What is Quality Improvement?

An organization philosophy that seeks to meet clients' needs and exceed their expectations by using a structured process that selectively identifies and improves all aspects of service.

Elements of Quality

Patient Safety

- ❑ The Reduction of unsafe acts within the health care system.
- ❑ Patient safety is to Avoid, Manage and Treat unsafe acts within health care system.

Patient safety areas:

1. Communication
2. Medication Use
3. Worklife
4. Infection Prevention and Control

Patient safety area	Goal
communication	**Improve effectiveness among care providers**
Medication use	**Safe administration of Drugs**
worklife	**Safe Physical Environment**
Infection prevention and control	**Reduce Risk of Organization-Acquired Infection**

Communication:

Client Verification: Implement a client verification protocol for all services and procedures

Medication Reconciliation: Reconcile the client's medications upon admission to the organization (including the emergency department or patient units)

Control of Concentrated Electrolytes: Remove concentrated electrolytes from client service areas.

Medication Reconciliation: Reconcile the client's medications to prevent **Adverse Drug Reactions**

Safe Surgical Practices: Develop a process and written protocol for preventing wrong-site, wrong – procedure and wrong-person strategy.

Worklife:

Training on Patient Safety: Deliver training and education on patient safety at least annually to senior leaders, staff, service providers and volunteers.

e.g. Good system of Fire Drill.

Infection control:

Hand Hygiene: provide easy access and resources for staff to comply with recommended hand hygiene guidelines.

Injection Safety: develop safe injection protocols and practices in order to prevent harm to clients, health care workers and community.

Antibiotic Prophylaxis during surgery: Administer prophylactic antibiotics to prevent surgical site infections.

Patient safety terms:

1. **Adverse Event:**

   Bad outcome from care.
2. **Medical Error:**

   Deficient process of care.
3. **Sentinel Event**

   Major and enduring loss of function.
4. **Near miss:**

   Event which could have resulted in loss, injury or illness but did not.
5. **Retrospective analysis:**

   An examination of past Events
6. **Prospective Analysis:**

   Identify risks and processes