What Is Patient Safety?

by Capella Healthcare

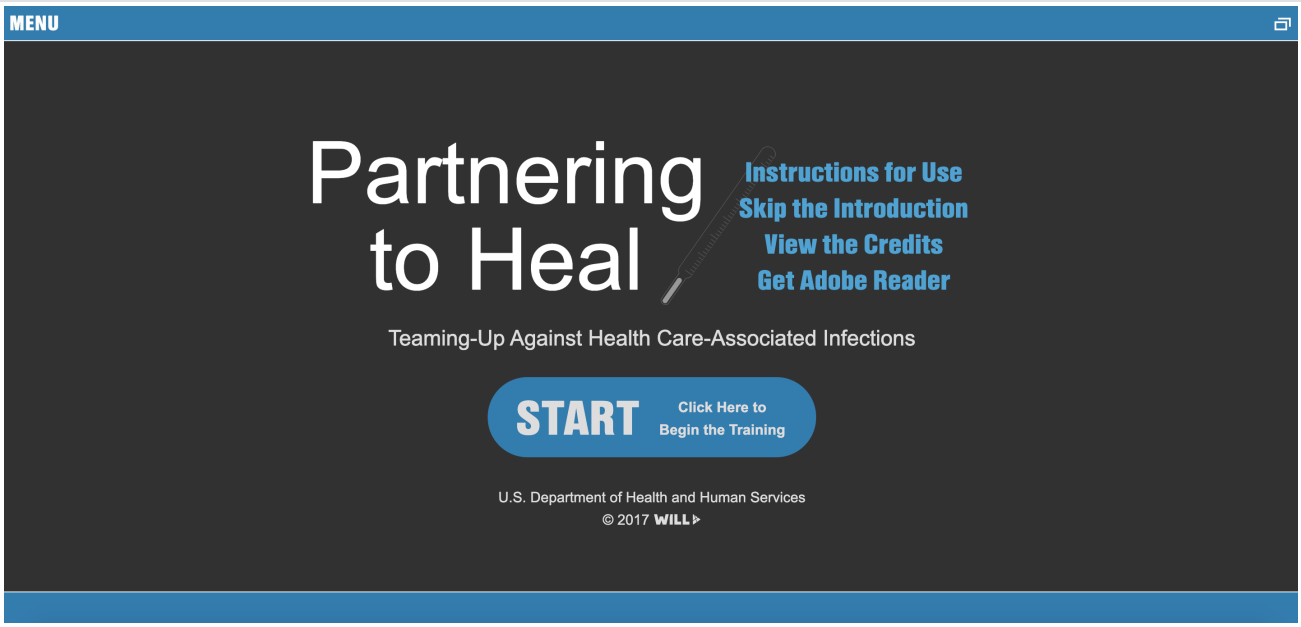
WHAT'S COVERED

This lesson will define patient safety. Specifically, this lesson will cover:

1. Introduction
2. Patient Safety Defined

1. Introduction

Visit **Partnering to Heal: Teaming Up Against Healthcare-Associated Infections** and watch the intro video.



Partnering to Heal: Teaming Up Against Healthcare-Associated Infections

Source: Partnering to Heal: Teaming Up Against Healthcare-Associated Infections. (n.d.). Retrieved from https://health.gov/hcq/trainings/partnering-to-heal/index.html

Unfortunately, the safety problems in this introductory video are not uncommon.

The Institute of Medicine's report "To Err is Human: Building a Safer Health System" estimated in 1999 that as many as 98,000 patients die in hospitals each year as the result of medical errors; most of these are deemed preventable. Error is the third leading cause of death in the United States. The magnitude of the issue has

motivated large societies, healthcare professionals, large employer groups, patient advocacy organizations, and researchers to take up the cause of reducing adverse events and patient harm.

This is not only a national problem but a global one. Many countries have reported a significant number of patients harmed, leading to permanent disability, prolonged hospital stays, and even death. The United Kingdom recently reported a rate of 1 error per 35 seconds. The World Health Organization created the World Alliance for Patient Safety in 2004 to raise global awareness about patient safety. Agencies, health policy-makers, and representative patient groups came together to advance the patient safety goal of “First do no harm” and reduce the adverse health and social consequences of unsafe healthcare.

Furthermore, it is estimated that the cost of harm due to permanent disability and the resulting loss in productivity and capacity for patients and families amounts to trillions of dollars every year. This also takes a significant psychological toll on patients and families who have lost a loved one or have had to become caregivers. However, the cost of preventing health-related harm is trivial in comparison. In the United States alone, Medicare reports a $28 billion savings in Medicare hospitals from 2010-2015 because of safety improvements.

Although gains have been made in patient safety, harm remains a global challenge. The focus began in hospitals; however, it needs to spread to the whole continuum of care. Gaps in continuity of care are responsible for morbidity and mortality. Effectively improving safety requires a more integrated approach and requires that we understand the complexities underlying errors that remain unaddressed.

Here are some practices to adopt that address these pertinent issues:

1. a systems approach requiring active involvement of all participants; for instance, collaboration with long term care, hospitals, home health care, primary care, and ancillary services to improve transitions of care
2. coordination and collaboration across organizations
3. promotion of safety culture
4. ensuring safety across the entire continuum of care. Attention also needs to be focused on cognitive decision making and diagnostic errors based on the information on hand at the time of the decision.

The sections that follow will provide the foundation for patient safety by explaining the science behind patient safety, how errors happen, and ways to prevent harm at the lower levels of safety that we need to have in place before we can expand to higher levels of safety and advance to a high reliability organization.

2. Patient Safety Defined

Patient safety has been defined by the Institute of Medicine as “freedom from accidental injury,” while the National Patient Safety Foundation considered it “the avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the process of care.” Another definition is “prevention of (health-associated) harm caused by error of commission or omission; the harm should have been preventable or predictable with the knowledge available at the time" (National Academies of Science, Engineering, and Medicine, 2015).

According to the Association for Healthcare Research and Quality (Emanuel, Berwick, Conway, et al, 2008), “Patient safety is a discipline in the healthcare sector that applies safety science methods toward the goal of

achieving a trustworthy system of health care delivery. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events."

Moving beyond these definitions, patient safety exists in response to adverse medical events that are largely preventable and result in patient harm. The goal of patient safety is to minimize adverse events using a proactive approach. It is person-centered and relies on the principle of "first do no harm." It focuses on the microsystem in which patient-caregiver interactions occur or the "sharp end," where safety failures emerge, and where patients are harmed. Patient safety depends on organizational and personal accountability focused on applying safety sciences optimally to create high-reliability system designs. It relies on learning from errors and adverse events with a culture of openness to divergent perspectives and the creation of a continuous cycle of learning for improvement.

An organization with a patient safety culture understands the inevitability of human failure; when failure happens they quickly minimize the harm and focus on system defenses to prevent a recurrence.

Furthermore, error encompasses acts of commission and of omission: all unsafe acts.

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Support

If you are struggling with a concept or terminology in the course, you may contact **RiskManagementSupport@capella.edu** for assistance.

If you are having technical issues, please contact **learningcoach@sophia.org**.