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Ovid® Synthesis

Ovid® Synthesis Quality Improvement  
Solution supports IHI initiatives for a  
culture of patient safety



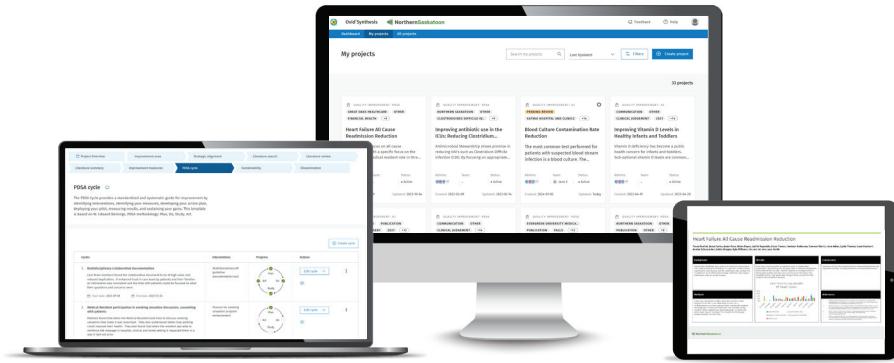
## Introduction

In 2000, the Institute of Medicine's publication, *"To Err Is Human: Building a Safer Health System,"* revealed that the estimated number of people who died in any given year from medical errors in hospitals exceeded those who died from motor vehicle accidents, breast cancer, or acquired immunodeficiency syndrome. However, despite improvements in the past two decades, a 2021 review article by authors associated with Johns Hopkins Medicine International shows that the safety culture varies both across hospitals and within different hospital departments.<sup>1</sup> The problem is compounded by today's complexity of care and fragmentation of delivery systems.

## IHI's sweeping initiative

To advance patient safety, a safe and just culture is needed. To further that culture and reinvigorate a national commitment to patient welfare, the Institute for Healthcare Improvement (IHI) released its National Action Plan to Advance Patient Safety in 2020. The sweeping initiative calls for a total systems approach to patient safety.<sup>2</sup> Four pillars define this approach; the fourth is a learning system by which patient safety can be improved, advanced, and errors averted or minimized.

Close calls occur approximately three hundred times more often than actual adverse events, often pointing to latent conditions rather than individual acts made in error.<sup>3</sup> Thus, a crucial aspect of advancing patient safety is reporting, studying, and analyzing those near misses and adverse events. That makes a comprehensive learning system — IHI's fourth pillar — an invaluable quality improvement (QI) tool in the journey for safer, more effective patient care.



**Ovid® Synthesis QI's workflow templates meet the needs of:**



Quality leaders and managers



Risk managers



Executive quality and safety officers



QI educators



Chief medical officers, and others.

## Where a learning system fits into IHI's initiative

To underscore the importance of a learning system, 5 of IHI's 17 recommendations in its National Action Plan center on what a learning system should do:<sup>4</sup>

- Facilitate intra- and inter-organizational learning
- Accelerate the development of the best possible safety learning networks
- Initiate and develop systems to facilitate interprofessional education and training on safety
- Develop shared goals for safety across the continuum of care
- Expedite industry-wide coordination, collaboration, and cooperation on safety.

For quality improvement teams, educators and those who prioritize improving outcomes, Ovid® Synthesis workflow solution provides QI infrastructure that supports IHI's learning system recommendations with its intuitive interface and helpful prompts.

### Ovid Synthesis solution structure and functionality for QI:



Allows selection of a preferred QI process: PDSA cycles, DMAIC, or A3



Automates literature reviews, evidence collection, and synthesis



Offers a dashboard to view all initiatives to avoid duplication of work



Enables collaborative discussions directly within the QI template



Optimizes project coordination, monitoring, coaching, and approval tracking



Enables you to upload SPC charts, Run charts, Process maps, Driver and Fishbone diagrams to visualize workflow, assess root causes, and identify drivers that affect accomplishing the aim



Provides multiple options for reporting outcomes (Word document, poster presentation, start of a manuscript draft); outputs align with SQUIRE guidelines for journal submissions



Accelerates learning via enterprise-wide equitable access and dissemination of results

In addition, Ovid Synthesis methodology can overcome the biggest challenges of participating in QI projects.

- Its standardized infrastructure and prompts address users' varying levels of understanding of QI concepts and processes.
- It breaks down silos in coordinating and communicating with interdisciplinary teams, which facilitates learning, training, and the building of safety learning networks.

### About the Institute for Healthcare Improvement (IHI)

Since its inception in 1986, IHI's focus has been to improve patient safety, outcomes, and healthcare equity. IHI's tireless work, grounded in Deming's science of improvement and modeled on PDSA (Plan-Do-Study-Act) cycles, teaches practice quality improvement methods to enable sustainable changes in healthcare.

### About Ovid Synthesis

**About Ovid Synthesis**  
Ovid Synthesis provides a QI infrastructure that supports a culture of learning and improvement. It supports IHI's fourth pillar of utilizing a learning system to facilitate sustainable changes that are part of a total systems approach to patient safety.



Wolters Kluwer

[synthesis.ovid.com](https://synthesis.ovid.com)

Unlike other learning systems that may be piecemeal or homegrown, Ovid Synthesis sets all the capabilities you need at your fingertips in one software solution. It enables users to be transparent about identifying, systematically analyzing, and implementing improvement. The Ovid Synthesis dashboard enables all stakeholders, from project managers to executive leadership, to review each project's progress and outcomes in real-time.

Ovid Synthesis' interactive project monitoring can accelerate the time projects take to completion. Completed projects become an immediate repository for both dissemination and training. This encourages the process of transforming safety practices into learning and competency management. Finally, the algorithm for estimating return on investment (ROI) provides an additional quantifiable metric for assessing all QI projects.

## Broader applications, future vision

Quality improvement training is an elective in many medical schools, so residents may receive inadequate training on the subject. In response to that potential gap, the Accreditation Council for Graduate Medical Education (ACGME) implemented the Clinical Learning Environment (CLER) Program, which includes focus areas of patient safety and healthcare quality. The CLER program aims to improve how clinical sites teach resident and fellow physicians to provide safe, high-quality patient care. Ovid Synthesis is a natural fit for meeting this need, as it walks users step by step through a QI project.

## Conclusion

Since its inception, IHI has been synonymous with patient safety and its mission to improve it. Wrapped in that is the premise that quality improvement depends on learning, experimentation, and innovation. The functionality of Ovid Synthesis is grounded in IHI's philosophy of continuous improvement for patient safety. The comprehensive workflow features of Ovid Synthesis supports organizations' quality improvement objectives, ultimately leveraging new innovation to improve patient care and safety.

## Acknowledgments

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Scan the QR code to visit the Ovid Synthesis website to learn more, or contact [sales@ovid.com](mailto:sales@ovid.com) for a personalized demo.

[synthesis.ovid.com](http://synthesis.ovid.com)



With an NPS score of more than 50, Ovid Synthesis customers report significant benefits from using the product.

**94%**  
report more streamlined oversight.

**95%**  
report an increase in collaboration.

**95%**  
report better standardization and guidance.

**86%**  
report decreased time to complete projects.

**89%**  
report better job satisfaction.

**88%**  
report improvement in financial outcomes.

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## References

1. Rigamonti D, Rigamonti KH. Achieving and maintaining safety in healthcare requires unwavering institutional and individual commitments. *Cureus*. 2021;13(2):e13192. DOI 10.7759/cureus.13192.
2. National Steering Committee for Patient Safety. *Safer Together: A National Action Plan to Advance Patient Safety*. Boston, Massachusetts: Institute for Healthcare Improvement; 2020.
3. Wu AW, Marks CM. Close calls in patient safety: should we be paying closer attention? *Can Med Assoc J*. 2013;185:119-20.
4. Institute for Healthcare Improvement. *National Action Plan: 17 Recommendations to Advance Patient Safety*. Accessed 3/15/24. <https://www.ihi.org/initiatives/national-steering-committee-patient-safety/national-action-plan-advance-patient-safety>.