Healthcare Excellence Canada

PATIENTS FOR PATIENT SAFETY CANADA | PATIENTS POUR LA SÉCURITÉ DES PATIENTS DU CANADA

Rethinking Patient Safety

A Discussion Guide for Patients, Healthcare Providers and Leaders

October 2023

Everyone
contributes
to patient safety.

Together we must
learn and act
to create safer
care and reduce
all forms of
healthcare harm.

To improve patient safety, we must start by thinking and talking about it differently.

After more than 20 years working to improve the state of patient safety, the healthcare system has made fewer gains than we had hoped.[1–3] Improving patient safety has not been as straightforward as expected.

Historically, patient safety efforts have focused mostly on measuring and responding to harm. However, safety is much more than the absence of harm. Instead, patient safety includes looking at the whole system: its past, present and future in all its complexity.[4]

Healthcare Excellence Canada and Patients for Patient Safety Canada held many conversations with users of the health system, people who work in healthcare and safety scientists (see Appendix). The ideas we collected suggest a new way of approaching patient safety – where everyone can contribute to creating safe conditions and where harm is more than physical.[4]

This discussion guide summarizes what we have learned so far and captured in this key statement:

Everyone contributes to patient safety. Together we must learn and act to create safer care and reduce all forms of healthcare harm.

Below we explain the thinking behind these words.

"Everyone contributes to…"

Everyone who delivers, supports, organizes and funds healthcare has a duty toward patient safety.

Plus, everyone who seeks or receives healthcare should be offered the skills and the opportunity to contribute to their own safety. They also should be made aware of the degree of risk they face and how they can influence their own safety outcomes.

Whether they realize it or not, everyone involved in giving or receiving care contributes to patient safety. A patient safety incident is frequently the result of multiple, complex contributing factors. Blaming and shaming individuals following an incident does not improve the safety of care.[5,6]

Supporting those involved in an incident is the right thing to do. It also restores trust and contributes to psychological well-being, building the path to patient safety.[7]

"...patient safety..."

"Patient" refers to anyone who seeks or receives care, including hospital patients, long-term care residents, home and community care clients and others across the care continuum.

"Care" includes health and social care, health promotion, disease prevention and treatment. Care also can take place in a wide variety of health and social settings.

Patient safety includes all these people and settings, including the interactions and transitions between them. Further, the safety of patients is highly dependent on the safety of those who care for them. Without safety for essential care partners[a], healthcare providers and others who work in healthcare, patient safety is compromised.[8–10]

"Together we must..."

Healthcare is founded on relationships. When we invest in relationships that foster respect, trust, collaboration, and open communication, we create a positive culture of safety.

Within this, courageous leadership is essential to create environments where patients, essential care partners, healthcare providers, and staff feel safe to explore, speak up and act when they see an opportunity to improve safety or reduce risk.[b] This responsibility requires psychological and cultural safety – for everyone.[8,9,11,12]

"...learn..."

By adopting an open and curious mindset – and by asking questions – the people closest to care can discover things that are working well, while also exploring safety concerns. In a safe culture, *everyone* can contribute by paying attention to what they see, hear, and feel in their gut.

Historically, many patient safety improvement efforts have focussed on harm, analyzing incidents and near misses and looking at factors like compliance to regulations and standards. These activities are still important.

Yet while global rates of harm remain unacceptably high, care is usually delivered without incident. So, safety is also about learning from these experiences: the things that went well, and the things that could have led to an incident but did not (yet).[13]

Patient safety efforts traditionally also have involved reassurance that care is safe. For example, scorecards, adherence to protocols, and audits are common. However, these approaches lack the flexibility to identify and understand new or emerging safety issues.[14]

Additionally, we can learn from informal experiences too like a short debrief between two people after a care encounter. We also can learn from larger innovations that proactively explore safety such as across departments, people, teams, technologies and processes that support patient care.

"...and act to create safer care..."

While learning can help us to identify and understand safety issues and opportunities, actions are then needed – small and large – to create safer care.

a Essential care partners provide physical, psychological, emotional, and spiritual support. They can include family members, close friends or other caregivers and are identified by the patient or their substitute decision-maker.

b We must recognize that those who feel they are in positions without power or have been systemically disempowered may not currently feel safe to speak up and act.

The absence of harm does not mean that care is safe.

Implementing safety practices has traditionally been the domain of clinical, quality and safety leaders. However, everyone needs to feel safe and be given the skills to act in the service of patient safety.

Some safety actions may involve formal projects or extra procedures. They also can be as simple as picking up something from the floor, having a conversation with a patient, or regularly participating in a quick safety huddle, sharing concerns, and then making improvements together.

Larger actions may include the design, implementation and management of innovations in technology, care processes or environments with the guidance of safety scientists and in partnership with system users.

"...and reduce..."

Managing risk and reducing avoidable harm – its frequency, severity, and impact – requires us to seize opportunities for deeper understanding and incremental improvements.

It also requires us to recognize that the complexity of healthcare continues to increase due to new discoveries, new treatments, new technologies, increased patient volumes, and health human resources' challenges.

Healthcare will always involve risks, so we must learn and act to manage them, together.

"...all forms of healthcare harm."

All types of harm must be considered in the work of patient safety.

In the past, focus has been mostly on physical harms – especially those that are easier to measure, such as falls and healthcare-acquired infections.[15]

But the person who experienced harm is often best positioned to define it and describe its impact on their life.[16]

Examples of other forms of harm that are often overlooked include under- and over-treatment, wrong treatment, delayed or incorrect diagnosis, dehumanization, and psychological harm.[4] Harm may also be compounded in the aftermath of an incident because of how it was managed.[16,17]

Plus, widespread societal inequities, power imbalances and systemic oppression can contribute to healthcare harm.[18,19] These include racism, ableism, ageism, sexual and gender discrimination, religious and class discrimination, and body size and mental health discrimination.

Additionally, the economic, social, educational, and environmental inequities faced by various groups and individuals can lead to healthcare harm. For example, ongoing colonial impacts and racism experienced by First Nations, Inuit and Métis in healthcare continue to be harmful.[20–22] Cultural safety is essential to patient safety.

Bottom line, all forms of harm matter. We must open our eyes, minds and hearts to this broader concept of harm. We also must embrace a shared commitment among patients, care providers, leaders and other key players to reduce harm, manage risk and create safety in healthcare.

All forms of harm matter.

For reflection

As you think about this new approach to patient safety, we encourage you to consider the shifts summarized in this chart.

Moving *beyond* a singular focus on…	to include…
Physical safety and physical harms	All forms of safety, including psychological and cultural safety[9] and recognizing how systemic inequities contribute to various forms of harm.[9]
Reacting/responding to past harm	Looking upstream. Exploring, learning and acting before harm occurs.[4]
Failures	Recognizing when, why and how things go well.[12]
Patients	Embracing safety for patients and their care partners, healthcare providers, staff and leaders.[10]
Assurance that care is safe	Acknowledging that care involves risks; and focusing on addressing them.
Safety activities led by managers and quality departments	Giving patient safety knowledge, skills and responsibility to all.[23]
Patient safety work is perceived as a project and thus as "extra" work	Seeing safety as a way of thinking, acting and relating to others and a part of everyday work. Realizing that sometimes simple actions can have big impact.[14]
"Hard" indicators (e.g., falls rate)	Recognizing "soft intelligence": perceptions, thoughts, feelings, observations, ideas and suggestions.[16]
The negative, stressful side of patient safety	Celebrating the opportunities for relationships and safe care delivery; being heard and valued; making a difference; finding joy at work.[24]
Risk awareness for providers	Sharing information about risks and risk reduction strategies with patients and their essential care partners.
Safety as separate from equity, access and other domains of quality	Seeking to understand how other domains of care relate to safety.[19,25,26]

For discussion

We encourage you to think about questions like the ones below, on your own or with others. Not only are they designed to help you begin to take steps toward improved patient safety, but also to support you in finding joy in this work by helping yourself and others feel valued and heard:

- What comes to mind when you think of healthcare harm?
- What does patient safety mean to you?
- How is the presence of safety different from the absence of harm?
- What makes you feel safe?
- Who do you speak to when you have a safety concern or compliment? How can you create safe spaces for people to talk about safety?
- How have you approached safety in the past? How might you approach it differently now? What could you start doing? What could you stop doing?
- How can you encourage the sharing of power among patients, caregivers, communities, providers, staff, and leaders to enhance patient safety?
- How can action on patient safety help reduce health inequities? How can action on health inequities help improve patient safety?
- How could you use this document to advance patient safety in your work or personal life?

Learn more

We invite you to join us on this journey for patient safety in Canada. Visit our website, access our easy-to-use tools and resources and learn more about our programs. Explore how we can go further, together, in helping to shape a future where everyone in Canada has safe and high-quality healthcare.

Appendix

How we developed this statement

Our stakeholders told us that a new patient safety statement needed to be:

- **Robust:** informed by the latest safety science and thought leaders.
- **Forward-looking:** going beyond past definitions and approaches and looking to the future of patient safety.
- **Creative:** developed using methods that bring out new ideas from stakeholders.
- **Inclusive:** involving a diverse set of stakeholders, such as patients, Healthcare Excellence Canada staff, front-line care providers, healthcare leaders, safety experts and thought leaders from other industries and academic disciplines.
- **Useful:** based on a solid understanding of how various end users would interact with and incorporate it.

Our core project team consisted of staff from Healthcare Excellence Canada and two patient partners from Patients for Patient Safety Canada. We also worked with internationally recognized experts in patient safety and cultural safety, along with communication specialists throughout the process. Activities included primary and secondary research, including literature scans, data collection via diverse methods and engagement with patient partners, people who work in healthcare, safety experts, people from other fields, and Healthcare Excellence Canada staff.

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About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners to spread innovation, build capability, and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaboration with patients, caregivers and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence. Launched in 2021, HEC brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement. HEC is an independent, not-for-profit charity funded primarily by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Disclaimer

In the spirit of continuous improvement, we look forward to our ongoing journey of engaging, learning, reflecting and refining and will update this discussion guide as we go forward with any new developments.

“If it’s not safe, it’s not care.”

– Dr Tedros Adhanom Ghebreyesus;
World Health Organization (WHO)