Health and Disease in Society

Quality & Safety in Healthcare

**Adverse Event** – Injury caused by medical management that prolongs hospitalisation, produces a disability or both; safety in healthcare can go wrong due to poorly designed systems that do not take human factors into account and due to culture & behaviour. This can include over reliance on individual responsibility, system failures, human factors or incompetent, careless, badly motivated, negligent individuals. Methods to prevent such occurrences include communication, team working, prioritising, immediate labelling, protocols, tools, checklists, safety questionnaires & clinical guidelines.

- **Never Event** – Something that should never happen
- **Preventable** – Adverse event that could be prevented given the current state of medical knowledge

**James Reasons’ Framework of Error** – States that errors arise from active failures which are acts occurring closest to the patient that lead to direct harm, or latent condition which are predisposing conditions that mean active failures are more likely to occur

**Clinical Governance** – Framework through which NHS organisation are accountable for continuously improving the quality of their services and safeguarding high standards of care. Quality improvement mechanisms include setting standards, commissioning, financial incentives, disclosure, regulation & clinical audit

- **Clinical Audit** – Seeks to improve patient care & outcomes through systematic review of care against criteria and the implementation of change
- **Evidence Based Practice** – Integration of individual clinical expertise with the best available clinical evidence from systematic research which can be found in medical journal, Cochrane collaboration & NHS centre for reviews & dissemination
  - **Practical Criticisms** – Difficult to create & maintain an extensive library for all specialities and dissemination of implementation findings
  - **Philosophical Criticisms** – Population outcomes aren’t best for all individuals, may create unreflective rule followers, can legitimise rationing & undermine doctor-patient trust
  - **Problems in Practice** – Doctor’s don’t know about evidence or how to implement it, organisation systems cannot support innovation, resources not available to implement

**Social Science Research Methods**

**Quantitative Research** – Collection of numerical data; has strengths of reliability & repeatability, but may force people into inappropriate categories, not allow people to express themselves & not access all important information

- **Primary Studies** – Experimental design studies, cohort studies, case control studies, cross sectional surveys
- **Secondary Analysis** – Data from official statistics, national/local/regional surveys

**Qualitative Research** – Aims to make sense of phenomena in terms of meanings people bring to them. Good for understanding patient perspective & explaining relationships between variables but not suited for finding consistent relationships

- **Methods** – Observation & ethnography, interviews, focus groups, media analysis