from doctor:
only the dimensions as points are required
without explanation

Activity 6

Watch the video to learn more about the 6 dimensions of quality healthcare according to Crossing the Quality Chasm: A new health system for the 21st-century report

Note: IT is preferable to watch the video and then read this summary thoroughly

**The doctor didn't tell what exactly is required from the video and didn't ask questions, but probably you have to memorize the 6 dimensions with brief definitions about them.*

These 6 dimensions are healthcare of areas to improve on, summarized a lot of research literature on current levels of performance like quality, safety, fuel efficiency, comfort, fun driving, and durability.

لما أشتري سيارة شو الاتجاهات الّي تحدد انها ممتازة: الأمان، كفاءة الوقود،...

-the 1st dimension: SAFETY:

***This includes not hurting people, not adding to the burden of the illness**

***safe health care system reduces hazards and risks.**

-the 2nd dimension: EFFECTIVENESS:

***stans for matching science to avoid overuse of care that doesn't help and assuring of using things that help(avoiding underuse).**

Ex: if science says this drug helps, so we use this drug

If science says this drug can't help, we don't use this drug.

***problems in effectiveness: the Rand Corporation published a study that showed the needed effective care, those 7000 Americans who range from well care to serious chronic illnesses failed to get 45%of the care that could help them.**

-3rd dimension: PATIENT CENTEREDNESS

***it is a subversive goal, stands on controlling our things and making our own decision, 'nothing about me, without me '**

***it puts the patient at the center of the care system, power.**

-the 4th dimension: TIMELINESS

***stands on avoiding delays**

***people are quite familiar with waiting for doctors and delaying non-instrumental appointments which oppose TIMELINESS**

***it is an important dimension of quality**

***it is the reduction of needless delay**

***some delays are instrumental for treatment reasons, they aren't included in this dimension, timeliness deals with non-instrumental delays.**

-the 5th dimension: EFFICIENCY

***it deals with avoiding waste and stopping waste staff**

***there is a lot of waste in healthcare, like duplicating procedures and tests, losing records, and losing the idea of the workforce by not inviting them to join in inventions.**

-the 6th and last dimension: EQUITY

***some people think it has to be the 1st dimension**

***it stands for closing the gap in justice in healthcare**

*** in America: the biggest predictor of your health status is RACE, ex: black baby born in inner city Baltimore has a life expectancy of males 7-8 years less than a white baby**

from the doc:
q1 and 2 only required

Activity 7:

Watch this video to know about the SWISS CHEESE MODEL OF SAFETY INCIDENTS(who came up with the Swiss cheese model? What do the slices and holes in the model represent?)

Note:

More than the answers to the questions will be written because the video is about 7 mins and the answers are in the first 2 mins, I think you got me ☹

AGAIN, watch the video please, memorize the answers and read the other information thoroughly.

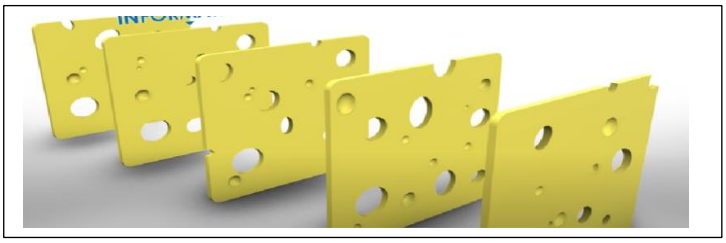
***Q1:who came up with the model?**

This model is one of the 40 SIRIs (serious incidents requiring investigation)over the past years, it was developed by Prof. James Reason.

***Q2: what does each slice and hole represent?**

-Each slice of cheese represents a protective factor, which can reduce the likelihood of an incident occurring.

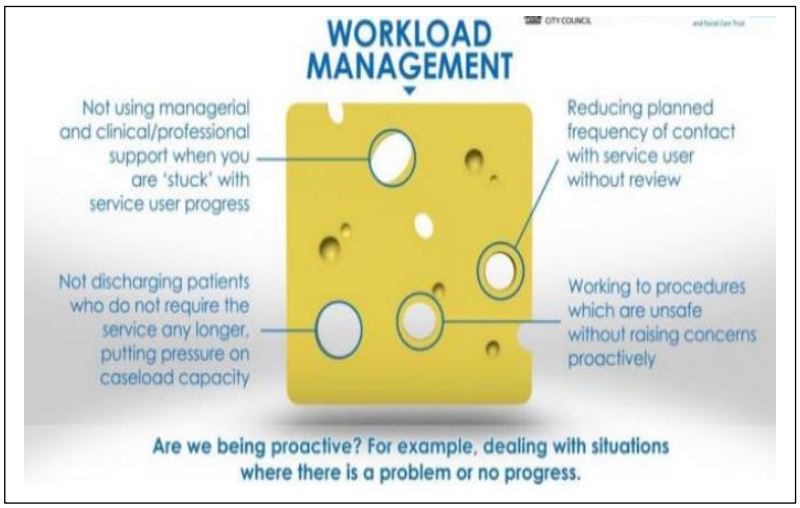
-each hole represents the error or the gap in the expected practice protective factor



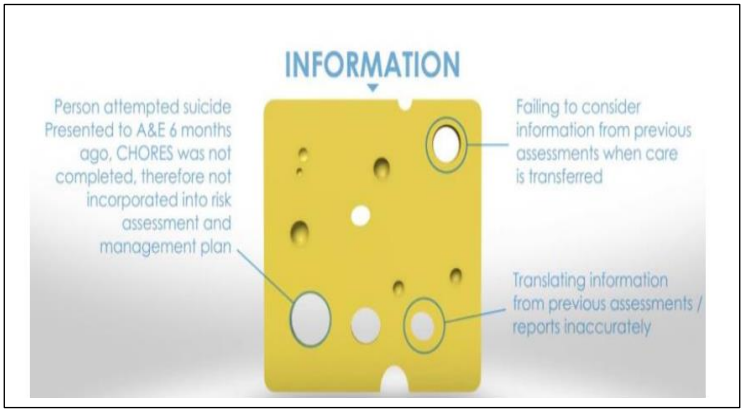
-here, are some examples of protective factors and their errors:

I think that they are just for understanding:)just read and enjoy:

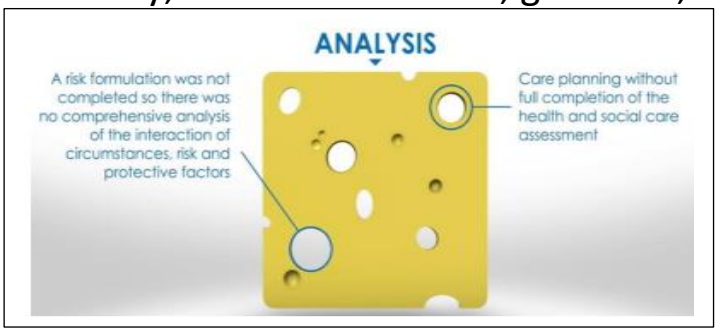
1. workload management: knowing and effectively managing our workload.



2. Information:

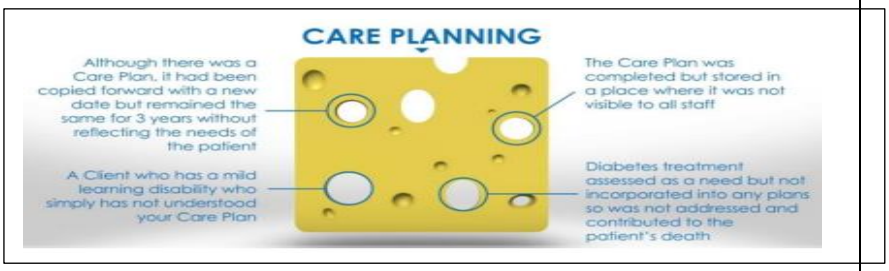


3. Analysis: knowledge of theory, research evidence, guidance, and best practice.

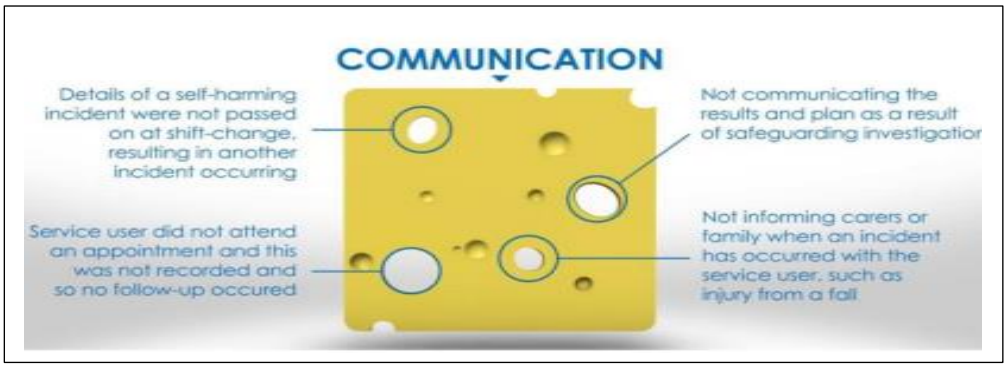


4. Care planning: effective care planning relies on sound information and analysis. There should be a clear thread from the assessment through formulation to any plan. Care planning

must be executed in partnership with patients through a process of shared decisions making



5. Communication underpins everything: which means accurate and timely record-keeping, any other relevant professional should be able to pick the patient record, understand the plan, understand why decisions have been made, and continue with support and treatment effects in our absence.



*There is a scenario in the video at 3:18 min, go back for it,

<u>The main idea from it is that if all protective factors have holes(errors) then we will get error propagation and a serious incident, however, if not all of them have defects but there are numbers of defects we call uncontrolled or unforeseen incidents but not serious!</u>

***here is the scenario from 2020 solutions:**

>>> Now let's apply this to a specific scenario, to see how a serious incident can

happen when there are errors and omissions :

Let’s consider the following example of a 23-year-old man who :

o has a diagnosis of schizophrenia

o he lives alone

o his mistrusting of care staff

o has a history of self-harm

Error :

1. The practitioner was having difficulty with the emotional impact of working

with a service user this was not discussed in management supervision and

they did not access clinical or professional supervision

2. The young man attempted to jump off a bridge this time last year, it is a

special anniversary, and his family recognized his becoming low when he stop

taking his medication and isolates himself,

3. A risk formulation was not completed, so there was no comprehensive

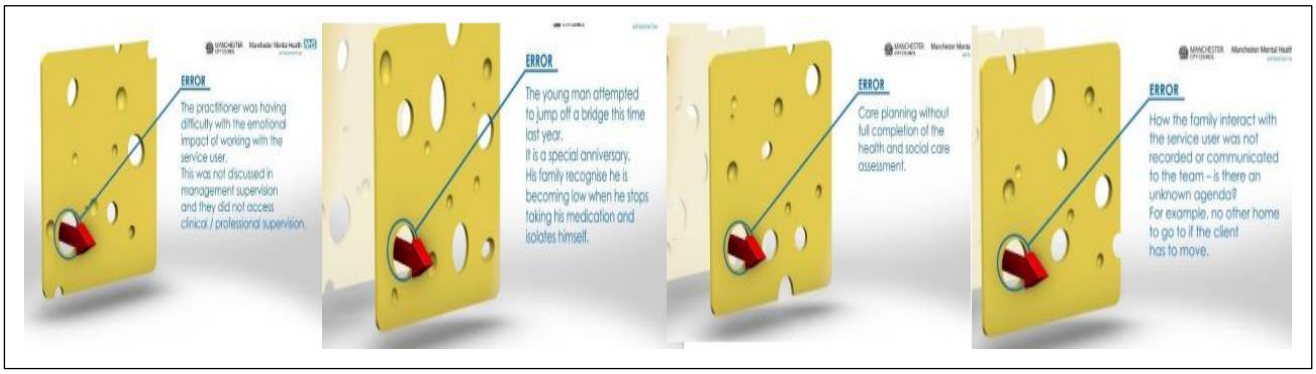
analysis of the interaction of circumstances risk and protective factors.

4. care planning without full completion of health and social assessment

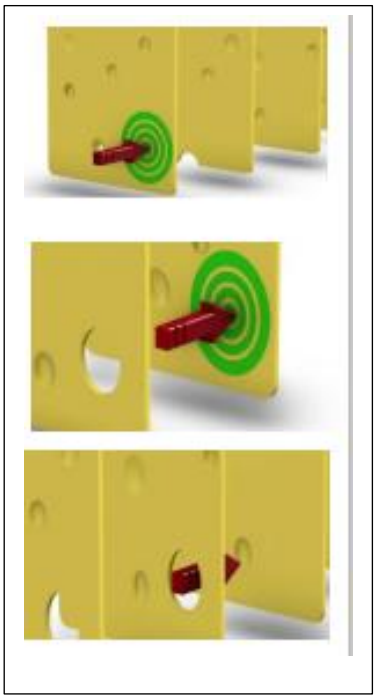
5. how the family interacts with the service user was not recorded or

communicated to the team - is there an unknown agenda? for example, no

other home to go to f the client has to move



> Now let's look at how by getting the basics right and by making small



incremental changes we can minimize or even illuminate errors and so prevent x if there are no holes or smaller holes in the cheese this means that we have reduced or eliminated the likelihood of errors and a potential incident is prevented. x if an error or omission does occur in the first slice, perhaps due to a patient service user missing or failing to attend analysis or a protective factor again stops the incidents from progressing, in this way we can see that the arrow could feasibly pass through for layers, but still be stopped at the last layer .x this would be an unusual coincidence of unforeseen or uncontrollable incidence, but as long as the protective factors are properly in place, we could still avoid serious incidental try to get things right, but we should also recognize occasionally we can all make mistakes too. it is not necessarily about making big alteration practices but rather small incremental changes that add up to larger positive outcomes. it's

about sticking to the basic principles of good practice. if we all do this we can dramatically reduce the likelihood of harm occurring. With this in mind, how safe is our practice what things can we do today to illuminate or reduce the size of holes in the cheese, the errors, or omissions in our practice?