Topic 1
What is patient safety?
Learning objective

Understand the discipline of patient safety and its role in minimizing the incidence and impact of adverse events, and maximizing recovery from them
Knowledge requirements

- Harm caused by health-care errors and system failures
- Lessons about error and system failure from other industries
- History of patient safety and the origins of the blame culture
- Difference between system failures, violations and errors
- A model of patient safety
Performance requirements

- Apply patient safety thinking in all clinical activities
- Demonstrate ability to recognize the role of patient safety in safe health-care delivery
Harm caused by health-care errors and system failures

- Extent of adverse events
- Categories of adverse events
- Economic costs
- Human costs
Lessons about error and system failure from other industries

- Large-scale technological disasters
- What investigations showed
- What is a systems approach?
Swiss cheese model (1)

Latent factors
Organisational processes — workload, handwritten prescriptions
Management decisions — staffing levels, culture of lack of support for interns

Error-producing factors
Environmental — busy ward, interruptions
Team — lack of supervision
Individual — limited knowledge
Task — repetitious, poor medication chart design
Patient — complex, communication difficulties

Active failures
Error — slip, lapse
Violation

Defences
Inadequate — AMH confusing
Missing — no pharmacist

Ian D Coombes, Danielle A Stowasser, Judith A Coombes and Charles Mitchell
Adapted from J. Reason’s model of accident causation
History of patient safety and origins of the blame culture

- Blame culture in health care
- Why do we blame?
- Person approach
- Systems approach
Difference between system failures, violations and errors

- Professional accountability
- Violations
- Types of violations
A model of patient safety

- Those who work in health care
- Those who receive health care or have a stake in its availability
- The infrastructure of systems for therapeutic interventions (health-care delivery processes)
- The methods for feedback and continuous improvement
A conceptual model of patient safety

**Methods:** CQI on info, hardware, plant, policy

**Systems for therapeutic action** designed to preempt/rescue from failure

**Workers:** teams trained to preempt / rescue from / manage failure

**Preparation on:**
- illness understanding,
- accessing care systems,
- advocacy

**Source:** A patient safety model of health care, Emmanuel et al, 2008
Communicating with Patients: Applying Knowledge & Expertise

Patients

- experience of illness
- social circumstances
- attitude to risk
- values
- preferences

Health professionals

- diagnosis disease
- etiology
- prognosis
- treatment options
- outcome probabilities

Source: A. Coulter, Picker Institute 2001
Understanding the multiple factors involved in failures

Students should:

- Avoid blaming
- Practise evidenced-based care
- Maintain continuity of care for patients
- Be aware of the importance of self-care
- Act ethically every day
Recognize the role of patient safety in safe health-care delivery

- Ask questions about other parts of the health system
- Ask for information about the hospital or clinic processes that are in place to identify adverse events