



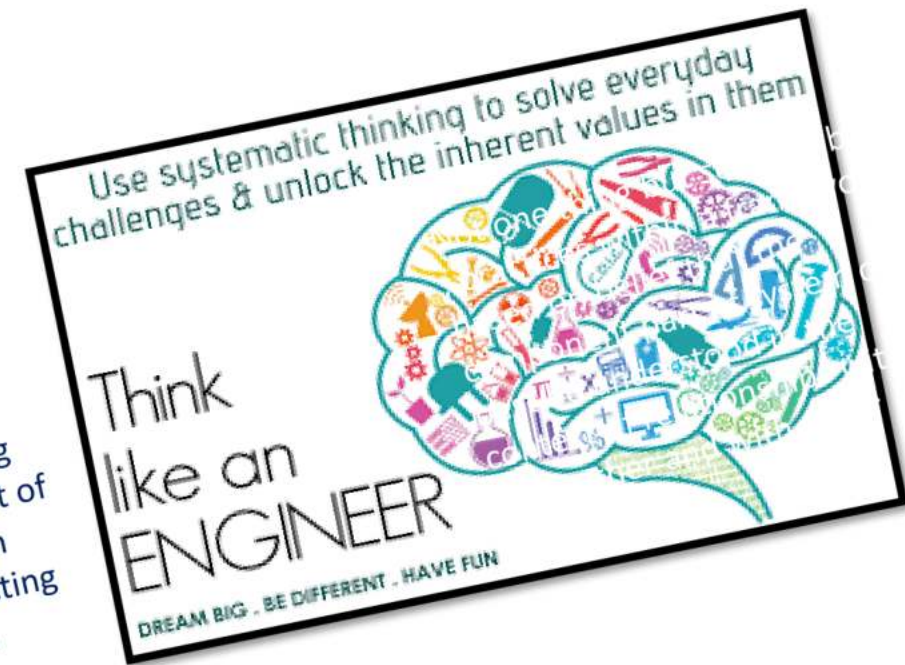
System thinking

- Approach of system analysis help a person to view system **from abroad perspective** that include seeing overall **structure** ,pattern and cycles in system rather than seeing only specific event in the system
- The ability or skills to perform **problem solving in complex system**
- Way to **optimize** every things u do

▪ System structure:

the pattern of **interrelationships** among all key components of the system, e.g.: Process flows, attitudes, decisions & hierarchy.

- Problem solving approach , viewing problems as apart of an overall system rather than reacting to specific part.





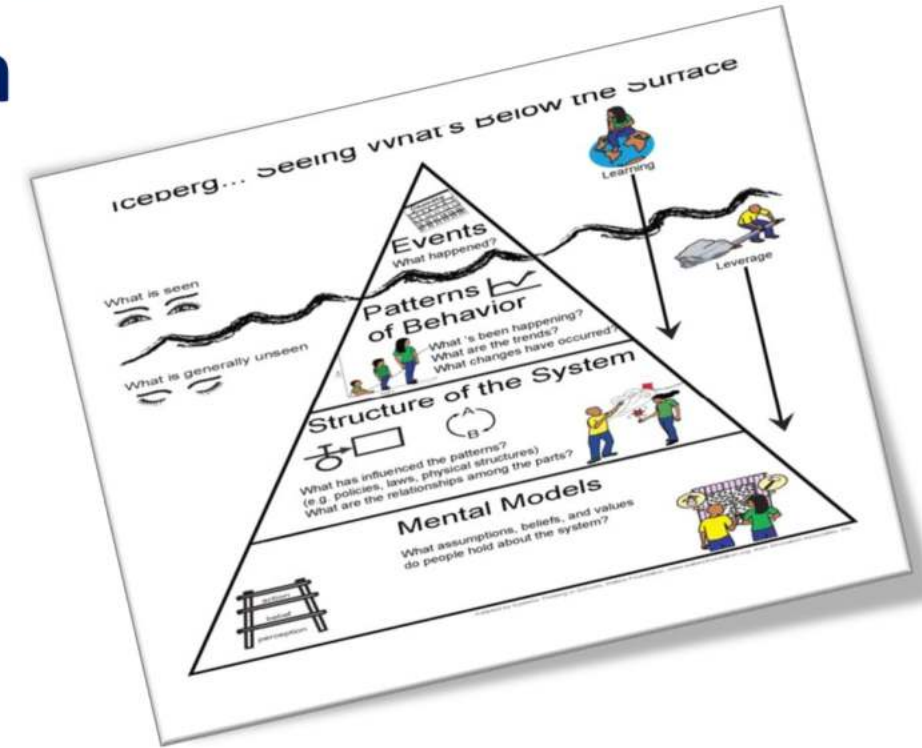
Levels of system

4 level in systems:

1. Events (occurrences).
2. Pattern or behavior (trend).
3. Systematic structure (interrelationship)
4. Mental models (beliefs & assumptions, mind set about the ways of work gets done).

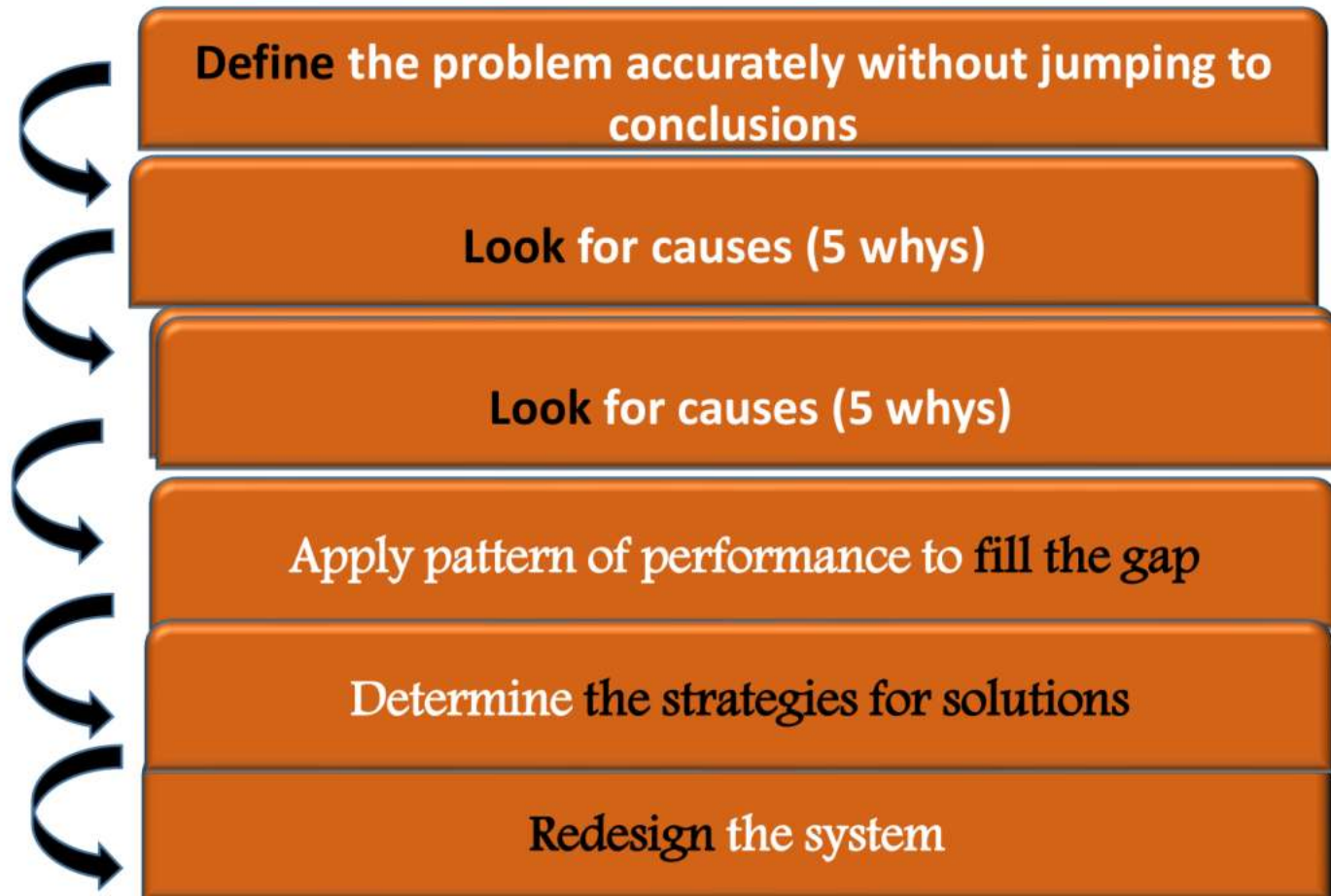
The goal of the system:

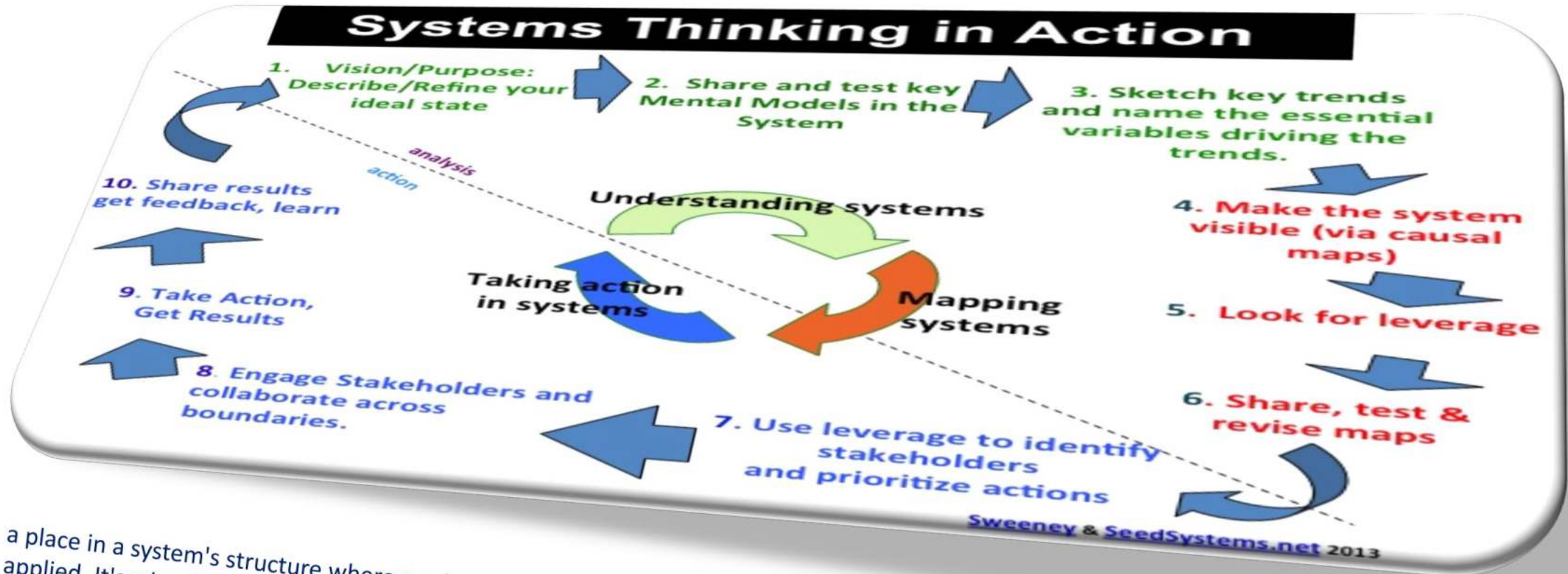
is **maximize the output** of the system **not** output of each of its components, **So** we must **optimize** rather than maximize **performance** of each components to maximize the output of the system.





How to use system thinking





a place in a system's structure where a solution element can be applied. It's a **low leverage point** if a small amount of change force causes a small change in system behavior. It's a **high leverage point** if a small amount of change force causes a large change in system behavior

party that has an interest in a company and can either affect or be affected by the business. The primary **stakeholders** in a typical corporation are its investors, employees, customers



- 1999: To Err is Human
- At least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors

To err is human...

- 44,000-98,000 deaths/year due to preventable medical errors in the United States
 - Less than cancer and heart disease
 - In the same range as influenza, pneumonia, diabetes, and alzheimer's
- IOM estimates that a hospitalized patient is at risk of 1 medication error per day

Kohn, S.T., ed. Corrigan, J., ed. Donaldson, M.S., ed. To Err is Human. 1999. www.iom.edu/publications/err.htm



- One death in every 343 to 764 admissions.



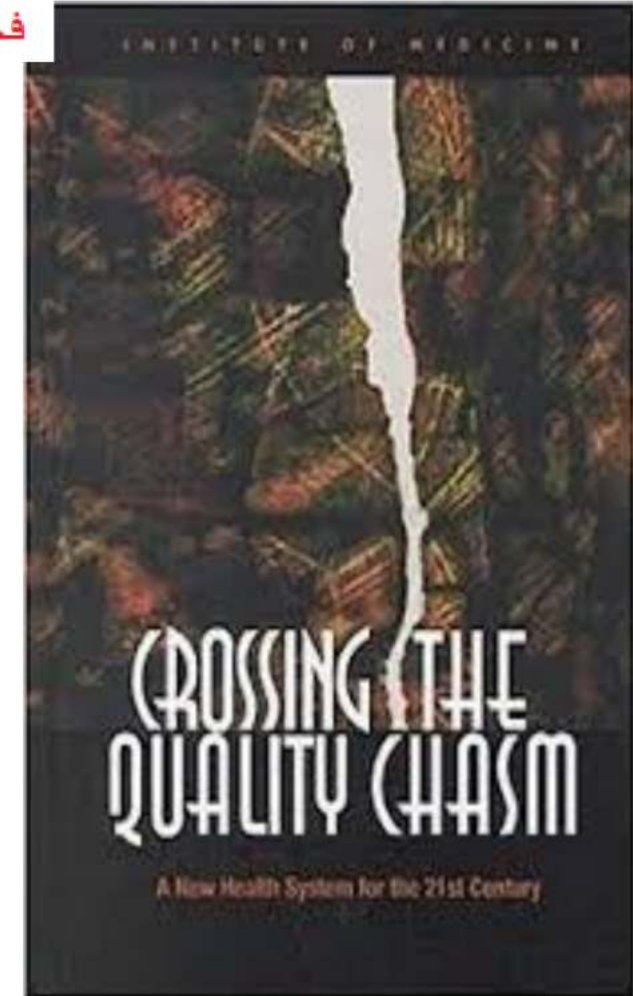


2001: Crossing the Quality Chasm

متشابكة

- The report described America's health system as "a tangled, highly fragmented web that often wastes resources by duplicating efforts."
- Should create new monitor and track quality in **six key areas (IOM aims or attributes of care).**

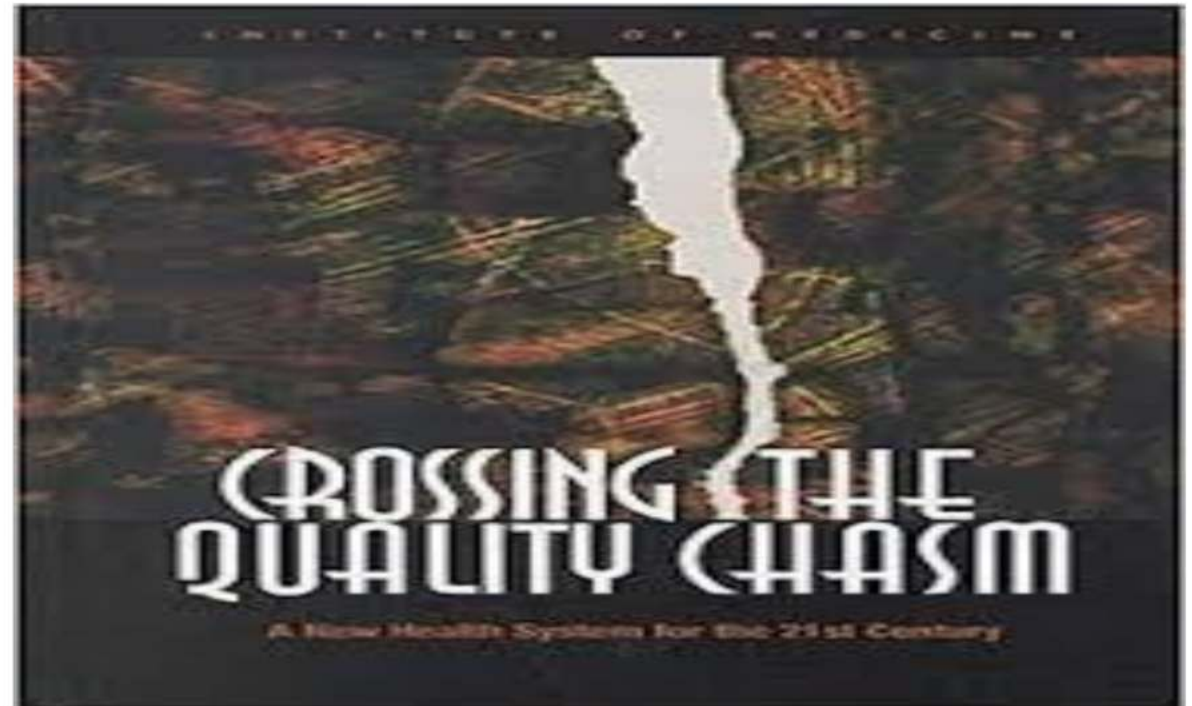
فجوة

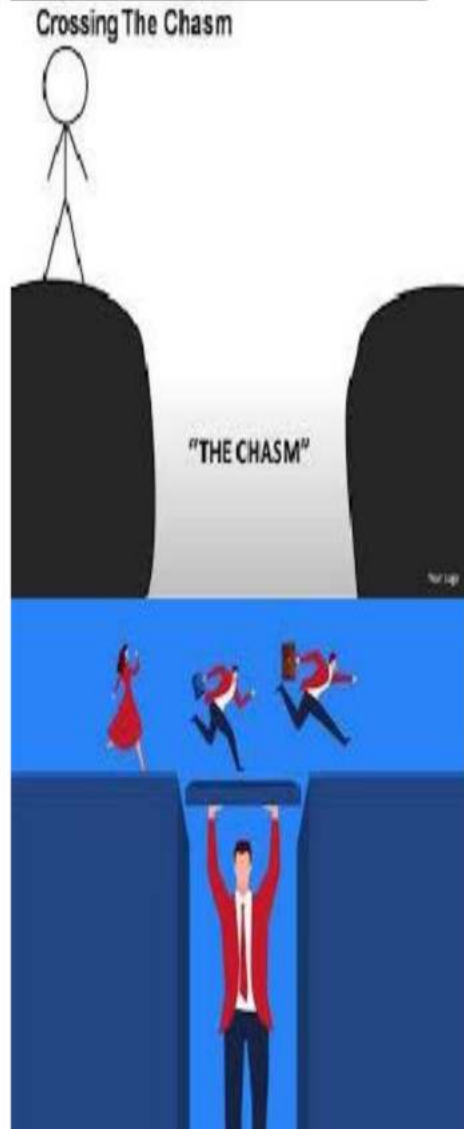


Six key areas (IOM aims or attributes of care)

STEEP

1. Safe care.
2. Timely care.
3. Effective care.
4. Efficient care.
5. Equitable care.
6. Patient-centered care.





Institute of Medicine: *Crossing the Quality Chasm* (2001)

10 Simple Rules

in many forms and at all times

1. Care based on continuous healing relationships
2. Care based on patient needs and values
3. Patient as the source of control
4. Patient access to medical information and clinical knowledge
5. Evidence-based decision making
6. Patient safety
7. Transparency of information
8. Anticipation of needs
9. Continuous decrease in waste
10. Cooperation among clinicians

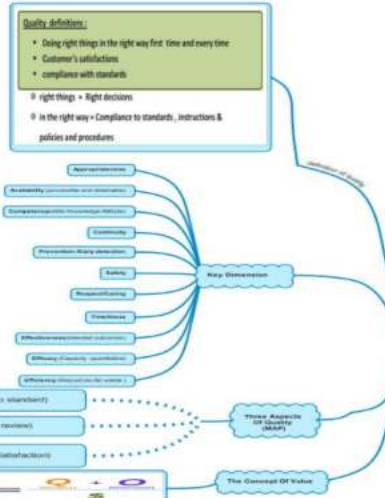
IOM Aims and HIT



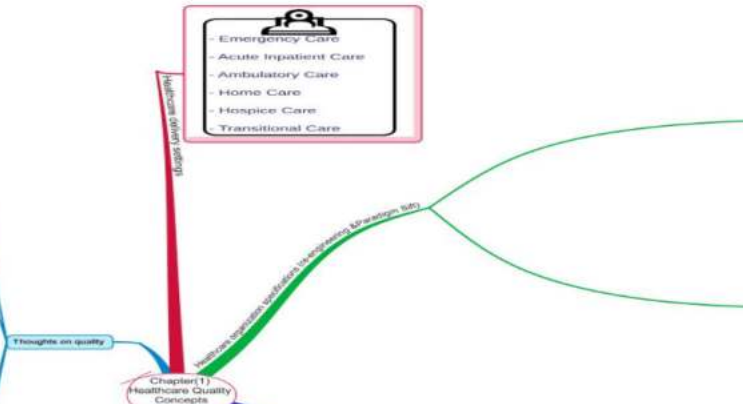


Designed by: **Beal Ahmed**

Appropriateness	Provided services are relevant to customer's needs - CORRECT as judged by peers
Timeliness	Care provided at most beneficial time
Availability	Care accessible and obtainable when needed by customer
Competency	Practitioner adhering to the standards when providing the care
Continuity	coherent address/ access of services
Effectiveness / Efficacy	Care provided as right manner to address the desired outcome
Ethical / Capacity	Respect Capacity or Capability of care to produce the desired outcome
Ethical + Resource	Availability between OUTCOME to be REDUCED (Patient Services)
Preventable/Bar Detection	Intervention identification of risk factors → Treatable health and prevent diseases
Respect and Care	Service provides are sensitive to the customer's needs and ending customer in distress
Safety	Minimizing risk of adverse outcome for both customer and provider



- Emergency Care
- Acute Inpatient Care
- Ambulatory Care
- Home Care
- Hospice Care
- Transitional Care

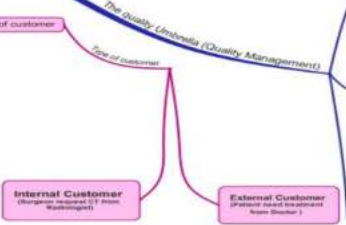
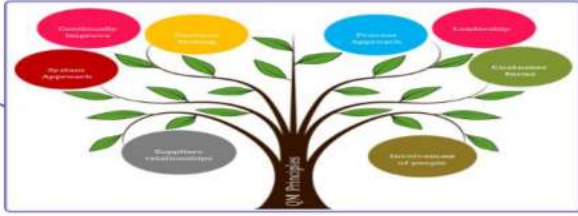


History of Quality



- Continuous Quality Improvement Demands**
- 1- Top commitment
 - 2- Suitable organization culture
 - 3- Customer focus
 - 4- Ongoing pursuit of customer satisfaction
 - 5- Systems and processes focus
 - 6- Constant learning and improving

- TQM Philosophy promotes:**
- 1- An increased top-down and bottom-up emphasis on quality
 - 2- A decreased emphasis on inspection, surveillance, and discipline and a focus on systems rather than individuals
 - 3- A substantially increased investment of managerial time, capital and technical expertise.
 - 4- An increased investment in education
 - 5- Long term vision
 - 6- Cautious use of minimal standards of care
 - 7- Continuous, ongoing quality improvement





الجمعية السعودية للعلاج الطبيعي
Saudi Physical Therapy Association

Medical^{K P I S}
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عطاء بلا حدود



Thanks a lot

