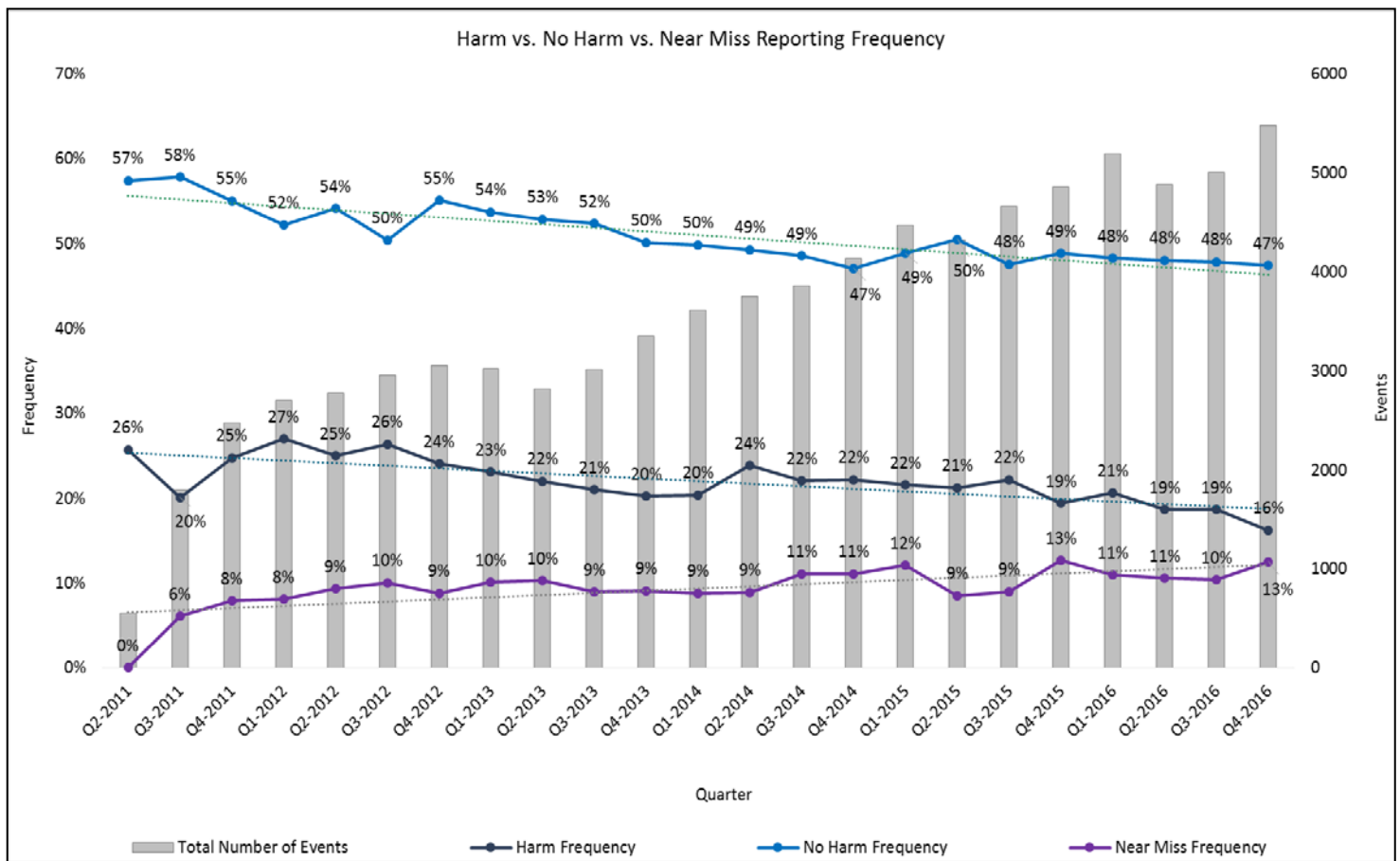


# Patient Safety Learning Series

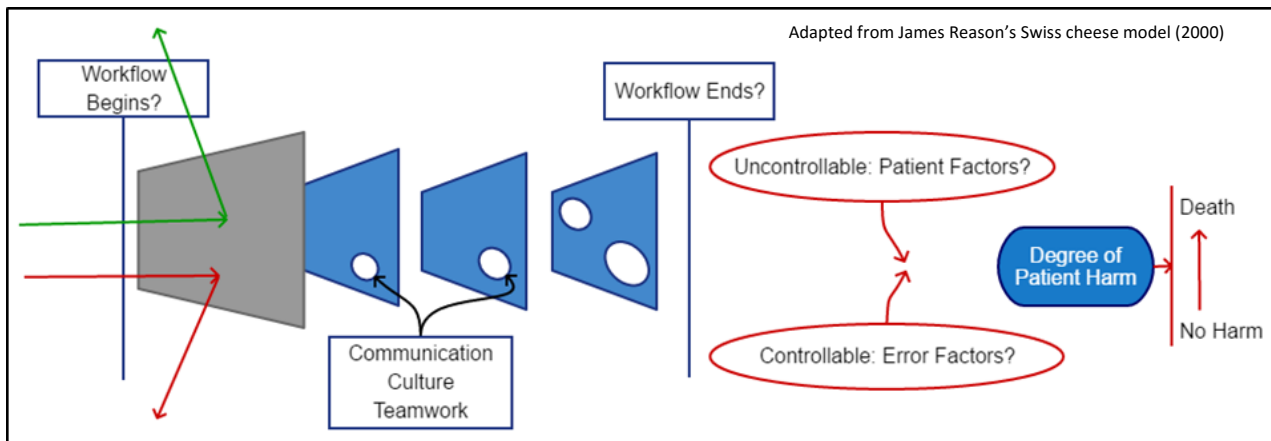
## Topic: Harm and the Care Delivery Process

In this edition of Clarity PSO’s Patient Safety Learning Series, we focus on harm. This is an excerpt from a larger harm report and project conducted by Clarity PSO with our own PSO participants. Our analysis surrounds three main categories of safety event reporting: near-miss events, no-harm events, and harm events. It is our belief that in order to more deeply understand the underlying factors, and what might prevent harm events, we have to look at the entire spectrum of error pathways in a given system – whether by physician, nurse, pharmacist, or other care provider type. Below depicts the distribution of our three categories of safety events.



The healthcare industry is inundated with multifaceted competing priorities throughout every step of the care delivery process. As such, healthcare has the potential to learn from non-healthcare zero-error, high-reliability industries such as aviation, nuclear power, and chemical processing. All of these share high stakes, high stress, complex processes, and multitudes of influencing factors. Yet healthcare’s output is the “healing” (whether that be curative or palliative) of a human being, and each human being is a unique ecosystem within their own constantly influencing and evolving macrosystem. If our primary purpose is to “heal”, then we *must* prioritize patient safety and fulfill our oath to “do no harm.”

Below is an adapted version of James Reason’s Swiss Cheese Model (2000). As James Reason’s Model explains, there are holes within our layers of defense (creating our care delivery process). When those holes align, an error reaches the patient. Yet, what distinguishes a no-harm error from a high-harm error? What are the controllable (error) factors, and uncontrollable (patient) factors that influence the ultimate degree of harm that a patient suffers? High-reliability organizations strive for zero preventable errors. An error can be considered any preventable deviation or defect from a process. An error is not solely dependent upon the outcome. When we are performing process improvement (exchanging slices of Swiss cheese), we may add layers and diminish the number of holes within a particular pathway, but at the same time, we may unknowingly create a new or altered pathway for other errors. We must consider whether there is a way to entirely avoid any potential for harm while delivering care. Can we replace the first slice of Swiss cheese with an impenetrable titanium sheet? Is it possible to design a workflow that controls the controllable error factors?



Two of our most respected thought leaders in this field of safety science wrote,

“If so much activity is going on, why isn’t healthcare demonstrably and measurably safer? Why has it proved so difficult to implement the practices and policies needed to deliver safe patient care? Why are so many physicians still not actively involved in patient safety efforts? What needs to be done to accelerate the pace of improvement in patient safety?...The answers to these questions are to be found in the culture of medicine, a culture that is deeply rooted, both by custom and by training, in high standards of autonomous individual performance and a commitment to progress through research.” (Leape & Berwick, 2005, p. 2387)

Still resonating with many of those involved in patient safety efforts today, those words identified our seemingly impossible challenge—safety culture. Yet, this element is healthcare delivery’s foundation. Our processes are built on top of this foundation. It is only when we begin to uncover and boldly address these deep-seeded cracks and weaknesses in our foundational structure that we will see transformative and sustainable change. It will take all of us—every single stakeholder—to transform this healthcare industry. And even though many of us are overwhelmed and frustrated, we have no choice but to fiercely pursue this transformation because we still continuously fail at our primary purpose: to “heal” and “do no harm.” No patient or family deserves to suffer simply because our system is flawed.

## RESOURCES

- [Revisiting Medical Error: Five Years after the IOM Report, Have Reporting Systems Made a Measurable Difference?](#)
- [In Hospital Deaths from Medical Errors at 195,000 per Year USA](#)
- [HealthGrades Quality Study: Patient Safety in American Hospitals 2005](#)
- [The Seventh Annual HealthGrades Patient Safety in American Hospitals Study March 2010](#)
- [The Fifth Annual HealthGrades Patient Safety in American Hospitals Study April 2008](#)
- [IHI Human Factors Design Principles](#)

## REFERENCES

Leape, L. & Berwick, D. (2005). Five years after To Err is Human: What have we learned? *JAMA*, 293(19) 2384-2390. doi:10.1001/jama.293.19.2384

Reason, J. (2000). Human error: Models and management. *BMJ*, 320(7237), 768-770. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117770/>