“La importancia de la Compasión”

Pablo Lemos, Planetree América Latina Sur

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INSTITUTO UNIVERSITARIO
DE CIENCIAS BIOMÉDICAS
DE CÓRDOBA

PLANETREE
AMÉRICA LATINA SUR

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Universidad Jesuita

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¿Por qué hablar de la Compasión?

¿Por qué hablar de la Compasión?

Capacidad organizacional para crear un cambio medible.
Cómo se configura la organización. Cómo funciona.
Calidad
Asociación
Compasión
Adopción de un enfoque personalizado y holístico de la atención.
Cohesión entre lo que hacemos y por qué lo hacemos.
Reorientar la prestación de cuidados para facilitar el cambio de los pacientes como receptores pasivos a participantes activos.

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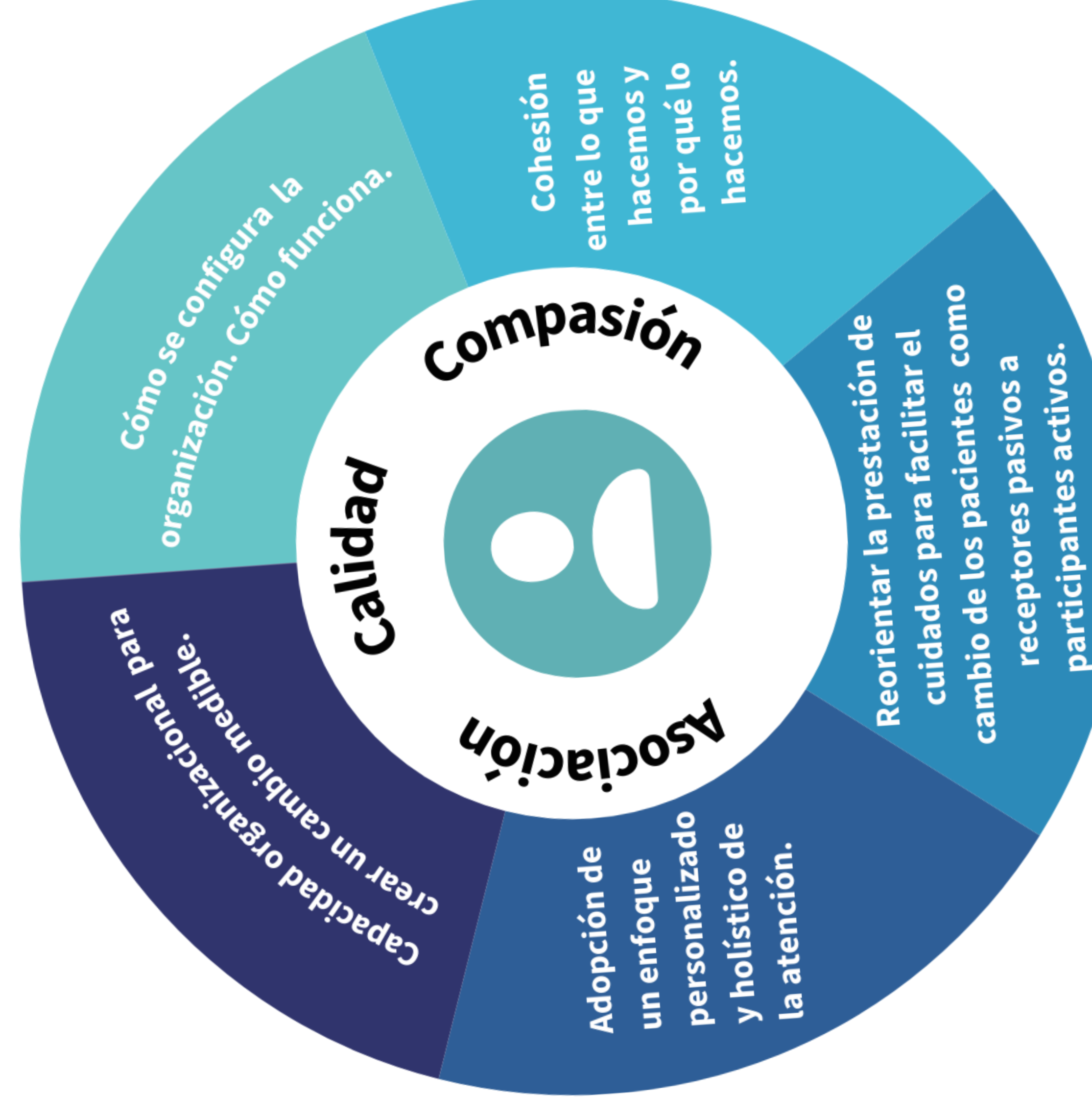
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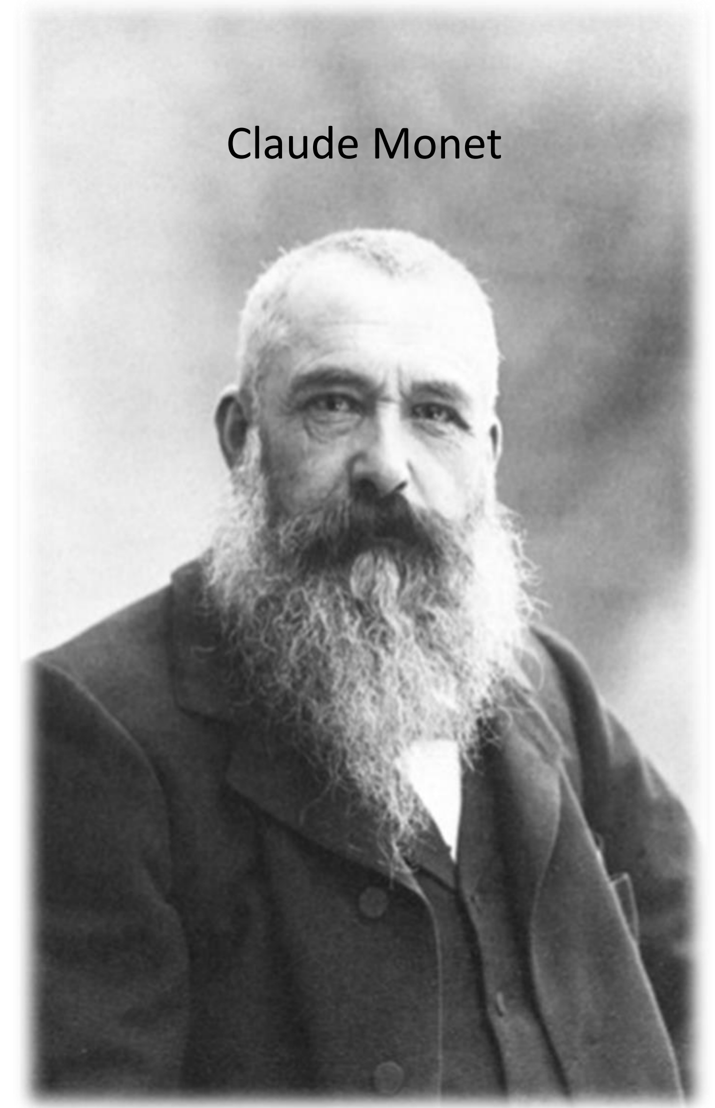
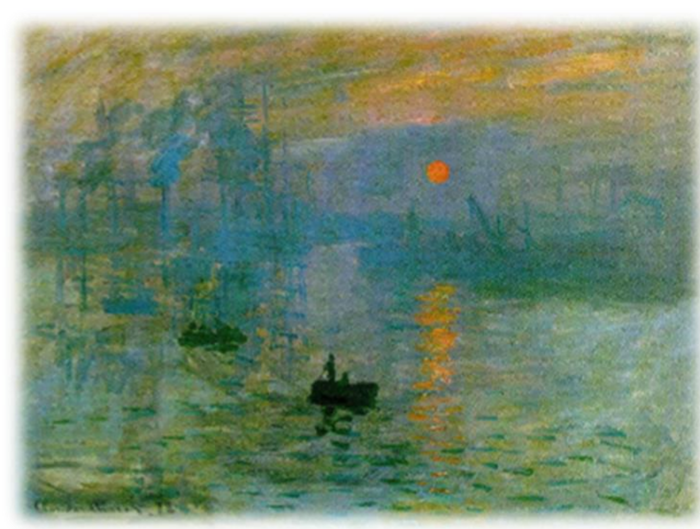


Claude Monet

Choza del guarda de aduanas en Verengeville

La catedral de Ruán

Dama con parasol



Impresión, sol naciente

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¿Cuándo muere la Compasión?

Empathy Decline and Its Reasons: A Systematic Review of Studies With Medical Students and Residents

Melanie Neumann, PhD, Friedrich Edelhäuser, MD, Diethard Tauschel, MD, Martin R. Fischer, MD, Markus Wirtz, PhD, Christiane Woopen, MD, PhD, Aviad Haramati, MD, and Christian Scheffer, MD, MME

Abstract

Purpose
Empathy is a key element of patient–physician communication; it is relevant to and positively influences patients' health. The authors systematically reviewed the literature to investigate changes in trainee empathy and reasons for those changes during medical school and residency.

Method
The authors conducted a systematic search of studies concerning trainee empathy published from January 1990 to January 2010, using manual methods and the PubMed, EMBASE, and PsycINFO databases. They independently reviewed and selected quantitative and qualitative studies for inclusion. Intervention studies, those that evaluated psychometric properties of self-assessment tools, and those with a sample size <30 were excluded.

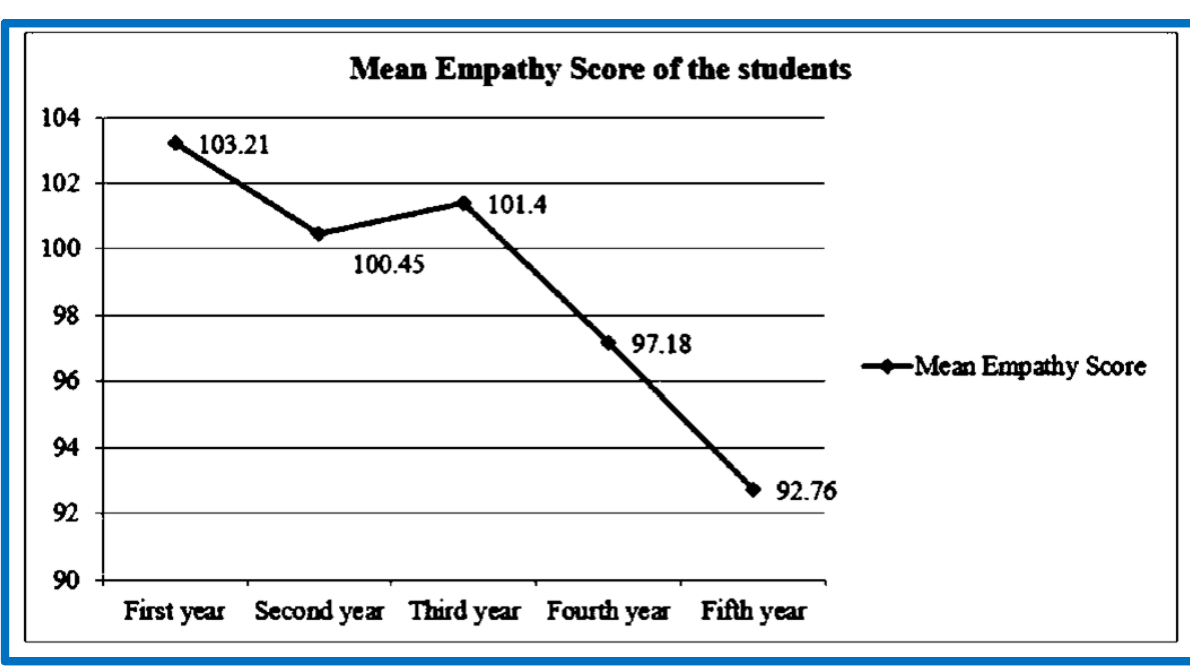
Results
Eighteen studies met the inclusion criteria: 11 on medical students and 7 on residents. Three longitudinal and six cross-sectional studies of medical students demonstrated a significant decrease in empathy during medical school; one cross-sectional study found a tendency toward a decrease, and another suggested stable scores. The five longitudinal and two cross-sectional studies of residents showed a decrease in empathy during residency. The studies pointed to the clinical practice phase of training and the distress produced by aspects of the "hidden," "formal," and "informal" curricula as main reasons for empathy decline.

Conclusions
The results of the reviewed studies, especially those with longitudinal data, suggest that empathy decline during medical school and residency compromises striving toward professionalism and may threaten health care quality. Theory-based investigations of the factors that contribute to empathy decline among trainees and improvement of the validity of self-assessment methods are necessary for further research.

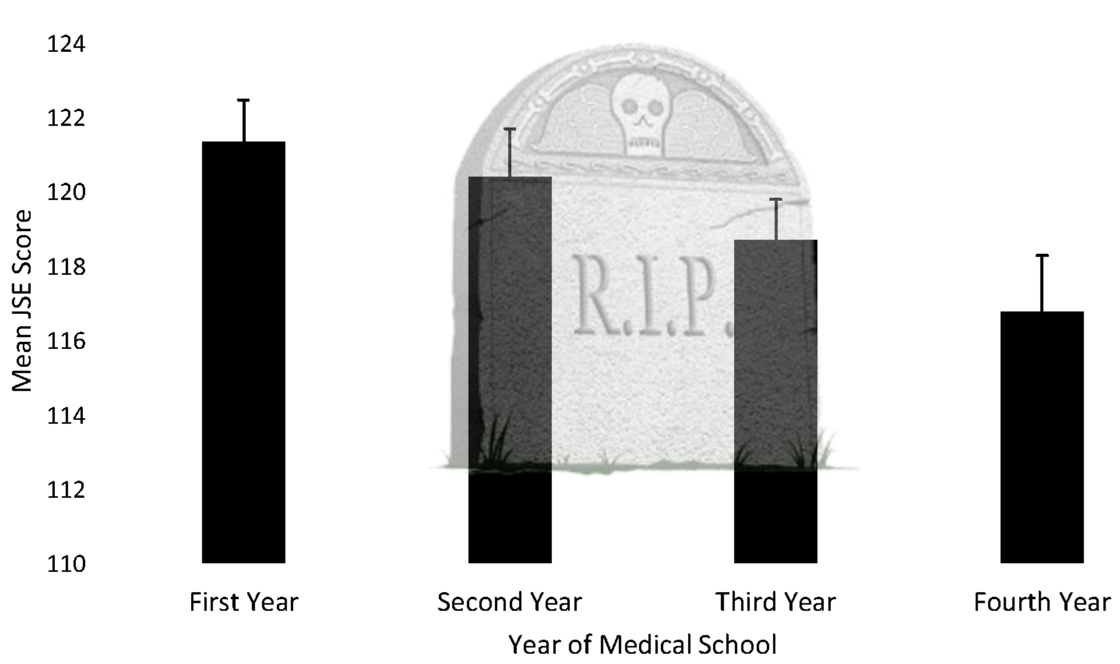
La empatía disminuye significativamente durante el curso de la escuela de medicina y la residencia.

Neumann, M y cols. (2011). Empathy decline and its reasons: a systematic review of studies with medical students and residents. *Academic medicine : journal of the Association of American Medical Colleges*, *86*(8), 996–1009.

¿Cuándo muere la Compasión?



Mirani, S.H., Shaikh, N.A., & Tahir, A. (2019). Assessment of Clinical Empathy Among Medical Students Using the Jefferson Scale of Empathy-Student Version. Cureus, 11.



Dinoff, A., Lynch, S., Hameed, A.S. *et al.* When Did the Empathy Die?. *Med.Sci.Educ.* **33**, 489–497 (2023)..

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Sticks and stones: investigating rude, dismissive and aggressive communication between doctors

Authors: Victoria Bradley,[A] Samuel Liddle,[B] Robert Shaw,[C] Emily Savage,[D] Roberta Rabbitts,[E] Corinne Trim,[F] Tunji A Lasoye[G] and Benjamin C Whitelaw[H]

ABSTRACT

Destructive communication is a problem within the NHS; however previous research has focused on bullying. Rude, dismissive and aggressive (RDA) communication between doctors is a more widespread problem and underinvestigated. We conducted a mixed method study combining a survey and focus groups to describe the extent of RDA communication between doctors, its context and subsequent impact. In total, 606 doctors were surveyed across three teaching hospitals in England. Two structured focus groups were held with doctors at one teaching hospital. 31% of doctors described being subject to RDA communication multiple times per week or more often, with junior and registrar doctors affected twice as often as consultants. Rudeness was more commonly experienced from specific specialties: radiology, general surgery, neurosurgery and cardiology. 40% of respondents described that RDA moderately or severely affected their working day. The context for RDA communication was described in five themes: workload, lack of support, patient safety, hierarchy and culture. Impact of RDA communication was described as personal, including emotional distress and substance abuse, and professional, including demotivation. RDA communication between doctors is a widespread and damaging behaviour, occurring in contexts common in healthcare. Recognition of the impact on doctors and potentially patients is key to change.

KEYWORDS: Medical education, rudeness, communication, incivility

Introduction

Destructive or negative workplace communication is recognised to be a problem both in the NHS and other organisations[1–4] and has attracted concern following recent care scandals such as Mid Staffordshire and Morecombe Bay.[5,6]

Negative workplace behaviours encompass a broad spectrum and most of the research on negative communication between doctors has analysed bullying or undermining as a discrete subset.[7–10] However, relatively little work has been done to describe more widespread rude, dismissive and aggressive (RDA) communication between doctors that can also be defined as workplace incivility.[11] RDA communication is distinct from bullying which is a more persistent and power-based form of abuse most commonly occurring within a department.[2,12]

Doctors who are recipients of bullying and negative communication have increased levels of stress and depression, and an increased desire to leave medicine.[9] There is increasing recognition that this kind of adverse staff interaction leads to worse patient outcomes and can represent a patient safety threat.[13–15]

In order to find out the scale of RDA communication in hospitals, and the impact it has on doctors, we conducted a mixed methods study at three teaching hospitals. The study involved surveying doctors to report their experiences of negative communication and conducting focus groups.

Methods

Comunicación Ruda (grosera), **Despectiva y Agresiva** (**RDA**).

entre los médicos que también puede ser definido como incivilidad en el lugar de trabajo.

Clinical Medicine 2015 Vol 15, No 6: 541–5

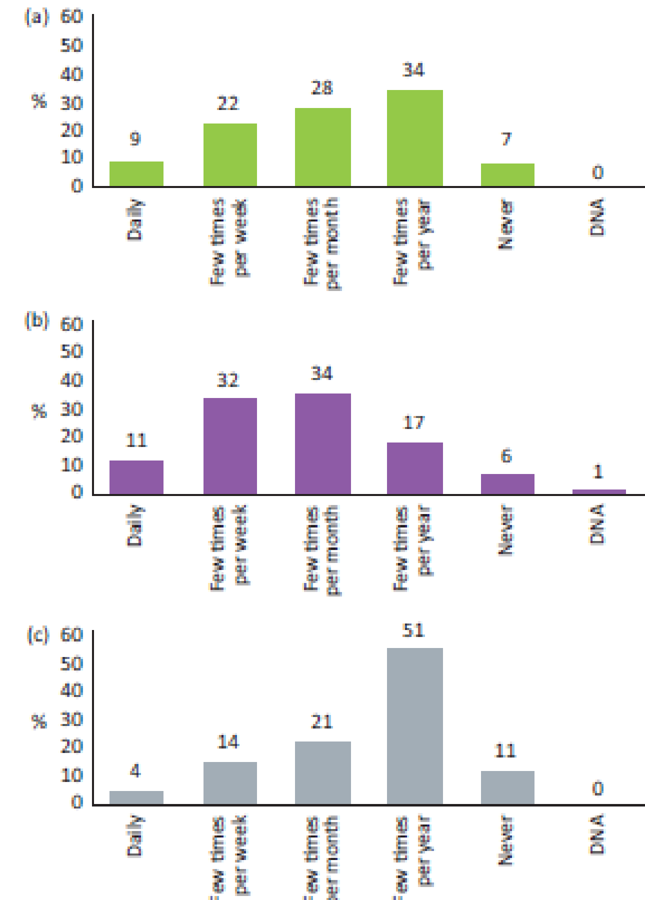


Fig 1. Combined data from three hospitals in answer to the question: How often do you personally experience rude, aggressive or dismissive communication in interactions with other members of staff? Visually represented are (a) all respondents', (b) junior doctors' and (c) consultants' answers expressed as a percentage. DNA = did not answer.

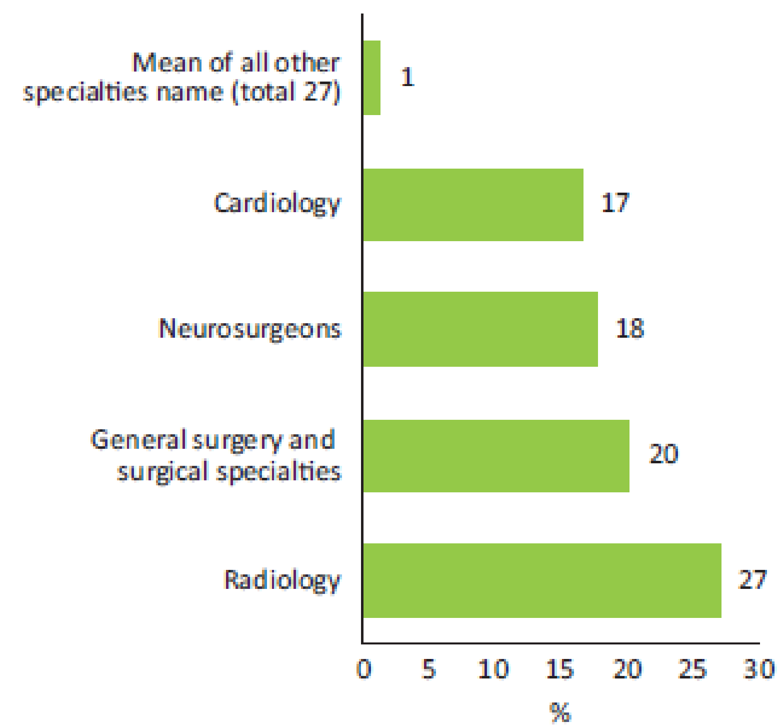


Fig 2. Combined data from three hospitals in answer to the question: In your experience have you noticed any particular departments and/ or types of staff who are more likely to be rude or dismissive to you or colleagues? Visually represented are all respondents' answers expressed as a percentage.

31% de los médicos reportaron sufrir comunicación RDA sobre una base diaria o semanal

Clinical Medicine 2015 Vol 15, No 6: 541–5

(a) % 60 50 40 30 20 10 0

Daily	Few times per week	Few times per month	Few times per year	Never	DNA
9	22	28	34	7	0

(b) % 60 50 40 30 20 10 0

Daily	Few times per week	Few times per month
11	32	34

(c) % 60 50 40 30 20 10 0

Daily	Few times per week	Few times per month	Few times per year	Never	DNA
4	14	21		11	0

Fig 1. Combined data from three hospitals in answer to the question: How often do you personally experience rude, aggressive or dismissive communication in interactions with other members of staff? Visually represented are (a) all respondents', (b) junior doctors' and (c) consultants' answers expressed as a percentage. DNA = did not answer.

	%
Mean of all other specialties name (total 27)	1
Cardiology	17
Neurosurgeons	18
	20
	27

20 25 30

%

Los médicos junior y residentes reportaron sufrir más del doble de veces comunicación RDA que médicos calificados como "consultores"

Fig 2. Combined data from three hospitals in answer to the question: In your experience have you noticed any particular departments and/ or types of staff who are more likely to be rude or dismissive to you or colleagues? Visually represented are all respondents' answers expressed as a percentage.

Clinical Medicine 2015 Vol 15, No 6: 541–5

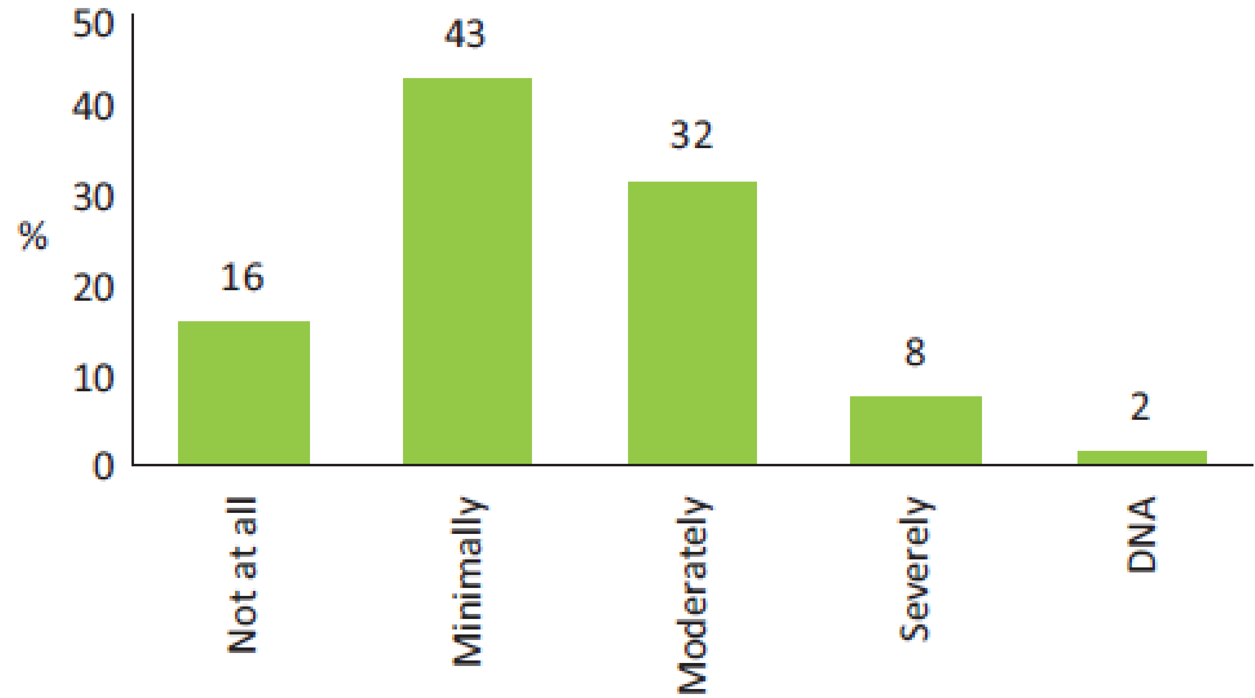


Fig 3. Combined data from three hospitals in answer to the question: How much does this behaviour affect your experience of the working day at the hospital? Visually represented are all respondents' answers expressed as a percentage. DNA = did not answer.

40 % de los médicos refirió que se ve afectado de forma moderada o severa en su trabajo del día a día!

Clinical Medicine 2015 Vol 15, No 6: 541–5

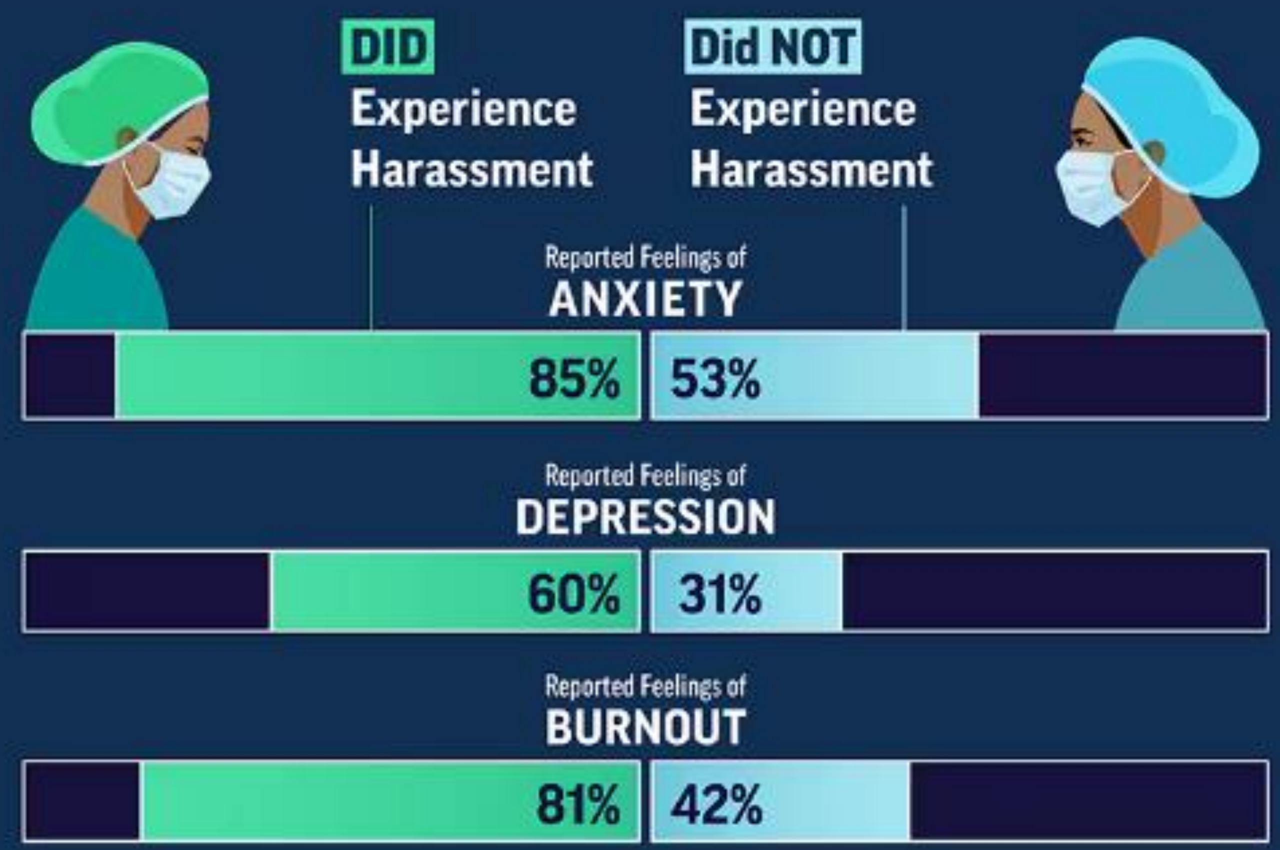
Por qué nos comunicamos en forma RDA

- Sobrecarga de trabajo
- Falta de soporte
- Amenaza a la seguridad de paciente
- Jerarquías
- **Cultura**

Clinical Medicine 2015 Vol 15, No 6: 541–5

Harassment Is Linked to Poor Health Worker Mental Health

El Acoso laboral está asociado a una pobre Salud Mental de los trabajadores de salud



CDC Vitalsigns™

Source: October 2023 *Vital Signs*

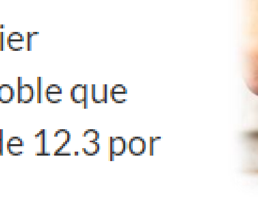
Se suicida un médico por día en EE.UU. | 15 MAY 18

Los médicos tienen la tasa más alta de suicido de todas las profesiones

A menudo tienen depresión no tratada o insuficientemente tratada u otras enfermedades mentales

210 9

Un médico se suicida en los EE. UU. Todos los días, la tasa de suicidio más alta de cualquier profesión. Y el número de suicidios de médicos -28 a 40 por cada 100,000- es más del doble que la población general, según una nueva investigación. La tasa en la población general es de 12.3 por 100,000.



> *Se suicidan más médicos que militares*

Margaret Mead (1901-1978)

Construir Cultura del Respeto

Innovations in Care Delivery

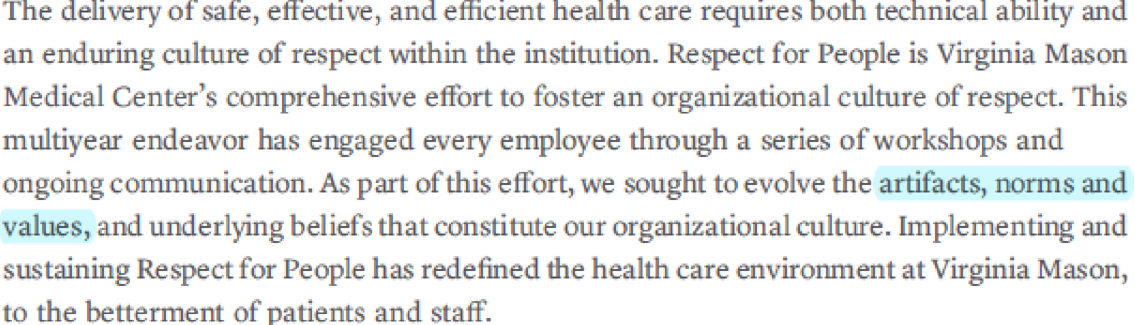
IN DEPTH

Building a Culture of Respect for People

Lynne A. Chafetz, JD, Alice M. Forsythe, MBA, Niki Kirby, MSN, RN, C. Craig Blackmore, MD, MPH, Gary S. Kaplan, MD

Vol. 1 No. 6 | November — December 2020

DOI: 10.1056/CAT.19.1110



The delivery of safe, effective, and efficient health care requires both technical ability and an enduring culture of respect within the institution. Respect for People is Virginia Mason Medical Center's comprehensive effort to foster an organizational culture of respect. This multiyear endeavor has engaged every employee through a series of workshops and ongoing communication. As part of this effort, we sought to evolve the artifacts, norms and values, and underlying beliefs that constitute our organizational culture. Implementing and sustaining Respect for People has redefined the health care environment at Virginia Mason, to the betterment of patients and staff.

NEJM Catalyst Vol. 1 No. 6 | November — December 2020

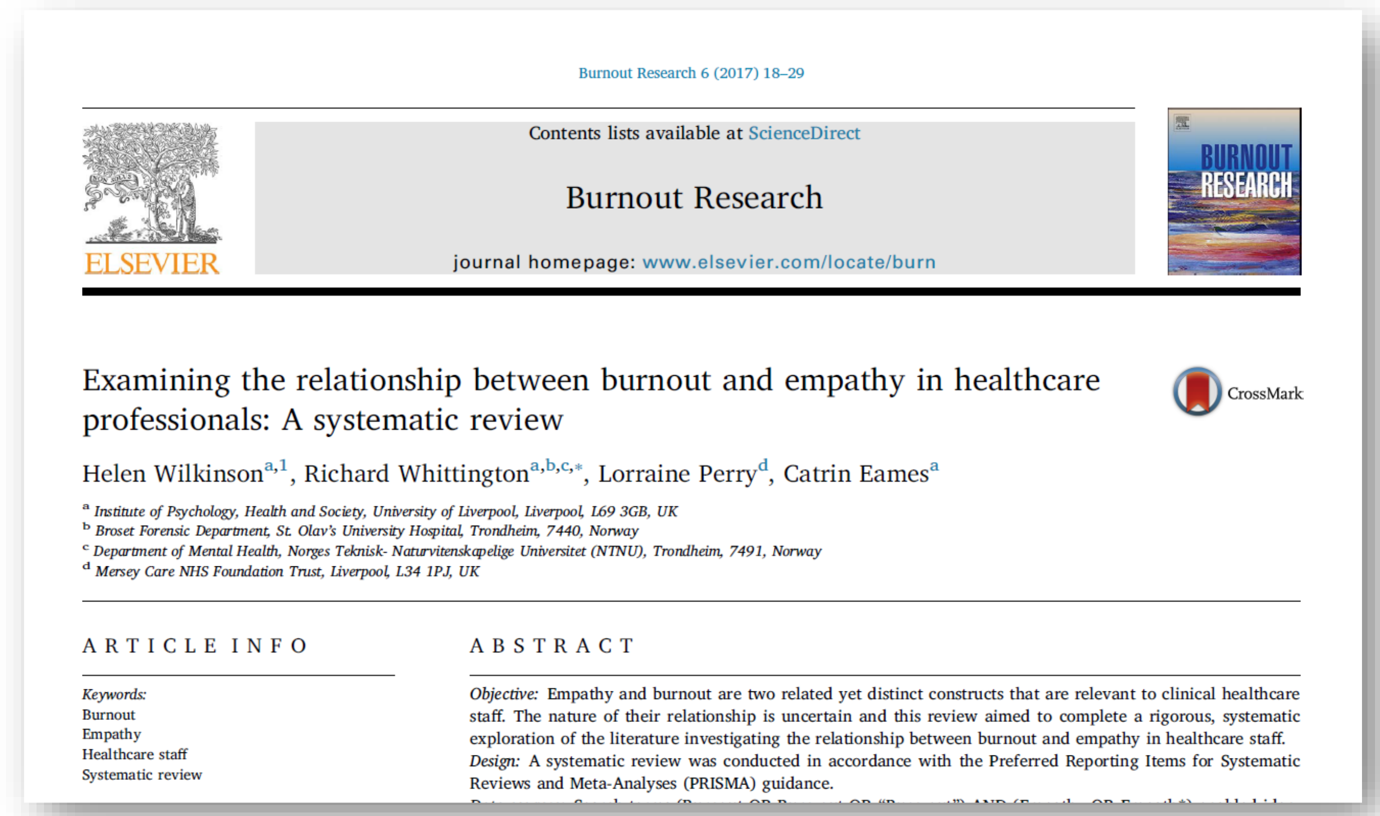
Compasión: Antídoto para el burnout

La compasión es un antídoto para el Burnout

Componentes:

- **Agotamiento emocional**
- **Despersonalización**
- Falta de realización personal

Bienestar Ocupacional


Burnout Research 6 (2017) 18–29

Contents lists available at ScienceDirect

Burnout Research

journal homepage: www.elsevier.com/locate/burn

Examining the relationship between burnout and empathy in healthcare professionals: A systematic review

Helen Wilkinson[a,1], Richard Whittington[a,b,c,*], Lorraine Perry[d], Catrin Eames[a]

[a] Institute of Psychology, Health and Society, University of Liverpool, Liverpool, L69 3GB, UK
[b] Broset Forensic Department, St. Olav's University Hospital, Trondheim, 7440, Norway
[c] Department of Mental Health, Norges Teknisk- Naturvitenskapelige Universitet (NTNU), Trondheim, 7491, Norway
[d] Mersey Care NHS Foundation Trust, Liverpool, L34 1PJ, UK

ARTICLE INFO

Keywords:
Burnout
Empathy
Healthcare staff
Systematic review

ABSTRACT

Objective: Empathy and burnout are two related yet distinct constructs that are relevant to clinical healthcare staff. The nature of their relationship is uncertain and this review aimed to complete a rigorous, systematic exploration of the literature investigating the relationship between burnout and empathy in healthcare staff.
Design: A systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance.

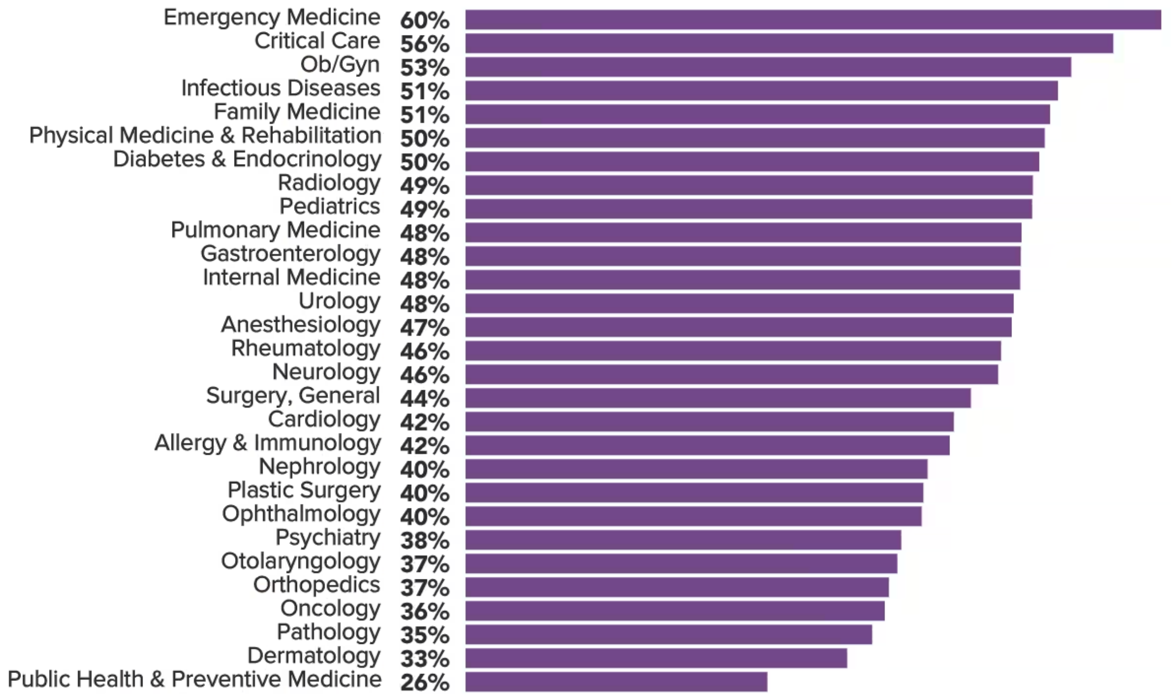
COMPASIÓN

BURNOUT

Relación inversa entre el agotamiento y la empatía entre el personal de atención médica

Wilkinson, H. Examining the relationship between burnout and empathy in healthcare professionals: A systematic review, Burnout Research. Volume 6. 2017. Pages 18-29

Bienestar Ocupacional

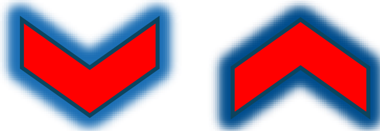


Del 2018 al 2022 se incrementó el Burnout del 42% al 47% promedio

El Burnout y la falta de compasión acoplan en un círculo vicioso

47% de los médicos experimentaron síntomas compatibles con Burnout

29% de los médicos citaron que el burnout era la mayor barrera para ser compasivos



Los profesionales más insatisfechos con su relación con sus pacientes tenían 22x riesgo de sufrir Burnout

https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664?icd=login_success_email_match_norm#1

En Colombia

La prevalencia global del síndrome de *burnout* o desgaste profesional fue de 65%. En profesionales de enfermería, fue de 63,2% y en auxiliares de enfermería, de 65,9%

Rev. Salud Pública. 23(6): 1-8, 2021.

Compasión y seguridad del paciente

Physician Burnout, Well-being, and Work Unit Safety Grades in Relationship to Reported Medical Errors

Daniel S. Tawfik, MD, MS; Jochen Profit, MD, MPH; Timothy I. Morgenthaler, MD; Daniel V. Satele, MS; Christine A. Sinsky, MD; Liselotte N. Dyrbye, MD, MHPE; Michael A. Tutty, PhD; Colin P. West, MD, PhD; and Tait D. Shanafelt, MD

Abstract

Objective: To evaluate physician burnout, well-being, and work unit safety grades in relationship to perceived major medical errors.

Participants and Methods: From August 28, 2014, to October 6, 2014, we conducted a population-based survey of US physicians in active practice regarding burnout, fatigue, suicidal ideation, work unit safety grade, and recent medical errors. Multivariate logistic regression and mixed-effects hierarchical models evaluated the associations among burnout, well-being measures, work unit safety grades, and medical errors.

Results: Of 6695 responding physicians in active practice, 6586 provided information on the areas of interest: 3574 (54.3%) reported symptoms of burnout, 2163 (32.8%) reported excessive fatigue, and 427 (6.5%) reported recent suicidal ideation, with 255 of 6563 (3.9%) reporting a poor or failing patient safety grade in their primary work area and 691 of 6586 (10.5%) reporting a major medical error in the prior 3 months. Physicians reporting errors were more likely to have symptoms of burnout (77.6% vs 51.5%; *P*<.001), fatigue (46.6% vs 31.2%; *P*<.001), and recent suicidal ideation (12.7% vs 5.8%; *P*<.001). In multivariate modeling, perceived errors were independently more likely to be reported by physicians with burnout (odds ratio [OR], 2.22; 95% CI, 1.79-2.76) or fatigue (OR, 1.38; 95% CI, 1.15-1.65) and those with incrementally worse work unit safety grades (OR, 1.70; 95% CI, 1.36-2.12; OR, 1.92; 95% CI, 1.48-2.49; OR, 3.12; 95% CI, 2.13-4.58; and OR, 4.37; 95% CI, 2.06-9.28 for grades of B, C, D, and F, respectively), adjusted for demographic and clinical characteristics.

Conclusion: In this large national study, physician burnout, fatigue, and work unit safety grades were independently associated with major medical errors. Interventions to reduce rates of medical errors must address both physician well-being and work unit safety.

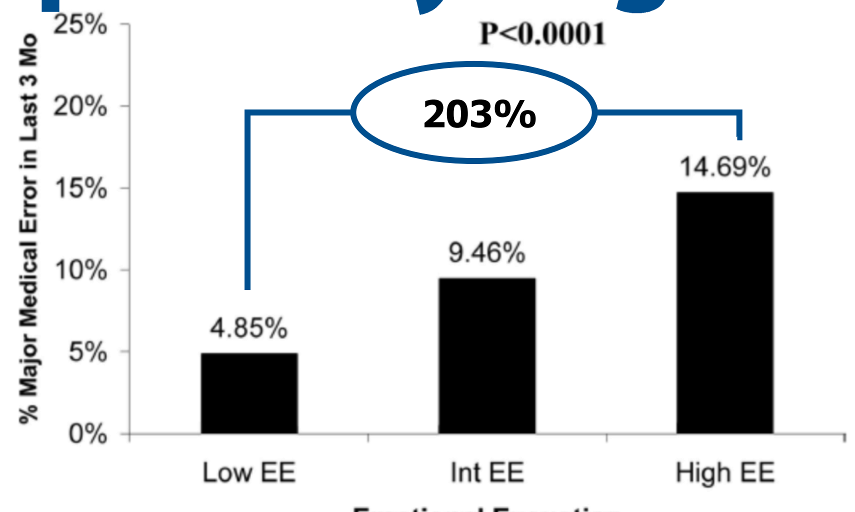
© 2018 Mayo Foundation for Medical Education and Research ■ Mayo Clin Proc. 2018;93(11):1571-1580

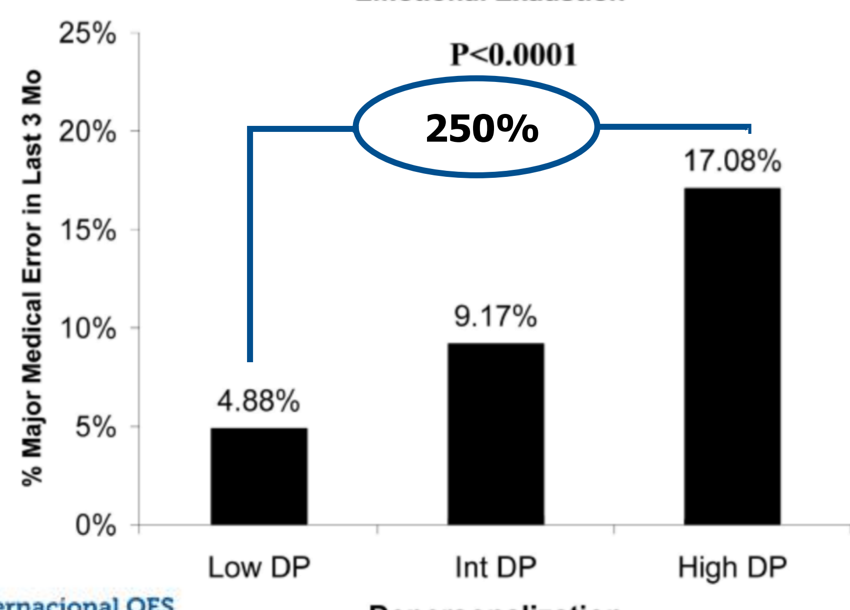
- Los médicos “quemados” tienen dos veces más probabilidades de cometer errores importantes.

Mayo Clin Proc. 2018;93(11):1571-1580

Compasión y seguridad del paciente

% de Cirujanos que respondieron preocupados por haber cometido un error grave en los últimos 3 meses





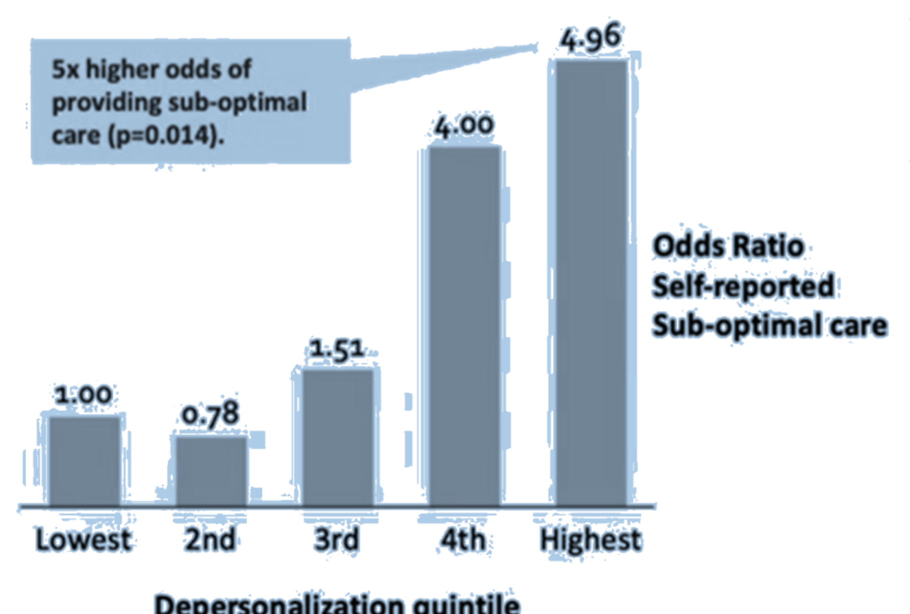
A 7905 miembros del American College of Surgeons se les envió una encuesta transversal anónima.

La encuesta incluía la autoevaluación de los principales **errores médicos**, una herramienta de detección de depresión validada y evaluaciones estandarizadas de agotamiento y calidad de vida (QOL).

"¿Le preocupa haber cometido algún error médico importante en los últimos 3 meses?"

Shanafelt, Tait D. y cols. (2002). Burnout and Self-Reported Patient Care in an Internal Medicine Residency Program. Ann Intern Med. Vol. 136, Issue 5

Compasión y seguridad del paciente



Falta de compasión = Mayor mortalidad en UCI

- Las unidades con **alto agotamiento emocional** tenían índices de mortalidad estandarizados más altos
- El **desgaste emocional** asociado con **mayor mortalidad en UCI**
  - 1435 médicos y enfermeros de 54 UCIs en 48 hospitales
  - Análisis de regresión demográfico multivariable (edad, entrenamiento) y factores organizacionales (carga de trabajo, experiencia de equipo)
  - El desgaste emocional tuvo asociación independiente con mayor ratio de mortalidad estandarizado (p=0,03)

West, C. y cols. (2009). Association of resident fatigue and distress and perceived medical errors. JAMA, 302. 12. 1294-1300.
Welp, A y cols (2015). Emotional exhaustion and workload predict clinician-rated and objective patient safety. Frontiers in Psychology. Vol 5.

Errores graves reportados y:

Despersonalización

OR 1.09; IC95% 1,05-1,12; p<0,001

Agotamiento Emocional

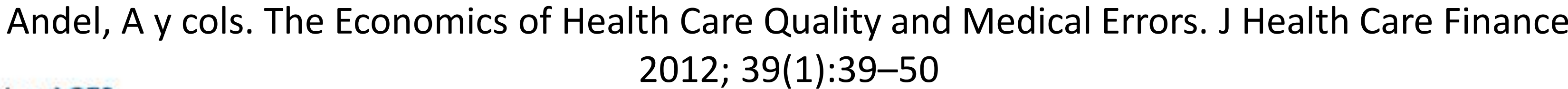
OR 1.06; IC95% 1.04-1.08; p<0,001

West, C. y cols. (2009). Association of resident fatigue and distress and perceived medical errors. JAMA, 302. 12. 1294-1300.

El costo de los errores

La economía de los errores médicos

Costo de estimado de los Errores en EEUU **$19.5 mil millones**.



Andel, A y cols. The Economics of Health Care Quality and Medical Errors. J Health Care Finance 2012; 39(1):39–50

El costo de los errores

133 Personas en situación de calle con un promedio de visitar de 7 veces al año

A Time until first repeat visit

Proportion returning

1·0
0·8
0·6
0·4
0·2
0

Conventional care

Modified care

33% menos visitas al Dpto de Emergencias

B Time until first repeat visit for patients who return only after at least a month

1·0
0·8
0·6
0·4
0·2
0

0 2 4 6 8 10

Time (months)

Redelmeier, D.A. y cols. (1995). A randomised trial of compassionate care for the homeless in an emergency department. The Lancet. Vol. 345, Issue 8958. Pgs 1131-1134

El costo de los errores

ORIGINAL RESEARCH

Patient-Centered Care is Associated with Decreased Health Care Utilization

Klea D. Bertakis, MD, MPH, and Rahman Azari, PhD

Purpose: This article uses an interactional analysis instrument to characterize patient-centered care in the primary care setting and to examine its relationship with health care utilization.

Methods: Five hundred nine new adult patients were randomized to care by family physicians and general internists. An adaption of the Davis Observation Code was used to measure a patient-centered practice style. The main outcome measures were their use of medical services and related charges monitored over 1 year.

Results: Controlling for patient sex, age, education, income, self-reported health status, and health risk behaviors (obesity, alcohol abuse, and smoking), a higher average amount of patient-centered care recorded in visits throughout the 1-year study period was related to a significantly decreased annual number of visits for specialty care ($P = .0209$), less frequent hospitalizations ($P = .0033$), and fewer laboratory and diagnostic tests ($P = .0027$). Total medical charges for the 1-year study were also significantly reduced ($P = .0002$), as were charges for specialty care clinic visits ($P = .0005$), for all patients who had a greater average amount of patient-centered visits during that same time period. For female patients, the regression equation predicted 15.47% of the variation in total annual medical charges compared with male patients, for whom 31.18% of the variation was explained by the average percent of patient-centered care, controlling for sociodemographic variables, health status, and health risk behaviors.

Conclusions: Patient-centered care was associated with decreased utilization of health care services and lower total annual charges. Reduced annual medical care charges may be an important outcome of medical visits that are patient-centered. (J Am Board Fam Med 2011;24:229–239.)

Keywords: Charges and Fees, Patient-Centered Care, Utilization

- ***Menos estudios diagnósticos***
- ***Menos derivaciones a especialistas***
- ***Menos internaciones***
- ***Reducción en un 51,4% de los costos promedio***

Bertakis, Klea D. (2011) Patient-Centered Care is Associated with Decreased Health Care Utilization. The Journal of the American Board of Family Medicine. 24 (3) 229-239

Rol del liderazgo

Journal of Healthcare Leadership

Dovepress

open access to scientific and medical research

REVIEW

Developing compassionate leadership in health care: an integrative review

Journal of Healthcare Leadership 2016:8 1–10

Rol del liderazgo

Harvard Business Review

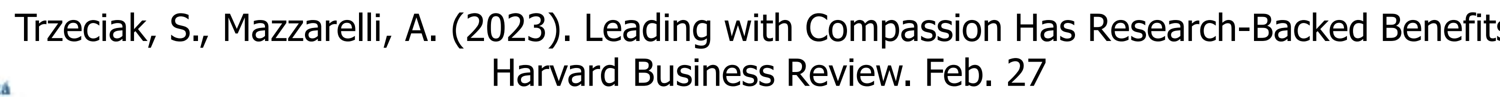
Health And Behavioral Science | Leading with Compassion Has Research-Backed Benefits

Health And Behavioral Science

Leading with Compassion Has Research-Backed Benefits

by Stephen Trzeciak, Anthony Mazzarelli, and Emma Seppälä

February 27, 2023



Trzeciak, S., Mazzarelli, A. (2023). Leading with Compassion Has Research-Backed Benefits. Harvard Business Review. Feb. 27

Desempeño Organizacional

Liderazgo compasivo

- **La compasión es un componente vital del liderazgo eficaz**.
  - Las respuestas son más positivas a los líderes que muestran compasión.
  - La creación de una cultura compasiva se ha relacionado con un menor agotamiento emocional de los trabajadores (uno de los elementos del burnout), así como con un menor ausentismo laboral.
- **Para una mejor retención de talentos y desempeño organizacional**
  - los gerentes deben reconocer que la compasión no es simplemente algo "agradable de tener".
  - Es una habilidad basada en evidencia que es integral para liderar de manera efectiva y mantener unidos a los equipos.
  - La compasión no solo pertenece al arte del liderazgo; Una investigación sólida muestra que la compasión también pertenece a la ciencia del liderazgo.

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Compasión y sus beneficios

Cultura de compasión beneficia a pacientes como a profesionales

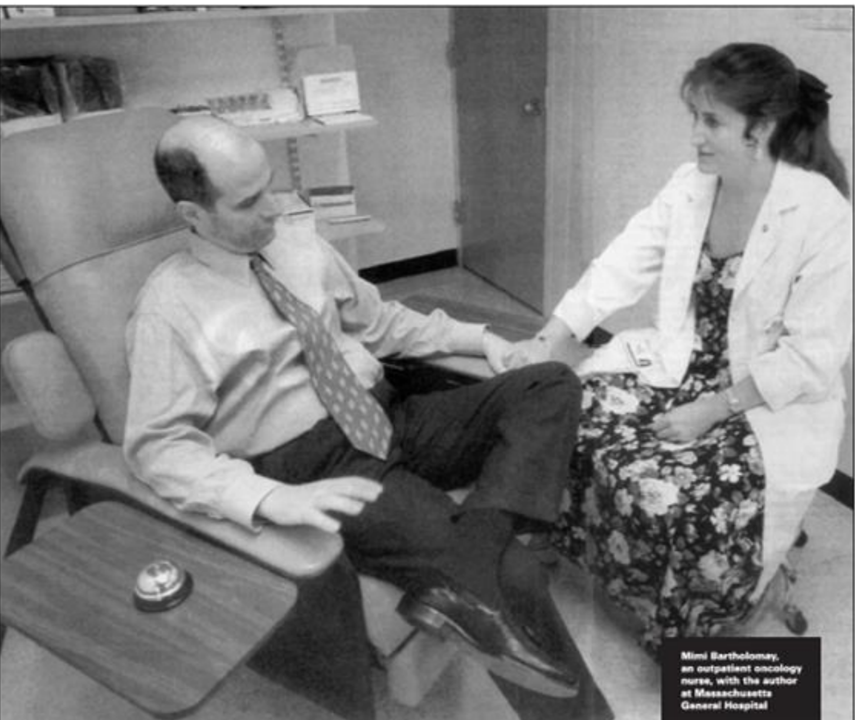
Pacientes	Profesionales
• Mejor calidad de vida	• Mejor experiencia de los profesionales
• Reducción de visitas a los departamentos de emergencia	• Mayor trabajo en equipo
	• Reducción del ausentismo
	• Reducción del desgaste emocional

Barsade, S. y cols (2007). Why Does Affect Matter in Organizations?. Academy of Management Perspectives. 21. 10.5465/AMP.2007.24286163.

Compasión en la práctica

The Boston Globe Magazine

July 16, 1995



Mimi Bartholomay, an outpatient oncology nurse, with the author at Massachusetts General Hospital

A PATIENT'S STORY

By Kenneth B. Schwartz

During September and October of 1994, I made several visits to the outpatient clinic of a Boston teaching hospital for treatment of a persistent cough, low-grade fever, malaise, and weakness. The nurse practitioner diagnosed me as having atypical pneumonia and prescribed an antibiotic. Despite continued abnormal blood counts, she assured me that I had a post-viral infection and didn't need an appointment with my physician until mid-November, if then. By mid-October, I felt so bad that I decided I could not wait until November 11 to be seen. Disappointed with the inaccessibility of my physician, I decided to seek care elsewhere, with the hope that a new doctor might be more responsive.

My brother, a physician who had trained at Massachusetts General Hospital, arranged for an immediate appointment with Dr. Jose Vega, an experienced internist affiliated with MGH. Dr. Vega spent an hour with me and ordered tests, including a chest X-ray. He called within hours to say he was concerned by the results, which showed a "mass" in my right lung, and he ordered a computerized tomography scan for more detail. I remember leaving my office for home, saying quickly to my secretary, Sharyn Wallace, "I think I may have a serious medical problem." Indeed, the CT scan confirmed abnormal developments in my right lung and chest nodes.

The next day, Dr. Vega, assuring me that he would continue to be available to me whenever I needed him, referred me to Dr. Thomas Lynch, a 34-year-old MGH oncologist specializing in lung cancer. Dr. Lynch, who seems driven by the ferocity of the disease he sees every day, told me that I had lung cancer, lymphoma, or some rare lung infection, although it was most likely lung cancer.

My family and I were terrified. For the next several months, my blood pressure, which used to be a normal 124 over 78, went to 150 over 100, and my heart rate, which used to be a low 48, ran around 100.

Within 72 hours of seeing Dr. Lynch, I was scheduled for a bronchoscopy and a mediastinoscopy, exploratory surgical procedures to confirm whether I indeed had lung cancer. Until this point, I had thought that I was at low risk for cancer: I was relatively young, I did not smoke (although I had smoked about a cigarette a day in college and in law school and for several years after that), I worked out every day, and I avoided fatty foods.

theschwartzcenter.org/programs/schwartz-rounds/

The Schwartz Center is committed to supporting healthcare professionals with additional resources on caring for their patients, themselves and their teams during challenging times. Please find mental health and wellness resources here.

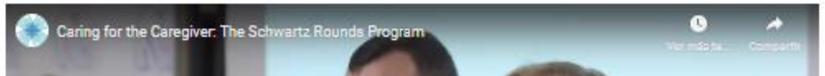
the schwartz center
FOR COMPASSIONATE HEALTHCARE

MEDIA CENTER CONTACT US MEMBER SITE DONATE

ABOUT JOIN PROGRAMS RESOURCES EVENTS COMMUNITY

SCHWARTZ ROUNDS AND MEMBERSHIP

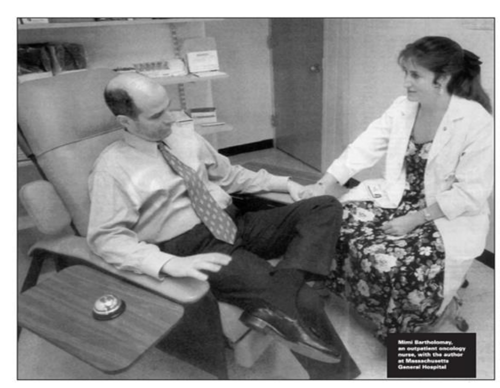
"Schwartz Rounds are a place where people who don't usually talk about the heart of the work are willing to share their vulnerability, to question themselves. The program provides an opportunity for dialogue that doesn't happen anywhere else in the hospital."
– Participant



Compasión en la práctica

“He recibido una extraordinaria variedad de respuestas humanas a mi difícil y humana situación. **Estos actos de bondad**, el simple toque humano de mis cuidadores, **han hecho soportable lo insoportable**.”

Kenneth B. Schwartz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¡Muchas Gracias!

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@palemos68

Estrategias para la participación de pacientes y sus familias en el cuidado

Carolina Mejía Posada, Gerente de Mercadeo y Experiencia del Paciente
Clínica Imbanaco

33° Foro Internacional OES
en alianza con la Fundación Santa Fe de Bogotá
y Planetree Internacional

Clínica Imbanaco

Vocación de Servicio

Cali, Colombia
Sede Principal

364
camas

269
camas de hospitalización

117.000 m2
ambulatorias

13 camas
UCI Pediátrica

47 camas
UCI Adultos

20
quirófanos

17 camas
de trasplante de médula ósea

9 camas
Cuidado Especial Obstétrico

2 salas
de cirugía Gineco Obstetricia

2 salas
procedimientos de angiografía

2 habitaciones
de Yodoterapia

24 camas
UCI Recién Nacidos

11 UCI
Cardiovascular

2 aceleradores lineales (Varian) y **1 unidad** Braquiterapia

Bogotá

Medellín

Cali

866 médicos

2.964 colaboradores

Camino a la Certificación Planetree

2020 Marzo
Creación del CEP

2020 Agosto
Afiliación a Planetree

2021 Enero
Creación del Comité de Experiencia de las Personas

2021 Noviembre
Visita de Diagnóstico

2023
Preparación

2023 Octubre
Visita de terreno

2024 Enero
Certificación ORO

QUALITY | PARTNERSHIP | COMPASSION
EXCELLENCE IN PERSON CENTERED CARE

EXCELLENCE IN
PERSON
CENTERED
CARE

1 Crear estructuras organizacionales que promuevan el compromiso

Cómo está organizada la entidad y cómo funciona.

2 Conectar valores, estratégias y acciones

Conexión entre lo que hacemos y por qué lo hacemos.

3 Implementar prácticas que promuevan la participación

Reorientar la entrega de atención, facilitando que los pacientes se conviertan de receptores pasivos a participantes activos.

4 Saber lo que importa

Cuidado personalizado. Determinar objetivos en conjunto.

5 Usar la evidencia para impulsar la mejora

La capacidad de la organización para generar cambios medibles.

QUALITY | PARTNERSHIP | COMPASSION |

Bienestar emocional

Cultura

Propósito

Integración del cuidado

Confort

Relación médico-paciente

Biopsicosocial

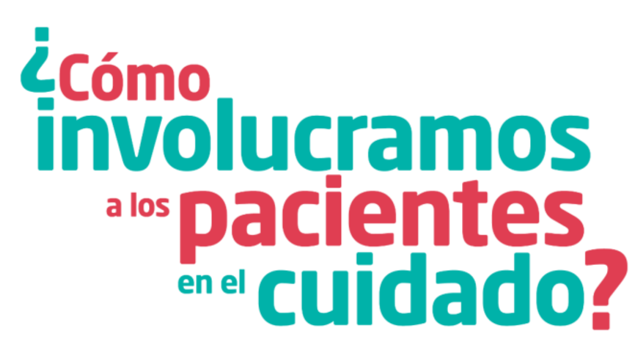
Calidad de la Atención

Colaboradores y Médicos

Pacientes y Familia

Identificación de necesidades

Voz


¿Cómo involucramos a los pacientes en el cuidado?
Clínica Imbanaco
Vocación de Servicio

Cómo involucramos a los pacientes y sus familias en su cuidado

Carolina Mejía Posada, Gerente de Mercadeo y Experiencia del Paciente
Clínica Imbanaco

33° Foro Internacional OES
en alianza con la **Fundación Santa Fe de Bogotá**
y **Planetree Internacional**

Cambio
de turno
545
Hill-Rom

Guía
Hospitalaria

Centro de
Experiencia
del Paciente

Educación
a pacientes
y sus familias
El autocuidado es importante cuando permaneces en nuestros servicios. Por eso como paciente, acompañante o visitante, tienes un papel fundamental. Contamos con tu participación activa y vigilante para que juntos podamos ofrecer la mejor atención.
Te invitamos a leer con detenimiento esta práctica guía de recomendaciones y señales de alerta que nos permitan ofrecer una atención más segura.
SÚMATE CONTIGO ES MÁS SEGURO
Porque CONTIGO evitaremos los riesgos de caídas en pacientes.
Asegúrate de mantener las barandas de la camilla arriba.
Revisa que en el piso no hayan objetos o esté mojado.
Sostén al paciente en todo momento.
Avisa al personal de salud que el paciente necesita levantarse o ir al baño.
Porque contigo supervisaremos mejor los efectos secundarios de la medicación de tu paciente.
Porque contigo estaremos atentos a los signos que alertan que tu paciente está en riesgo, para dar aviso rápido.
Hay señales de alerta específicas de acuerdo al tipo de paciente, por eso es importante distinguirlas y tenerlas presente.
En neonatos (recién nacidos)
Avisa rápido a nuestro personal si notas alguno de estos signos en tu bebé:
No se mueve ni responde al estímulo.
Vomita.
Está desmadejado.
No recibe el seno por más de 3 horas.
Llanto que no calma.
Palidez.
Frialdad.
En niños y pacientes pediátricos
Avisa rápido a nuestro personal si notas alguno de estos signos:
Llanto que no calma.
Somnolencia.
Palidez y frialdad.
Dolor incontrolable.

Educación
al Personal

Riesgo Alergias
Riesgo Caída
Decisiones
Compartidas

SÚMATE

¡Demos voz a nuestros pacientes!

Semana de la Seguridad del Paciente

23

SÚPER PLUS

nombre

Contigo sumamos para el cuidado de tu paciente, eres un héroe de su seguridad y su vida.

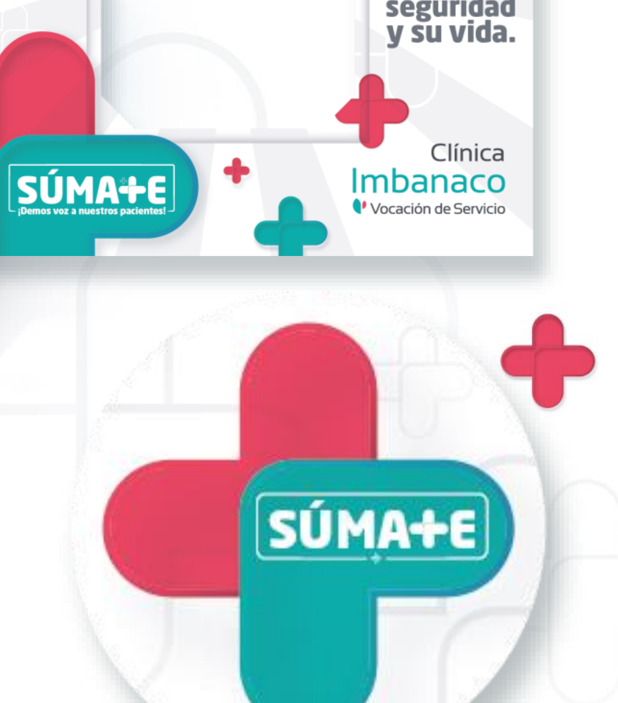
2023

SÚMATE

¡Demos voz a nuestros pacientes!

Clínica Imbanaco

Vocación de Servicio



Hoy es
Domingo
Lunes
Martes
Miércoles
Jueves
Viernes
Sábado
Fecha
Meta clínica diaria:
Movilidad
Medicación:
Riesgos:
Alergias:
Soy tú paciente, CONÓCEME
Prefiero que me llamen:
Mis cosas favoritas:
Clínica Imbanaco
Tableros de Metas Diarias

Historia
Clínica en
tiempo real

Escuela de Cuidadores
Luz

quirónsalud
Portal del paciente
Acceso Usuarios de Mi Quirónsalud
E-mail:
Ej.: nombre@empresa.com
Contraseña:
¿Has olvidado tu contraseña?
Entrar
No eres usuario. Regístrate ahora
Bienvenido a Mi Quirónsalud
Para poder acceder a Mi Quirónsalud y a los servicios online es necesario que se identifique mediante su E-mail y contraseña
Solicitud y consulta de cita online.
Solicitud de certificados de asistencia online.
Consulta de resultados de pruebas diagnósticas.
Consejos de salud.
Transformación
Digital

¿Cómo lo medimos?

Carolina Mejía Posada, Gerente de Mercadeo y Experiencia del Paciente
Clínica Imbanaco

Consolidado Institucional RGC - Planetree de Ítem 2024

100%
90%
80%
70%
60%
50%
20%
10%
0%

Ítem	Resultado
¿El personal que recibe el turno se presenta con el paciente asignado?	98%
El personal que recibe turno, ¿le indica al paciente y/o acompañante cuales son las metas de cuidado del día?	76%
¿Se realiza actualización del tablero con nueva información de las metas?	80%
¿En la ronda de enfermería, el personal contesta las preguntas, aclara las dudas e involucra al paciente y/o acompañante?	100%
¿Conoce usted las metas de cuidado del día?	82%
¿Le han preguntado si tiene dolor y sus necesidades personales?	97%

Cómo medimos el NPS

Consolidado Institucional RGC - Planetree de Ítem 2024

Ítem	NPS
Trámite autorizaciones	84.33
Información para la preparación de la cirugía	89.63
Recepción administrativa	89.55
Esperar hasta entrar al quirófano	70.37
Trato de enfermería	94.07
Trato del cirujano	99.26
Trato del anestesista	96.30
Información clínica y recomendaciones al alta	94.81
Mobiliario e instalaciones	94.81
Limpieza	98.52
Privacidad y respeto	92.59
Información sobre Derechos y Deberes	93.23
Confianza respecto a la competencia y conocimientos del profesional	97.01

Eje: 0%, 20%, 40%, 60%, 80% (meta), 100%

Carolina
Mejía

MUCHAS
GRACIAS

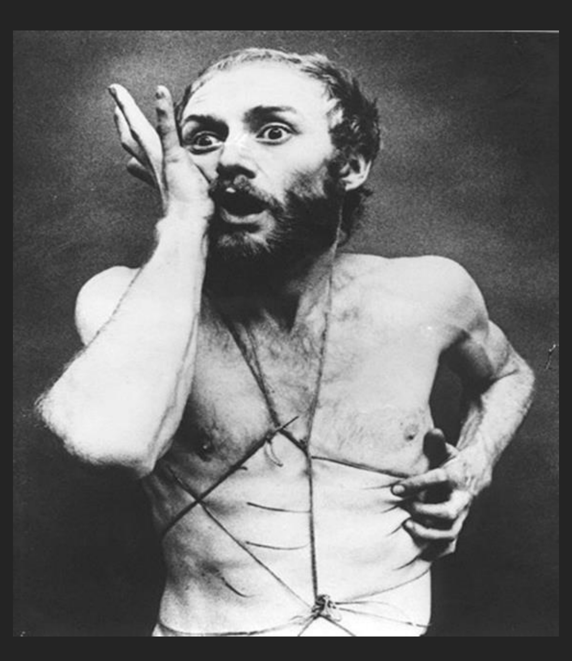
Contacto:
carolina.mejia@quironsalud.com

Estrategias para la participación del paciente y su familia.

Pinares Mind & Health.

Somos Pinares Mind & Health

Un lugar único, especializado en la atención de la salud mental; donde la estética, la naturaleza y la calidad, hacen una mezcla sanadora para nuestros pacientes.



¿Pacientes con trastornos en salud mental puede participar de su proceso terapéutico?

¡¡¡CLARO QUE SÍ!!!

3 momentos…

1. Ingreso

- Asesoría presencial del paciente y su familia
- Identificación de necesidades

3 momentos…

2. Hospitalización

- Reunión entre médicos tratantes y familia de paciente
- Rondas de satisfacción del paciente
- Case manager
- Elección de su alimentación
- Elección de personal que lo atiende*
- Terapias ocupacionales
- Visitas (mascotas)

3 momentos…

3. Egreso

- Encuestas de satisfacción del paciente
- Encuestas de **experiencia** del paciente
- Encuesta de satisfacción de la familia