January 2005

Its all about the patient

Follow this and additional works at: https://opencommons.uconn.edu/pcare_articles

Recommended Citation
"Its all about the patient" (2005). Articles - Patient Care. 4.
https://opencommons.uconn.edu/pcare_articles/4
“It’s all About the Patient”

**Endorsed by our Board of Directors, we have set out to become the safest hospital within the State of Connecticut.**

Our priority is safety. Our goal is to provide the safest environment for our patients as well as our staff. *What does this mean for you?*

Involvement and support from everyone is essential. Faculty, healthcare providers, students, receptionists, transporters – all of us will need to vigorously participate. We are asking for a far greater commitment to this goal than we have ever asked before. This will mean significantly enhanced awareness, communication, team planning and participation throughout the Health Center. It will mean we will all need to work smarter not harder.

*We are a safe hospital already, aren’t we?*

Hospitals provide very complicated care. **On average, 60 people interact with a single admitted patient.** Each health care worker is highly trained and has a high degree of freedom when providing a service. Therefore, the potential for errors, at a minimum, can occur with the hand-off from one of these 60 people to the next. The technology we use also adds to patient risks. These errors and risks are not theoretical problems.

**In Connecticut, there are 30 deaths per month reported to the Department of Public Health as a result of adverse events.**

There are 31 hospitals in the state, so on average; someone dies each month as a result of a preventable adverse event. These are only the cases we know about. Surveys show that most healthcare workers can easily recall some type of preventable adverse event during their career.

We have an ethical responsibility to do better. You would expect the best possible care for your sibling, child, parent or loved one. We ask you to remind each other about this with every patient encounter. No one—absolutely no one—can abandon their responsibility in this regard. *Above all else, we should do no harm.*

We know a lot about what needs to be improved and where we need to focus our efforts. **At JDH, there are four areas responsible for the vast majority of adverse events: medication errors, patient falls, infections acquired while in the hospital and errors related to pain management.**

Understanding this information is very important because it sets the stage for an action plan to prevent these risks from occurring in the future. We also know that to impact these areas, there must be a significant shift in our culture to one driven by better communication, clearer goals, better systems, more measurement, and – the essential element – greater ownership and personal responsibility.