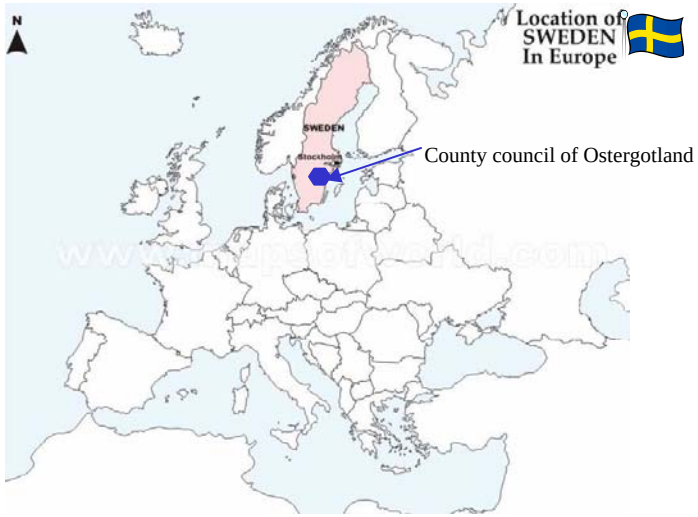
Risk Analysis
– a tool for IT development and patient safety



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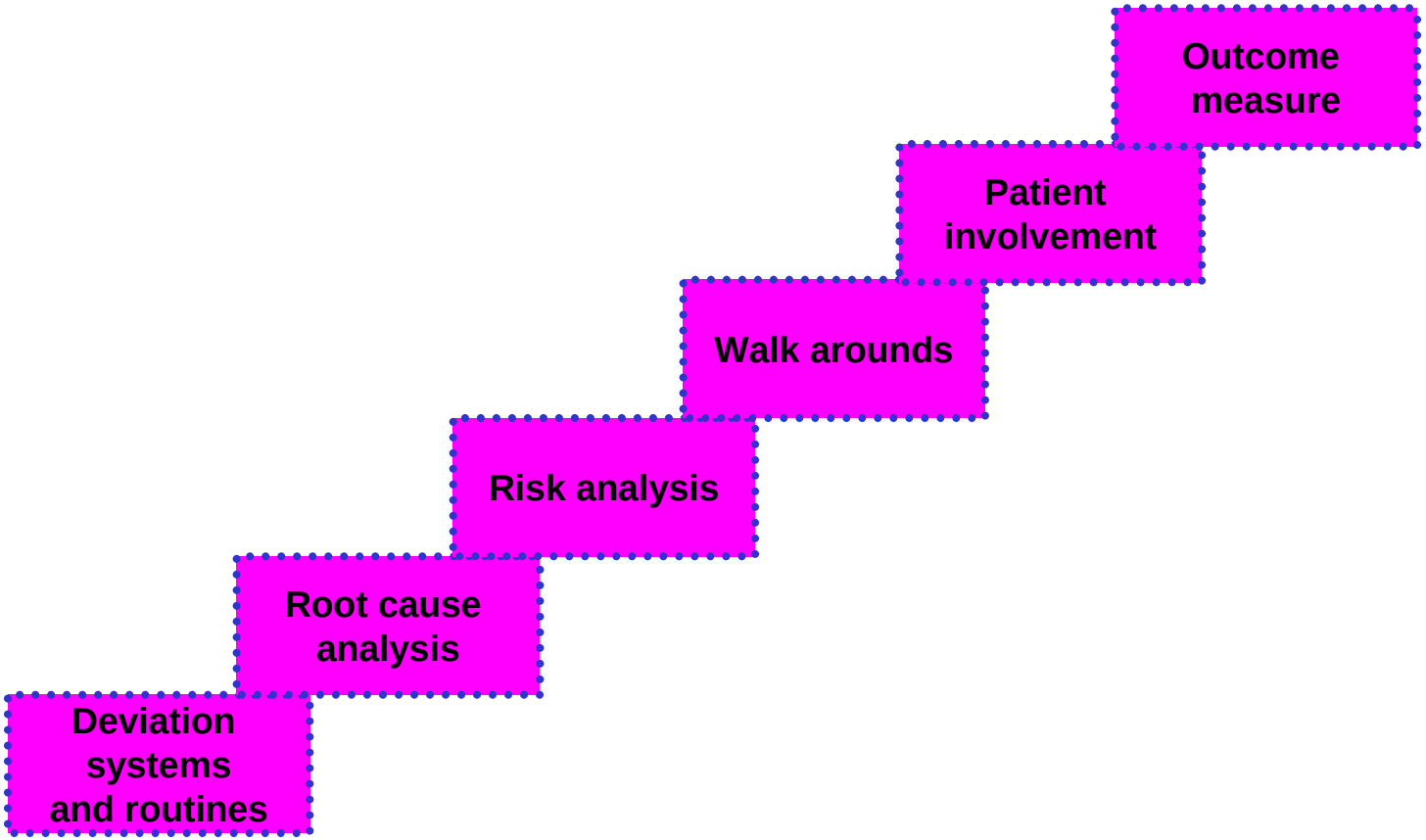
Aim

A comparing study of weaknesses before and after implementation of a health care system

Introduction

- The county council in Ostergotland, Sweden
  - work systematic and structure with patient safety since year 2000
  - has implemented a supporting system for requests and laboratory reports during the last year and a half.

Introductions



The model for patient safety in county council of Ostergotland, Sweden

Methods

- Risk analysis has been performed before and after the implementation of the system

- Risk analysis is a systematic tool, including:
  - process mapping
  - risk identification
  - determination of the severity and probability of each risks
  - action plans

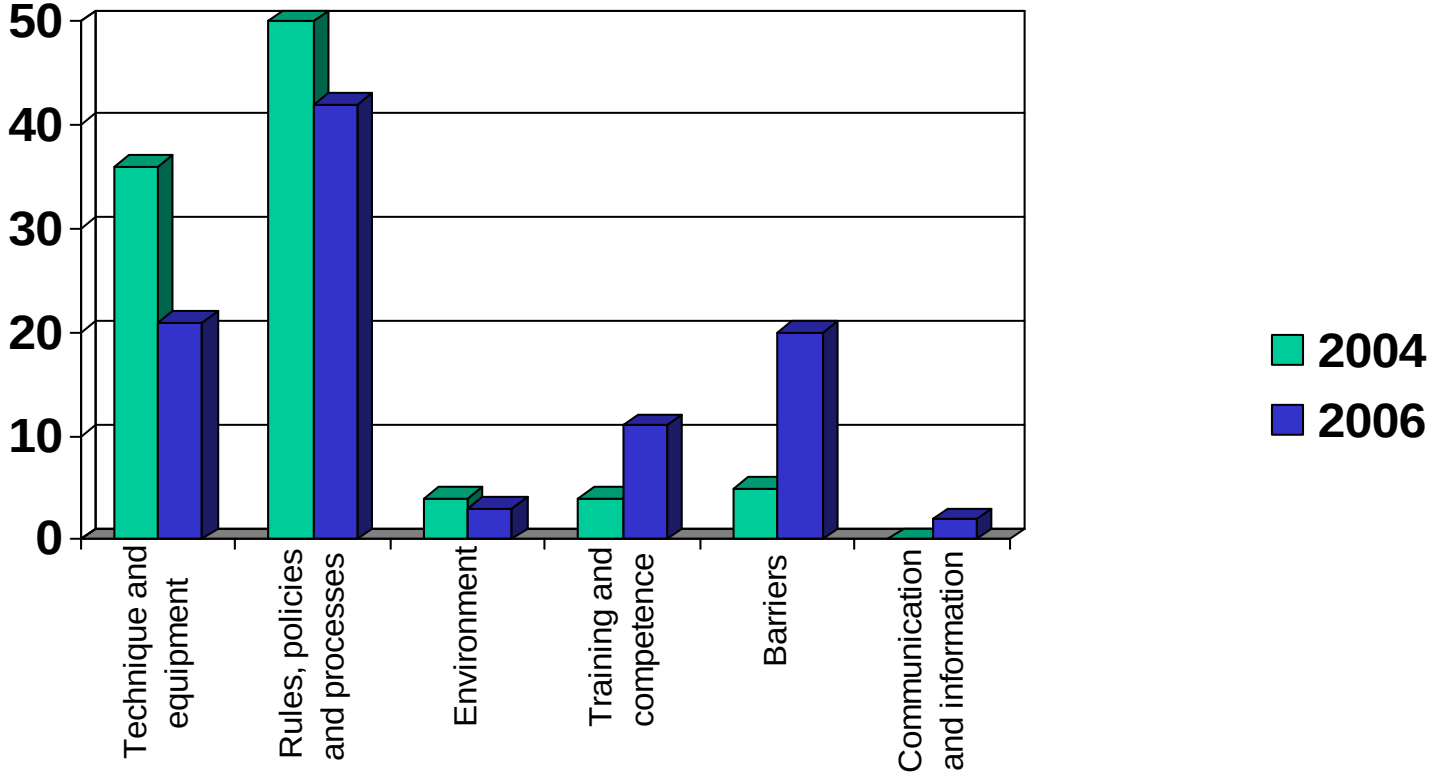
Methods

- The analysis has a patient safety perspective
- Team with trained risk analysis team including members from different roles/specialities.

Methods

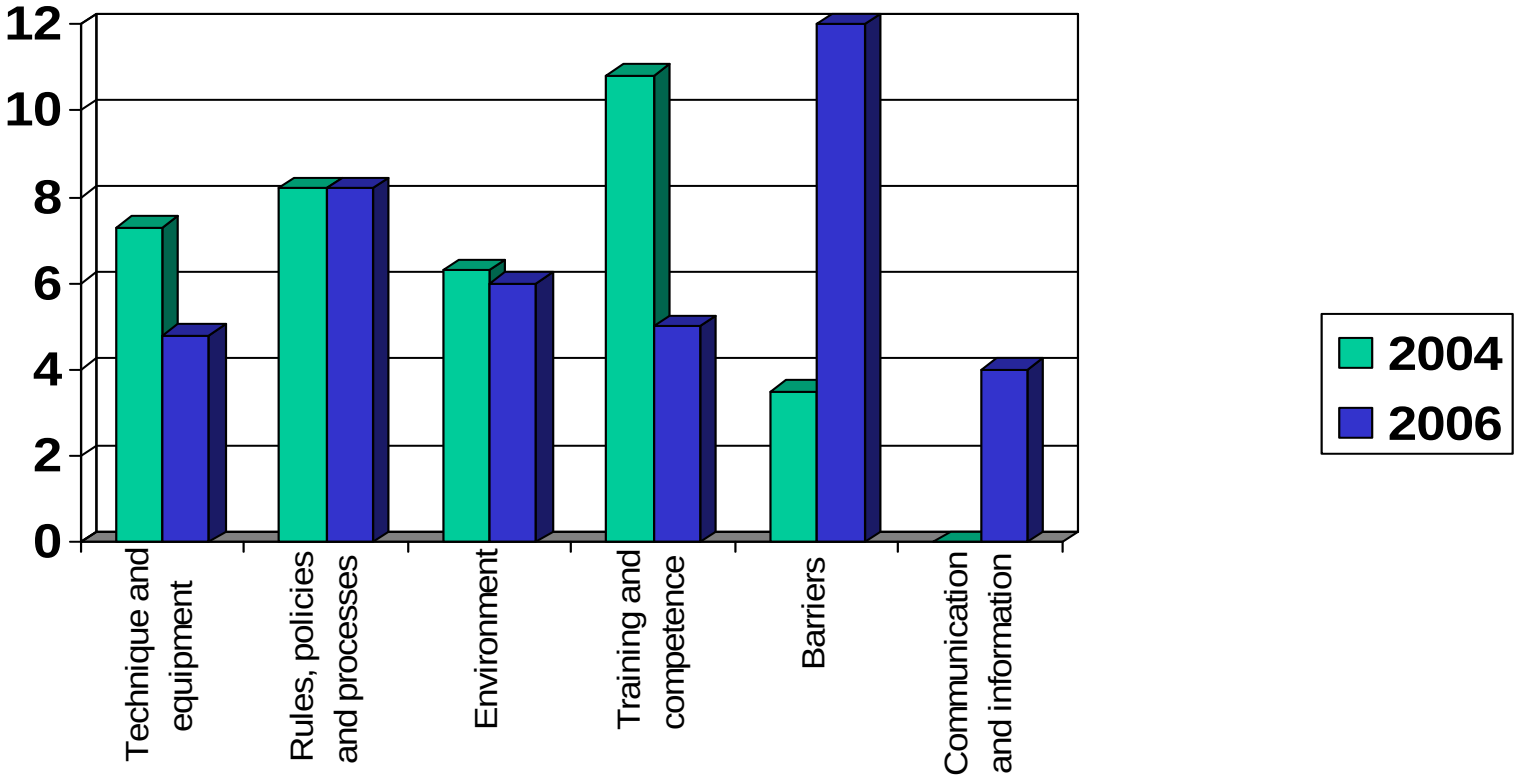
- The risks were categorised in areas of six potential sources;
    - technique & equipment
    - rules/policies/procedures
    - environment
    - training & competence
    - barriers
    - communications & information

Results



The risk share/risk areas. A decrease in the number of risks in technique & equipments and rules, policies/procedures shows but the risks in training & competence and barriers has increase between the year 2004 and 2006.

Results



The risk profile/risk areas.
A decrease in the risks severity in technique & equipments and training & competence shows but the severity in barriers has increase between the year 2004 and 2006.

Results

- The risk profile within technique & equipment demonstrated that most of the risks prior to the implementation have been dealt with.

- Training of the personal drastically decreased the risk profile within training & competence.

Conclusion

- Risk analysis is a useful method for identifying and managing possible patient safety risks and also a method for proactive work in health care organisations.

- Systematic and regular risk analysis is preventive of managing new routines.

- This may be a constructive tool for the patient safety work.

References

Stalhandske, E. DeRosier, J. Patail, B. Gosbee, J.
How to make the most of failure mode and effect analysis, Biomed Instrum Technol. 2003 Mar-Apr;37(2):96-102

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