Ensuring safety, even in the middle of the night

Safety is not centralized,” says Dr. George Blike, DHMC’s patient safety officer. “It’s what happens in the middle of the night when nobody is watching.”

Patient safety is everyone’s business, he insists. “You’ve got to empower your staff—that’s where safety lives,” says Blike, an anesthesiologist. “And you’ve got to invest in prepping for that and help them have the tools and the means to be successful.”

Blike Patient safety has always been a concern of the medical profession, but efforts to improve quality and patient safety intensified after the Institute of Medicine issued a report in 1999 on medical errors; it estimated that 98,000 hospital deaths every year were due to medical errors. The report noted that the vast majority of errors weren’t the fault of individuals, but of systems that didn’t work. So medicine began using a systems approach—and an understanding of the interface between people and systems—to protect human error.

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