Slide 1

Unit 2 Principles of Quality and
Safety for HIT

Improving Patient Safety

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Slide 2

Bilateral cued finger movements

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Slide 3

retained lap sponge

retracted ureteral stent

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Slide 4

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Slide 5

The Problem is Large

In U.S. Healthcare system
- 7% of patients suffer a medication error
- 44,000- 98,000 deaths
- 100,0000 death from HAI
- Patients receive half of recommend therapies
- $50 billion in total costs

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Similar results in UK and Australia

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Slide 6

How can this happen?

Need to view the delivery of
healthcare as a science

Health IT Workforce
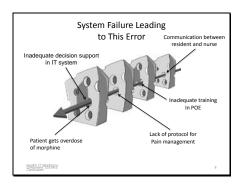Component 12/Unit2
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Slide 7

How can we improve?
Understand the science of safety

1. Accept we are fallible- assume things will go wrong rather than right
2. Every system is perfectly designed to achieve the results it gets
3. Understand principles of safe design
   standardize, create checklists, learn when things go wrong
4. Recognize these principles apply to technical and team work
5. Teams make wise decision when there is diverse and independent input
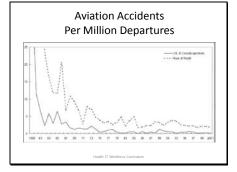
Caregivers are not to blame

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Slide 8

System Failure Leading to This Error

Inadequate decision support in IT system

Communication between resident and nurse

Inadequate training In POE

Patient gets overdose of morphine

Lack of protocol for Pain management

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Slide 9

System Factors Impact Safety

Institutional
Hospital
Departmental Factors
Work Environment
Team Factors
Individual Provider
Task Factors
Patient Characteristics

Adopted from Vincent

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Slide 10

Slide 11

Aviation Accidents
Per Million Departures

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Slide 12

Principles of Safe Design

- Standardize
  – Eliminate steps if possible
- Create independent checks
- Learn when things go wrong
  – What happened
  – Why
  – What did you do to reduce risk
  – How do you know it worked

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Slide 13

Standardize

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Slide 14

Eliminate Steps

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Slide 15

Create Independent Checks

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Slide 16

Basic Components and Processes of Communication

Figure 1. Some of the basic components and processes of communication, as derived from communication theory and organizational studies, are shown.

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Elizabeth Dayton, Joint Commission Journal, Jan. 2007
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Slide 17

Sweets

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Slide 18

Don't Play Man Down

When you feel something say something!

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Slide 19

Your Role

- Assume things will go wrong
- Develop lenses to see systems
- Work to Mitigate Technical and Teamwork Hazards
  - Standardize work
  - Create independent checks
  - Learn from mistakes
- Make wise decisions by getting input from others
- Keep the patient the north star

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Slide 20

Summary

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