Institute for Healthcare Improvement Open School

Patient Safety 100: Introduction to Patient Safety
Summary Sheet

Lesson 1: Understanding Medical Error and Patient Safety

- How can health care practitioners prevent inadvertent harm to their patients?
  - The first step is to acknowledge that such harm occurs and may be the result of medical error.
- According to the World Health Organization, patient safety means offering "freedom … from unnecessary harm or potential harm associated with healthcare."
- According to Institute of Medicine's 1999 report *To Err is Human*, **between 44,000 and 98,000 Americans die in hospitals each year** due to mistakes in their care.
- Why is health care so dangerous?
  - Diagnosing and treating patients is incredibly complex.
  - Practitioners are often inadequately trained or prepared to deliver care as a well-integrated team.
  - Errors often occur as a result of flawed processes or systems of care — not because of negligent or irresponsible individuals.
  - The culture of safety — "the attitudes, beliefs, perceptions, and values that employees share in relation to safety" — that exists in most health care organizations is weak compared to many other high-risk, complex businesses such as the airline, petroleum, and nuclear power industries.
- Making dramatic improvements in patient safety will require the following commitments from both individuals working in health care and the organizations in which they work:
  - Acknowledge the scope of the problem of medical errors and make a clear commitment to redesign systems to achieve unprecedented levels of safety.
  - Recognize that most patient harm is caused by bad systems and not bad people, and therefore we must end our historic response to medical error, which has been saddled with finger-pointing and shame.
  - Acknowledge that individuals alone cannot improve safety; it requires everyone on the care team to work in partnership with one another and with patients and families.

Lesson 2: Understanding Unsafe Acts

- Unsafe acts are categorized as either errors or violations.
  - The first type of error is called either a **slip** or a **lapse.**
    - An example of a **slip** is accidentally pushing the wrong button on a piece of equipment — you and others can see that you pushed the wrong button.
    - An example of a **lapse** is some form of memory failure, such as failing to administer a medication — no one can see your memory fail, so the error is not observable.
  - The second type of error, in which an action goes as intended but is the wrong one, is a **mistake.**
- A **violation** is a deliberate deviation from an operating procedure, standard, or rules.

Lesson 3: A Call to Action – What YOU Can Do

- Here are five behaviors that any practitioner can do to improve safety for patients in his or her direct care:
    1. Follow written safety protocols.
        - For example: Sanitize and wash your hands to reduce the spread of infection.
    2. Speak up when you have concerns.
        - For example: Report unsafe working conditions, close calls, and adverse events.
    3. Communicate clearly.
        - For example: Use SBAR – Situation, Background, Assessment, Recommendation.
    4. Don't let yourself or others get careless.
        - For example: Confront "drift," when colleagues make slow, incremental moves away from safe actions.
    5. Take care of yourself.
        - For example: Get an appropriate amount of sleep and control your stress.