



# ***What is Patient Safety?***

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# Objectives for today

- What is Patient Safety?
- Why is Patient Safety Important?
- How Do We Improve Patient Safety?
- Your Role in Patient Safety



# What is Patient Safety

- A way of doing things (philosophy)
- A discipline (safety science)
- A property or goal/attribute to minimize adverse events and eliminate preventable harm
- Keeping patients free from harm
- Providing high quality healthcare
- Decreasing risks to patients
- Implementing evidence-based interventions



# Why is Patient Safety Important?

## Canadian Adverse Events Study

- Baker and Norton (2004) studied the rate of adverse events (AE) in Canadian Hospitals
- AE - unintended injury related to healthcare management

## AE rate - 7.5 per 100 admissions

- 36.9% of these were preventable
- 20.8% of patients with AE died - in 9% of these, AE were highly preventable
- 5.2% of AE resulted in permanent disability
- 15.9% of AE resulted in death

## Most common

- Surgical procedures
- Drug and fluid-related events

# Definition of Terms

## Adverse Event:

- Unintended, unexpected and undesirable negative outcome resulting from health care management
- Not related to natural progression of disease or expected complication

## Near Miss (Good Catch):

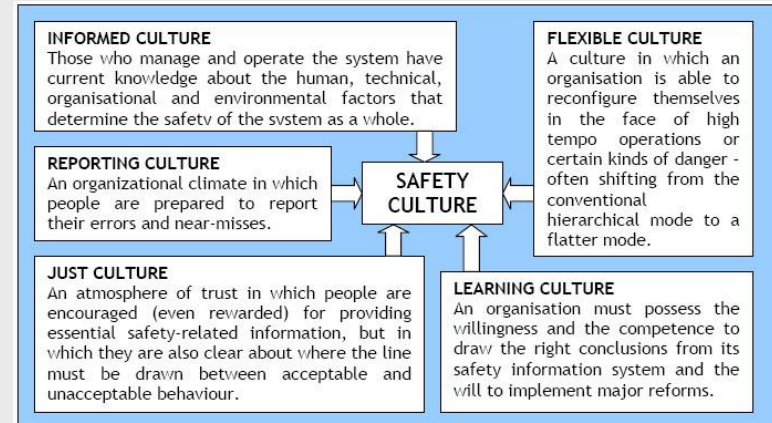
- An event or situation that could have resulted in harm but did not, either by chance or timely intervention
- It did not reach the patient



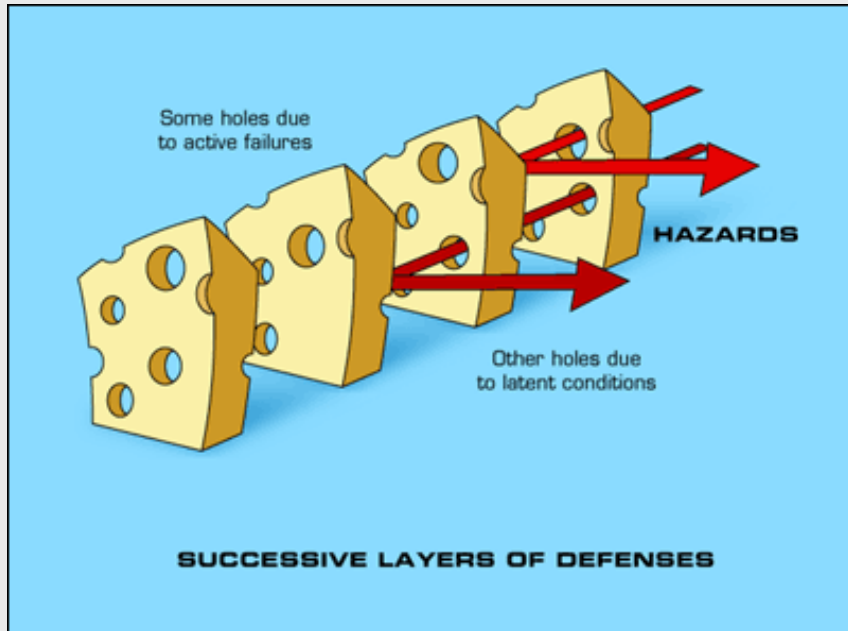
# How Do We Improve Patient Safety?

## Create a Culture of Safety – “Just Culture”

- Prevention of errors and adverse events
- Capture near misses
- Learning from events when they do occur
- Move away from “Shame and Blame”
- Focus on system issues
- Emphasis on teamwork and communication
- Disclosure of harm
- Continuous improvement



# How Adverse Events Occur – System Factors



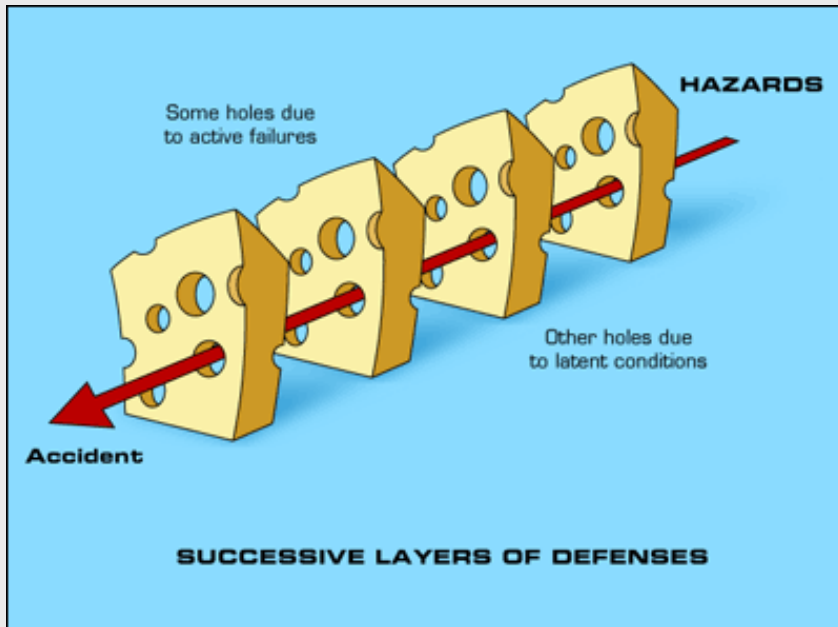
Each slice of cheese is a defensive layer in the process/system.

The holes are opportunities for the process/system to fail.

Reason's Swiss Cheese Model of System Failure



# How Adverse Events Occur – System Factors



When all the holes align for each step of the process the hazard defeats the defenses and causes an incident.

Reason's Swiss Cheese Model of System Failure



# Improving Patient Safety: Reporting

- To promote continuous quality improvement
- Incident reporting is **NOT** intended for disciplinary measures
- May require some review of procedures/ protocols
- Trending
- Important to learn from adverse events



# Improving Patient Safety

## Initiatives at LHSC

- Hand Hygiene
- Adverse Event Reporting
- Disclosure of Harm
- Removal of Dangerous Abbreviations in Medication Orders
- **Medication Reconciliation**
- Safe Surgery Checklists
- Using Two Client Identifiers
- Falls Prevention Strategy
- **VTE Prophylaxis**
- Accreditation
- Canadian Patient Safety Week at LHSC



# Key Points – Your Role in Patient Safety

- You have a responsibility to maintain and improve patient safety
- You provide care in a complex system
- The interaction of the components of the system can impair or improve safety
- **Communication is of utmost importance**
- Speak up when you are unsure – ask questions
- Report patient safety incidents



# Resources

- [CMPA](#)
- [Canadian Patient Safety Institute \(CPSI\)](#)
- [LHSC Patient Safety](#)

## Patient Safety Team

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# Questions

