Professionalism Team
435

Revised by
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# PROFESSIONALISM

## Lecture3:

## Patients' Safety

| Team members: | Color index: | Important links: |
|---|---|---|
| - **Nouf altwaijri**<br>- **Luluh Alzeghayer**<br>- **Malak Alsharif** | - **Important.**<br>- **Extra note.** | - Correction file.<br>- Quizzes file.<br>- Lectures file (revised). |

Please note that this file contains summaries and important notes only, your original source for studying is the full lectures file made by team 434, which will be revised by team 435 after each lecture. Link: Lectures file (revised).

## Summary:

### Defining patient safety:

The reduction of risk of unnecessary harm associated with health care to an acceptable minimum. (WHO, World Alliance for Patient Safety 2009).

## The key dimensions of healthcare quality:

1. **Safe:**
   Avoiding injuries to patients.

2. **Effective:**
   Providing services based on scientific knowledge to all who could benefit and avoiding underuse and overuse. Doing the right thing for the right person at the right time.

3. **Timely:**
   Reducing waits for both who receive and those who give care.

4. **Family (patient) -centered:**
   Providing care that is respectful of individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.

5. **Efficient:**
   Avoiding waste, in particular waste of equipment, supplies, ideas and energy.

6. **Equal:**
   Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status.

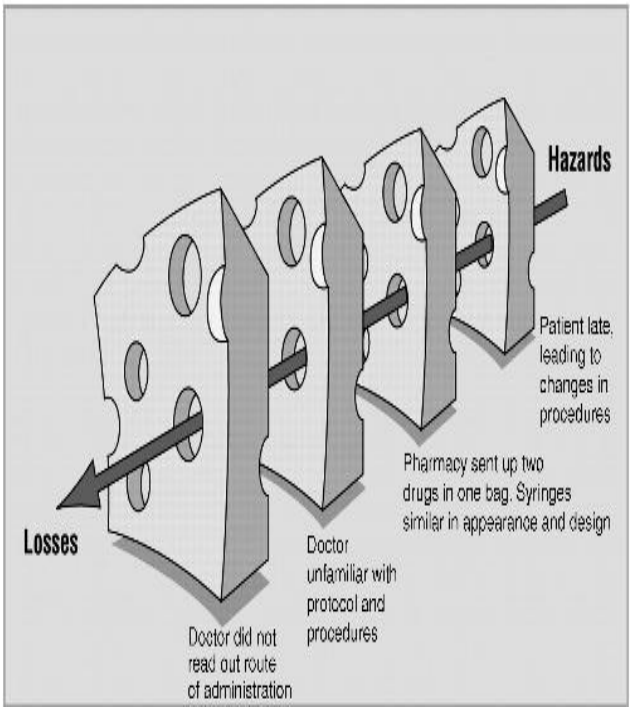
## Sources of System Error:

1. **Active errors or human error:**
   Are committed by frontline staff and tend to have direct patient consequences. Example, giving the wrong medication.

2. **Latent or system errors (most often):**
   Are those errors that occur due to a set of external forces and indirect failures involving management, organizational culture, protocols/processes, transfer of knowledge, and external factors. Example : understaffed wards or inadequate equipment.

## "Swiss cheese" model of accident causation:

Only when the holes in many layers momentarily line up does the trajectory of accident opportunity reach the victim causing the damage.




## Culture of patient safety:

### Definition:

An integrated pattern of individual and organizational behavior that continuously seeks to minimize patient harm that may result from the process of care delivery.

### Approaches:

1. **Blame culture:** we look for the individual person resopnsible for the adverse incident & hold him accountable.

2. The opposite of a 'blame' culture is a **'blame-free'** culture, which is equally inappropriate. In some instances, the responsible individual should be held accountable in case of negligence or recklessness.

3. **Just Culture:** balancing the 'blame' and 'no blame' approaches. we look for the system defect such as communication & protocols, in addition to investigating the negligence or recklessness of the worker. It is the most effective approach.

## The concept of Clinical incident:

A clinical incident is an event or circumstance resulting from health care which could have, or did lead to unintended harm to a person, loss or damage, and/or a complaint. (deviation from standard of care and safety )

### Types:

1. **Adverse Events:**

   a) Sentinel events:

   A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk of Serious injury specifically includeing loss of limb or function. Example: Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.

   b) Never Events:

   Events that should never happen while in a hospital, and can be prevented in most cases. Example: Infant discharged to the wrong person.

   c) Adverse drug reaction:

   A response to a drug which is noxious and unintended, and which occurs at normal doses.

2. **Near miss:**

   Is any situations that did not cause harm to patients (that did not reach the patient) , but could have done.

## Seven levels of safety:

1. **Patient factors:**
   Such as personality, language and psychological problems may also be important as they can influence communication with staff.

2. **Task factors:**
   The design of the task, the availability and utility of protocols ….

3. **Individual factors:**
   Include the knowledge, skills and experience of each member of staff

4. **Team factors:**
   The way an individual practices, and their impact on the patient, is influenced by other members of the team and the way they communicate and support each other.

5. **Working conditions:**

These include the physical environment, availability of equipment and supplies and the light, heat, interruptions and distractions that staff endure.

6. **Organizational factors:**
   The team is influenced in turn by management actions and by decisions made at a higher level in the organization.

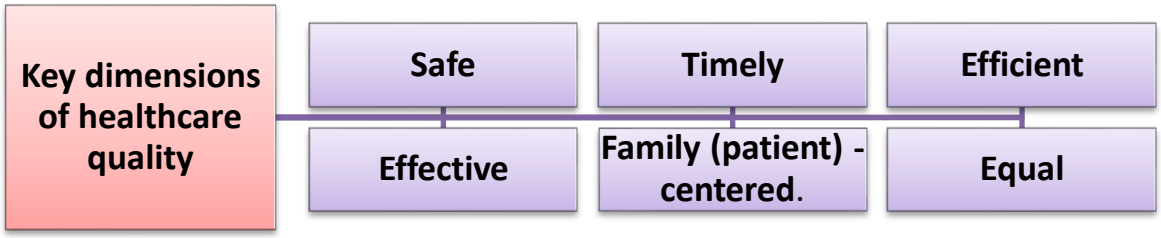
7. **External environment factors:**
   The organization itself is affected by financial constraints, external regulatory bodies and the broader economic and political climate.

## ROP-Patient Safety Goals:

- Adverse reporting
- Client verification
- Medication reconciliation
- Dangerous abbreviations
- Safe injection practices
- Safe surgical practices
- Preventive maintenance program

## Recommended actions:

- Pharmacists / Technicians should CHECK carefully the label of each medication they prepare.
- DOUBLE CHECKING.
- Look-Alike medications should be stored separately with proper labeling or change the brand the hospital purchases of either drugs if possible
- Label all syringes. Be suspicious of unlabeled syringes & Never use them unless you have drawn the medication up yourself.
- Communication.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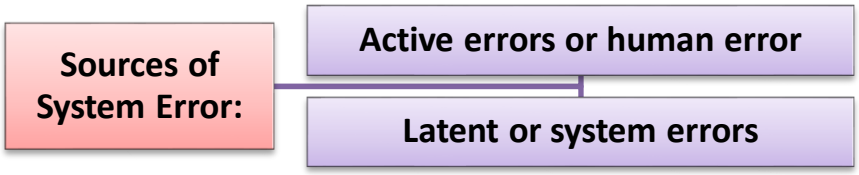
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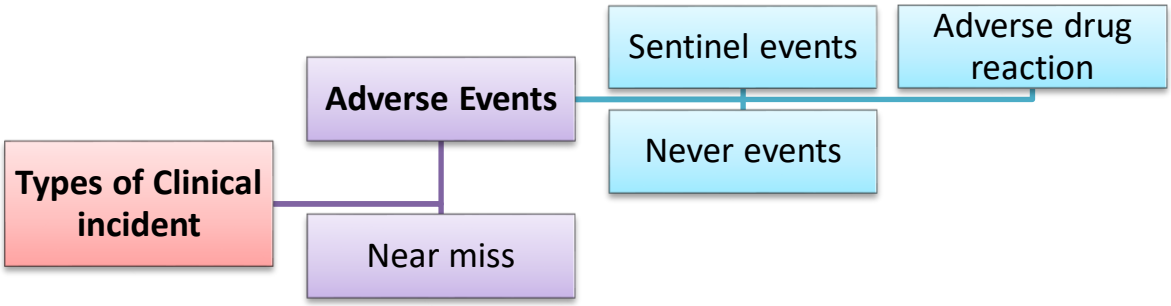
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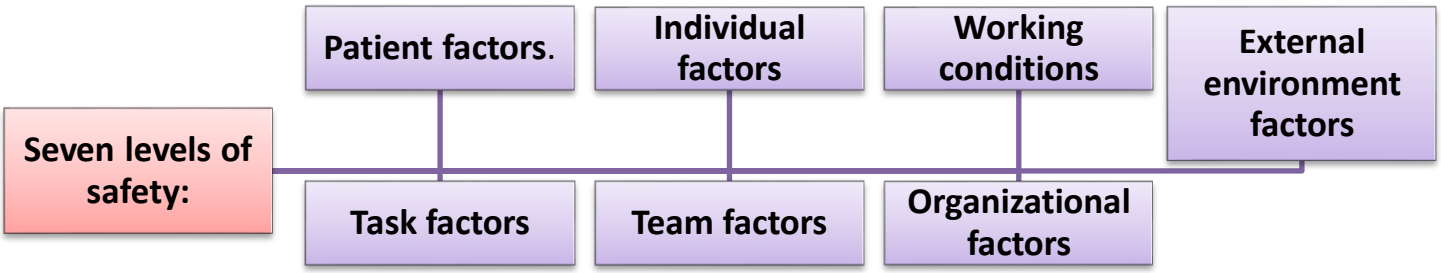
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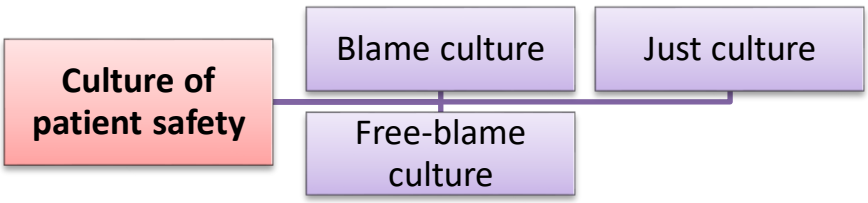
Individual factors
Working conditions
External environment factors
Task factors
Team factors
Organizational factors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Just culture
Free-blame culture