



Patient safety

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Slides



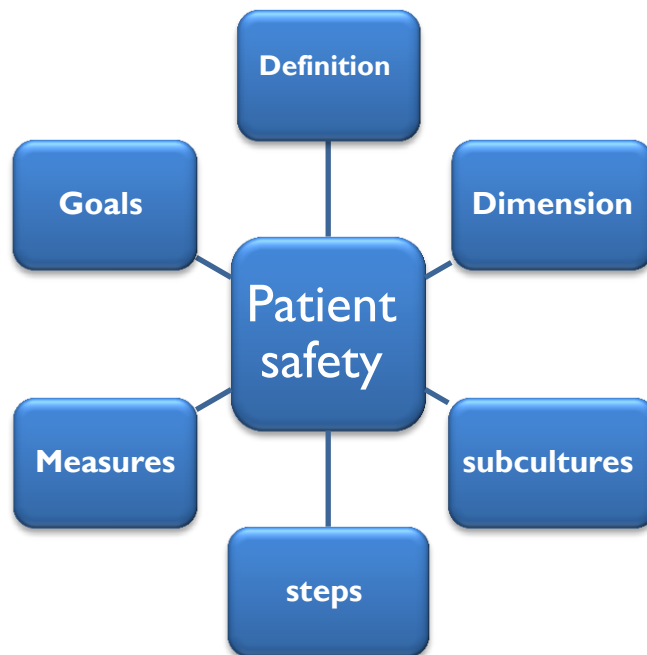
Important



Explanation

Objectives and Mind Map

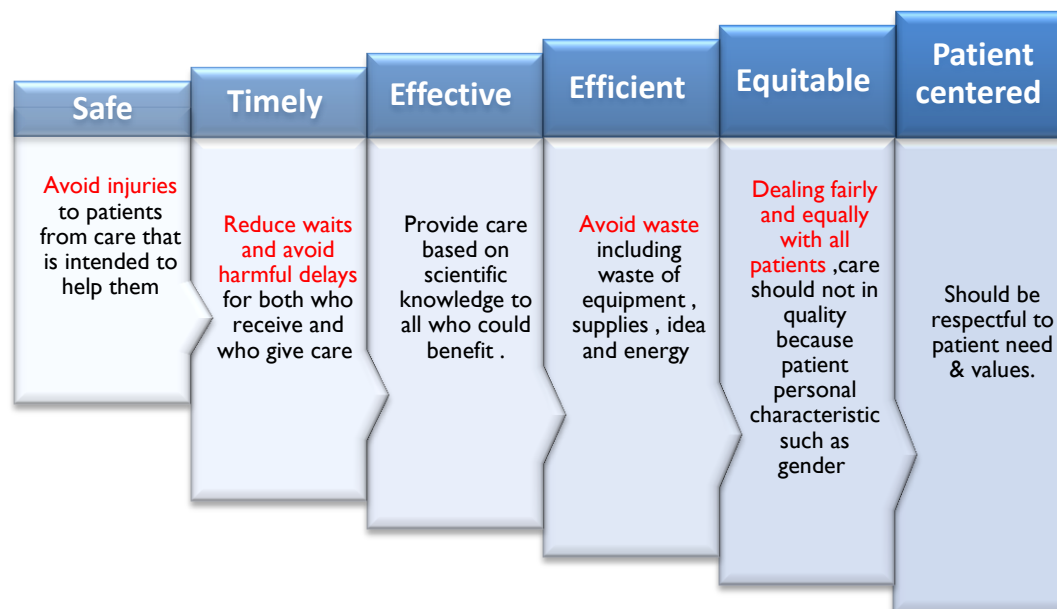
Mind Map:



Definition of patient safety

- The **IOM Institute of medicine** defines patient safety as “**the prevention of harm to patients**”.
- The **Canadian Patient Safety** defines patient safety as “**the reduction and mitigation of unsafe acts within the healthcare system**, as well as through the use of best practices shown to lead to optimal patient outcomes
- The **World Health Organization’s (WHO)** defines patient safety as , “**the reduction of risk of unnecessary harm** associated with healthcare to an acceptable minimum.”

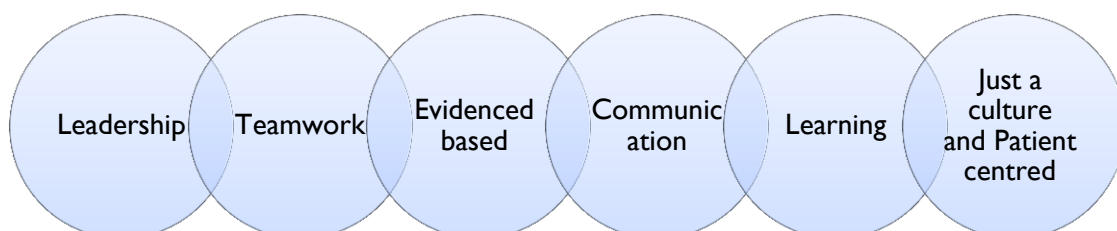
Patient safety Dimension:



Culture of patient safety (Definition from the Health and Safety Commission)

The safety culture of an organization is the product of **individual and group** values, attitudes, perceptions,, and patterns of behavior that determine the commitment to, and the style and proficiency of an organization’s health and safety management.

Safety culture divided into seven subcultures and defined as:



Seven steps for patient safety culture:

- **1) Build a safety culture:** Create a culture that is open and fair
- **2) Lead and support your staff:** Establish a clear and be focus on patient safety throughout your organization
- **3) Integrate your risk management activity:** Develop systems and processes to manage your risks and identify and assess things that could go wrong
- **4) Promote reporting:** Ensure your staff can easily report incidents locally and nationally
- **5) Involve and communicate with patients and the public:** Develop ways to communicate openly with and listen to patients
- **6) Learn and share safety lessons:** Encourage staff to use root cause analysis to learn how and why incidents happen
- **7) Implement solutions to prevent harm:** Embed lessons through changes to practice, processes or systems

Approaching patient safety within an Organization requires a review in six key areas:

1. Safe Structure	Involves reviewing whether the facilities are designed to promote safety ,i.e. right supplies.
2. Safe Environment	Include an assessment of lighting, temperature and noise level.
3. Safe Equipment/technologies	— Include an examination of labels, instruction and safety features when using various devices.
4. Safe Process	Include an assessment of whether redesign would improve safety by looking at some factors i.e. complexity.
5. The effect of people	(i.e. Staff) include attitude, motivation ,health education and training.
6. The leadership/culture	Can drive safety issues when there is a willingness to allocate appropriate resources (i.e. equipment).

— Patient Safety Goals – Required Organizational Practices (ROPs)

1. Communication	2. Medication Use	3. Work life
<p>1-Verification Client identification methods At least 2 identifiers</p> <p>2-Transfer of client information</p> <ul style="list-style-type: none"> - Read back technique - SBAR - e-Medical Records - Transfer forms /Check list <p>3-Medication reconciliation* At admission, transfer and discharge</p> <p>4- Safe surgical practice</p> <ul style="list-style-type: none"> - Surgical safety check list - Pre-operative verification - Pre- operative marking - Time out prior to procedure <p>5-Dangerous abbreviations</p>	<p>6-Control of Concentrated electrolytes</p> <p>7-High alert medications (includes former drug concentrations)-New</p> <p>8-Infusion pump training – New</p>	<p>9- Training on patient safety</p> <p>10-Preventive maintenance program – New</p>
4. Infection Control	5. Safety Culture	6. Risk Assessment
<p>11-Hand hygiene</p> <p>12-Prophylactic antibiotics</p> <p>13- Safe injection practices</p>	<p>14-Adverse Event Reporting</p>	<p>15-Pressure ulcer prevention- New</p> <p>16-Falls prevention - New</p> <p>17-Venous thromboembolism prophylaxis- New</p>

*Is a formal process of obtaining and verifying a complete and accurate **list of each patient's current medicines**. Matching the medicines the patient should be prescribed to those they are actually prescribed.

Clinical Patient Safety Performance

Measures :

1. Number of Sentinel events
2. Number of repeated Sentinel events
3. Reported significant of Medication errors
4. Patient fall with injury rate
5. Number of serious injury/death associated with device.
6. Device associated bloodstream infection rate
7. Nosocomial respiratory infection rate

Tips of improvement patient safety:

- Constitution of patient safety committee
- Develop clear policies and protocol for patient safety
- Discuss regularly patient safety initiative within hospital staff
- Orientation hospital staff on patient safety
- Encourage transparency in the regular death review
- Non punitive reporting by staff
- Review , monitor and evaluate safety procedures regularly

Questions

1. Patient safety defined as " the prevention of harm to patients " By:

- A. World Health Organization
- B. Canadian Patient Safety
- C. IOM Institute of medicine

2. One of the Patient Safety Goals is infection control which includes:

- A. Hand hygiene
- B. e-Medical Records
- C. Surgical safety check list

3. Medication reconciliation is one of the :

- A. Patient Safety measures
- B. Patient Safety goals
- C. Patient Safety subcultures

1.C 2.A 3.B