Patient safety in Health care Logistics

Sari Nieminen Spring 2020

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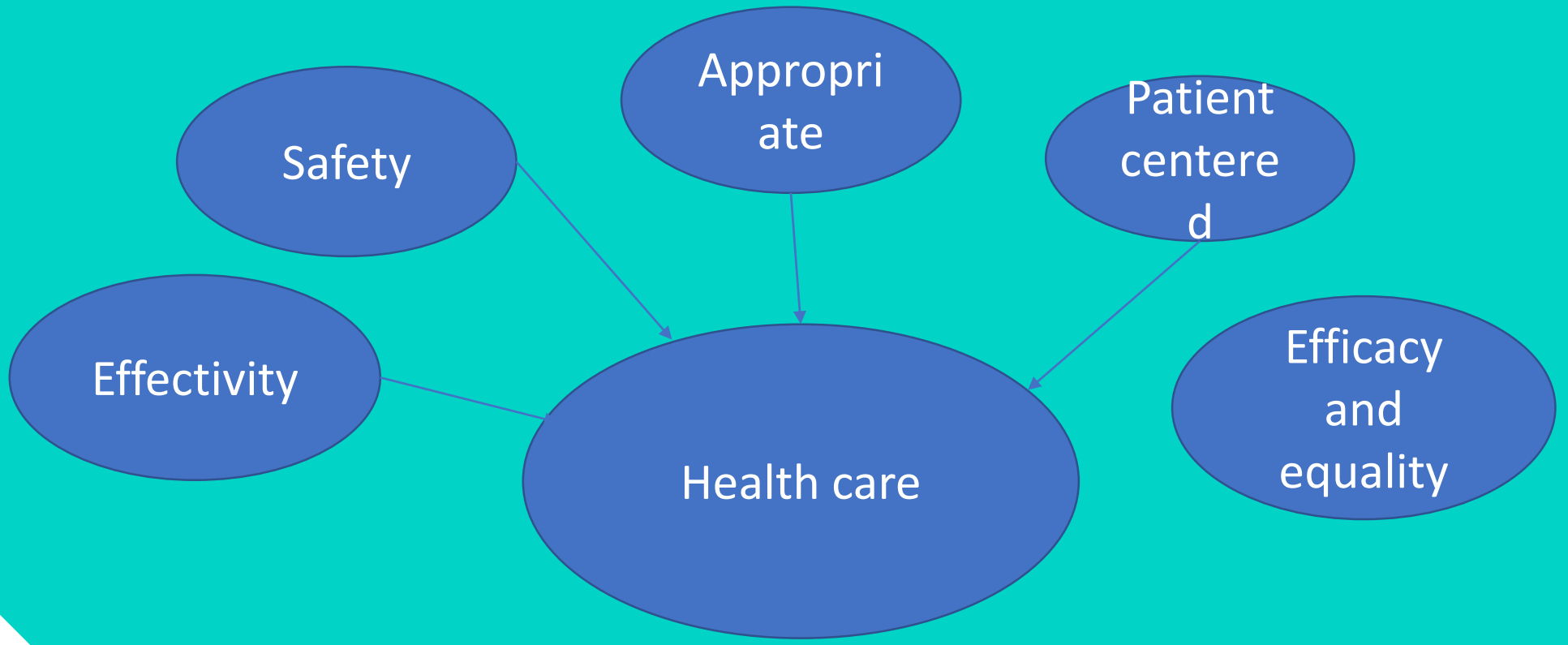
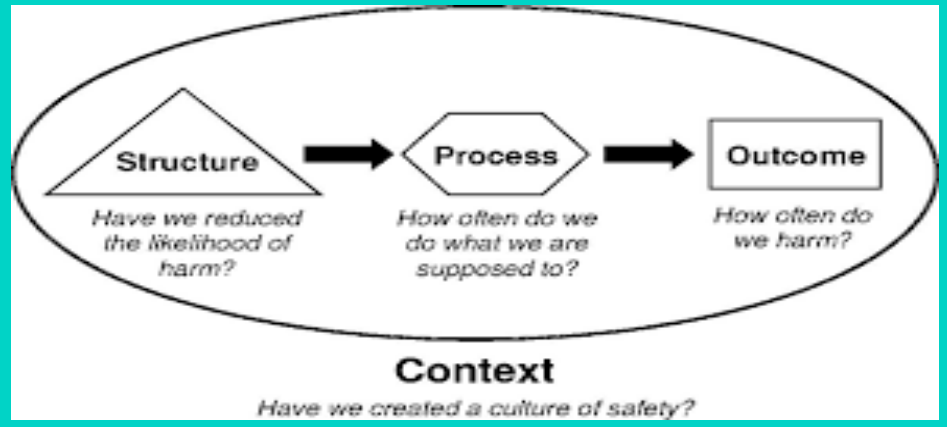
Quality in Health care



Definitions of quality in Health care

- **Donabedian´s triangle:**
- Quality consists of:
- - Structure: how the system has been organized?
- - Processes in health care: what is included in health care process?
- - Outcome of care: has health been improved?



European commission´s definition:

- High-class quality in Health care is effective and safe
- It considers patients´ needs and preferences
- Availability and equality of health care services are a part of high quality

WHO´s definition

- The quality of health care describes:

 - how the system achieves the objectives concerning health benefits

 - how the health care system is able to respond to populations´s expectations concerning health care needs

So, patient safety by Finnish Institute for Health and welfare is:

- Essential part of quality in health care
- Means that patient gets the needed and right treatment
- The treatment will not cause any harm for the patient
- There are no damages or mistakes in given care
- Damage in given care: patient has got a personal damage concerning examination or treatment
- Mistake in given care: there has been a mistake in given care or care has been neglected. It may be linked to systems, processes or equipment

Damages and mistakes in Health care

Think what kind of damages and mistakes may appear?

- Give examples

https://www.youtube.com/watch?v=ZP4QRB6H7rY

Functional aims of patient safety actions in Finland

- Developing patient safety is a part of quality management in Health care
- Risks concerning patient safety will be recognized and analyzed for improvement
- When mistakes appear they will be followed, analyzed and registered even nationally in order to improve patient safety

Principles of developing patient safety

- Good clinical knowhow is the basic element among Health care employees (mentoring and education)
- Understanding the system and its´ principles
- Understanding the tasks and responsibilities of co-workers
- Understanding that mistakes may appear – learning from them by not blaming anyone
- Listening to feelings and experiences of patients and relatives

System-oriented thinking in developing patient safety

- If a mistake appears it may be caused of the weakness of the system
- ALL of health care workers must be alert concerning patient safety and act in improving it

- Why mistakes may appear in health care?

List three reasons.

Human factors in affecting patient safety

- Misunderstandings, fatigue, huge workload, interaction and communication skills may affect negatively to patient safety among health care workers – according to studies these are main reasons
- Openness, transparency and learning from mistakes are key elements
- Important to recognize mistakes and analyze them
- Important to find out why the mistake occurred and try to develop the process

Documentation concerning patient safety

- Important to document everything – otherwise it´s not possible to examine what has happened
- Important to have updated systems and enough computers
- Different kind of databases have to be available easily (different kind of databases about guidelines, pharmacology etc.)
- Management has to be supportive and lead the development concerning patient safety

Co-operation with patients and relatives

- Patients and relatives observe health care system and given care closely
- The have a lot of experiences to take into consideration
- Feedback should be collected and analyzed regularly in order to develop patient safety: what do they think about patient safety and what could risk it?

Patient safety in practice

- Instructions for possible damages and mistakes: how to act?
- Recognition, registration, analyzation and following instructions: what is the whole process like?
- Finding out what has happened in a non-blaming way

Patient safety aspects in clinical work

- Knowledge of how patient safety is obeyed
- Knowledge of infection prevention
- Knowledge of pharmacology
- Knowledge of technical equipment in Health care (Operation room, Intensive Care Unit etc.)
- Knowledge of patient transportation

Conclusion:

- Do no harm (HIGH ETHICS): the safety of patients must be the paramount concern of professionals and the systems they work in. Some health-care-associated infections can be reduced by as much as 70% with proper patient safety interventions that include:
- standardised clinician education
- proper notification processes
- strict hand hygiene procedures

- Patient safety is a two-way partnership. Patients must be involved—indeed be central—in their own care.
- Evidence suggests that involving patients, service users, and carers in important decisions relating to care and treatment strengthens patient safety and is the best way for patients to achieve a positive outcome. As WHO comments, “safe health care starts with good communication”.

- Addressing all improvements necessary for increased patient safety require resources worldwide

- https://www.who.int/features/factfiles/patient_safety/en/

References

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