

# SARAIMER

Safety is a fundamental system property without which there can be no quality of care. This view was clearly articulated by the IOM in its 2001 Report “*Crossing the Quality Chasm*”. According to some estimates, up to 200,000 avoidable deaths per year occur in the USA in outpatient settings alone. The United Nations World Health Organization is working toward making patient safety a Basic Human Right.

In the USA the healthcare industry is highly fragmented and decentralized. This poses a complex and huge challenge for desired reform aimed at furnishing value for money at the individual and national levels. What is needed is a logical theoretical model for understanding the causes of errors in, the role of these healthcare systems in contributing to errors, the propagation of errors through complex systems and, importantly, for understanding any specific setting, such as primary care office, in the context of the larger healthcare system. The authors have developed such a model that is innovative. It is a visual model of the system/s, at micro and macro-levels. Applications, apart from education, include providing a framework to help focus research efforts, creation of new (visual) error reporting and taxonomy systems, furnishing a common and unambiguous vision for the healthcare team, and facilitating retrospective and particularly prospective analyses of errors and adverse events. It is aimed at system redesign for safety improvement through a computer-based **safety enhancement and monitoring instrument** that is **patient centered (SEMI-P)**. This instrument is at the heart of our overarching methodology of **Systematic Appraisal of Risk And its Management for Error Reduction (SARAIMER)**. Our visual model enhances the meaningful use of electronic Health records (EHRs) and Patient Safety Organizations (PSOs).

This illustrates the prize-winning Macro-model of the healthcare:

