

## Patient Safety 101: Fundamentals of Patient Safety

### Summary Sheet

#### Lesson 1: To Err Is Human

- Latent errors are defects in the design and organization of processes and systems that can lead to failures and errors.
  - Latent errors, first suggested by psychology professor James Reason, are often unrecognized or just become accepted aspects of the work.
  - Latent errors lead to active errors, whose effects are felt immediately.
- To prevent errors, you need to **design processes that make it easy for people to do things right, and hard to do things wrong.**

#### Lesson 2: Responding to Error

- Blaming and punishing an individual does not address the underlying issues that led to an event and does not prevent a recurrence.
  - Only about 5 percent of medical harm is caused by incompetent or poorly intended care.
  - In contrast, 95 percent of medical harm involves conscientious, competent individuals involved in circumstances that lead to a catastrophic result.
- **The Josie King story** is an example of responding to error – and, in this case, tragedy – without blaming or seeking punishment.
- Although blaming and punishing individuals for errors are not appropriate responses, individuals should still be accountable for their actions.

#### Lesson 3: Identifying and Reporting Errors

- Every error may represent an opportunity to improve a process; however, in order to improve, these errors must be recognized and made known so they can be analyzed.
- Voluntary reporting systems, used to capture data about errors, are used internally in many health care organizations and can take many forms, including paper-based or computerized forms or hotlines.
  - Some local, state, and national requirements also mandate error reporting.
- Estimates are that voluntarily reported medical errors reflect 10 to 20 percent of actual errors.
  - Errors are not always recognized when they occur.
  - Fear of punitive response inhibits reporting.
  - Reporting systems are sometimes cumbersome.
- When an error occurs and you recognize it, you should report it, so that system-wide learning and performance improvement can take place.

#### Lesson 4: Error versus Harm

- **The Swiss cheese model** is a useful way to think about errors in complex organizations. Imagine several slices of Swiss cheese lined up next to one another. Usually the holes do not all line up. If you try to pass a string through all the slices, each slice would act as a barrier.
  - However, something might be all the way through by using different holes in the slices, and every once in a while, all the holes might line up.
- As we work in health care to achieve greater safety for patients, it is essential to keep in mind the following points about error and harm:
  - Not all errors reach patients or cause harm; however, organizations must still learn from these as there may be opportunities to improve processes.
  - **Errors that lead to serious patient harm are rarely the result of just one error involving one person.** Rather, there are typically a series of errors or breakdowns in process, most of which have probably been occurring for some time, just not all at once.
  - Sometimes there is not a clear source of error; however, that does not diminish the harm experienced by the patient. Organizations must always consider these events as opportunities to make the system better.