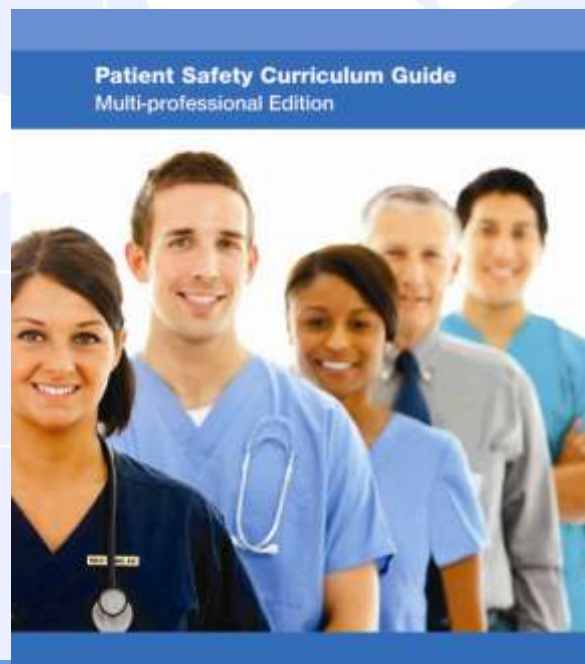


# Topic 1

## 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

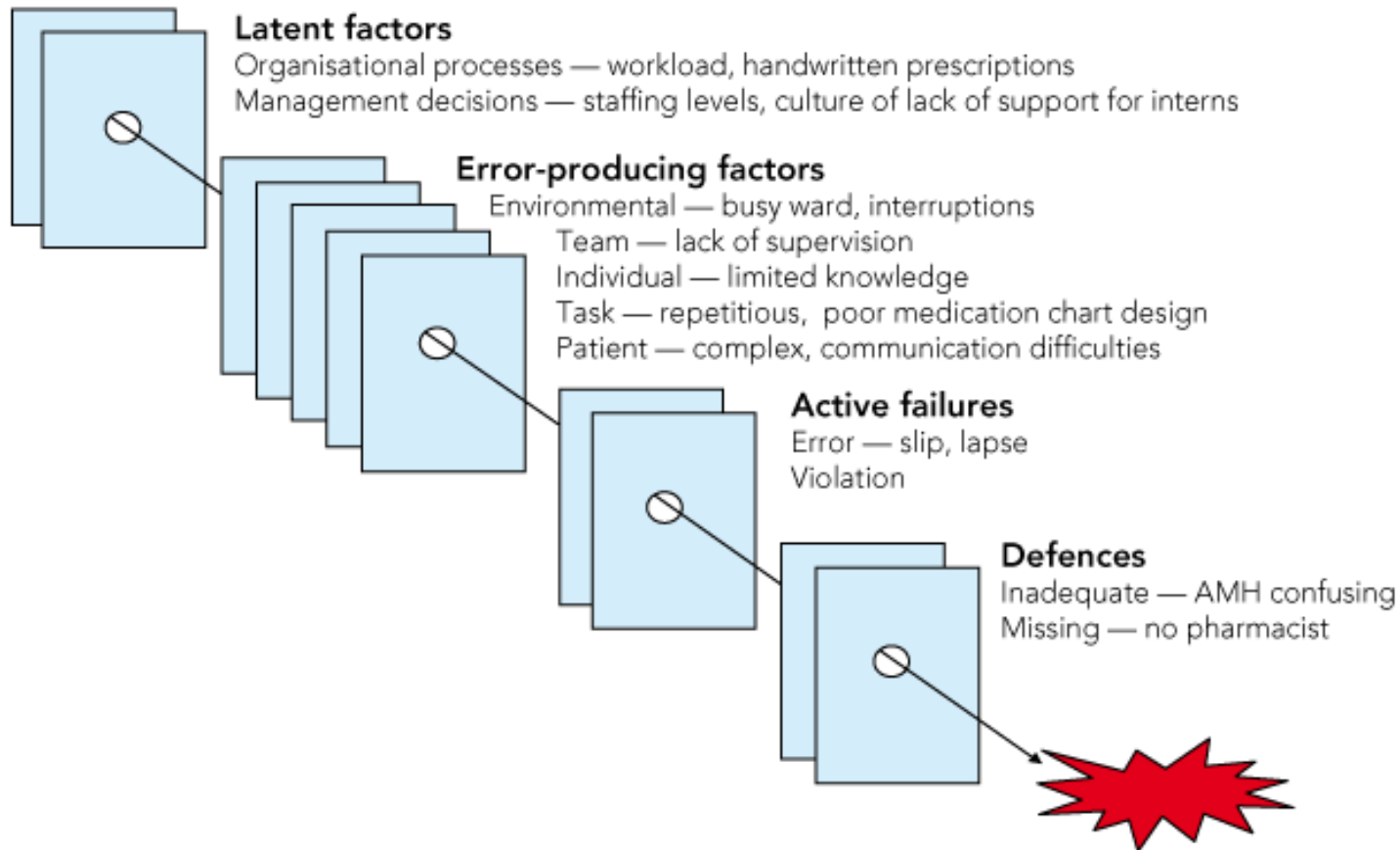
# Harm caused by health-care errors and system failures

- 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)



Source: *Why do interns make prescribing errors? A qualitative study* MJA 2008; 188 (2): 89-94

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



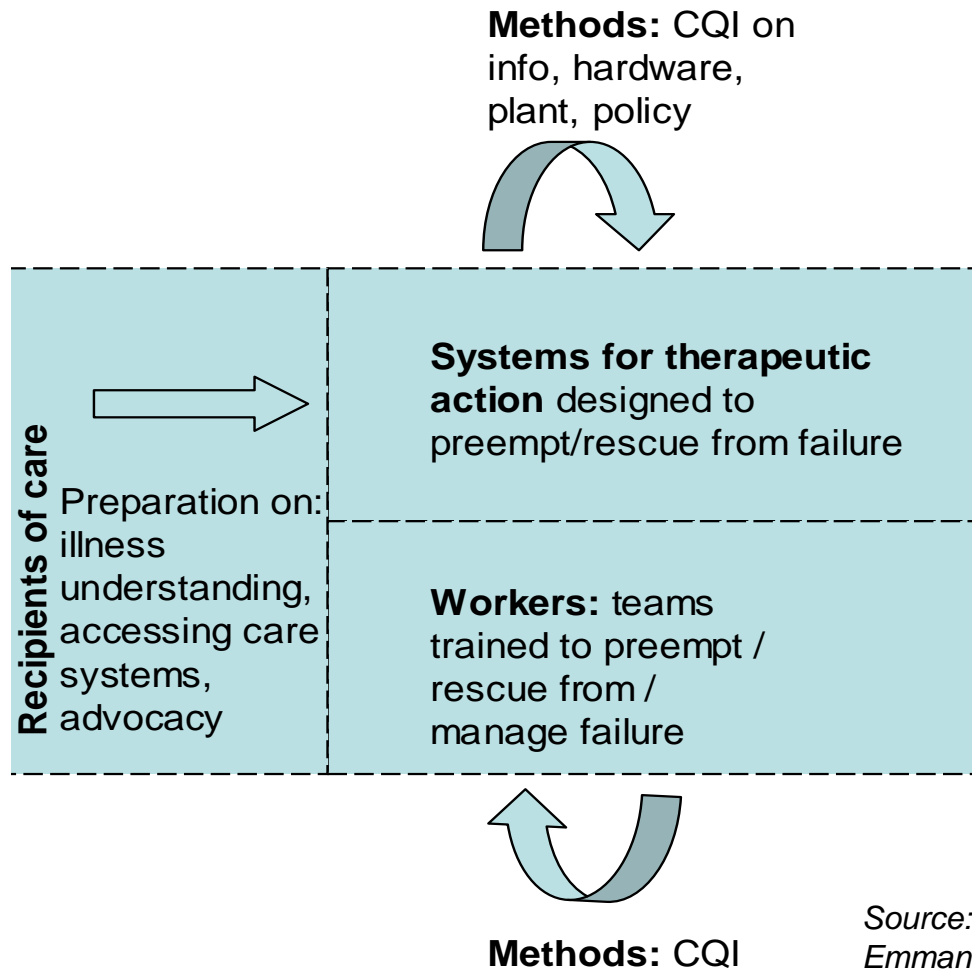
# Difference between system failures, violations and errors

- Professional accountability
- Violations
- Types of violations

# A model of patient safety

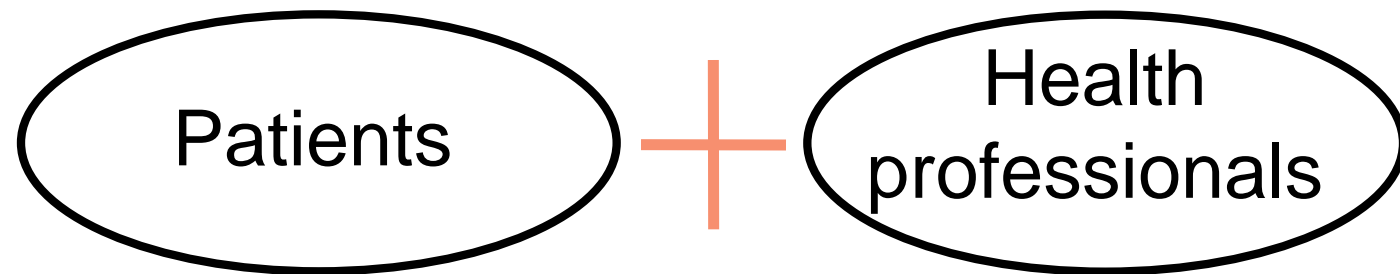
- Those who work in health care
- Those who receive health care or have a stake in its availability
- The infrastructure of systems for therapeutic interventions (health-care delivery processes)
- The methods for feedback and continuous improvement

# A conceptual model of patient safety



*Source: A patient safety model of health care,  
Emmanuel et al, 2008*

# Communicating with Patients: Applying Knowledge & Expertise



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

- 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