UNITED ARAB EMIRATES
MINISTRY OF HEALTH & PREVENTION

الإمارات العربية المتحدة
وزارة الصحة ووقاية المجتمع

The science of patient safety

Patient Safety Conference and Workshop

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6. Effectiveness of improvement actions
7. Stories and numbers
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04 Conclusion

	Assumptions	Reality
1	Hospitals are safe places for healing	Hospitals are places associated with risk & patients' harm. Risk to die 1:300- Air line 1: 3 millions
2	Well-trained, passionate and compassionate practitioners do not make errors	Adverse events often occur because of system breakdowns including handoff patients care between practitioners
3	There is a single or few root causes why people make errors that lead to adverse events	Errors are complex. Systems engineering design contributes to prevent errors and improve patient safety
5	Errors happen due to mistakes during the interactions between front line staff and patients	"active" errors at the "sharp end"—where practitioners interact with patients or equipment—result from "latent" errors
6	Training and counselling as well as developing strict policies and procedures shall reduce the percentage of errors and patients' harm	Errors could be reduced by redesigning systems and processes using human factors principles. including standardization, simplification, and the use of constraint
7	Reporting adverse events is a bad experience lead to inappropriate consequences including shame and psychological harm	Blaming individuals had a toxic effect and lead to low reporting. The more error-related information are shared, the better lessons could be implemented industry-wide

The science of patient safety

Definition:

Patient safety is **a discipline** in the health care sector that **applies safety science methods** toward the goal of achieving a trustworthy system of health care delivery. It minimizes the incidence and impact of, and maximizes recovery from, adverse events. *Linda Emanuel & etal 20*

Dimensions of Quality

- Safety
- Effectiveness
- Patient-Centeredness
- Timeliness
- Efficiency
- Equity

No Needless deaths

, pain or suffering or even unwanted waits as well as no waste for Anyone

Modified definition from IHI

The science of patient safety

"ومن أحياها فكأنما أحيا الناس جميعا"
سورة المائده (32)

"If any saves a life it is as if he saves the lives of all mankind"
the Feast verse 32

- The unique situation it is about human life or a human function
- The opportunities of improvement in patient safety are plenty

03

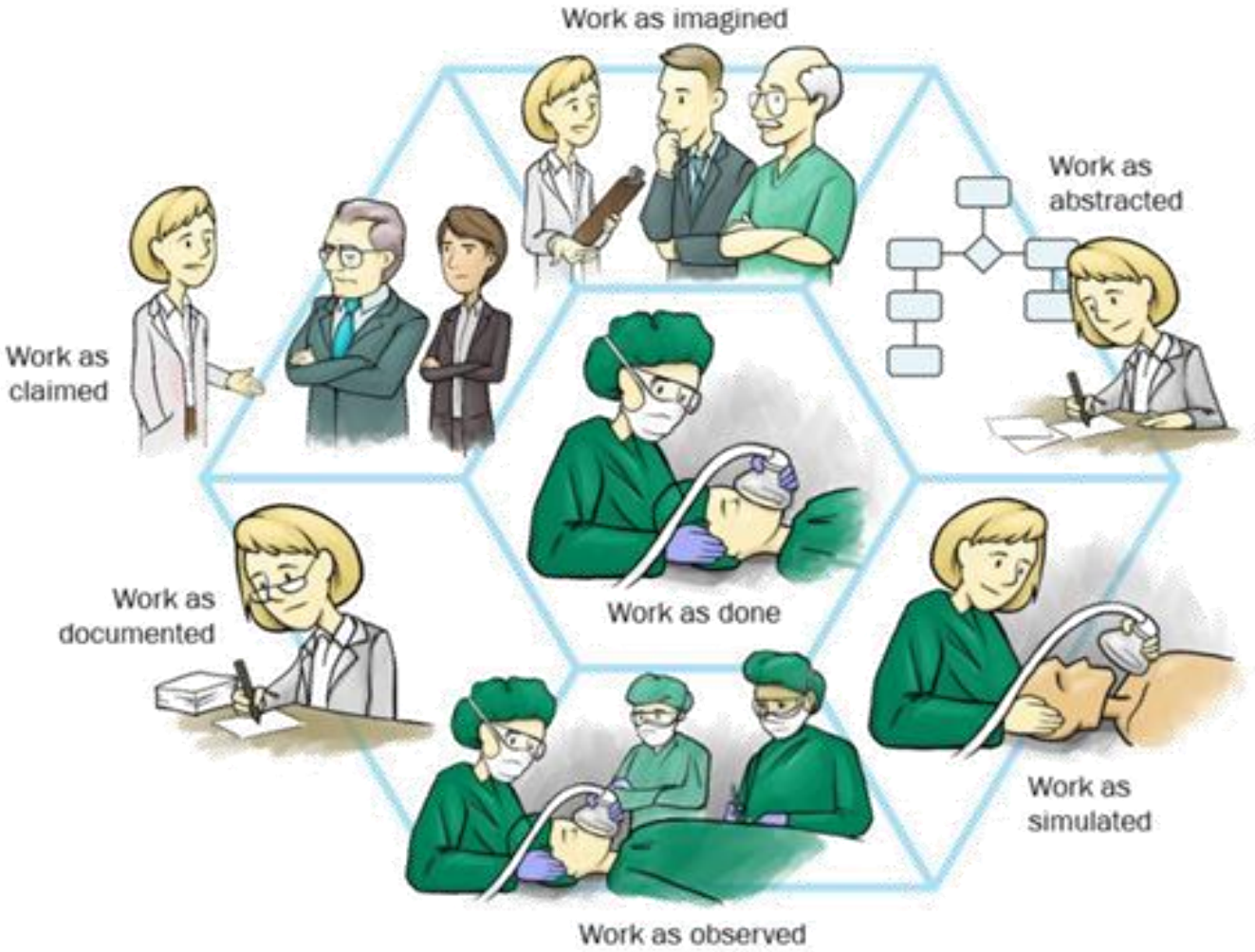
How to make it happen

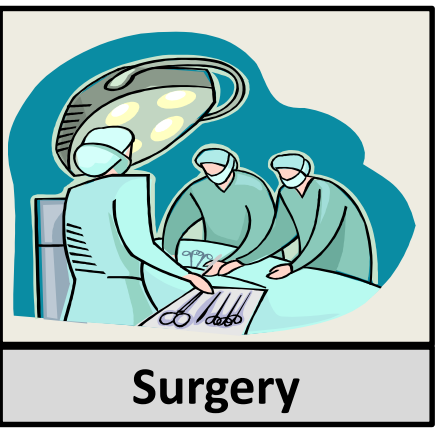
Leadership of the program

- The leader is the chief meaning officer
- High calliper individuals
- Shows commitments
- Gets involved
- Provide resources

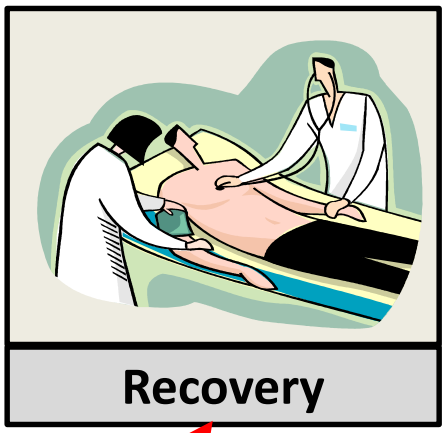
Work as imagined and work as done

WAI&WAD

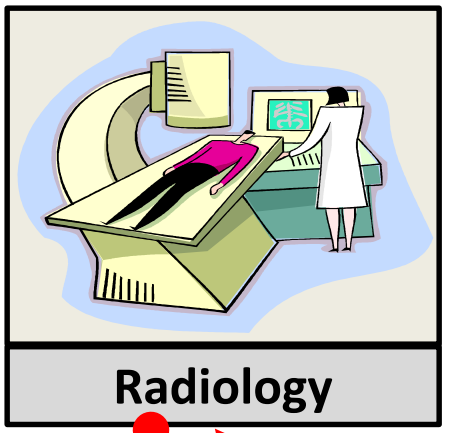




Surgery

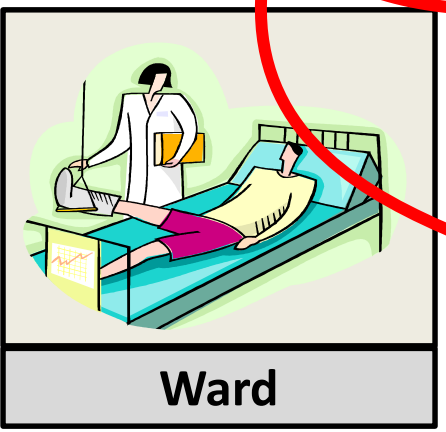


Recovery



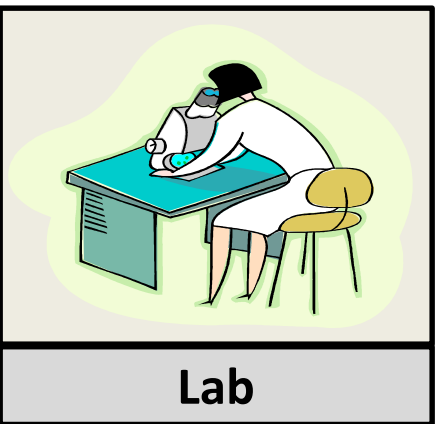
Radiology

Exam Room



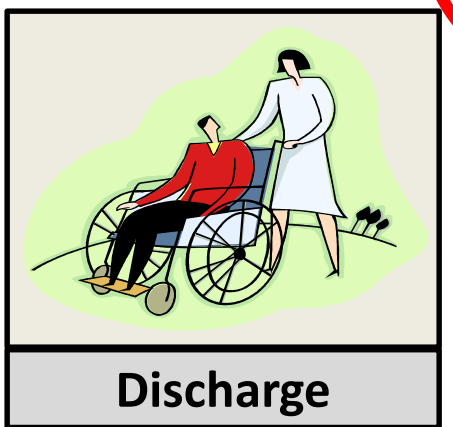
Ward

Waiting Room

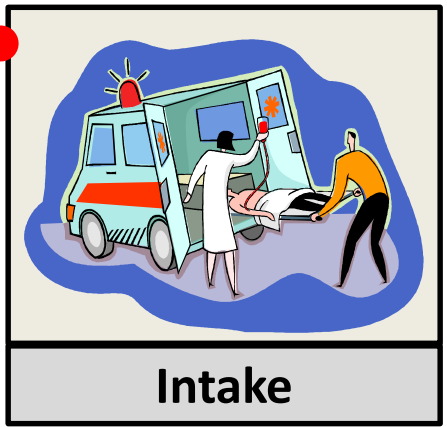


Lab

Pre-Op

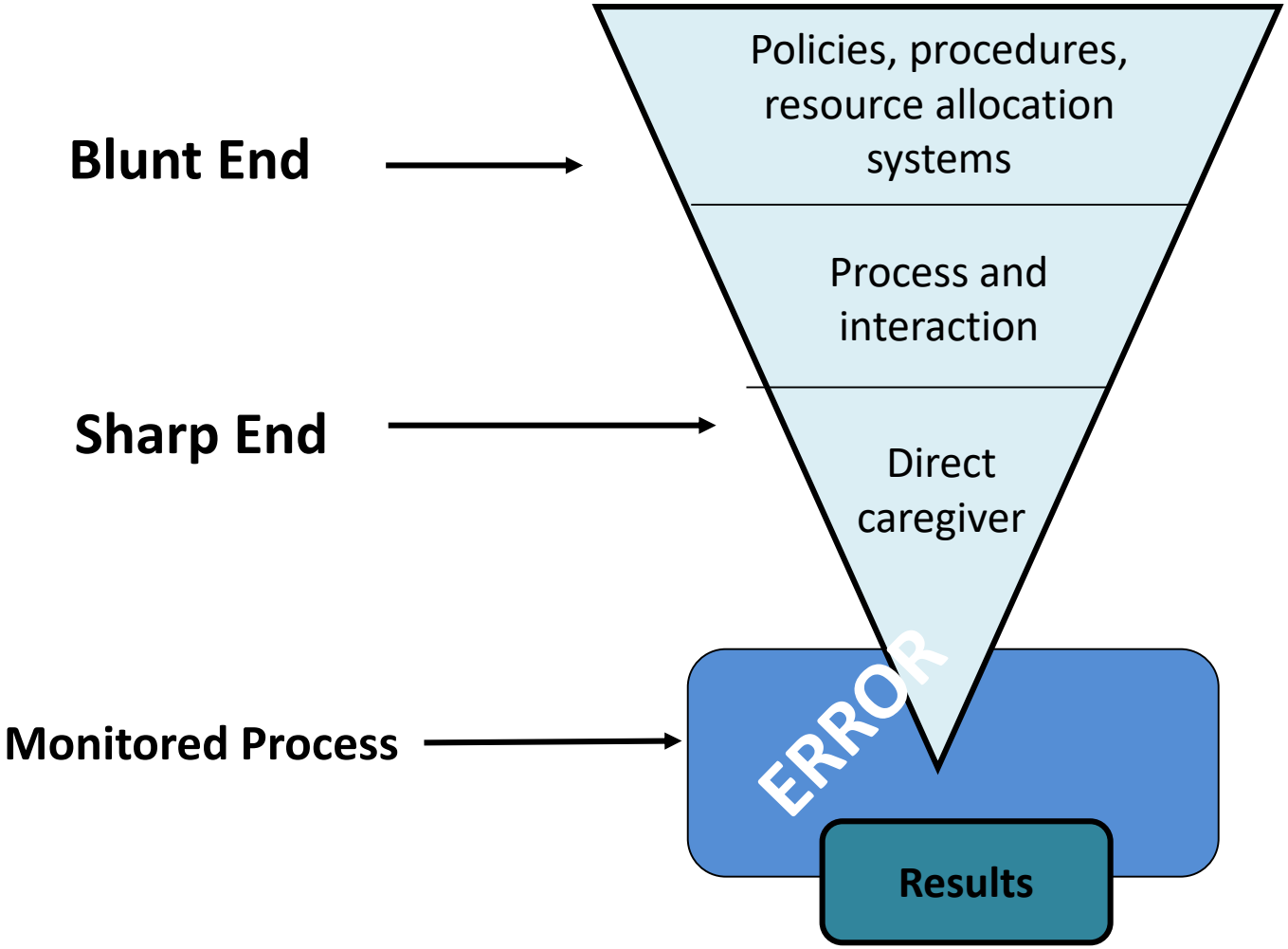


Discharge



Intake

System design for patient safety



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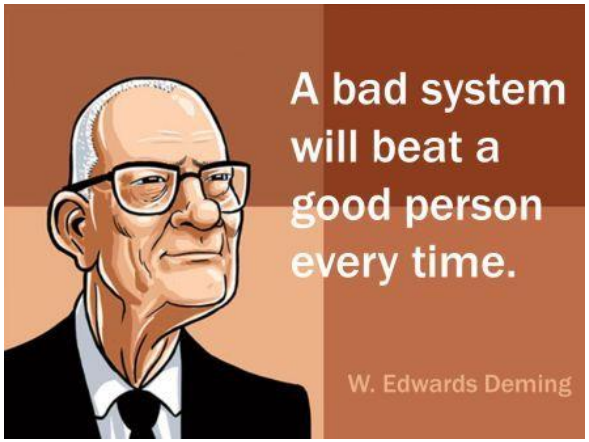
System design



A bad system will beat a good employee every time

Culture of patient safety

Starts with reporting the opportunities

Normalization deviances

At-risk behavior

Reckless behavior

It's the way how things are done here…

In the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on cultural change than on a new regulatory regime

Don Berwick

People encouragement

- Make it simple
- What's in it for me.
- Listen to people
- Involve every one
- Focus on out come
- Link with performance appraisal

OUTCOME FOCUS
EVIDENCE ACTION CHANGE

Effectiveness of patient safety improvement actions

- **Weak actions** these action are considered as weak actions . Related to human
  - Training
  - Policy
- **Intermediate actions.**
- Actions are connected with tools to facilitate human compliance (checklist)
- **Strong actions**
- Actions of systems or process design which minimize or eliminate the role of the human.

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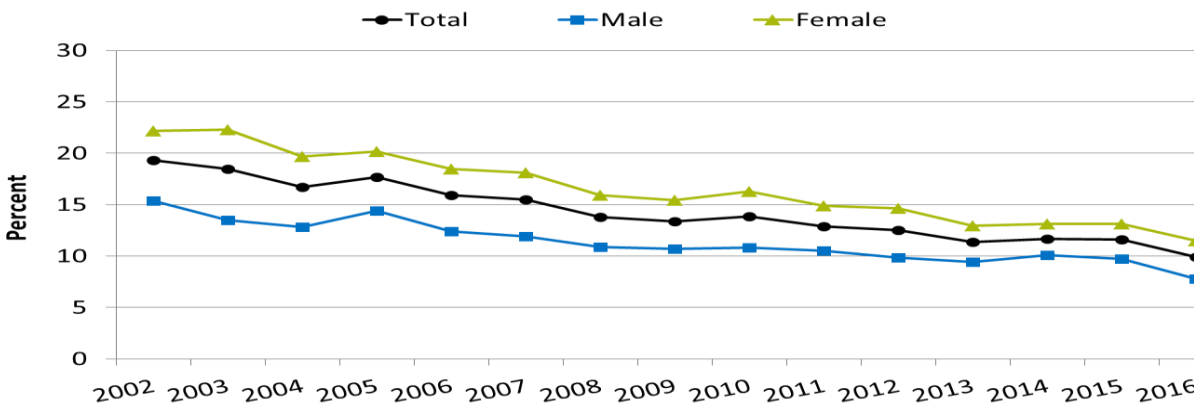
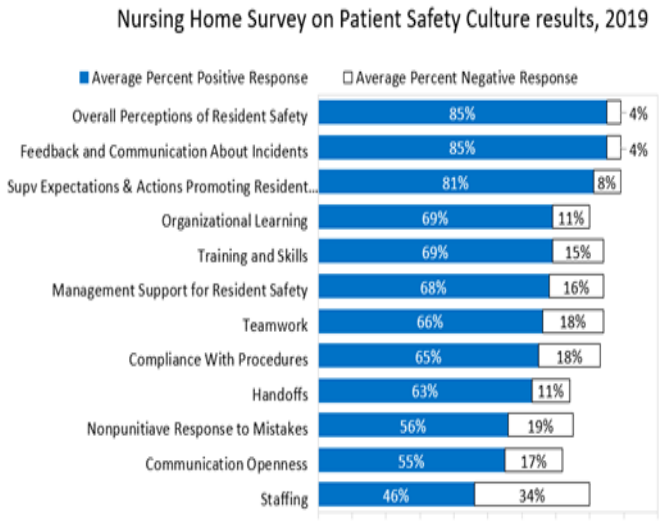
Stories and numbers

- Tell stories to the governance and leaders
- Credible analysis and data validity
- Feedback

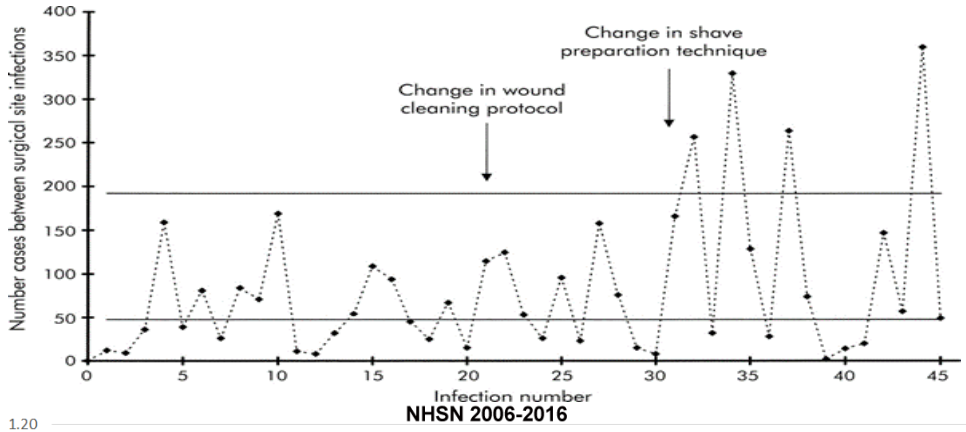
Adults age 65 and over who received in the calendar year at least 1 of 33 potentially inappropriate prescription medications for older adults, by sex, 2002-2016

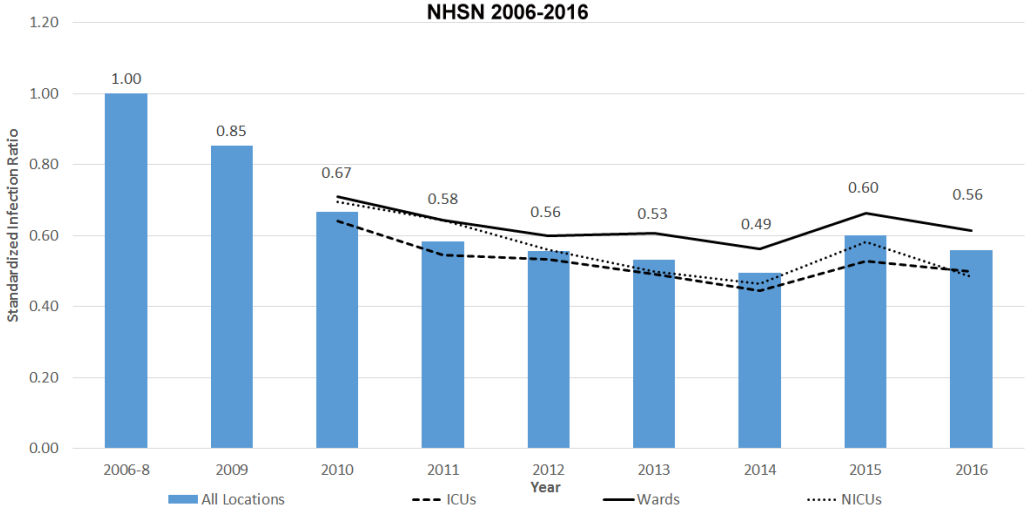




Sustainability of the improvement

A common scenario





Patient safety improvement initiatives are projects to be implemented with a time frame limit. …

How can you sustain improvement ?

- There are 2 ways for sustaining improvement:
  1. Being very lucky
  2. Planning for sustained improvement

Conclusion

Take Home Message

- Focus on system design
- Take care of people
- Close the loop of improvement

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