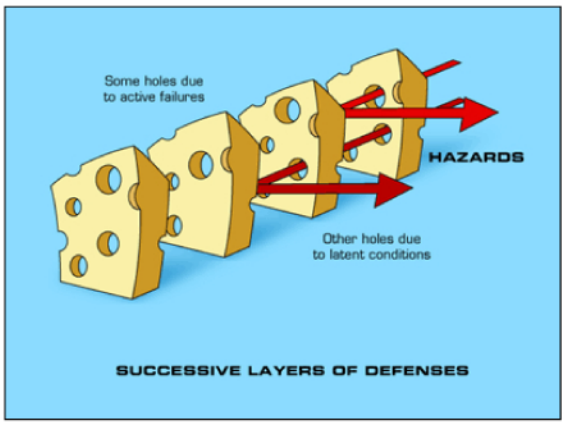
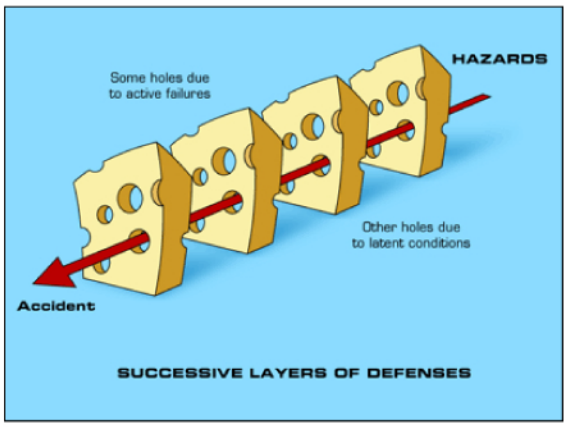
Your understanding of patient safety concepts and how they are integrated into the daily work of health care is critical in providing safe patient care. At London Health Sciences Centre, the ISTEP framework provides the overarching foundation for quality patient care.

Integrated • Safe • Timely • Effective • Patient & Family Centred

The Swiss Cheese model of accident causation is a commonly used risk analysis and risk management model. It likens human systems to multiple slices of Swiss cheese stacked side by side. The risk of a threat becoming a reality is mitigated by the differing layers and types of defenses, which are "layered" behind each other. Therefore weaknesses in one defense do not allow a risk to materialize because other defenses also exist, preventing a single point of weakness.





The Swiss Cheese model includes both active and latent failures. Active failures include unsafe acts directly linked to an accident, such as (in the case of aircraft accidents) pilot error. Latent failures include contributory factors that may lie dormant for days, weeks, or months until they contribute to the accident.

According to the Canadian Patient Safety Institute (CPSI), there are six domains of safety competencies for health care professionals:

1. **Contribute to a Culture of Patient Safety - A commitment to applying core patient safety knowledge, skills and attitudes to everyday work.**

- You must understand and apply the Accreditation Canada standards for your area and the Required Organizational Practices (ROPs) for Patient Safety under the following areas:
    - Safety Culture
    - Communication
    - Medication Use
    - Work-life/workforce
    - Infection Control
    - Risk Assessment (http://www.lhsc.on.ca/priv/accreditation/)

2. **Work in Teams for Patient Safety - Working within interprofessional teams to optimize both patient safety and quality of care.**

- Within your interprofessional teams, you have a responsibility to support a culture of safety through:
    - The prevention of errors
    - Capturing near misses
    - Move away from “Shame and Blame”
    - Focus on system issues
    - Emphasis on teamwork and communication
    - Continuous improvement
    - Disclosure of Harm as per policy (PCC050)

3. **Communicate Effectively for Patient Safety - Promoting patient safety through effective communication.**

- Included in the glossary are several commonly used acronyms to frame communication in a structured approach for patient safety. Additionally, involve your patients in their own health care by using the following tips from the Ontario Hospital Association:
    1. Be involved in your health care. Speak up if you have any questions or concerns about your care.
    2. Tell a member of your health care team about your past illnesses and your current health condition.
    3. Bring all of your medicines with you when you go to the hospital or to a medical appointment.
    4. Tell a member of your health care team if you have ever had an allergic or bad reaction to any medication or food.
    5. Make sure you know what to do when you go home from the hospital or from your medical appointment.

4. **Manage Safety Risks - Anticipating, recognizing and managing situations that place patients at risk.**

- In additional to applying patient safety principles to minimize and manage risks, you have a role to recognize and identify safety issues and report these through the Adverse Events Management System (AEMS).

Definition

- An electronic documentation system
- A formal process for identifying, documenting, and investigating any unexpected and undesirable event or near miss in the hospital
- A method of collecting and managing information to identify risks

Purpose:

- Used to promote continuous quality improvement and patient safety
- Allows identification of gaps in our patient care systems
- Assist in the investigation and management of potential legal and insurance claims
- Web-based system with automated notifications
- Events created, submitted and reviewed online
- Submitted event creates email notification to most responsible leader for review
- Others can be notified by the leader as required for follow-up or information purposes

Include as many details as possible

- Where event occurred
- Type of event (e.g. Medication, fall)
- Severity of harm to the patient
- Actions you took in response to the event
- Information about disclosure to patient/SDM
- Remember to include the patient's name if it is a patient event

Types of Events

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:

- 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

5. **Optimize Human and Environmental Factors - Managing the relationship between individual and environmental characteristics in order to optimize patient safety.**

Engagement to manage this relationship occurs at three levels:

- Organizational level – culture, policy and procedure, standards
- Team level – team training, communication, situational awareness
- Individual level – personal error control, self-awareness, compliance

Be cognizant of:

Physical demands: *fatigue, illness, substance abuse, stress*
Skill requirements: *inexperience, fear, procedural shortcuts*
Mental workload: *boredom, cognitive shortcuts, reliance on memory*
Team dynamics: *stress, shift work*
Device design: *equipment/programs*
Environment: *fixed lighting, heat, workflow space, controllable noise, clutter*

6. **Recognize, Respond to and Disclose Adverse Events - Recognizing the occurrence of an adverse event or near miss and responding effectively to mitigate harm to the patient, ensure disclosure, and prevent recurrence.**

- *The communication of information by health practitioners to a patient/SDM regarding an adverse event or adverse outcome that either affects or may affect the patient's health.*
- *Obligation proportional to degree of harm*
- *Does not imply assignment or acceptance of fault*

http://appserver.lhsc.on.ca/policy/search_res.php?polid=PCC050&live=1

Level 2 events - No Injury/Harm - Intervention/Monitoring Required

- *Inform physician and area leader*
- *Disclose to patient with coordinator/charge nurse*
- *Document disclosure in patient's health record*

Level 3 and higher – Harm Events

- *Inform physician and area leader*
- *Decision regarding who discloses based on the degree of harm to patient*

Glossary

Terms you should familiarize yourself with (adapted from CPSI):

Adverse event -*An event that results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient's underlying medical condition.*

ARC - *A team communication tool. The acronym stands for: Ask a question, Request a change, voice a Concern.*

Authority gradient - *Balance of decision-making power or the steepness of command and hierarchy in a given situation.*

Briefing - *A structured communication used to share information, often before an activity (e.g., a surgical time out)*

CHAT - *A communication tool for monitoring a situation. The acronym stands for: Context, History, Assessment, Tentative plan.*

Briefing - *A structured communication used to share information, often before an activity (e.g., a surgical time out)*

Close call/Near miss/Sentinel event - *An event with the potential for harm that did not result in harm because it did not reach the patient due to timely intervention or good fortune (sometimes called a near miss). The term "good catch" is a common colloquialism to indicate the just-in-time detection of a potential adverse event.*

Cognitive biases - *Mental shortcuts or heuristics that can lead to error such as a pilot who is so focused on malfunctioning landing gear, that she runs out of fuel.*

Cultural competency - *The ability to interact successfully with people from cultures other than one's own.*

Culture of patient safety - *A health care organizational approach in which the provision of safe care is a guiding principle. A culture of safety reflects the knowledge, skills and commitment of all leaders, management, health care professionals and staff to the provision of the safest possible patient care. The culture appropriately and adequately supports providers in the provision of safe care, including continuous professional development. The culture encourages learning from adverse events and close calls to strengthen the system. Where appropriate, it supports and educates health care providers to help prevent similar events in the future. Justice is an important element; all are aware of what is expected, and are held professionally accountable in a fair way. Fairness and due process are fundamental to the determination of the reasons for adverse events. The interests of both patients and providers are protected.*

CUS - *A mutual support communication tool. The acronym stands for: I am Concerned, this is Unsafe, I am Scared.*

DESC Script - *A constructive approach to managing and resolving conflict. The acronym stands for: Describe the specific situation or behaviour; provide concrete data, Express how the situation makes you feel / what your concerns are, Suggest other alternatives and seek agreement, Consequences should be stated in terms of impact on established team goals, Strive for consensus.*

Disclosure - *The process by which an adverse event is communicated to the patient by health care providers.*
Initial disclosure: The fi rst communication made with the patient as soon as reasonably possible after an adverse event, focusing on the known facts and the provision of further clinical care.
Post-analysis disclosure: Subsequent communications with the patient about known facts related to the reasons for the harm after an appropriate analysis of the adverse event.

Ergonomics - *The application of the science concerning human limitations to the design of objects, systems and the environment for human use.*

Error, provider (medical) - *An act (plan, decision, choice, action or inaction) that when viewed in retrospect was not correct and resulted in an adverse event or a close call.*

Event - *A significant occurrence.*

Fatigue - *Extreme tiredness that results in diminished ability to perform both cognitive and physical tasks.*

Harm - *An outcome that negatively afects the patient's health and/or quality of life.*

High reliability organization (HRO) - *An organization with fewer than normal accidents in an environment where accidents can be expected in view of inherent risk factors and the complexity of the activity, and in an industry where errors have a high potential to result in disastrous consequences.*

Human factors and human factors engineering - *Study of human abilities and characteristics as they affect the design and smooth operation of equipment, systems and jobs. In North America the term human factors engineering is used to reflect psychological work, whereas the term ergonomics is used to refer to physical work. The two terms are often used synonymously.*

I PASS THE BATON - *A handover communication tool. The acronym stands for: Introduction, Patient, Assessment, Situation, Safety concerns, THE, Background, Actions, Timing, Ownership, Next.*

I'M SAFE - *A self-assessment tool to help monitor a situation. The acronym stands for: Illness, Medication, Stress, Alcohol and drugs, Fatigue, Eating and Elimination.*

Just culture - *A phrase that refers to the principles for achieving a culture in which front line personnel feel comfortable with errors, including their own, while maintaining professional accountability.*

No-harm event - *An event that reaches the patient but does not result in harm.*

Normalization of deviance - *The tendency to regularly bend the rules to achieve best performance and the acceptance of this deviance as normal required behaviour.*

Patient safety - *The pursuit of the reduction and mitigation of unsafe acts within the health care system, as well as the use of best practices shown to lead to optimal patient outcomes.*

Reporting - *The communication of information about an adverse event or close call by health care providers through appropriate channels inside or outside of health care organizations for the purpose of reducing the risk of adverse events in the future.*

Safety - *Freedom from the occurrence or risk of injury, danger, or loss.*

SBAR - *A simple yet effective way to standardize communication between care givers, the acronym stands for: Situation, Background, Assessment or Analysis, Recommendation.*

Situational awareness - *The degree to which one's perception of a situation matches reality.*

STAR - *A thinking tool. The acronym stands for: Stop, Think, Assess/Act, Review.*

Substitute decision-maker - *A person who is legally authorized to make decisions on behalf of the patient; authority may be granted by the patient himself or herself with a legal document such as an advance medical directive, by provincial/ territorial legislation, or by the courts.*

Surge conditions - *An increase in patient and/or health care flow during particular periods.*

System failure - L*ack, malfunction or failure of policies, operational processes, or supporting infrastructure for the provision of care*

Technology - *A piece of equipment or a tool used to perform an activity. This includes the simplest tools to the most complex engineered and designed devices and systems used to accomplish human tasks, activities and goals (e.g., ranging from alergy alert wrist banks to CT scanners to computerized physician order entry systems).*

Work flow - *The way that work is completed over time.*