurumda hasta güvenliği deneyimlerinin geliştirilebilmesi için öncelikle hasta güvenliği kültürünün kurumda yerleştirilmesi ve yöneticilerin bu konudaki inanç ve tutumlarını kararlılıkla devam ettirmeleri önerilmektedir.

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