**CASE STUDY**

**A System-Oriented Analysis Model to Enhance Patient Safety in Healthcare Organizations**

PART 1

For a health organization, patient safety is of utmost importance and a systems approach for the same is under discussion. The current status of hospital patient safety systems is not close to meeting IOM recommendations and this forms the basis of researching this area. The paper puts forward the significance of the system-oriented analysis model for the same. It shows a four-step System Oriented Event Analysis model which is based on system theory. A risk management model for social-technical systems also forms a part of it. A philosophical approach mechanism has been used to move towards the concept of systems thinking. A System Oriented Event Analysis (SOEA) model has been proposed to build up the capability of safety control. The significance of the model has been discussed. A pre-step and the following four steps for the model have been discussed in great detail which divide the objectives, form matrix, classify and analyze system components to result in better patient safety. The usefulness and future implications of the model also form a part of the study. Various safety indicators and system control matrix have been explained in detail to get an understanding of the entire working procedure.

PART 2

The current status of hospital patient safety systems is not close to meeting IOM recommendations as mentioned in the paper. The major barrier in the path of patient safety is the lack of knowledge and understanding of errors and this is where the importance or need of this proposed model comes into place. Creating the knowledge of system thinking for health care practitioners in applying foreign risk management techniques has been an essential concern for patient safety. Safety improvement is without question, the biggest ask of the entire healthcare system. Thus, there is a greater need for the understanding of the system thinking for a better opportunity for safety improvement. The risk management performed is not completely integrated which leaves us with another problem and a greater need for a better system model. A new model to understand errors in system thinking was needed that resulted in System Oriented Event Analysis Model (SOEA).

PART 3

As discussed in the very beginning, “lack of knowledge and understanding of errors is one of the major barriers in blocking the success”. The proposed model doesn’t guarantee knowledge abundance. An ideal understanding of errors may still be too far from being achieved. When we discuss this model, it has been stated in the paper that “logic of event analysis in the SOEA model is not different from other analytical approaches” so the question remains that if the logic of event analysis is similar to other analytical approaches and it is exceptionally effective, then it would have already been proven by now. There are still a high number of errors in the model as stated “521 errors”. Thus, proving that there hasn’t been any significant decrement in the number of errors and the fact that patient identification errors have decreased, it is still a problem to ponder upon.

PART 4

Healthcare is a forever developing field and as long as there is human existence, the healthcare needs would be persistent and would require a greater understanding and technical improvements. With the various health hazards coming up now and then, it is inevitable. Even if we consider the usefulness of this model, we need to take up the challenge of applying the concepts to more sophisticated hospitals and healthcare systems. A system that is more complex to test the tolerance of the model proposed. The paper discusses the management of limited safety control matrices and, likely, a vast hospital architecture or a much more extensive healthcare system for the sophisticated hospital would require a greater number of safety control matrices. When it comes to healthcare. One cannot risk making a model for a limited or a smaller group. The credibility of the model for a more extensive scenario must be at all times validated, only then can one conclude that the model proposed is a complete one.