LEARN TO BE SAFE –
A SIMULATION LEARNING EXPERIENCE

PATIENT SAFETY: A PRIMER

Brought to you by:

MANITOBA INSTITUTE FOR PATIENT SAFETY

June 2011

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Patient Safety: A Primer is one component of ***Learn to be Safe: A Simulation Learning Experience***, which consists of materials to support teaching and learning about key components of patient safety through simulation. A sincere thank you is extended to the Simulation Working Group members for contributing your expertise, time, and creativity to the development of these resources. Thank you to the students and healthcare providers who reviewed this document and who participated in the pilot of the case simulation resources. Your time and input is much appreciated.

For more information on **Learn to be Safe: A Simulation Learning Experience** and other resources of the Manitoba Institute for Patient Safety, go to www.mbips.ca and www.safetoask.ca.

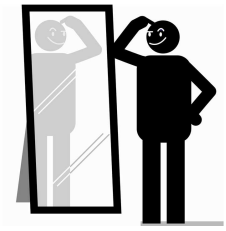
About Patient Safety: A Primer

The Manitoba Institute for Patient Safety (MIPS) has developed this primer to support education and continuing professional development in patient safety. The primer is also part of a set of learning materials for patient safety case simulations developed by MIPS that focus on communication, interprofessional teamwork, and patient and family centred care. Patient simulation provides training on real life healthcare situations in simulated environments.

Patient Safety: A Primer has been designed to:

- prepare learners on the basic concepts of patient safety, including where healthcare teams can apply these concepts in their daily practice;
- enhance participation in interprofessional patient safety case simulations; and
- stimulate self-reflection of one's own practice, and practice within teams.

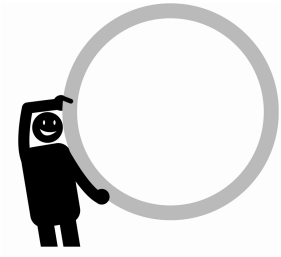
Throughout the primer, the icons displayed below will guide the learners on:



- questions for reflection

- additional readings and resources

- self-study



- link to Accreditation Canada's Required Organizational Practices[1]

Target Audience

The primer is intended for use by practising healthcare providers and students representing the full continuum of healthcare disciplines.

Why Focus On Patient Safety?

PATIENT SAFETY
Actions and processes of healthcare providers, healthcare organizations, and the public to prevent patient harm associated with healthcare services and to promote the best possible patient outcomes.

Most of the time, people's experiences as patients, family members, and healthcare providers in the healthcare system are positive. However, at times things do not go as planned.

In Canada and the world, there are significant numbers of people who are harmed or who die as a result of their care and not the treatment process or risks involved.

Patient safety involves the complicated interaction among institutions, technologies, and individuals, including patients themselves. In other words, patient safety is everyone's responsibility.

Healthcare providers try to do the right thing, but because they work in a complicated, imperfect system, at times patient safety incidents reach the patient. Some incidents do not cause harm, but others do affect patients - the people healthcare providers are committed to helping.

In a 2004 study, there was an adverse event rate of 7.5% of the almost 2.5 million annual hospital admissions in Canada. About 185,000 of the admissions were associated with an adverse event and the study estimated that close to 70,000 of those were potentially preventable.[2]

The tradition and culture of healthcare provision has been one that suggests that error is unacceptable, and acknowledgement of mistakes is an admission of lack of skill. It has become evident from our successes, and from patients who have been harmed during the healthcare delivery process, that this approach has not led to the development of a culture that supports learning.

Everyone Can Learn

An important example of the way in which this kind of learning can occur across an entire healthcare system is documented in the process following the Manitoba Pediatric Cardiac Surgery Inquest.[3]

The report of the investigation following the deaths of 12 babies in 1994 at the Health Sciences Centre:

- identified the conditions that existed when the patients were harmed, which allowed other organizations to assess for similar vulnerabilities in their processes;
- included recommendations that other organizations could implement to facilitate the creation of a safer system for all Manitobans; and
- highlighted three key areas:
  - Leadership – development of a leadership and accountability system at all levels of the organization;
  - Team Approach – use of a team approach for program management and day-to-day healthcare delivery; and
  - Interprofessional Collaboration – strengthening the processes and infrastructure to better support interprofessional collaboration.

Topics Covered In The Primer

The topics covered in the primer are aimed at providing answers to the following questions:

1. How do key human and environmental factors contribute to patient safety?
2. What is a culture of patient safety?
3. What are the key elements of effective patient and family centred care?
4. What are key factors that promote effective teamwork in multidisciplinary healthcare teams?
5. What are key interpersonal and communication skills required for effectively working with patients and families, and within multidisciplinary healthcare teams?
6. What are the major concepts related to recognizing and managing risks to patients in healthcare environments?
7. What are the key elements required in responding to and disclosing harmful incidents (adverse events)?

Self-Assessment

1. What do you think the key conditions are that need to be present to create a culture of patient safety?
2. Why is it essential to engage patients and families in the healthcare delivery process? Do patients expect healthcare professionals to tell them exactly what they should do?
3. Which knowledge, skill, and attitude competencies are important in creating an effective healthcare team?
4. What can interfere with your ability to effectively communicate with a patient?
5. Is it possible for patient safety to be the key characteristic of the healthcare organization where you are employed or study?
6. Why is interprofessional collaboration central to patient safety?
7. Name one method/strategy that you personally use to embody the principles of patient safety in your daily practice.
8. Why is it important to apologize to patients and families when patients are harmed as a result of the healthcare services they receive?

Additional Reading & Resources

Agency for Healthcare Research and Quality (AHRQ). Patient Safety Network (PSNet). Patient Safety Primers. Available at: http://psnet.ahrq.gov/primerHome.aspx

Henriksen K, Battles JB, Keyes MA, Grady ML. Advances in patient safety: new directions and alternative approaches. Rockville, MD: Agency for Healthcare Research and Quality; 2008. Available at: http://www.ahrq.gov/qual/advances/

Vincent C. Section three: from accident analysis to system design. Patient safety, 2nd edition. BMJ Books, Wiley Blackwell; 2010.

TOPIC 1: How Do Key Human And Environmental Factors Contribute To Patient Safety?

Key Concepts

- Human factors include stress and fatigue. Environmental factors include situations such as a busy workplace and work interruptions.
- Managing the relationship between individuals, the job, environmental factors, and the conditions of work is necessary in order to optimize patient safety.[4]
- The three essential concepts for consideration in understanding this relationship include: Reason's Swiss Cheese Model, human factors engineering, and situational awareness.

Reason's Swiss Cheese Model

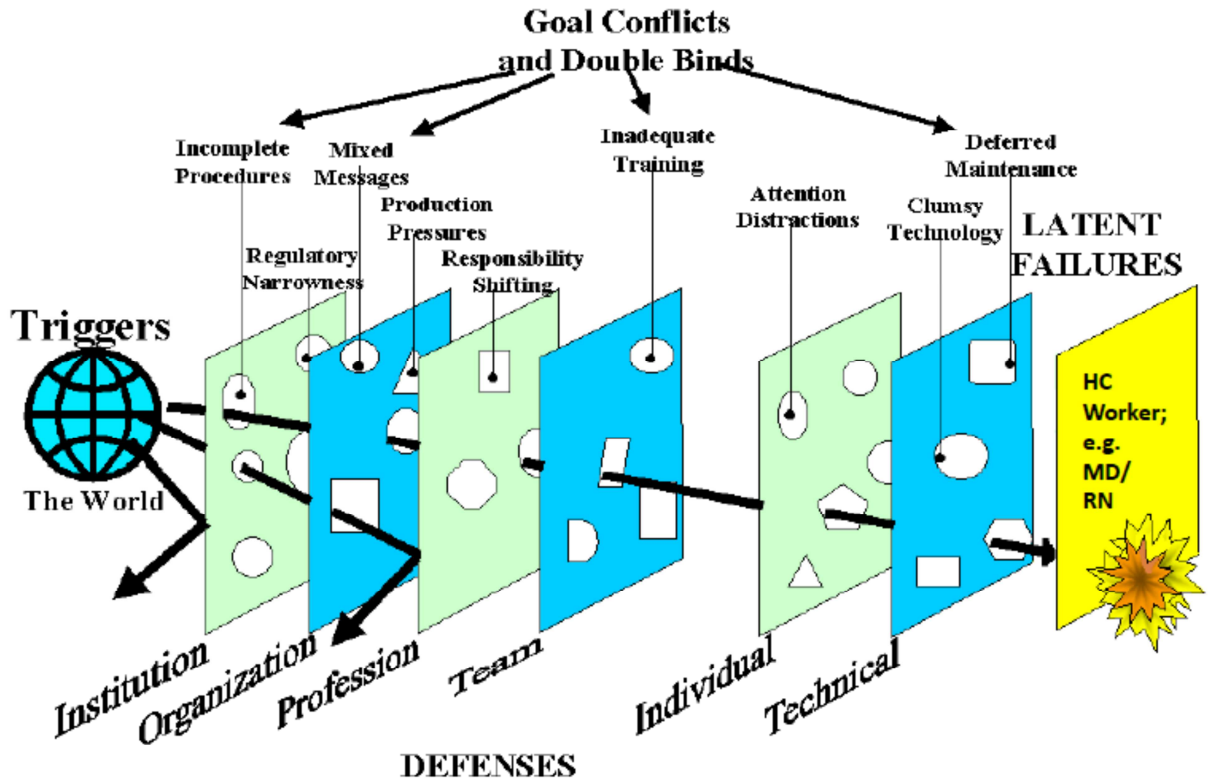
James Reason is a leader in understanding why adverse events occur. Reason suggests two approaches, the person approach and the system approach.[5]

- The person approach:
  - focuses on the individual;
  - puts blame for the adverse event on the failings of individuals (e.g., forgetfulness, inattention); and
  - is the most prevalent approach still observed in many healthcare organizations.
- The system approach:
  - focuses on conditions under which individuals work;
  - puts priority on building defenses to avert errors, and putting systems in place to mitigate effects of a mishap; and
  - creates a preoccupation with trying to prevent adverse events and assessing the possibility of a failure (not solely addressing incidents after they happen). Two tools that organizations use are: (1) Failure Modes and Effect Analysis (FMEA), to proactively look for areas where there may be potential failure in their environment, and (2) retrospective analysis (such as Root Cause Analysis (RCA)[6]), to examine the conditions that existed when something went wrong and to identify potential solutions to address any system weaknesses.

The system approach is illustrated in Kaiser Permanente's adaption of Reason's Swiss Cheese Model (see Figure 1). Systems set up safeguards or defenses to prevent hazards from resulting in patient harm, and to minimize the chance of human and environmental factors contributing to harm. As no defenses are perfect, unintended weaknesses or

"holes" exist. These "holes" open and close at random. For example, equipment that does not work one day can be fixed and operating the next day. When the "holes" align, the defenses do not work and the hazard reaches the patient, resulting in patient harm. High performing organizations have used this model to systematically focus on implementing strategies that will reinforce and strengthen any potential "holes" or vulnerabilities in their system, thereby creating a safer system.

Figure 1: Swiss Cheese Causation Model



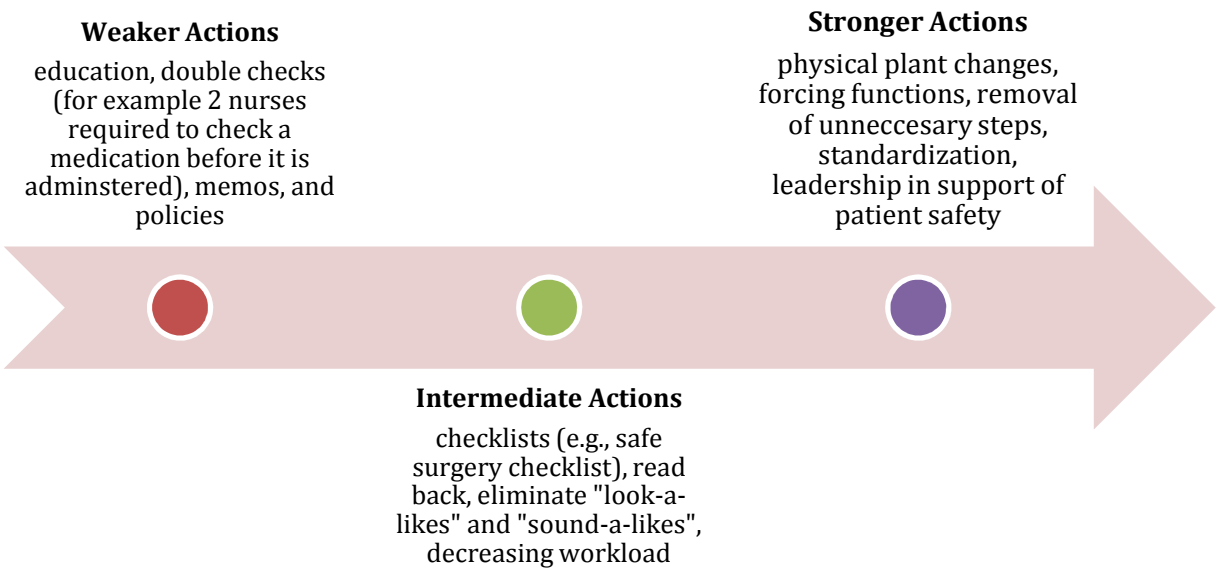
Permission granted by Kaiser Permanente (Adapted and reproduced by permission of the publisher and author from: Reason J. Managing the risks of organizational accidents. Aldershot (Hampshire, England): Ashgate; 1997. 9:120)

Human Factors Engineering

- focuses on the design of systems, devices, software, and tools to fit human capabilities and limitations;
- considers factors that can affect an individual's performance (e.g., lighting, sounds, surge conditions, work interruptions, and use of technology); and
- applies these factors when designing systems to better support individuals in their daily practice.

Figure 2 provides examples of how the knowledge of human factors engineering can be translated to healthcare. The examples are summarized from the work of the Veteran's Affairs National Center for Patient Safety.[7] MIPS' website contains links to other patient safety initiatives that are based on these principles. The principles are displayed on a continuum from weaker to stronger actions that an organization can employ in its effort to produce a safer system.

Figure 2: Stronger Actions to Weaker Actions to Improve Safety (Adapted from the NCPS RCA Tools 2002)



Situational Awareness

"Situational awareness" refers to being aware of what is happening around you.[8] It requires that the healthcare provider be aware of:

- "what is going on";
- "the meaning of the information received"; and
- "making a conclusion".

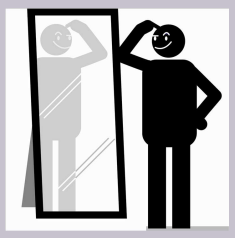
Working in teams requires each member of the team to have a shared understanding of the situation, and to:

- communicate concisely;
- use briefings and updates;
- verify perceptions;
- anticipate next steps and discuss contingencies; and
- assert opinions and perspectives.

Table 1 provides an example of the way in which the concept of situational awareness can be applied to the individual and to the team.

Applied to Individual Practice	Applied to Team Practice
1. You assess a patient's vital signs. 2. You review the vital signs and listen to the patient, who is telling you s/he is not feeling well. 3. You determine that, based on the vital signs and what the patient is telling you, the patient is deteriorating and you take appropriate action. **Summary:** The individual intentionally maintains her/his own mental attention on each task.	1. There is a plane crash and the ER team receives 20 critical admissions from the mass casualty. 2. The healthcare team works together to triage and provide care to the patients, working with other key services in the hospital, e.g., OR, ICU, Diagnostic Services, and Medical/Surgical Units. **Summary:** The team collectively maintains awareness of all the inputs, and is able to make the appropriate healthcare decisions.

Table 1: Situational Awareness in Individuals and Teams



QUESTION FOR REFLECTION

How can I apply these concepts to my personal practice?

Additional Reading & Resources

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TOPIC 2: What Is A Culture Of Patient Safety?

Key Concepts

- The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior.[9] The simplified definition is "*How we do business here*".
- Organizations that embody a safety culture are often referred to in the safety literature as, "High Reliability Organizations" (HRO). Commercial aviation, air traffic control, and nuclear power industries are three examples of HROs. Individuals feel comfortable drawing attention to potential hazards or actual failures without fear of reprimand or punishment.
- HRO's operate in hazardous conditions but have fewer than their fair share of adverse events.

Table 2 provides an overview of key characteristics of high reliability organizations.[10]

1.	Preoccupation with failure, the acknowledgement of the high risk, error prone nature of the organization's activities, and the determination to achieve consistently safe operations.
2.	Commitment to resilience that is the ability to detect potential threats in the environment or the ability to recover when "bad things happen".
3.	Encourages staff to report errors or near misses without fear of reprimand or punishment.
4.	Supports collaboration across all disciplines and levels of the organization to seek solutions to patient safety problems.
5.	A systems approach that acknowledges that the causes of a patient safety incident cannot simply be linked to the actions of the individual healthcare providers involved. All incidents are also linked to the system in which the individuals were working.[11]
6.	Commits resources to the creation of a culture of safety demonstrated by the application of core patient safety knowledge, skills, and attitudes at all levels of the organization from the Board to the frontline.[12, 13, 14]

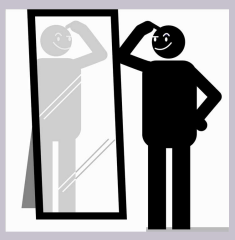
Table 2: Characteristics of High Reliability Organizations

STEPS TO CREATE A CULTURE OF SAFETY

1. MEASURE
Know your baseline safety culture, unit by unit. Remember all culture is **local.**
Tool: Use Accreditation Canada's Patient Safety Survey.

2. AWARENESS & ENGAGEMENT
Engage staff across the organization and create partnerships that extend to patients and families.
Process: Share safety survey results and develop action

3. Sustain Organizational Energy
Nurture the partnerships, allow healthcare providers, patients, and families to speak and share in the redesign of systems.
Process: Set up monitoring systems to ensure sustainability over time.



QUESTION FOR REFLECTION

Does my organization or practice site embody a culture of patient safety?

Additional Reading & Resources

Canadian

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TOPIC 3: What Are The Key Elements Of Effective Patient And Family Centred Care?

PATIENT AND FAMILY CENTRED CARE: FOUNDATIONAL CONCEPTS

DIGNITY AND RESPECT
Healthcare practitioners listen to and honour patient and family perspectives and choices.

INFORMATION SHARING
Healthcare practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful.

PARTICIPATION
Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.

EDUCATION AND SUPPORT
Healthcare practitioners ensure that appropriate education and support is provided to patients and family members and others involved in their care.

COLLABORATION
Healthcare leaders collaborate with patients and families in meaningful ways.

A System Committed To Patient And Family Centred Care:[15]

- is designed for patient/family engagement;
- includes patients, families, and advocates as active members of the healthcare team;
- identifies gaps in healthcare delivery;
- involves patients/families when building/enhancing physical facilities;
- is focused on collaboration and healthcare team management;
- delivers culturally sensitive care;
- respects patient needs and preferences; and
- encourages free flow and accessibility of information.

Tips For Transitioning To A Patient And Family Centred Care Model

- Attain demonstrated commitment of leadership from the top, including the CEO and the Board.
- Design and implement a plan that addresses the key contributing factors[16] to patient and family centred care, including:
  - a strategic vision that is clearly and consistently communicated to every member of the organization;
  - mechanisms to engage patients and families at multiple levels, e.g.,
    - development of the appropriate infrastructure to support and enable healthcare providers to embody patient and family centred approaches to care delivery,
    - implementation of processes that support the ability of patients and families to report potential critical incidents or other issues that they deem important,

- use of patient/family advisory councils and engagement of patients/families on internal committee structures to give them a voice in the healthcare delivery process,
- encouragement of patients and families to play an active role in their own safety by asking questions, getting an advocate, knowing and showing their medications on a list, and being vigilant in hand washing; and

o use of a proactive measurement and evaluation system to monitor the organization's progress in the transition.

QUESTION FOR REFLECTION

What are some of the barriers that prevent the consistent integration of patients and families in a meaningful way in the healthcare delivery process?

Additional Reading & Resources

Agency for Healthcare Research and Quality (AHRQ). Patient Safety Network (PSNet). Patient Safety Primers: the role of the patient in safety. Available at: http://psnet.ahrq.gov/primer.aspx?primerID=17

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TOPIC 4: What Are Key Factors That Promote Effective Teamwork In Multidisciplinary Healthcare Teams?

Effective Multidisciplinary Healthcare Teams Can Help:

- reduce service duplication and minimize unnecessary interventions;
- reduce healthcare costs;
- enhance patient health outcomes;
- improve retention and recruitment of healthcare providers;
- enhance clinical effectiveness;
- promote integrated, seamless healthcare; and
- improve patient safety.

The Many Faces Of Teams In Healthcare

Teams can take many forms in healthcare:

- as a part of a unit or community team;
- quality/process improvement teams;
- ad hoc teams, e.g., teams charged with understanding when "things go wrong in the organization"; and
- specialty care teams (e.g., code teams, community intravenous program, rapid response teams).

Support effective teamwork through:[17]

1. communication
2. team training
3. coordination
4. leadership
5. engaging patients & families

TEAMS NEED A PLAYBOOK!

- Determine team membership by the needs of the patient.
- Define strategies to actively engage patients and families.
- Understand the objectives of healthcare and services from the perspective of the patient/person (the client).
- Build team members' skills in the use of the "equipment" (tools and resources) to effectively carry out the team's goal.
- Share accountability and decision-making with all team members.

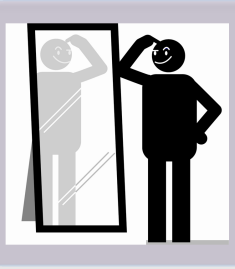
Did you know that teamwork plays an important role in the contribution to and prevention of harmful incidents?

Table 3 provides a listing of key tips and strategies that can be used to enhance collaborative team practice and communication. Effective communication and teamwork is essential for the delivery of high quality, safe patient care.[18]

TIPS/STRATEGIES TO ENHANCE TEAM FUNCTIONING	
Clarify roles	• know your role and the roles of others • perform role in a respectful manner • communicate role, knowledge, skills, and judgment using appropriate language • access others' skills and knowledge when needed • consider the roles of others in determining your professional and interprofessional role
Be familiar with the natural stages that your team will move through	Four stages of team formation and development [19] • Forming: when group members are learning to deal with one another, during which time minimal work is accomplished. • Storming: a time of stressful negotiation of the terms under which the team will work together, a trial by fire. • Norming: a time in which roles are accepted, team feeling develops, and information is freely shared. • Performing: when optimal levels are finally realized in productivity, quality, decision-making, allocation of resources, and interpersonal interdependence.
Develop your team	• develop a set of principles for working together that respects the ethical values of members • facilitate discussions and interactions among team members • participate, and be respectful of the participation of all team members in shared decision-making • regularly assess team functioning with team members and patients/clients/families • respect team ethics, including confidentiality, resource allocation, and professionalism
Manage conflict	• recognize that conflict occurs, and there is value in the potential positive nature of conflict • identify common situations that are likely to lead to disagreements or conflicts, including role ambiguity, power gradients, and differences in goals • know and understand strategies to deal with conflict • set guidelines for addressing disagreements effectively • work to address and resolve disagreements, including analyzing the causes of conflict and working to reach an acceptable solution • establish a safe environment in which to express diverse opinions • develop a level of consensus among those with differing views, allowing all members to feel their viewpoints have been heard regardless of the outcome • be aware of the potential impact of "silo thinking" on team development
Use quality improvement processes to improve team functioning	• regularly assess key factors known to affect team functioning, and share the information with all team members • engage all team members in the plan-do-study-act process • be innovative when opportunities for improvement are identified, and look to other industries for improvement ideas, e.g., the physician leader who learned from a Ferrari pit crew about processes to improve handovers in the pediatric ICU team[20]

Table 3: Strategies to Enhance Team Functioning

Remember –no single healthcare discipline is responsible for the delivery of care to a patient. How each person interacts with team members contributes to the delivery of high quality, safe healthcare.



QUESTION FOR REFLECTION

Who are the members of my team, and how can I contribute to and foster interprofessional teamwork in my practice?

Additional Reading & Resources

Canadian

Baker GR, MacIntosh A, Porcellato C, Dionne L, Stelmacovich K, Born K. High performing healthcare systems: delivering quality by design. Toronto, ON: Longwoods; 2008. Available at: http://www.longwoods.com/publications/books/571

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TOPIC 5: What Are Key Interpersonal And Communication Skills Required For Effectively Working With Patients And Families, And Within Multidisciplinary Healthcare Teams?

What Patients Say They Want:

- a healthcare provider who:[21]
  - shows respect and empathy;
  - provides content in a language that is understandable and culturally sensitive to the patient;
  - listens to the patient and other healthcare team members;
  - actively engages patients in the decision-making process; and
  - facilitates smooth transfer of healthcare from shift to shift, and care setting to care setting.

Did you know that we usually let people talk for only 18 seconds before we interrupt them, and if we waited just 2 to 3 minutes longer we would hear the vast majority of their story? [22]

Developing Effective Interprofessional Communication Within A Team Involves:[23]

- establishing teamwork communication principles that foster openness and shared decision-making;
- actively listening to other team members, including patients/clients/families;
- communicating in a way that ensures a common understanding of healthcare decisions;
- developing trusting relationships with patients/clients/families and other team members;
- effectively using information and communication technology; and
- involving patients and families as partners in the healthcare team, considering the impact of their health condition, culture, and health literacy.

Communication pitfalls are often at the root of events that contribute to patient harm.

Examples Of Strategies To Enhance Interprofessional Healthcare Team Communication[24]

- Use the tool "SBAR", which structures communication using the headings "Situation-Background-Assessment-Recommendation". This tool helps standardize communication between members of the healthcare team.
- Standardize the use of safety huddles and safety briefings as part of the healthcare delivery process to promote open communication.
- Develop a consistent program of education to support development of core team and interpersonal skills. An example is "Crew Resource Management" (CRM) from the aviation industry, which includes two key communication components of CRM, improving collaboration through **briefings** and promoting appropriate **assertiveness** within teams.

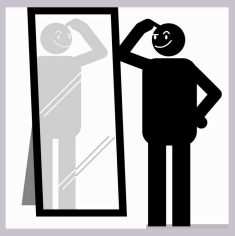
EXAMPLE OF A RESPONSE FROM THE AVIATION INDUSTRY

After discovering that two-thirds of air crashes involve failures in teamwork, the air transportation industry began focusing on standardized training of their crews (crew resource management - CRM) to improve team communication.
Example in healthcare: train all providers in the assertiveness techniques needed for voicing concerns regarding the patient's status, treatment protocol, care plans at transition of care (e.g., admission from an outpatient setting, nursing shift change), or prior to an invasive procedure.

Team Members Demonstrate Good Interprofessional Communication When They:[25]

- effectively express their knowledge and opinions to others involved in care;
- demonstrate confidence and assertiveness in expressing views respectfully and with clarity;
- employ language understood by all involved in healthcare and explain discipline-specific terminology;

- explain rationale for opinions;
- evaluate effectiveness of communication and modify accordingly;
- actively listen to the knowledge and opinions of other team members;
- listen to and show genuine interest in the perspectives and contributions of others;
- are observant and respectful of non-verbal as well as verbal communications;
- confirm that they understand all ideas and opinions expressed;
- use technology and other tools to ensure others are continuously updated;
- are aware of and use information resources from other professions; and
- plan and document care on a shared health record.



QUESTION FOR REFLECTION

How can I better communicate with patients and within my healthcare team?

Additional Reading & Resources

Canadian

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World Health Organization: http://www.who.int/patientsafety/patients_for_patient/en/

TOPIC 6: What Are The Major Concepts Related To Managing Risks To Patients In Healthcare Environments?

Key Concepts

Managing risks to patients in the healthcare environment requires an understanding that things can and will go wrong. Actions to improve patient safety include areas previously covered in topics 1 through 5:

- designing work systems to reinforce any potential vulnerabilities, e.g., standardize processes (topic 1);
- situational awareness, e.g., observe the environment and think ahead (topic 1);
- developing a culture that draws attention to potential hazards or actual failures with the aim to learn and improve (topic 2);
- commitment to engage patients and families in solutions (topic 3);
- developing effective multidisciplinary healthcare teams that anticipate and effectively manage situations that place patients at risk (topic 4); and
- effective communication skills within teams and with patients and families (topic 5).

Application of key concepts to manage risks, and the use of safety practices, will support efforts of the:

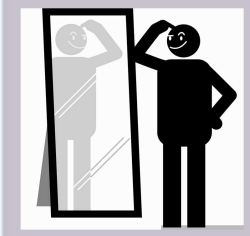
- organization in creating a systematic approach to proactively identify and manage risks in the environment; and
- individual in competently performing in this system.

Safety Practices For Individuals And Organizations To Manage Risks

Table 4 provides examples of safety practices at the individual and organizational levels to successfully manage risks.

Individual	Organization
Integrate key safety practices that reduce the risk of adverse events into everyday practices. For example: • infection control, including aseptic technique, hand hygiene, screening, and surveillance; • proper handling and maintenance of equipment; • injury prevention, including safe patient transport, handling and transfers, and the removal of physical hazards; • the safe administration of medication, including independent double checks, recognition of sound-alike and look-alike medications, use of only approved abbreviations, consistent reconciliation of medication across the continuum and reliable patient identification and alerts; • use of checklists and other cognitive aids that are designed to reduce the potential of harm to patients, e.g., tools to support the avoidance of wrong-site surgery; and • become knowledgeable about the organization's policies and processes.	Integrate proactive learning and improvement into organizational culture. For example: • establish processes to report concerns about patient safety and patient incidents, and learn from near misses and situations involving patient harm (including the lessons of others); • establish consistent, organization-wide, standard approaches and processes to guide clinical practice, e.g., evidence-informed practice guidelines and checklists;[26] • ensure that patient safety and risk management data are integrated for analysis, including patient incidents, staff safety data, complaints, litigation, financial and environmental risks;[27] • implement a consistent process to analyze clinical, financial, and operational risks to identify opportunities for improvement;[28] and • communicate lessons learned from all risk-related information to healthcare providers and staff.

Table 4: Individual and Organizational Safety Practices to Manage Risks



QUESTION FOR REFLECTION

How can I communicate better with patients and within my healthcare team?

Additional Reading & Resources

Canadian

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TOPIC 7: What Are The Key Elements Required In Responding To And Disclosing Harmful Incidents (Adverse Events)?

Key Concepts

As a general principle, any time a patient suffers harm, for any reason, the healthcare provider or organization should communicate to the patient about the harm.[29]

In Manitoba, disclosure of critical incidents to patients is required by law.

TERMS

Check the terms that are used in your jurisdiction. Terms evolve through time as we learn.

Harmful incident (same as "adverse events") refers to an unintended, undesirable patient experience or outcome that may or may not be a result of the care provided to the patient (i.e., may not have been preventable) and has resulted in patient harm.

Critical incidents, as defined in Manitoba legislation, are unintended events that occur when health services are provided to an individual. The event results in a consequence to the individual that, a) is serious and undesired, such as death, disability, injury or harm, unplanned admission to hospital, or unusual extension of a hospital stay, and b) does not result from the individual's underlying health condition or from a risk inherent in providing the health services.[30]

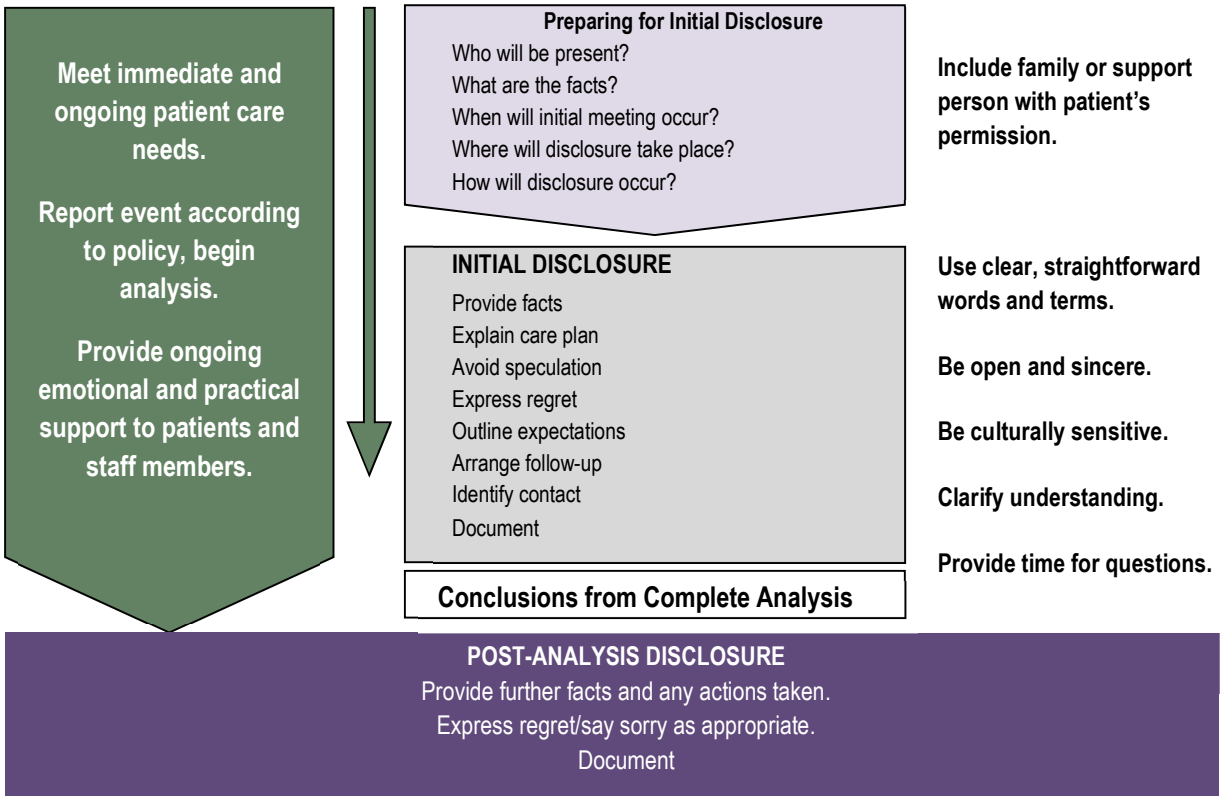
Near miss is an incident that did not reach the patient.[31] If it had, it could have resulted in patient harm.

No harm event is an incident that reached a patient but no discernable harm resulted.

Disclosure is the process (verbal and written) of informing patients/families about harmful incidents.[32] Depending on the jurisdiction, the disclosure policy may include critical incidents, and may extend to incidents in which there is potential for harm, and/or when no harm is apparent.

Figure 3 provides an overview of the key components involved in the disclosure process.[33]

Figure 3: Overview of the Disclosure Process (CPSI)



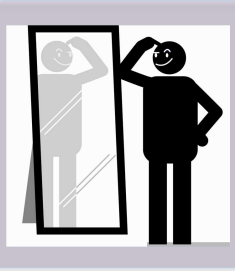
What Do Organizations In Manitoba Need To Do Following A Critical Incident?[34]

- give the facts about what happened;
- apologize;
- tell what has been done so far, and what will happen next;
- complete a disclosure record;
- provide a copy of the disclosure record upon request;
- investigate the incident to learn how to prevent the same thing from happening;
- provide information to the patient/family on:
  - the how and why of the event,
  - recommended changes to improve patient safety to try to prevent the same harm from happening again, and,
  - the process to improve the health system, not to assign blame; and
- report investigation findings to government.

Key components covered in each step of the disclosure process are summarized in Table 5.

1. Foundation	The organization ensures that it has defined processes, policies, and procedures that explain the way in which it will respond to an adverse event or near miss. Staff and physician partners are appropriately educated and deemed competent in the disclosure process.
2. Preparation for the Initial Disclosure	The organization ensures that an appropriate team is assembled, with clear assignments to support the patient/family through the entire disclosure process. The organization is clear about who will be present, the facts that will be shared, when and how the meeting will be conducted, and the identification of a lead team member to guide the process.
3. Initial Disclosure	The organization ensures that the facts are shared in a manner that makes it easy for the patient/family to fully understand the entire scope of what is known. It is key that the team expresses regret in way that is perceived as open, sincere, and culturally sensitive by the patient/family. A skilled team completes an analysis of the event.
4. Post-Analysis Dislosure	The team shares all additional facts discovered, and any actions taken. The full process is documented in accordance with the organization's processes.
5. Sharing Lessons Learned	The Winnipeg Regional Health Authority Safety Learning Summaries (SLS) are shared with staff and are online so other organizations across Manitoba, nationally, and internationally can learn from the reviews of critical incidents.[35] In November, 2010, the Government of Manitoba released a report with patient safety and critical incident information in Manitoba.[36] The Canadian Patient Safety Institute (CPSI) developed the website "Global Patient Safety Alerts",[37] which supports organizations across Canada and the world in learning from each other.

Table 5: Steps in the disclosure process



QUESTION FOR REFLECTION

What disclosure process is followed in my organization?

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