

# Workgroup Wrap-up

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## Wrap-Up, 1

- The IOM reports, *To Err is Human* and *Crossing the Quality Chasm* recommended that health care professionals, health care organizations, and professional societies should focus greater attention to patient safety.
- This conference and the workshop has been designed to foster an approach to patient safety for laboratory medicine.

## Wrap-Up, 2

### An approach

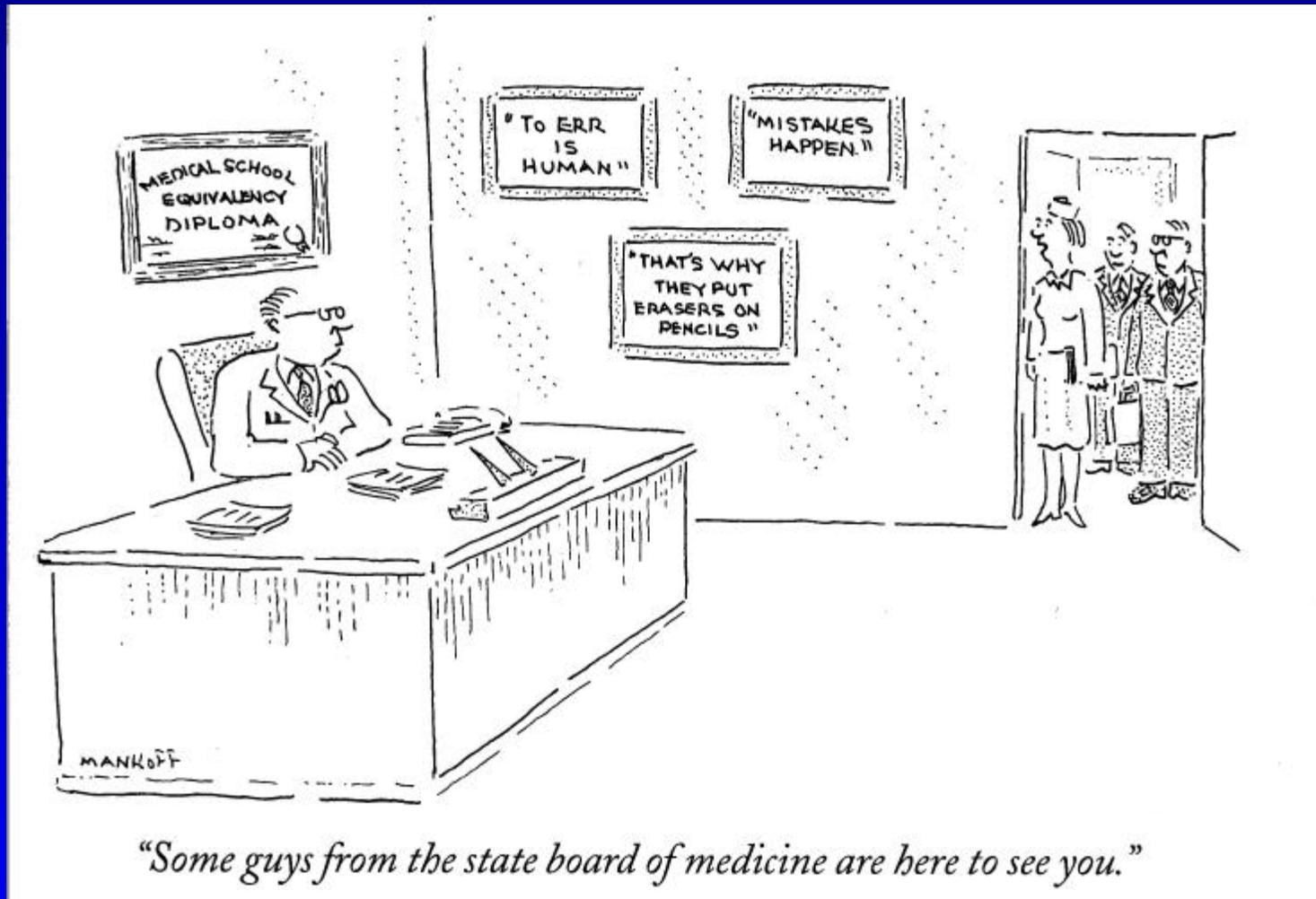
- *A National Report on the Quality of Laboratory Services*
  - Indicators of the Quality of Laboratory Services
  - Quality Institute
- . . . could foster development of policies, programs and activities that could reduce errors in the use of laboratory services, assure patient safety, and improve the quality of laboratory services.

## Wrap-Up, 3

- Support activities that create a culture of safety in your laboratory, health care organization, professional societies.
- Develop & implement an approach to patient safety in your laboratory, organization, and professional society.

Stop Blaming Person Who Made the Error

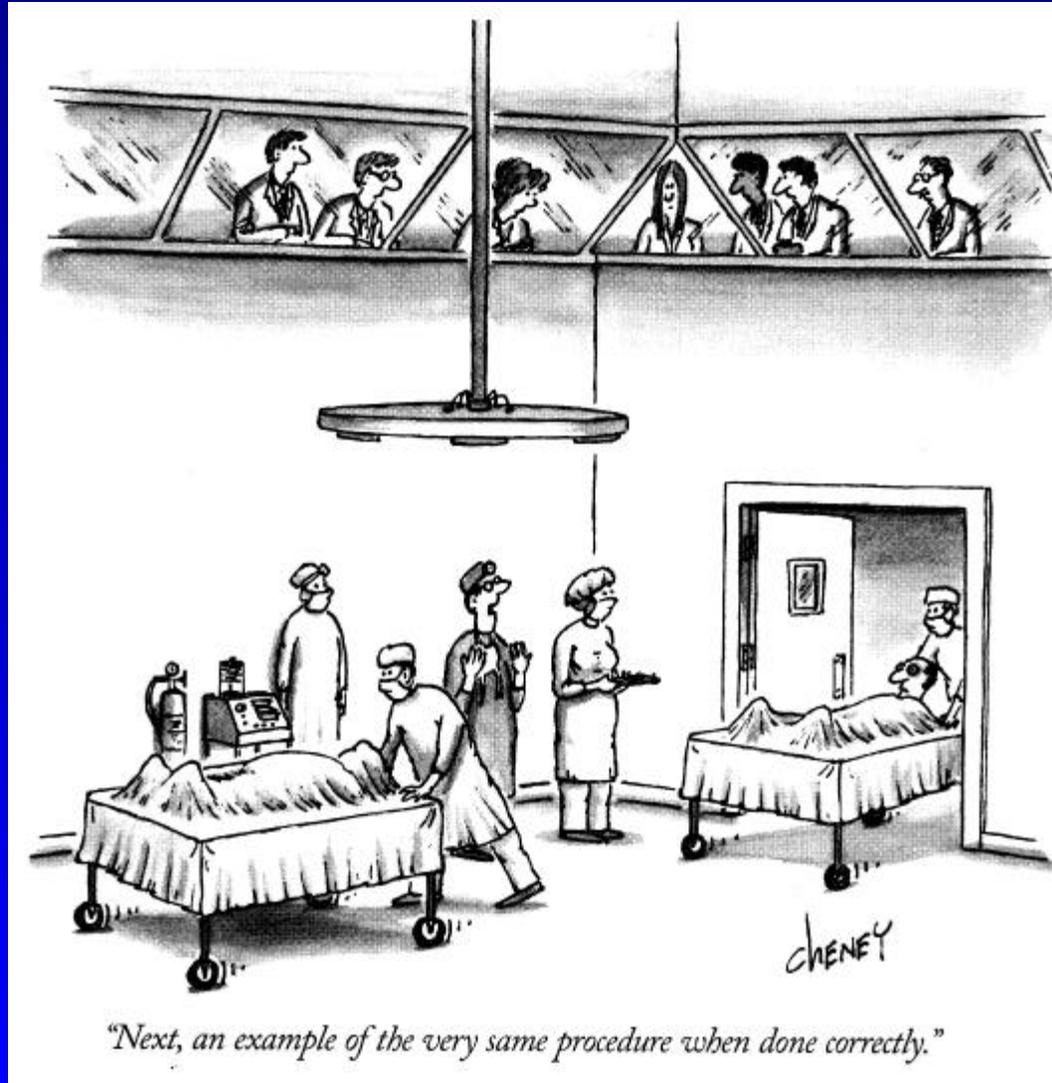
*"Some guys from the state board of medicine are here to see you."*



*"Some guys from the state board of medicine are here to see you."*

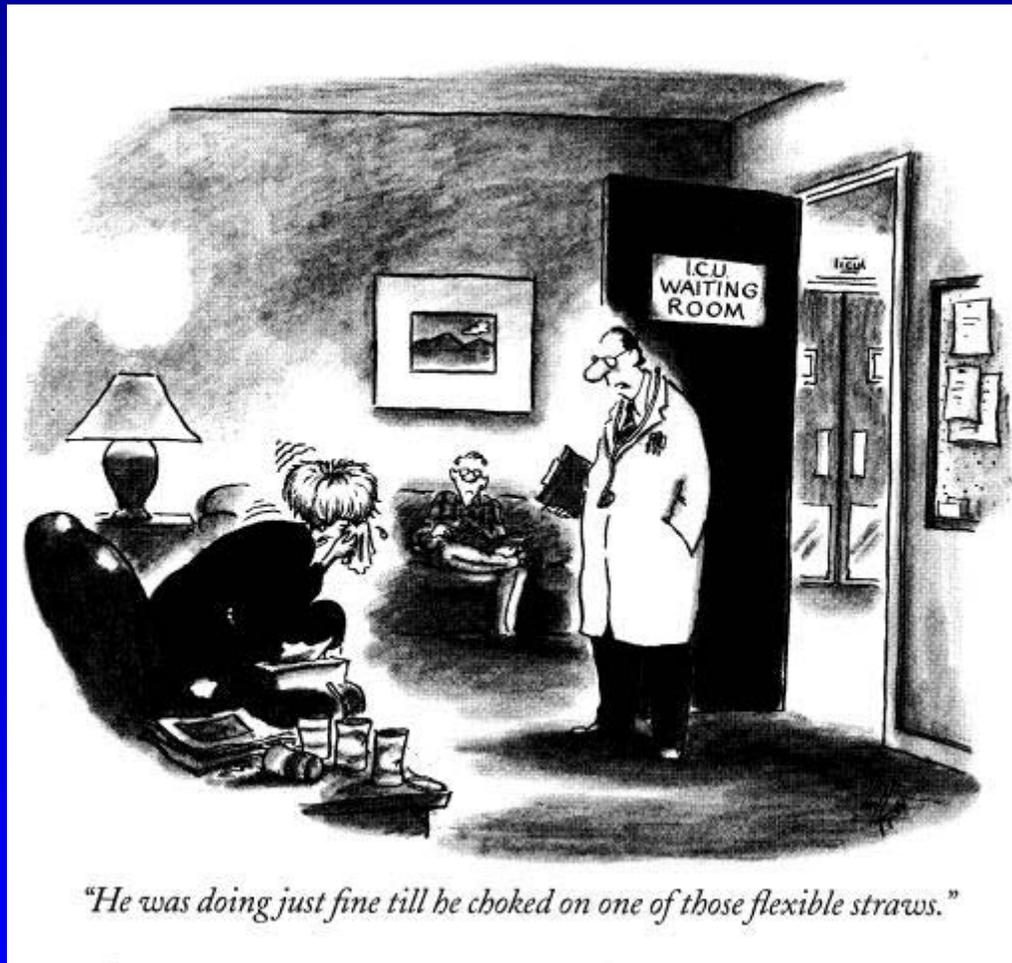
# Train Personnel & Develop Safe Patient Care Systems

*"Next, an example of the very same procedure when done correctly."*



# Recognize Complexity of Health Care & Potential for Errors & Injuries

*"He was doing fine until he choked on one of those flexible straws."*



*"He was doing just fine till he choked on one of those flexible straws."*

*Let's thank the Workgroup  
Leaders (and all the meeting  
attendees) for participating in  
Workgoups!*