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# of Patient Safety

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**Patient Safety Education and Support**  
*Giving the Patient and Family a Voice!*

- **Support** – learning from the patient.
- **Education** –
  - Grassroots, get into the community
  - Teaching what you already know

# WHAT DO THEY HAVE IN COMMON?

- They want answers.
  - We can all learn from these answers.
- Make sure it doesn't happen again.
  - Talk about it!
- They may be entitled to compensation.

# WHERE IS THE:

- Red Cross?
- Crisis Team?
- Black Box with all the Answers?

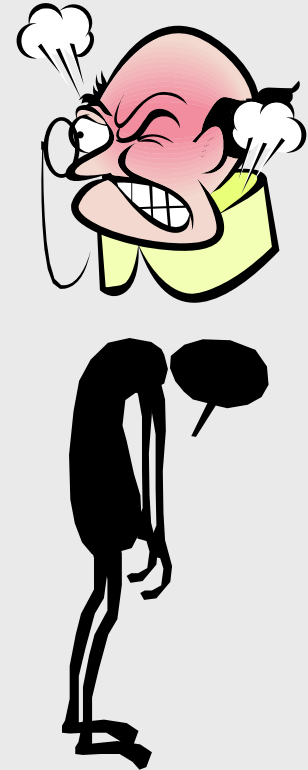
*Who is helping the survivors?*



# 3 STAGES AFTER AN UNEXPECTED OUTCOME

- 1) Anger / Guilt
- 2) Sadness / grief
- 3) What can I do to make sure this never happens again?

**THESE ARE YOUR FUTURE PATIENTS**



# WHO HAS A STORY:

Physicians - Teachers - Religious Leaders  
Nurses - Housewives -  
Lawyers – Doctors – Hospital Administrators  
Legislative Aids  
Top Lawmakers  
Working and non-working families  
Many different races

## YEARS AGO WE DIDN'T TALK ABOUT..

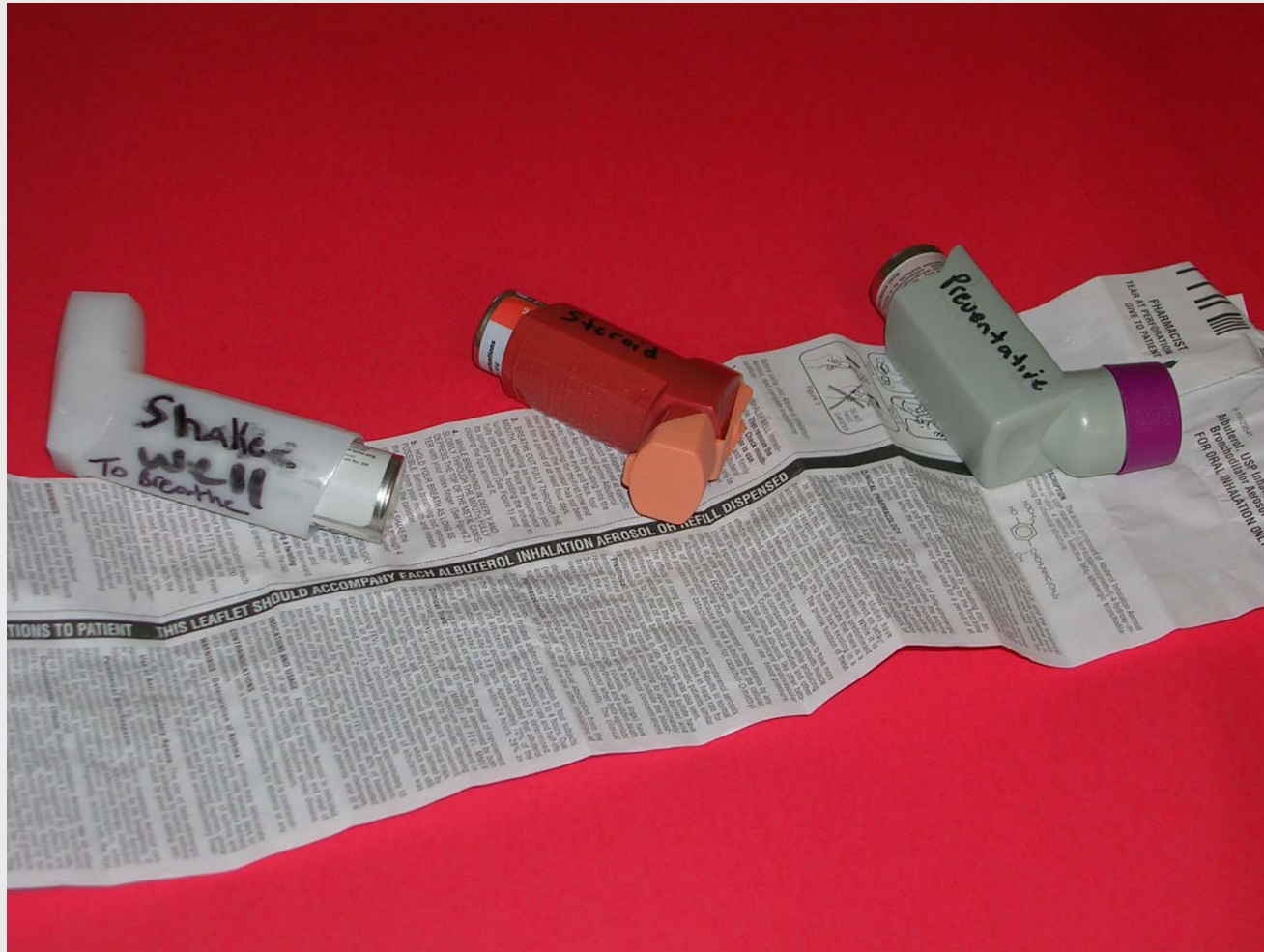
- breast cancer
- "safe sex"
- condoms to avoid sexually transmitted diseases.

**TALK ABOUT PATIENT SAFETY!**

# Imagine if this is What You See









# The Joint Commission

## Minimizing Fuel Risks

During Preparation

- Avoid pooling or wicking of flammable liquid preps.
- **Allow flammable liquid preps to dry** fully before draping; pooled or wicked liquid will take longer to dry than will prep on the skin alone.
- **Use a properly applied incise drape**, if possible, to help isolate head and neck incisions from O<sub>2</sub>-enriched atmospheres and from flammable vapors beneath the drapes. Proper application of an incise drape ensures that there are no gas communication channels from the under-drape space to the surgical site.

# NUMBERS!!!

- 1.5 million medication errors  
IOM 7/06
- 90,000 deaths from  
infections. CDC
- \$29 Billion a year IOM 1999
- 44,000 – 98,000 deaths IOM  
1999

# THE CULTURE

## WHAT WELL MEANING PEOPLE SAY:

- “I hope you are going to sue!”
- “Make them pay for what they did!”
- “Not at THAT Hospital!”



# “WHAT DO YOU WANT TO DO?”



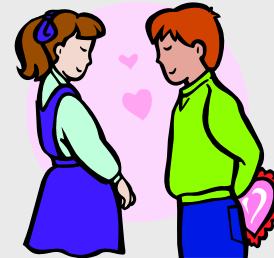
# SAFETY

■ Motorcycle safety 

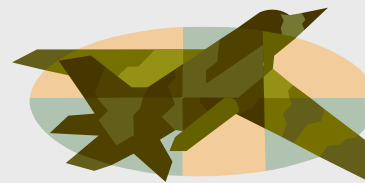


■ Seatbelt and car seat safety

■ Fire safety 



■ Airplane safety

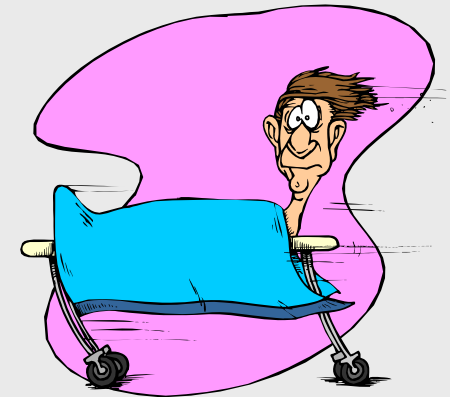
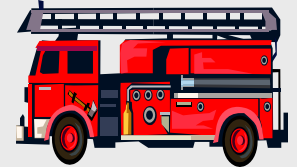


“WELCOME TO YOUR  
LOCAL FAMILY  
HOSPITAL”



# LESSONS LEARNED:

- What is “Patient Safety”?
- What is a bedsore?
- Communication is a problem.
- Health literacy.





# WHAT WE NEED NOW:

- Programs in the hospitals and in communities.
- Offer assistance if there is an unplanned outcome or error.
- Acknowledge that patients can play a role in reducing errors.
- Teach us how.

# WHAT WE NEED NOW:

- What is the “mood” of the staff?
- Understand how errors happen.
- Support for staff and patients.
- Is staff aware or is it only administration?
- Recognize that staff can be patients as well as partners.
- Include the staffs input.



# PULSE PROGRAMS

- 24 hour availability
- Hospital programs to work with staff/patients and the community
- Teen Program
- Community Programs:
  - Caring in a Crisis
  - Patient Empowerment
  - Work groups



# Let's All Be Part of the Solution!

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