NHS Education for Scotland

Driving Improvements in Healthcare: Implementation Evidence

1 Learning Brief 1: Introduction to Patient Safety

Patient Safety in Context

- Healthcare aims to preserve health, treat disease and alleviate suffering. It also aims to ensure that no harm is inflicted during any health service encounter.
- Healthcare staff are hardworking professionals who aim to deliver safe, effective and person-centred care.
- However, research suggests that patients are currently inadvertently harmed by the system.
- For instance, it is estimated that approximately 10% of all hospital admissions result in some form of unintended harm (1).
- Less is known about primary care, but it is estimated that approximately 1-2% of consultations may involve adverse events (2).

To Err is Human

- The publication of 'To Err is Human' (3) opened the international conversation of actively addressing quality and patient safety in healthcare.
- It highlighted the urgent need for a concerted multi-professional effort to supporting patient safety, through the prevention of future errors by designing safety into healthcare systems.
- Recommendations emanating from the report centred on four broad areas: leadership and patient safety knowledge; identifying and learning from errors; systemising standards and expectations for safety; and ultimately, implementing safety systems within healthcare organisations.

Models of Error and Error Management

- Reason (4) suggested two approaches to classifying error: the person and the system.
- The person approach focuses on unsafe acts, and highlights areas like forgetfulness, inattention, poor motivation and carelessness.
- On the other hand, the system approach highlights how errors are the result of contextual conditions.
- Errors are not to be confused with violations, negligence or recklessness.
- Error management involves detecting and reducing errors, and in creating systems that will minimise their occurrence and their damaging effects (4).
- In addition, error management is most effective when individual (person) and system approaches are combined.

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A 'Just Culture'

- A just culture is a balance between blame and blame-free cultures, and aims to improve reporting and investigation from errors, adverse events and incidents.
- It balances accountability for both individuals and organisations responsible for designing and improving systems (5,6).
- In a just culture, gross negligence and reckless behaviour are not tolerated, and those responsible are held accountable.

Safety and Improvement Educational Resources

- The remainder of this series presents a range of educational tools and resources to support ongoing improvement in patient safety.

References

1. The Health Foundation. Evidence scan: Levels of harm. London: The Health Foundation; 2011. Available from: http://www.health.org.uk/sites/default/files/LevelsOfHarm_0.pdf
2. The Health Foundation. Levels of harm in primary care. London: The Health Foundation; 2011. Available from: http://www.health.org.uk/publication/levels-harm-primary-care
3. Committee on Quality of Health Care in America & Institute of Medicine. To Err is Human: Building a Safer Health System. Washington D.C.: National Academy Press; 2000.
4. Reason J. Human error: models and management. BMJ. 2000;320(March):768–70.
5. Boysen PG. Just Culture: A Foundation for Balanced Accountability and Patient Safety. Ochsner J. 2013;13(3):400–6.
6. Dekker SWA. Just culture: Who gets to draw the line? Cogn Technol Work. 2009;11(3):177–85.

Further Information

- Driving Improvements in Healthcare: Implementation Evidence. Learning Briefing 1: Introduction to Patient Safety. NHS Education for Scotland, 2017.
- Safety and Improvement Educational Resources: A toolkit for delivering safe, effective and person-centred care. NHS Education for Scotland, 2015.

NHS Education for Scotland is a national health board responsible for education, training and workforce development for those who work in NHS Scotland. We undertake a range of patient safety educational research to support the delivery of safe, effective and person-centred care.

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