الجمعية السعودية للعلاج الطبيعي
Saudi Physical Therapy Association

KPIS Medical
Infinite Giving
عطاءٌ بلا حدود

Patient Safety

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Patient Safety System

- Emphasis is placed on the system of care delivery that:

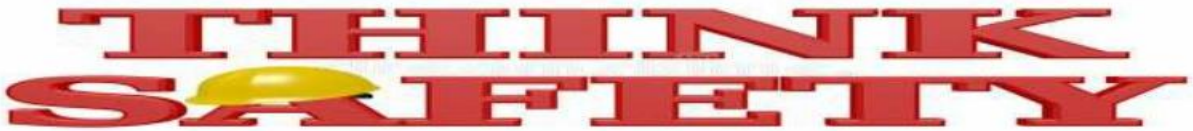
1. prevents errors;

2. learns from the errors that do occur;

3. is built on a culture of safety that involves health care professionals, organizations, and patients.

The Safety Thinking…

- Patient safety involves prevention.
- Think of safety at all times, safety is everyone's business
- "Safe Practice Saves Lives"
- "Safety culture", "Non blame culture"
- "System Approach"
- Learn from incident/error & share
- Emphasize & share right practice also



Definition of a Safety of Culture

- A culture of safety is an atmosphere of mutual trust in which all staff members can talk freely about safety problems and how to solve them, without fear of blame or punishment.
- Essential to improving patient safety in any organization.

safety Culture

- ***The safety culture of an organization is comprised of values, attitudes, perceptions, competencies, and behaviors, which determine the commitment to, and proficiency of, an organization's health and safety management.***
- ***safety culture is characterized by communication founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.***
- ***An organization with a culture of fear of retribution****, will not be very open to reporting errors or potential errors.*
- ***an organization with a recognized 'Just Culture'*** leads to *process changes, not individual retribution, and has a better patient safety culture .*
- ***The safety culture assessment helps*** *identify and measure conditions in healthcare organizations which lead to adverse events and patient harm.*
- ***The outcomes of these efforts may be reflected positively or negatively.***
- ***All healthcare organizations should periodically assess their patient safety culture.***

The assessment diagnoses the current safety culture and tracks changeover time. It raises patient safety awareness, helps prioritize quality strategies, and provides an opportunity for internal and external benchmarking.

Assessment of safety culture within a hospital should be at the unit level.

There is more variability between units in a typical hospital than there is between hospitals. Because interventions to improve safety are implemented at the clinical area level, it is critical to understand culture at that level.

The Agency for Healthcare Research and Quality (AHRQ) *released the Hospital Surveyon Patient Safety Culture(Consumer Assessment for Healthcare Providers and System (CAHPS) Survey) in November 2004 .*

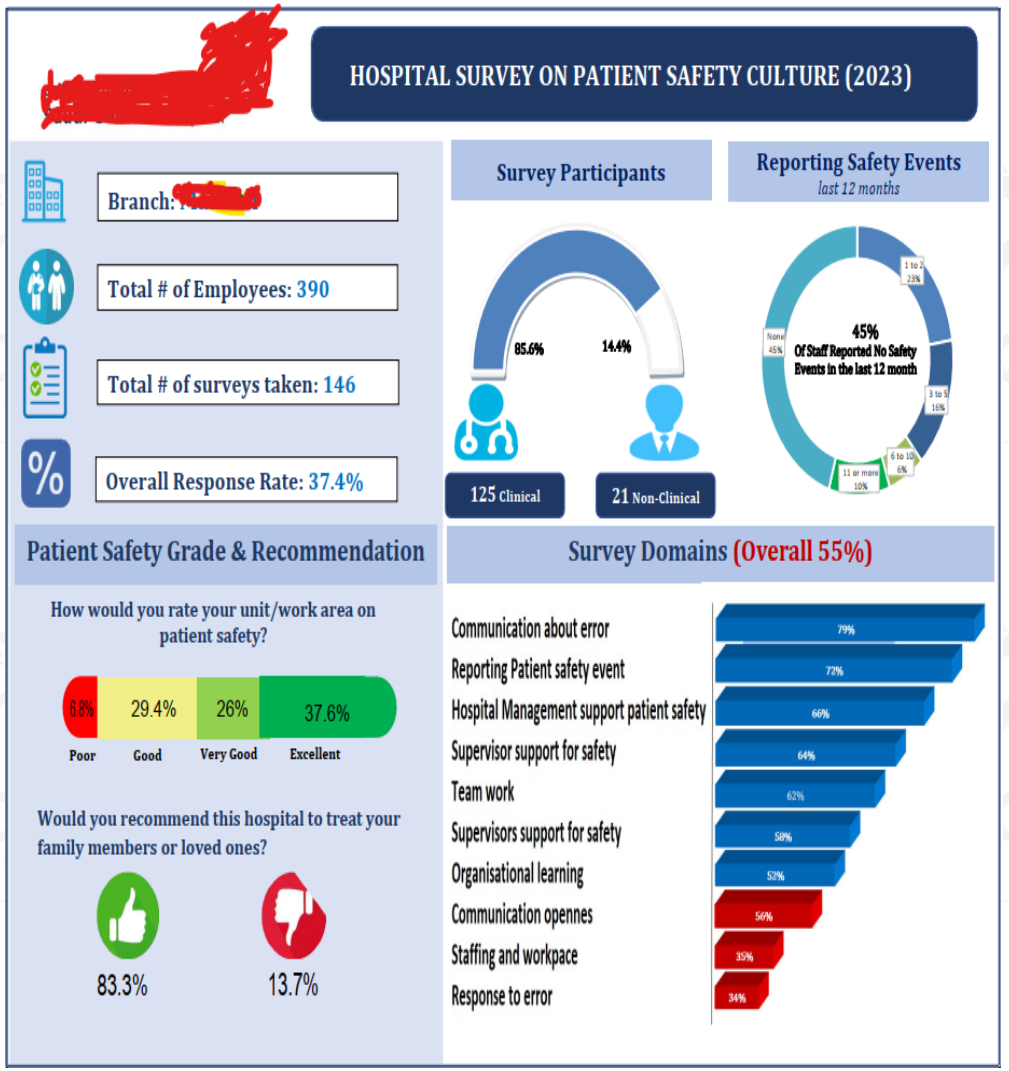
Measurement tool:

- AHRQ free “Hospital survey on patient safety culture”
- The safety culture assessment helps identify and measure conditions in healthcare organizations that lead to adverse events and patient harm.
  - Surveys occurring every two years.

- ***The Agency for Healthcare Research and Quality (AHRQ) released the Hospital Survey on Patient Safety Culture in November 2004 (every two years).***

- ***Why???***

1. ***Raise staff awareness about patient safety***
2. ***Diagnose and assess the current status of patient safety culture***
3. ***Identify strengths and areas for patient safety culture improvement***
4. ***Examine trends in patient safety culture change over time***
5. ***Evaluate the cultural impact of patient safety initiatives and interventions***
6. ***Conduct internal and external comparisons***



Safety Culture

- It is the product of values, competencies, and behavior of the organization that determines the commitment to safety management.

Components of a safety culture include:

- Commitment to safety as the primary priority
- Availability of the necessary resources
- Incentives, and rewards for safety
- Openness about errors and problems
- Commitment to organizational learning
- Unity, loyalty, and teamwork among staff
- Non Punitive Environment (culture of safe reporting) **leads to increase number of reported errors**


Just Culture
Reporting Culture
Learning Culture
Informed Culture
Safety Culture
Flexible Culture

Definition

- It is refer to a safety-supportive system of shared accountability where health care organizations are accountable for the systems they have designed and for responding to the behaviors of their staffs in fair and just manners.

Just Culture

- *"Most serious medical errors are committed by competent, caring people doing what other competent, caring people would do"*
  - Everyone has a job to protect the patient and others and to be part of the solutions to reduce the risk of errors.

Just Culture

- In a 'Just Culture' all employees, practitioners and others understand that the mission and the vision of the organization guides them to do the best that they can in completing their job.

Just Culture

- The IHI estimated that 80% of medical errors are system-driven.
  - A just culture recognizes that professionals should not be held accountable for system failings over which they have no control.

Just culture

A just culture is about ensuring everyone is confident they will be treated fairly when something goes wrong. It recognises that everyone makes mistakes and focuses on changing systems and processes to make it easier for people to do their jobs safely.

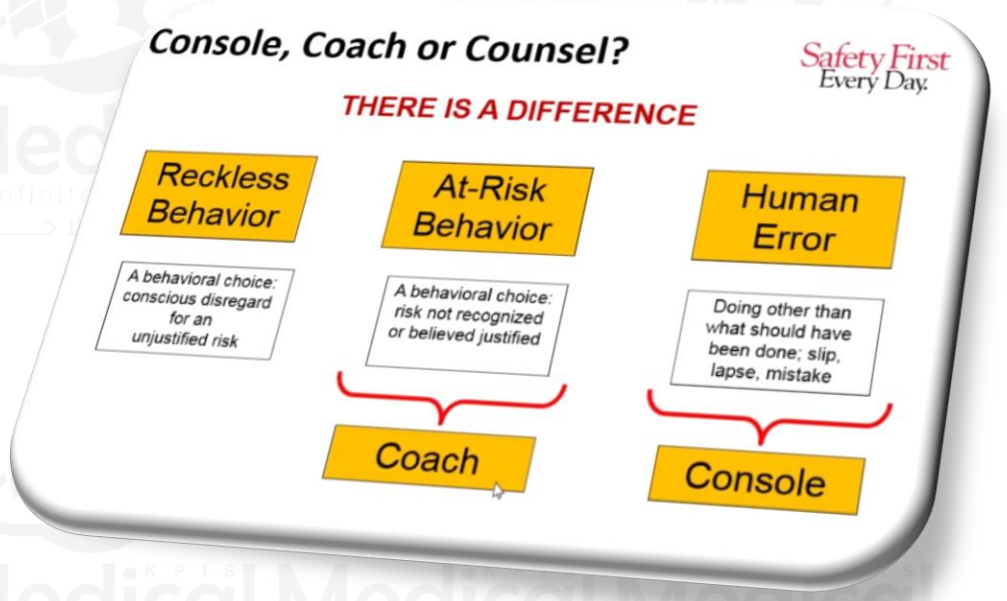
Just Culture

- Just culture defines three possible behavior choices that an individual makes and needs to manage

just Culture

People can and will make mistakes, It does not matter who that person is

- Just culture is recognized that reporting errors leads to process changes, not individual retribution (punishment).
- Everyone has a job to protect the patient and others and to be part of the solutions to reduce the risk of errors.
- most errors are a result of a process and not necessarily the individual, human factors play an important factor in whether an error occurs.
- The Just Culture structure defines what behavior should be undertaken for the individual who directly makes the error.



To Err is Human...

Human Error	At-Risk Behavior	Reckless Behavior
غير متعمد (an inadvertent action, a lapse or a mistake)	مبرر	متهور
Product of our current system design	*A Choice: Risk believed insignificant or justified*	*Conscious disregard of unjustifiable risk*
"I forgot to do the 2- hour check" starting an operative procedure without a time out	"I did a one person transfer with a resident who requires a two-person transfer because the resident needed to use the bathroom and everyone else was busy"	"I knowingly avoided completing a treatment because it is complex and time-consuming"
Manage through changes in: • Processes • Procedures • Training • Design • Environment	Manage through: • Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	Manage through: • Remedial action تصحيحي • Disciplinary action
واسى **CONSOLE**	علم **COACH**	**PUNISH**

"Professionals should not be afraid to make mistakes. They should be afraid of not learning from the ones they do make."

Sidney Dekker, "Just Culture; Balancing Safety and Accountability", 2007

Establish Learning Boards

- The learning board is posted on the unit and utilized to display safety concerns identified by staff
- promotes visibility of specific concerns (transparency).
- This transparency demonstrates to the staff and others that their input is critical to having a well functioning patient safety program.
- Being able to anonymously report concerns in this manner may be valuable for the staff and others to report the safety concerns without fear of reprisal

Learning Board			
Visual	Identified	Active	Resolved
Measures	# of defects identified/ Month	# of defects without action > 30 days	# defects resolved in past 30 days
	Data collection: Count on the first day of each month	Data collection: Monitor and move	Data collection: Count on the first day of each month

For the purpose of improvement, assessment of safety culture in a hospital is best conducted at the level of the

A. individual.
B. unit.
C. hospital.
D. system.

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A. Review post-surgical infection rate data

B. Review data collected through incident reports

C. Survey patients admitted in the last 6 months

D. Survey employees and physicians

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An organization has achieved a culture of patient safety when

A.fear of reprisals for reporting incidents has been eliminated.

B. its patient safety goals have been implemented.

C. patient safety training of employees has completed.

D. reports of incidents and near misses have decreased.

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