Quality Systems & Patient Safety

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Agenda

- Define Quality, System & Patient Safety
- Examples of measurement instruments
- Why do we require support tools?
- What are the consequences of omission?
- Conclusion

What is Patient Safety?

- According to the WHO:

  "Patient safety is the **absence of preventable harm** to a patient during the process of health care and **reduction of risk of unnecessary harm** associated with health care to an acceptable minimum.

  An acceptable minimum refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment"

- Medication errors cost an estimated 42 billion USD annually

Patient Safety

- It is claimed you have a 1 in 3 million chance of dying in an aeroplane crash, yet a 1 in 300 chance of dying due to a preventable medical accident.

- Patients are at risk in health facilities and we need to do all we can to keep them safe. Medication errors is the major contributor.

What is Quality?

- Quality for you and I may differ?
- Analogy of a pen and a motor vehicle
- In terms of trying to define quality the following is offered as one definition – “Quality has to do with efficient, effective, purposeful **care** that gets the job done at the right time for the right cost”.

What is Quality Measurement?

- **Quality measurement** in **health care** is the process of using data to evaluate the performance of **health** plans and **health care** providers against recognised **quality** standards. ... **Measuring** the **quality** of **health care** is a necessary step in the process of improving **health care quality**

What is a system?

- If one looks at Business Dictionary you will find two definitions:
  - 1. A set of detailed methods, procedures and routines created to carry out a specific activity, perform a duty, or solve a problem.
  - 2. An organised, purposeful structure that consists of interrelated and interdependent elements (components, entities, factors, members, parts etc.). These elements continually influence one another (directly or indirectly) to maintain their activity and the existence of the system, in order to achieve the goal of the system.

What is a system? (cont)

- So in simple terms, a system is a number of inter-related tasks (or team members) which play specific roles in order to achieve a common goal/outcome (patient safety).

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- Prior to surgery – SSCL
- Accreditation of facilities – COHSASA, JSI, ISQUA, OHSC, Care Quality Commission (NHS)……
- Medication errors
  - Wrong dose, route, medication, patient, time, etc
- Patient monitoring – BP, blood sugar, INR

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- Do no harm
  - No professional intentionally harms a patient, and the patient expects to be kept safe.

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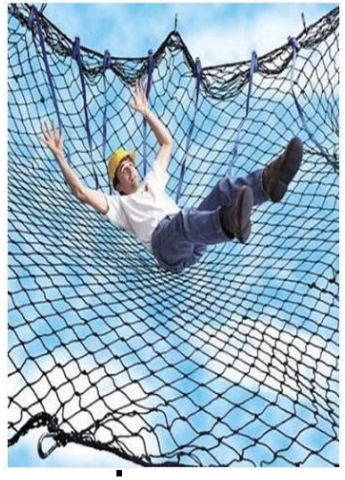

- The healthcare environment has become more complex due to new medications, generics, more sophisticated medical procedures, increase in litigation, etc.
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- We need to improve our standards and to do this we need to measure regularly.

An example

- In a private hospital in SA the pharmacy team decided to look at the medication errors. These were listed and classified and then a continuous improvement project initiated to reduce these errors.

- These errors were caused by human factors (e.g. doctors handwriting), team factors (e.g. nursing not administering medication timeously) and individual factors (skill or knowledge)

An example (cont)

- By addressing the 5 principles of Right Medication, Right Dose, Right Time, Right Route to Right Patient, they studied to actions of the multidisciplinary team to see what led to the errors

- By addressing the contributing factors they were able to significantly reduce the number of medication errors in a 6-month period.

- Achieved by identification, measurement and improvement process. Then repeat and repeat.

What are the consequences of omission?

- We can have all the checklists and accreditations in the world, but if we do not apply them we will fail the patient.

- A STRONG leadership is required who continually drives the processes. Every member has a role to play.

Conclusion

- It is not rocket science
- Can be introduced in “baby-steps” – one at a time
- Needs continual improvement
- Remember….. One day YOU may be the patient who may or may not be able to speak for yourself.

THANK YOU!

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