

INCIDENTS

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Understanding the concepts underlying patient safety incidents is useful because it helps to anticipate situations that are likely to lead to errors and highlights areas where preventative action can be taken. The problem of error can be viewed in two ways – from a person approach or from a system approach.

Human factors
Inadequate patient assessment; delays or errors in diagnosis
Failure to use or interpret appropriate tests
Error in performance of an operation, treatment or test
Inadequate monitoring or follow-up of treatment
Deficiencies in training or experience
Fatigue, overwork, time pressures
Personal or psychological factors (e.g. depression or drug abuse)
Patient or working environment variation
Lack of recognition of the dangers of medical errors
System failures
Poor communication between healthcare providers
Inadequate staffing levels
Disconnected reporting systems or over-reliance on automated systems
Lack of coordination at handovers
Drug similarities
Environment design, infrastructure
Equipment failure owing to lack of parts or skilled operators
Cost-cutting measures by hospitals
Poor governance structures and inadequate systems to report and review patient safety incidents
Medical complexity
Advanced and new technologies
Potent drugs, their side effects and interactions
Working environments – intensive care, operating theatres

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