433 Teams

PRIMARY HEALTH CARE

Lecture (15)

Patient Safety

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Lecture content

- **QUALITY OF CARE**
- **ACCREDITATION**
- **ELEMENTS OF QUALITY**
- **PATIENT SAFETY AREAS**
- **OCCURRENCE VARIANCE REPORT**

QUALITY OF CARE:

The degree to which patient care services increase the probability of desired patient outcomes and reduces the probability of undesired outcomes.

Accreditation: its focus on Quality to :

- Improve the quality of **patient care** and **outcome**.
- Improve the **Patient Safety**, **Save Environment**.
- Competition for excellence.
- Enhance the confidence of public.
- Shows accountability.

ELEMENTS OF QUALITY:

Policies: are guidelines or instructions on what "needs to be done"

Patient Safety:

is to Avoid, Manage and Treat unsafe acts within health care system.

Required Organization Practice (ROP):

An essential practice that organizations must have in place to enhance Patient / Client Safety and Minimize Risk.

Patient Safety Areas:

AREA	GOAL
Communication: 1. Client Verification 2. Medication Reconciliation 3. Control of Concentrated Electrolytes 4. Safe Surgical Practices	**Improve effectiveness among care providers**
Medication Use	**Safe administration of Drugs**
Worklife: 1. Training on Patient Safety, e.g. Good system of Fire Drill.	**Safe Physical Environment**
Infection Prevention and Control: 1. Hand Hygiene 2. Injection Safety 3. Antibiotic Prophylaxis during surgery	**Reduce Risk of Organization-Acquired Infection**

Why Errors Occur:

System Factors

- **Complexity of health care processes.**
- **Complexity of health care work environments.**
- **Lack of consistent administration practices.**
- **Deferred maintenance.**
- **Clumsy technology.**

Human factors

- **Limited knowledge.**
- **Poor application of knowledge.**
- **Fatigue**
- **Sub-optimal teamwork.**
- **Attention distraction.**
- **Inadequate training.**
- **Reliance on memory.**
- **Poor handwriting.**

Occurrence Variance Report (OVR):

It is a process for reporting errors, deviations and improper actions.

Sentinel Events: death of the patient or loss of organ or function,

Near Miss: incident about to happen , but by chance it didn't occur

Major incidents : revisable damage or risk for permanent loss

Medical Error : Deficient process of care.

Prospective Analysis : Identify risks and processes before they happen.

Steps to Insure Patient Safety:

1. **Develop and Support the principles of patient safety.**
2. **Identify key individuals to be involved- key stakeholders.**
3. **Identify activities/action steps to develop and implement your patient safety program.**
4. **Make ongoing improvements to patient safety.**

Reporting and Critical Test Notification:

The Lab will call the assigned person to notify certain critical tests

The nurse/Physician receiving the result must inform the attending physician /team leader immediately.

Patient call for action

Patient fall: what are you going to do?

- **Put the patient back on bed/chair**
- **Check his vital signs and quick assessment**
- **Inform the physician**
- **Write an OVR**

Patient suffering pain : What do you do?

- **Do Pain assessment**
- **Use pain scale and document the grade**
- **Inform the physician**
- **Follow instruction and monitor pain intensity**

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