

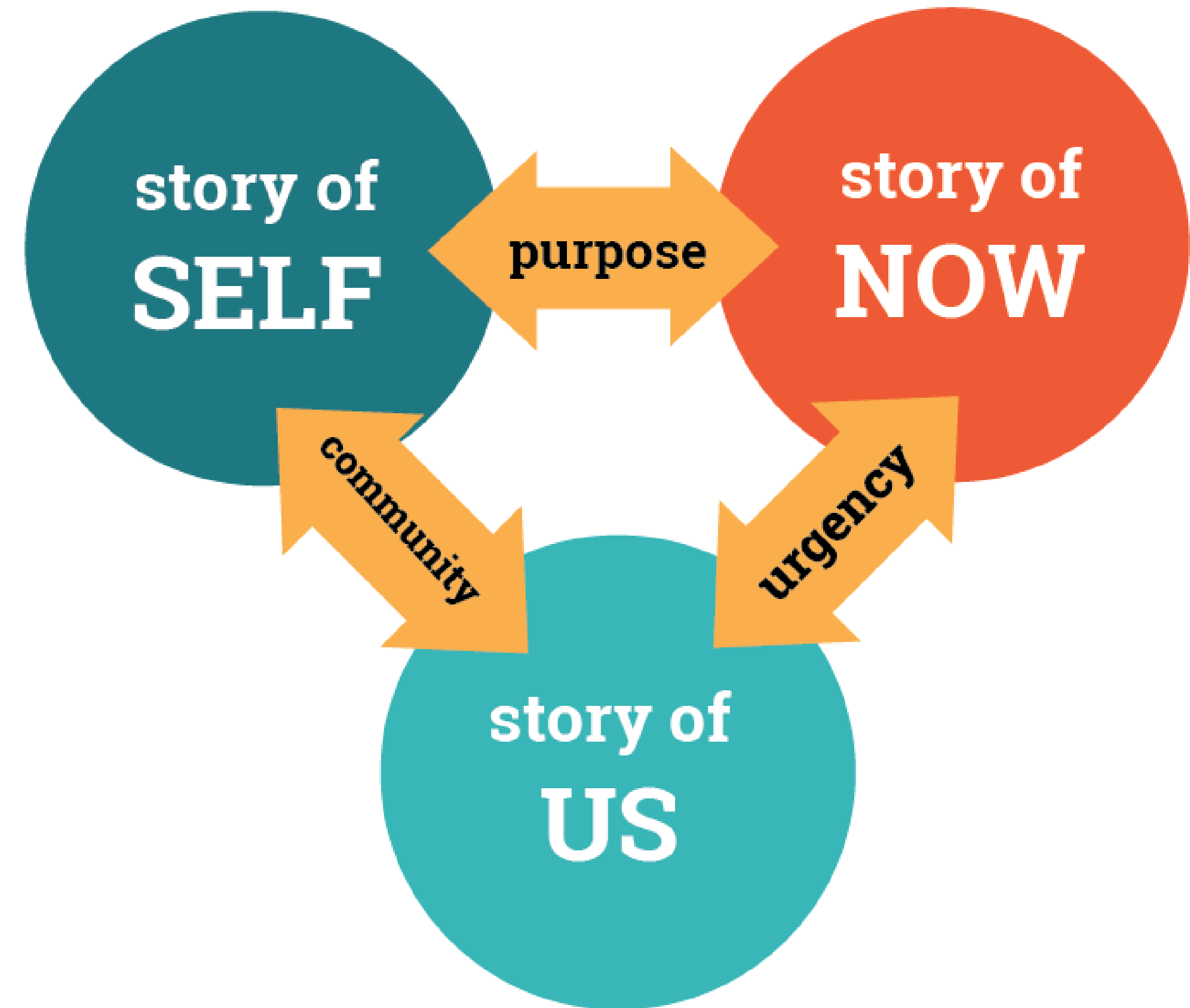
# Cultura sigurantei începe cu o poveste

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# De ce povesti?

- Sistemul medical e social, complex, si dinamic
- Marshall Ganz: narativa comuna = schimbare sociala
  - Povestea mea
  - **Povestea noastra**
  - Povestea momentului acesta



<http://marshallganz.usmblogs.com/files/2012/08/Public-Narrative-Worksheet-Fall-2013-.pdf>

<https://www.nourishleadership.ca/blog/2018/11/13/telling-the-story-of-self-us-and-now-seeing-environmental-nutrition-in-health-care-in-new-ways-nourish-wasan-retreat-october-2018>

A fost odata...

*Stories have wings: they fly from  
mountaintop to mountaintop.*

*— Romanian proverb*



<https://friendsofblueridge.org/category/blue-ridge-stories/> &  
<https://thebanffblog.com/moraine-lake/>

# Ce contribuie la siguranta



“The Journey: All the Way Home to my Self” by Dominique Hurley from [HeART of HealthCARE](#)

# Intelegere natura umana (biases)

Cunoașterea dintr-un studiu al oamenilor din diferite regiuni, nu contează  
în ce ordine se află lițele într-un cuvânt, semnificativul lor  
important este ca prima și ultima literă să fie la locul lor. Restul  
poate fi o vrzăă colpemtă și tot o vei petua cții frăă prboeme.

<https://www.dictie.ro/curiozitati-lingvistice-test-de-citire/>

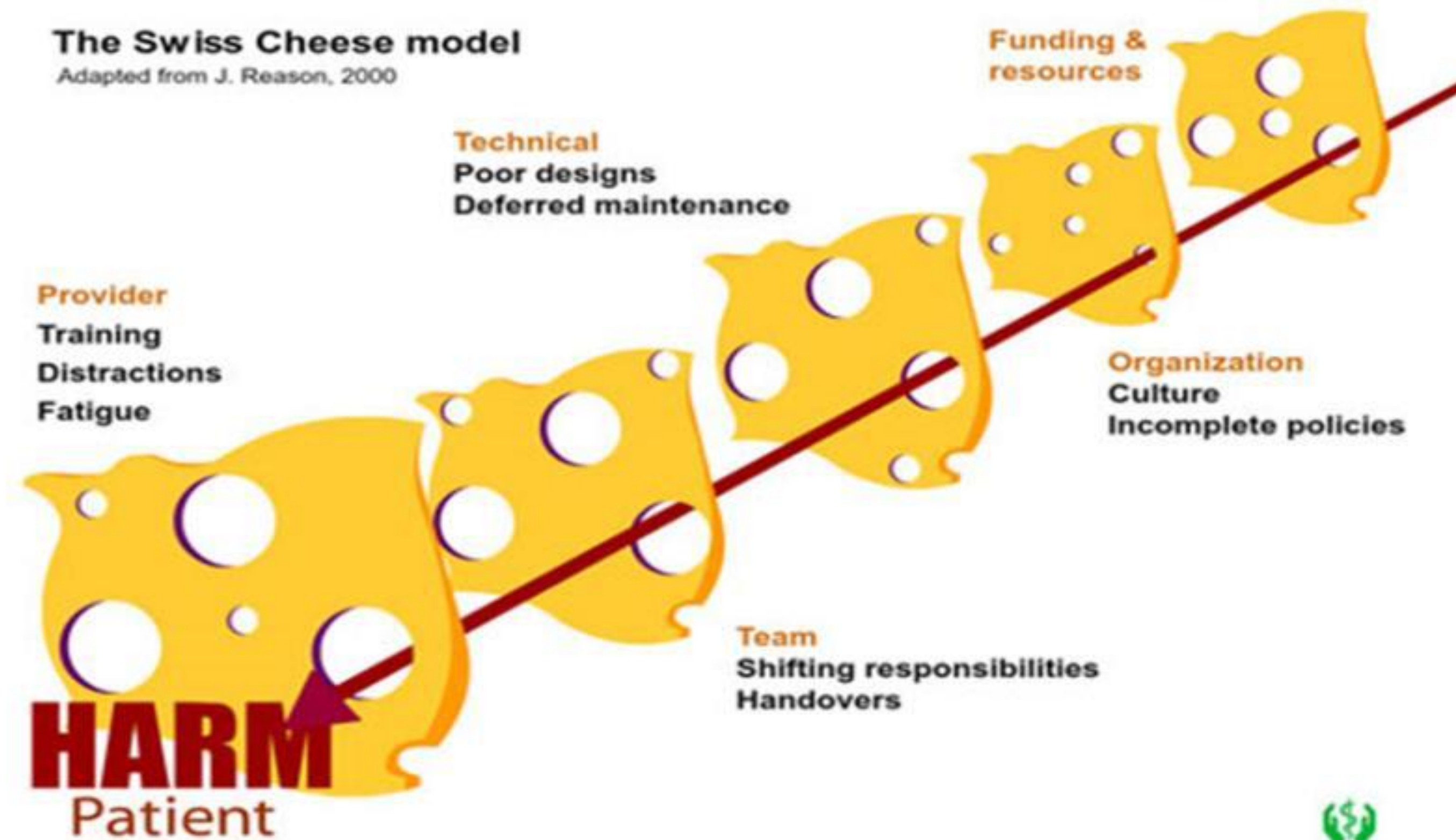
[https://www.youtube.com/watch?v=IGQmdoK\\_ZfY](https://www.youtube.com/watch?v=IGQmdoK_ZfY)



# Intelegere sistemul

- Examineaza toti factorii mai ales cei mai departe de persoana

[https://www.linkedin.com/company/joint-commission-resources/posts?lipi=urn:li:page:d\\_flagship3\\_detail\\_base;8MggqhoxSNOoznlh4CC8BQ==](https://www.linkedin.com/company/joint-commission-resources/posts?lipi=urn:li:page:d_flagship3_detail_base;8MggqhoxSNOoznlh4CC8BQ==)



# Prevenire

- Anticipati unde sunt riscurile cele mai mari
- Aflati cum le-au adresat altii
- Testati solutii local

<https://ismpcanada.ca/resource/do-not-use-list/>

## Do Not Use

### Dangerous Abbreviations, Symbols and Dose Designations

The abbreviations, symbols, and dose designations found in this table have been reported as being frequently misinterpreted and involved in harmful medication errors. They should NEVER be used when communicating medication information.

Abbreviation	Intended Meaning	Problem	Correction
<b>U</b>	unit	Mistaken for "0" (zero), "4" (four), or cc.	Use "unit".
<b>IU</b>	international unit	Mistaken for "IV" (intravenous) or "10" (ten).	Use "unit".
<b>Abbreviations for drug names</b>		Misinterpreted because of similar abbreviations for multiple drugs; e.g., MS, MSO <sub>4</sub> (morphine sulphate), MgSO <sub>4</sub> (magnesium sulphate) may be confused for one another.	Do not abbreviate drug names.
<b>QD</b> <b>QOD</b>	Every day Every other day	QD and QOD have been mistaken for each other, or as 'qid'. The Q has also been misinterpreted as "2" (two).	Use "daily" and "every other day".
<b>OD</b>	Every day	Mistaken for "right eye" (OD = oculus dexter).	Use "daily".
<b>OS, OD, OU</b>	Left eye, right eye, both eyes	May be confused with one another.	Use "left eye", "right eye" or "both eyes".
<b>D/C</b>	Discharge	Interpreted as "discontinue whatever medications follow" (typically discharge medications).	Use "discharge".
<b>cc</b>	cubic centimetre	Mistaken for "u" (units).	Use "mL" or "millilitre".
<b>µg</b>	microgram	Mistaken for "mg" (milligram) resulting in one thousand-fold overdose.	Use "mcg".
Symbol	Intended Meaning	Potential Problem	Correction
<b>@</b>	at	Mistaken for "2" (two) or "5" (five).	Use "at".
<b>&gt;</b> <b>&lt;</b>	Greater than Less than	Mistaken for "7" (seven) or the letter "L". Confused with each other.	Use "greater than"/"more than" or "less than"/"lower than".
Dose Designation	Intended Meaning	Potential Problem	Correction
<b>Trailing zero</b>	∅.0 mg	Decimal point is overlooked resulting in 10-fold dose error.	Never use a zero by itself after a decimal point. Use "∅ mg".
<b>Lack of leading zero</b>	. ∅ mg	Decimal point is overlooked resulting in 10-fold dose error.	Always use a zero before a decimal point. Use "0.∅ mg".

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Adapted from ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations 2006

# Cultura sigurantei

Obiectiv: imbunatatire



Left Behind by Kim Neudorf from [HeART of HealthCARE Gallery 2: Healing](#)



# Justa

- Nu esti pedepsit pe nedrept
- Factori externi au condus la actiune
- Exemplu: etichete asemanatoare stocate impreuna

[https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS\\_0932\\_JC\\_Poster\\_A3.pdf](https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf)

▼ Start here - **Q1. deliberate harm test**

1a. Was there any intention to cause harm? **Yes** **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. **END HERE**

▼ **No** go to next question - **Q2. health test**

2a. Are there indications of substance abuse? **Yes** **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. **END HERE**

2b. Are there indications of physical ill health? **Yes** **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. **END HERE**

2c. Are there indications of mental ill health? **Yes** **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. **END HERE**

▼ if **No to all** go to next question - **Q3. foresight test**

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question? **If No to any** **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

3b. Were the protocols/accepted practice workable and in routine use? **If No to any** **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

3c. Did the individual knowingly depart from these protocols? **If No to any** **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

▼ if **Yes to all** go to next question - **Q4. substitution test**

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances? **If Yes to any** **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

4b. Was the individual missed out when relevant training was provided to their peer group? **If Yes to any** **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

4c. Did more senior members of the team fail to provide supervision that normally should be provided? **If Yes to any** **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

▼ if **No to all** go to next question - **Q5. mitigating circumstances**

5a. Were there any significant mitigating circumstances? **Yes** **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

▼ if **No**

**Recommendation:** Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

# Echitabila

- Oricine e tratat la fel, indiferent de rol sau pozitie
- Procesul e transparent

Canadian incident analysis framework:

<https://www.healthcareexcellence.ca/media/gilnw3uy/canadian-incident-analysis-framework-final-ua.pdf>



# Restaureaza

- Cine e afectat si de ce au nevoie?
- Cine e responsabil sa raspunda?
- Cum pot fi relatiile reparate?
- Cum putem reduce riscul in viitor?

<https://www.safetydifferently.com/wp-content/uploads/2018/12/RestorativeJustCultureChecklist-1.pdf>

<https://internationalforum.bmj.com/london/wp-content/uploads/sites/20/2024/04/D3.pdf>



# Din Canada



7 Feathers b Marcie Dolce from [HeART of HealthCARE](#)

# Salutari de la

## Infection Prevention and Control (IPAC) Canada



2025 Bursa Internationala

<https://ipac-canada.org/international-attendee-award>

[info@ipac-canada.org](mailto:info@ipac-canada.org): [www.ipac-canada.org](http://www.ipac-canada.org)



Gerry Hansen  
Director Executiv

### Resources / Publications

National Infection Control Week ▶

Guidelines & Standards ▶

Position Statements and Practice Recommendations

Canadian Journal of Infection Control

Industry Innovations ▶

Infectious Disease Resources ▶

Coronavirus (COVID-19) ▶

Antibiotic-Resistant Organism (ARO) Resources ▶

Infection Prevention and Control Resources ▶

CNISP Protocols & Publications

Hand Hygiene E-Learning Tool

IPAC Canada Products

IPAC Canada Recipe Book

IPAC Canada Publications

Infection Prevention Websites and Associated Organizations

# Pacientii/ familia = parteneri

- Perspectiva pacientilor/ famillior (P/F) e vitala:
  - Au curajul sa ridice probleme pe care noi nu putem
  - Ajuta sa gaseasca solutii inovative si ieftine
  - Stiu cum sa comunice cu publicul
  - Pot ajuta alti pacienti/ familii
- Implicarea P/F: la momentul potrivit cu oamenii potriviti  
**NIMIC DESPRE NOI FARA NOI**

<https://www.canadiansepsisfoundation.ca/our-sepsis-stories>

<https://www.saskhealthquality.ca/blog/from-a-patient-family-advisor-5-ways-to-create-a-culture-of-safety-on-world-patient-safety-day-and-beyond/>

<https://pubmed.ncbi.nlm.nih.gov/32049622/>

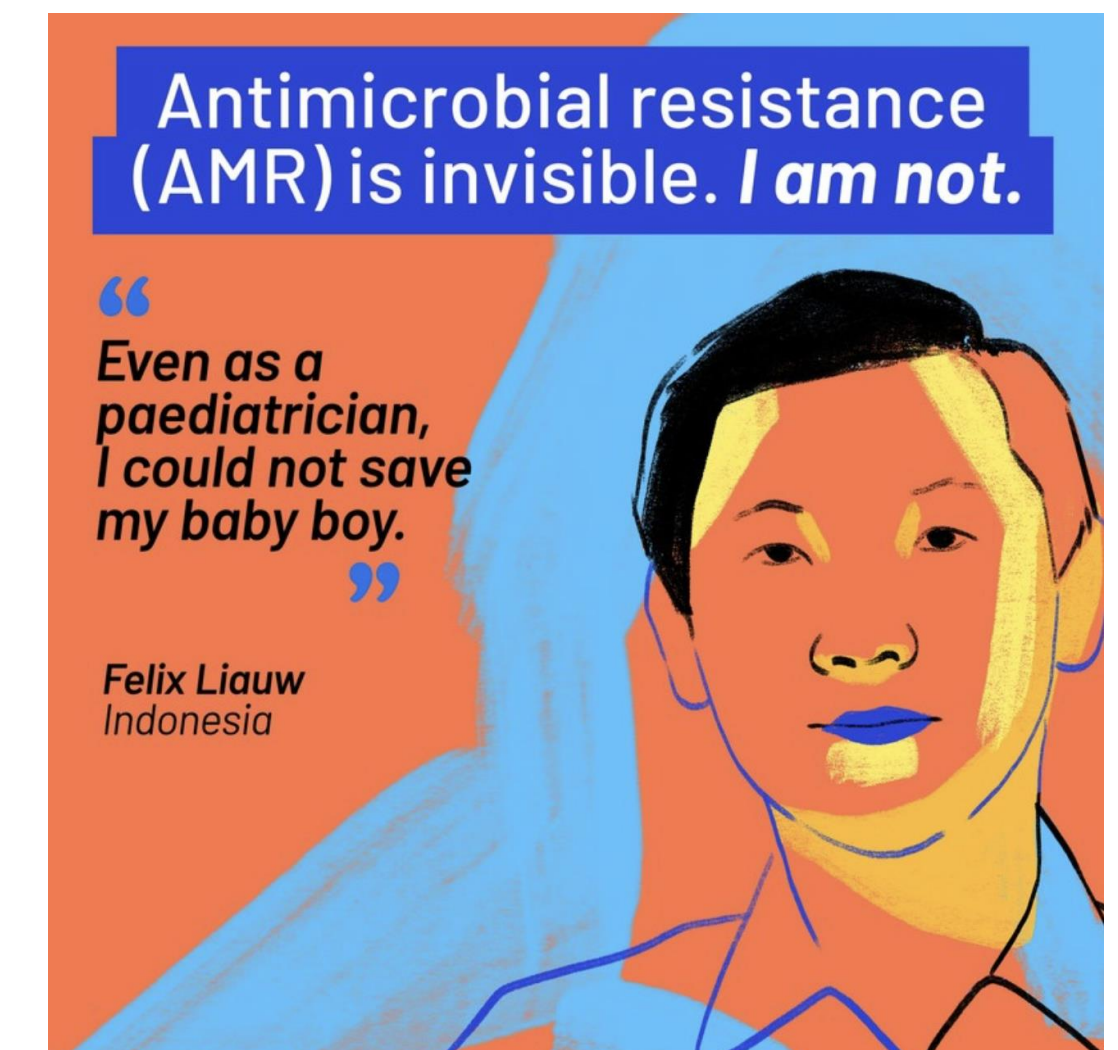


Kim Neudorf

Reprezinta publicul la IPAC Canad Bord  
Membra in comisi de standarde de dezinfectie  
Co-conduce campanii resistentă antimicrobială  
Membra Patients for Patient Safety Canada

# O poveste mondiala

- Ziua mondiala de prevenirea sepsisulu - 13 septembrie
- Ziua mondiala pentru siguranta pacientilor - 17 septembrie
- Saptamana Canadiana pentru siguranta pacientilor - ultima din octombrie
- **Saptamana mondiala pentru rezistenta antimicrobiana - 1-24 noiembrie 2024**
  - <https://www.who.int/campaigns/world-amr-awareness-week/2024/amr-is-invisible-i-am-not>
- Ziua mondiala a igienei mainilor - 5 mai

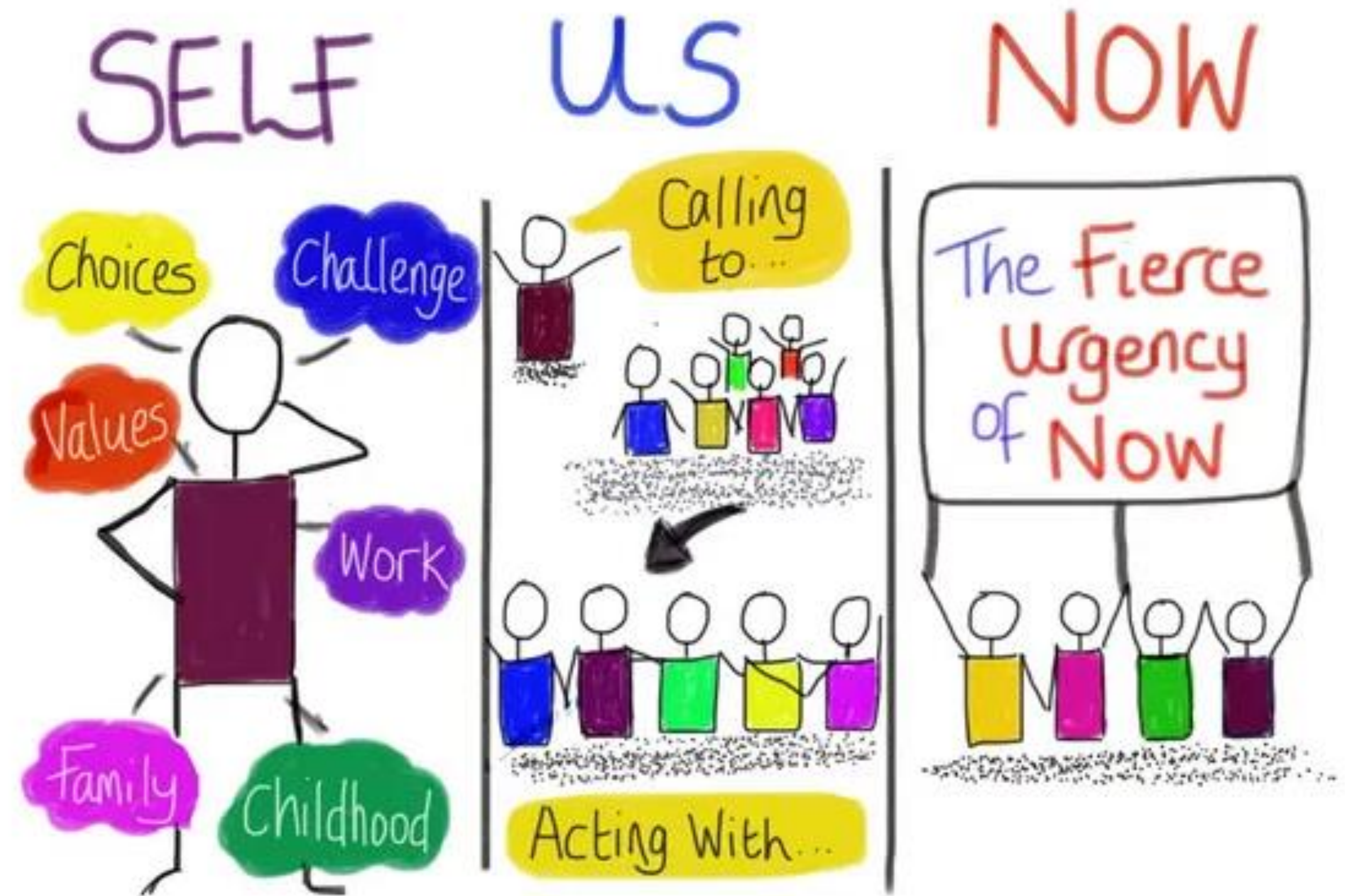


<https://who.canto.global/v/K8JF8QNR43/folder/J6VL8?viewIndex=0>

# Povestea noastră

Marshall Ganz: povestile ne invata sa facem alegeri. Prin povesti invatam sa accesam resursele morale si emotionale de care avem nevoie in fata incertitudilor, a necunoscutului, si surprizelor.

<https://horizonsnhs.com/the-power-of-storytelling-and-public-narrative/>





# Va multumesc

[i.c\\_popescu@icloud.com](mailto:i.c_popescu@icloud.com)



Our Journey by Gaia Orion

From HeART of HealthCARE virtual art gallery

<https://sway.cloud.microsoft/deo9HqOtf8iouJFd?ref=Link&loc=play>