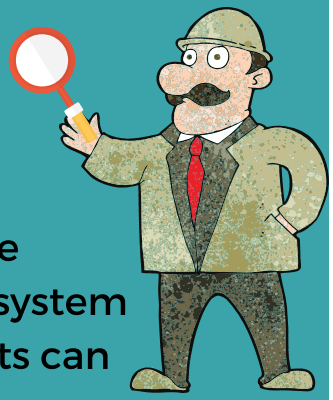
QUALITY IMPROVEMENT & PATIENT SAFETY

Reviewing & Learning from Patient Safety Events

Every reported patient safety event is an opportunity to learn and improve the care we deliver to patients & families.

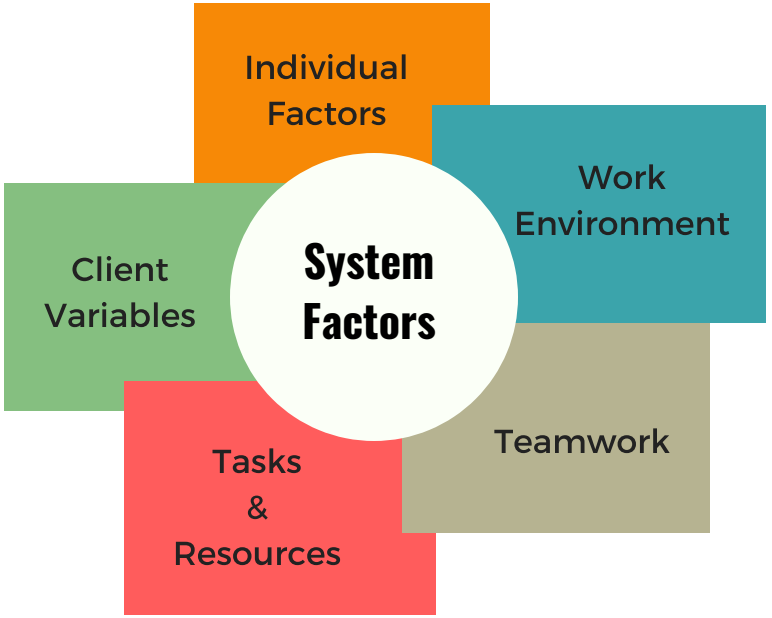
Reviewing



What happened?

- Explore processes in place
- Focus on the gaps in the system
- Identify how similar events can be prevented

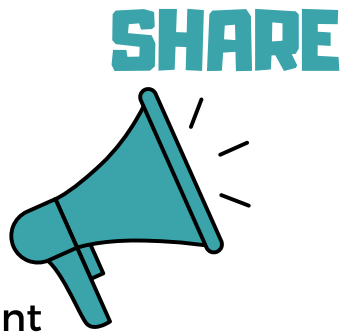
fair & just culture



Learning

What will we do to improve?

- Collaborate with patients, families & other care providers
- Identify improvements
- Implement changes to enhance patient safety



Resources

WRHA Resources

- WRHA Quality Improvement & Patient Safety Website http://home.wrha.mb.ca/quality/
- WRHA Patient Safety Event Standard Operating Procedures http://home.wrha.mb.ca/quality/SOPs.php
- WRHA Critical Incident Reporting & Management 10.50.040 Critical Incident Reporting & Management http://home.wrha.mb.ca/corp/policy/files/10.50.040.pdf
- WRHA Occurrence, Near Miss Reporting & Management Policy 10.50.020 Occurrence, Near Miss Reporting & Management http://home.wrha.mb.ca/corp/policy/files/10.50.020.pdf
- Evidence-Informed Decision Making http://www.wrha.mb.ca/osd/EIPSeries.php

Additional Resources

- Improvement Frameworks Getting Started Kit by CPSI and Safer Healthcare now http://www.patientsafetyinstitute.ca/en/toolsResources/ImprovementFramework/Pages/default.aspx
- Culture Change Toolbox BC Patient Safety & Quality Council https://bcpsqc.ca/resources/culture-improvement/
- How to Improve [PDSA]. Institute for Healthcare Improvement. http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx
- The Patient Safety Education Program http://www.patientsafetyinstitute.ca/en/education/PatientSafetyEducationProgram/PatientSafetyEducationCurriculum/Pages/default.aspx

Questions?

Contact patientsafety@wrha.mb.ca