Objectives:

- **Understand the discipline of patient safety and its role in minimizing the incidence and impact of adverse events, and maximizing recovery from them.**
- **Understand human factors and its relationship to patient safety.**

Done by : Thani Moafa & Faris Almutairi

Edited & Revised by: Abdullah Alghizzi & Khaled Al Jedia

[Color index : Important | Notes | Extra]

Editing File

Health services:

- **health services** present as a **complex system** system (such as : Buildings, People, Processes, Equipments), Yet unless the people involved and understand the common purpose and aim, the system will not operate in a unified fashion.

- **People** are the **glue** that binds and maintains the system.

The health services are complex, and people making this complex system are being to be useful to help other people.

Why Healthcare Is Complex?

Physicians will be helped by educative, nurses, administrators..etc which make that complex.

1- The diversity of tasking involved in the delivery of the patient care.
2- The dependency of health-care providers on one another.
3-The diversity of patients, clinicians and other staff.
4-The huge number of relationships between patients, carers, health-care providers, support staff, administrators, family and community members.
5-The vulnerability of patients (Vulnerability is a different presentation of the patients).

Quality of Care: defined as the degree to which patient care services **increase** the probability of desired patient outcomes and **reduces** the probability of undesired outcomes.

Accreditation (الاعتماد الاكاديمي) :

- Accreditation focus on the quality.

What is the importance and benefits of Accreditation?

1-Improve the **quality of patient care** and **outcome**.
2-Improve the **Patient Safety**, Save Environment.
3-Competition for excellence.
4-Enhance the confidence of public.
5-Shows accountability (responsibility).

What is Quality Improvement?

- It's 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 services.

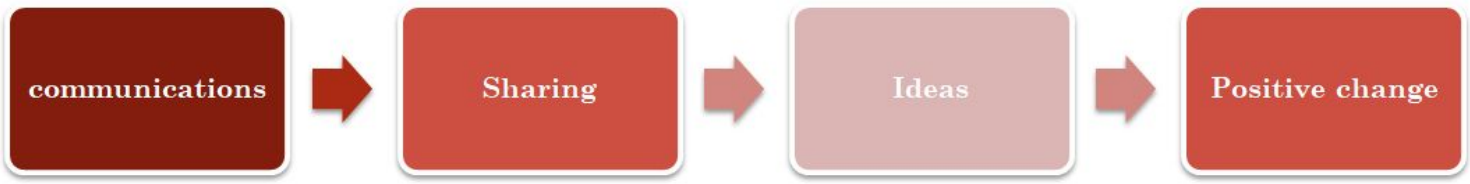
A Systems Approach

A system approach = no blame culture.

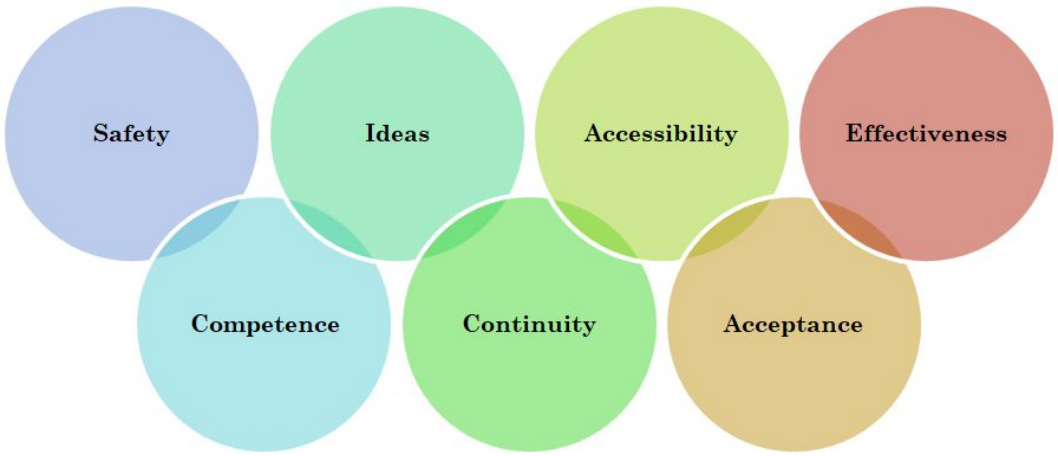
-A systems approach requires us to look at health care as a **whole system** (not as distinct individuals), with all its complexity and interdependence, shifting the focus from the **individual** to the **organization**.

- It forces us to move away from the blame culture towards a system approach.

❖ How will be benefit ?



❖ Elements Of Quality: it is all about client



❖ Policies and Procedures:

-Policies are guidelines or instructions on what needs to be done!

-Guides for organizational strategies objectives.

-Policies are statements about pre-determined courses of action.

Patient safety:

-it's the Reduction of **unsafe acts** within the health care system.

-Patient safety is to **Avoid, Manage and Treat unsafe acts** within health care system.

❖ The goal areas for patients safety :

Patient safety area	The goal is:
1- Communication	Improve effectiveness among care provider**.**
2-Medication Use	Safe administration of Drugs
3-Worklife	safe physical environment.
4-Infection Prevention and Control	Reduce Risk of Organization-Acquired Infection.

Steps to Insure Patient Safety: these steps are done by accreditation.

1-Develop and Support the Principles/Standards 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.

ROP (required organization practice):

ROP = means patient safety.

-It's an essential practice that organizations must have in place to enhance **Patient / Client Safety** and **Minimize Risk.**

❖ Patient Safety Area :

❖ 1- Communication: Most important area.

Communication			
• **Client Verification:** Implement a client verification protocol for all services and procedures (If similar to other patient, ask for hospital card or his ID). e.g. Call patient, his name, father's name and family name.	• **Medication Reconciliation:** (medications that taken by patient from outside the hospital and should be written in patient's file) Reconcile the client's medications upon admission to the organization (including the emergency department or patient units)	• **Safe Surgical Practices:** Develop a process and written protocol for preventing wrong-site by marking the site, wrong –procedure and wrong-person strategy	• **Control of Concentrated Electrolytes:** Remove concentrated electrolytes from client service areas.

2- Medication Error :

- **Prescription**

paper ones; where the handwriting is not clear; solved by electronic system).

- **Dangerous abbreviation**
- **Doses**
- **Interaction with other medications**

3- Hand Hygiene:

Provide easy access and resources for staff to comply with recommended hand hygiene guidelines.

4- Worklife

- **Training on Patient Safety:**

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

5- Infection Control:

- **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.

❖ Some reasons Why Errors Occur:

System Factors	Human factors
• Complexity of health care processes. • Complexity of health care work environments. • Lack of consistent administration practices. • Deferred maintenance[1]. • Clumsy technology.	• Limited knowledge. • Poor application of knowledge. • Fatigue • Sub-optimal teamwork. • Attention distraction. • Inadequate training. • Reliance on memory. • Poor handwriting.

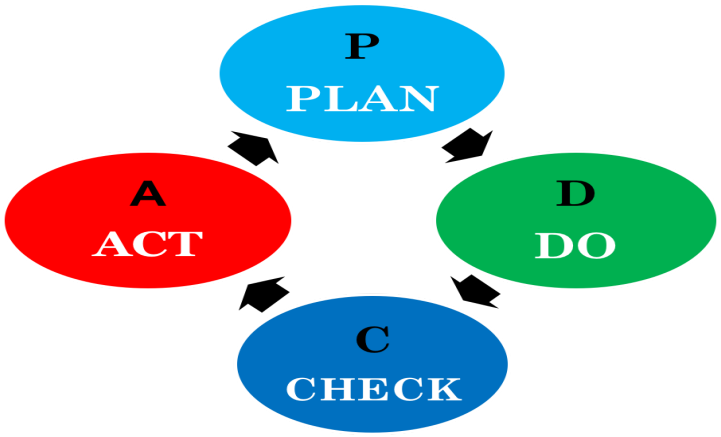
❖ Patient Safety terms:

1. **Adverse Event:** Bad outcome from care.
2. **Medical Error:** Deficient process of care.
3. **Sentinel Event:** death of the patient or major loss of organ or function
4. **Near miss :** incident about to happen could have resulted in loss, injury or illness but by chance it didn't occur. .
5. **Major incidents :** revisable damage or risk for permanent loss.
6. **Retrospective analysis:** An examination of **past** events.

[1] Postponing maintenance activities such as repairs in order to save costs, meet budget funding levels, or realign available budget monies

7. **Prospective Analysis:** Identify risks and processes **before they happen.**

- **Quality Improvement Plan :** The PDCA



OVR (Occurrence Variance Report):

- **What is OVR?**

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

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.

Q: 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

Q: 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