Understanding Patient Safety

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CONTENTS

Note

Health care practice and knowledge are constantly changing and developing as new research and treatments, changes in procedures, drugs and equipment become available.

The author and publishers have, as far as is possible, taken care to confirm that the information complies with the latest standards of practice and legislation.

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FOREWORD

Seven years after the publication of *An Organisation with a Memory* patient safety has become a global priority for healthcare. Between 2000 and the present time there has been a proliferation of developments in the UK National Health Service (NHS), not least the establishment of the National Patient Safety Agency (NPSA) and the National Reporting and Learning System (NRLS), which is the first national reporting system in the world. We can be justly proud of these developments.

The title of this book encapsulates its purpose. We hope that on reading this book you will begin to see the importance of building a safer healthcare system that keeps patients safe from accidental harm. As our healthcare system becomes increasingly more complex, this complexity makes it likely that opportunities for error will continue to proliferate. Improving patient safety requires a concerted effort by government, professional organisations, healthcare regulators, professionals, policy makers and consumers. It becomes ever more important to ensure that tribal boundaries between professions are overcome, and any remnants of a culture of blame be disassembled. Organisations need to be better at reporting failures in patient safety, and continuously demonstrate their ability to learn from past mistakes. Patients and the general public will expect no less.

We hope this book will appeal to a wide range of readers that includes healthcare professionals, patients and the wider general public. Chapter 1 provides the context in which patient safety has become an international priority, and includes an overview of the role of the media, a description of key terms and definitions; an outline of key policy initiatives, and a discussion on the impact organisational silence has on patient safety. Chapter 2 outlines the importance attached to engendering a culture of safety across the NHS and outlines the differences between safety culture and safety climate. Through a series of case studies Chapter 3 explores the professional, organisational and bureaucratic inadequacies that have led to breakdowns in patient safety. Chapter 4 outlines the context in which greater patient and publication participation has been instrumental in shaping the work of the NPSA. Chapter 5 considers the impact of nursing staffing shortages on patient safety through an examination of the research evidence. Chapter 6 highlights some of the national imperatives that are driving the way healthcare organisations manage risk. Chapter 7 outlines the background to, and principles of infection control, and describes the actions required by organisations, patients and the general public. Chapter 8 considers the range of patient safety resources currently available via the Internet, and offers readers a number of ways to navigate the rapidly expanding information highway.

However, no single book can fully hope to cover an area as diverse as patient safety. As this book goes to press new books and journal articles abound on the many diverse elements of patient safety. Anyone whose interest in patient safety has been stimulated by reading this book is directed to read some of the seminal works that are referenced, and search out the wealth of material that is being produced by people who are committed to improving the safety of patients across the world.

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CHAPTER 1

An Introduction to Patient Safety

Lynne Currie, Susan Watt

'More people die in a given year as a result of medical errors than from motor vehicle accidents…breast cancer….or AIDS'

Institute of Medicine, 2000: 1

Healthcare, we are told, is a risky and increasingly complex business. However, the idea of keeping patients safe throughout their illness experience underpins the very essence of healthcare, and is grounded in the Hippocratic Oath to '*do no harm*'. The concept of 'patient safety' has gained prominence over the last decade or so, with concerted efforts to improve patient safety emphasising the need to ensure that patients, wherever they receive care and treatment, are kept safe from unintended injuries, accidental injuries, or harm. The emphasis on unintended injury or unintended harm is crucial, and is premised on a belief that no one working in healthcare sets out to deliberately harm a patient.

There are of course some exceptions to this (Shipman Report, 2004), however the vast majority of healthcare workers do their very best to ensure all patients are kept safe from harm. Failures in patient safety occur as a result of organisational system failures, or what are sometimes referred to as (unintended) errors, and these are the subject of this chapter. The issues surrounding cases of intentional or malicious harm are expanded in chapter three.

This chapter begins by providing the background or context in which patient safety came to be seen as an international priority for healthcare. It includes an overview of the influential role of the media in providing added impetus in the drive to improve patient safety across the world, considers the implications arising as a result of key patient safety failures in the United Kingdom (UK), and provides a description of some of key terms and definitions around patient safety. The chapter then moves to a discussion of the key policy initiatives pertaining to patient safety, including a description of the number of errors occurring in the NHS, and how these errors are, or are not reported, before describing a range of methods used to investigate patient safety failures. The chapter also provides a synopsis of a wide range of patient safety research initiatives and the ethics of disclosing errors, before culminating in a discussion around organisational silence and its impact on patient safety.

Background

The first concerted emphasis on patient safety occurred in Australia in 1987 with the establishment of the Australian Patient Safety Foundation (Runciman, 2002). This in turn led to the creation of the Australian Incident Monitoring System (AIMS), which was the worlds' first voluntary, anonymous national reporting system. The purpose of a national reporting system is fivefold:

- Collect information from a range of sources
- Be just
- Separate the processes for accountability from the processes of learning
- Provide feedback and information about action plans
- Involve and inform patients, public and professionals.

More recently, both the World Health Organisation (WHO) and the European Union (EU) have grasped the nettle of patient safety with the launch of the Patient Safety Alliance (WHO, 2004), and the Luxembourg Declaration on Patient Safety (European Commission, 2005).

Role of the Media

Over the last 15 years the media can be seen as being very influential in raising the profile of failures in patient safety in both the UK and the United States of America (USA). There is rising public concern over safety failures in health care, which have resulted in diminishing levels of public trust in healthcare professionals (Millenson, 2002). Whilst error rates are substantial, as will be discussed below, they are also perceived as being isolated and unusual events (Leape, 1994). Furthermore, a leading commentator in the field of patient safety has suggested that many in the medical professional remain in denial about the true scale of patient safety problems (Bagian, 2005). Bagian has argued that the failure to accept the numbers of patient safety failures ranges from:

> *'…a lack of acceptance that a problem exists…[or] a combination in varying degrees of ignorance and arrogance'*
>
> Bagian, 2005: 4

Patient safety developments in the USA came to the fore following the publication of an influential report (IOM, 1999), which estimated that large numbers of people die in hospitals each year as a result of preventable medial errors. These estimates were extrapolated from two large studies undertaken in US hospitals (Brennan et al, 1991). Although the problems surrounding