The Patient Safety Education Project™
CANADA

WHAT IS PATIENT SAFETY?
(IT ISN'T WHAT IT USED TO BE)

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Objectives

- Discuss the origins of patient safety and its conceptual framework
- Explore the relationship between patient safety and quality improvement
- Outline a simple model for understanding work in the patient safety field

CPSI Patient Safety Competencies

Domain 1: Contribute to a culture of patient safety

Key competency: Describe the fundamental elements of patient safety

- ability to describe the fundamental elements of patient safety, core theories and terminology, and epidemiology of unsafe practices

Introduction

- Problem: hospitals are not always safe
  - incidents are frequent and preventable
- Response: Patient safety discipline
  - growing interest
  - more knowledge and tools
- Challenges: Progress has not been fast
  - missed benchmarks, impatience, avoidance

Shift in paradigm

- "Old look" vs. "new look"
  - patient safety is changing thinking about causation
- Transformative?
  - paradox of progress
  - complexity, change, new patient vulnerabilities

First leap: questioning blame

- Old look: trained perfectibility
  - errors = incompetence
  - punishment used as motivation not effective
  - blame leads to hiding mistakes
- New look: accidents are normal
  - most incidents are multi-causal
  - many causes are latent
  - “blunt end” vs. “sharp end” prevention work

Second leap: systems thinking

- Incidents can be reduced by system redesign
- "Safety science" - knowledge and precedents from outside of healthcare
  - industrial engineering, cognitive psychology, etc.
- High reliability organizations
  - complexity, change, resilience, Reason's "swiss cheese" model
  - technology, organizational and human factors
  - healthcare is not a closed system - blunt-end extends to external factors

Transparency and professionalism

- Transparency

  sharing of incidents and near misses prevents harm

- Professionalism

  First, do no harm

  patients have a right to information about their health

History of accountability

- Early traditions
  - rooting out the charlatans
  - individual accountability for adverse incidents
  - embedded in medicine and law
- Medical accountability to society
  - scientific method, 3-phase clinical trials
  - standards for education, certification, professionalism
  - stopped short of sharing information about failure

Health care as an industry

- Systems thinking initiated by industrial era
  - applied to product and service lines
  - medicine remained focused on patient-physician relationship
- Rising cost and exposure of errors propelled search for solutions
- Rethinking risk
  - Anesthesiology (1980s), Harvard Medical Practice Study (1991), Annenberg Conference (1996), IOM (1999)

Culture/paradigm shift

- Change needed that:
  - refrains from blaming sharp end workers
  - incentivizes sharing
  - retrains and supports healthcare worker teams
  - discloses to patients and families

What is patient safety?

- A philosophy (way of thinking)?
- A discipline (body of knowledge)?
- A component of quality (underuse, overuse, misuse)?
- An attribute (property of the healthcare system)?
- A social movement (demand for change)?

Defining patient safety

- IOM definition: Freedom from accidental injury

  (*To Err is Human*, 1999)

- Canadian definition: The reduction and mitigation of unsafe acts within the health-care system, as well as through the use of best practices shown to lead to optimal patient outcomes.

  (*Canadian Patient Safety Dictionary*, 2003)

(Leape, 1997, p. 221)

Defining patient safety

- A discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery
- An attribute of health care systems
  - minimize the incidence and impact of adverse events
  - maximize recovery from adverse events
  - culture perceived as just

(Leape, 1997, p. 221)

Patient safety as a discipline

- Integrating knowledge and tools from numerous disciplines
- Distinct from quality by its attention to professionalism and ethics?

Patient safety as a systems attribute

Descriptor of:

- High reliability design and management of risk
- Reporting and continuous improvement
- Openness to sharing lessons learned
- Leadership and teamwork strategies for managing risk
- Just culture and support for healthcare workers
- Openly communicating with patients about risk
- Trustworthiness
- Other?

What is the locus of patient safety?

- Point of care/microsystems
- Organizational blunt end
- Social policies and attitudes

How is it achieved?

- High reliability design & safety science
  - forcing functions, human factors design, etc.
- Continuous improvement methods
  - PDSA, RCA, FMEA, measurement, etc.
  - learning from stories
- Change management
  - leadership, modeling, teamwork, just culture, etc.
  - listening to patients and families

Who is a practitioner?

- All members of health care can practice patient safety
- From patients to politicians…

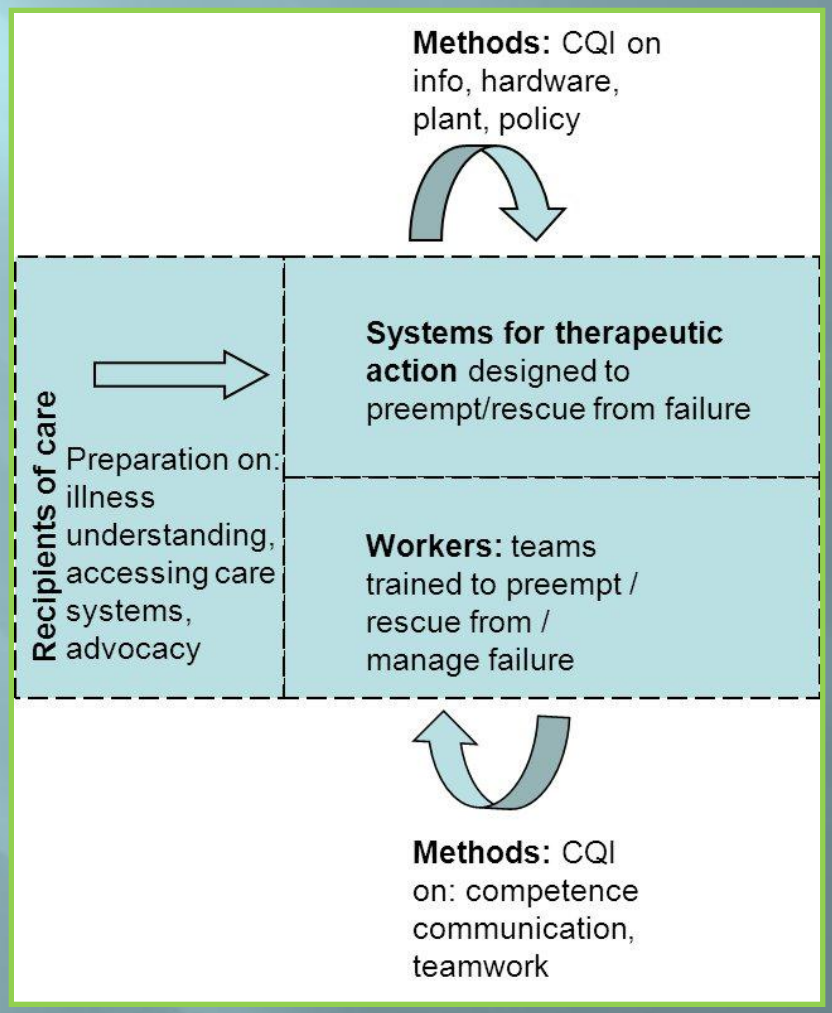
Vicente KJ, Patient safety: From patients to politicians: a cognitive engineering view of patient safety, *Qual Saf Health Care 2002;11:302-304*

Patient safety model

Four domains in healthcare organizations

Healthcare workers	**Recipients of care**
Systems for therapeutic action	Methods

Patient Safety Model



Summary

- Patient safety is a discipline that integrates knowledge and expertise from other disciplines
- Patient safety can also be thought of as an attribute or property of work focused on preventing or mitigating patient harm
- Patient safety arguably is distinguishable from quality improvement by its emphasis on professionalism and ethics
- A simple model for patient safety contains four domains: healthcare workers, recipients of care, systems for taking therapeutic action and methods.

Potential pitfalls

- Patient safety is inherently controversial. Discussion can feel threatening or overwhelming because it challenges prevailing beliefs
- Patient safety is not an exact science

Pearls

- Patient safety work is leading to transformative change in healthcare culture
- Trustworthiness is a powerful concept emerging in discussion of patient safety that resonates with many audiences
- Learning from stories is an important and distinctive attribute of patient safety work