

PATIENT SAFETY

Health Systems Science Learning Series



INTRODUCTION TO PATIENT SAFETY

Patient Safety is when health care professionals work together to protect patients from system errors and preventable harm. Despite technological advances, understanding how to deliver safe care in a complex, rapidly changing environment with tremendous time constraints is one of the greatest challenges in health care today. Medical errors and preventable deaths cost nearly \$20 billion annually in lost income and health care expenditures. Too often, errors have been attributed to the mistakes of individuals. As a medical student, learning the basics of patient safety will allow you to improve patient care.

BASIC PRINCIPLES OF PATIENT SAFETY

According to the World Health Organization, patient safety is “the reduction of risk of unnecessary harm associated with health care to an acceptable minimum.” These terms describe different types of events and the intent or actions behind those events:



Adverse Event

Harm caused by medical treatment, whether or not it is associated with an error or considered preventable



Preventable Adverse Event

An adverse event that is attributable to an avoidable error



Negligent Adverse Event

A preventable adverse event that satisfies the legal criteria for negligence, where the care provided to the patient did not meet the standard of care an average physician would provide



Sentinel Event

Any unanticipated event in a health care setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness



Error

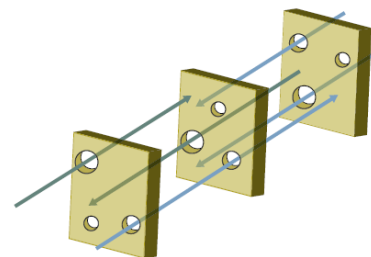
The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim

Defective systems have been identified as the most common source of error. Other common errors include medication, surgical, diagnostic, transitions of care and teamwork & communication. It is critical that health care adopt a systems approach to eliminate preventable errors. A systems approach focuses on improving and redesigning the environment and care processes. It provides a comprehensive approach to anticipate and evaluate errors instead of focusing on the behavior of a few individuals.

BASIC PRINCIPLES OF PATIENT SAFETY CONTINUED

Most adverse events don't happen because one person made one mistake one time. When an adverse event occurs, it's usually because there were multiple smaller events along the way. It takes an average of 4.5 errors in the system to result in an adverse patient event.

Consider the Swiss Cheese Model of Systems Failure. In this example, the health care system is the stack of cheese, each slice represents system defenses. The holes represent a failure or system error. In order for harm to reach the patient, the error must pass through holes in multiple defense mechanisms.



ELEMENTS OF FULL DISCLOSURE AND APOLOGY

Full disclosure of a medical error includes four steps:

Step 1 <i>Explain</i>	Step 2 <i>Apologize</i>	Step 3 <i>Communicate</i>	Step 4 <i>Prevent</i>
Provide an explanation of why the error occurred	Provide an apology when appropriate	Share how the health impact will be minimized and include an explanation of how this will impact the patient's future care	Discuss actions that will be taken to minimize the chance of recurrence

FACTORS THAT IMPROVE PATIENT SAFETY

It starts with you! We are all citizens of the system, each doing our part to minimize error. Consider these ways to work to improve patient safety:

Change mindset	Have a mindset to look for potential systems issues that you think can cause harm and then try to address those. Think of yourself as a citizen of the system, "Systems Citizenship."
Look for gaps	Not only are you taking care of this patient, you're also scanning your environment for gaps. Where can this patient be susceptible to a patient safety event? You should always be on the lookout with your colleagues.
Awareness of framework	Don't assign blame, work with your team to report any error or safety concerns through your hospital-based reporting system.

QUESTIONS TO ASK:

- How are errors classified?
- When you know a mistake has been made at work, what should you do?
- What can be done to improve patient safety?