BACKGROUND

In recent years, patient safety has emerged as an important issue on health policy agendas at both the national and provincial level. At the national level, the Health Council of Canada and the Canadian Patient Safety Institute (CPSI) were established in 2003. Within Nova Scotia, a number of actions have also been taken. For example, regulatory bodies have:

• worked with CPSI’s Safer Healthcare Now! initiative to improve healthcare delivery
• partnered with the national Institute for Safe Medication Practices (ISMP) to support safe medication practices
• collaborated with agencies and the Department of Health to present patient safety education sessions
• developed a provincial policy on the disclosure of adverse events
• initiated quality assurance programs that include documenting and reporting known, alleged and suspected medication errors as well as the necessary step required to resolve the root problems.

The growing interest in patient safety has been fuelled, in large part, by the release of reports such as the Adverse Events Study in Canada (Baker et al., 2004). According to Baker et al, 36.9% of adverse events in Canadian hospitals are preventable (in 2001, Leape et al. found that close to two-thirds of adverse events were preventable).

The majority of ‘near misses’ and adverse events, which often go unrecognized and unreported, arise from systems issues. Outcomes associated with these events, in terms of both human and financial costs, underscore the urgent need to address systems issues.

The major causes of harm to patients in hospitals relate to surgical procedures, adverse medication events (including adverse drug, contrast and vaccine reactions), infections, falls and pressure ulcers. Additional threats to patient safety include: prolonged work hours; poor communications or teamwork; inadequate and/or inappropriate staffing/guidance/supervision; lack of continuity of care; punitive, silencing and oppressive (work) cultures; poorly planned changes; and a lack of resources and supports.
Although most research studies on patient safety focus on adverse events in hospitals, it is important to note, particularly with the shift toward primary health care and the delivery of care in settings other than hospitals, that adverse events can occur in any setting in which healthcare is delivered (e.g., in homes, clinics, facilities).

In fact, there is evidence that adverse events may actually increase during transitions in care (e.g., hand-off between caregivers, shift change, and following discharge). Unfortunately, there are few Canadian studies available, but primary health care systems also need to be reviewed to improve patient safety. According to the College of Registered Nurses of British Columbia (2005) significant gains in patient safety relate directly to improving the practice environment of health professionals in all practice settings. The concept of a ‘just’ culture (one component of a safety culture) is now being promoted by more and more healthcare agencies. Promoting just and fair reporting environments does not, however, mean that intentional violations, sabotage or willful neglect and/or negligence would be ignored. Rather it places these incidents in an appropriate context when adverse events arise through systems issues (Hoppes, 2004).

A ‘just’ culture fosters:

- learning versus blaming
- a culture of reporting and learning
- open discussion of adverse events
- support for a culture of safety
- fair and bias-free investigations
- fair and open feedback to staff
- accountability within the system in which the adverse event occurs
- individual accountability for one’s own performance
- commitment to improving and implementing change
- organizational policies promoting patient safety (Hoppes, 2004).
In terms of the disclosure of adverse events, national guidelines were recently developed to promote more effective reporting environments. According to the CPSI (2007), healthcare systems in Canada, and indeed throughout the developed world, are supporting open and transparent disclosure of adverse events (to patients and families) through their adoption of increasingly comprehensive policies.

According to the Canadian Medical Protective Association (CMPA), the use of the word ‘error’ to mean an adverse event in clinical practice should be discouraged. Adverse events do not directly imply negligence. In fact, some adverse events may be unforeseeable (e.g., the first time a patient experiences an allergic reaction to a medication).

Error, on the other hand, carries with it a sense of blame and fault that may be inappropriate, especially before all the circumstances and facts about a case are known (Wallace, G., 2006). In addition, the ‘blame and shame’ often associated with the term ‘error’ leaves many healthcare professionals reluctant to participate in adverse event reporting as they believe they could be targeted for discipline or retaliation.

Further to CMPA’s position not to use the term ‘error’ in relation to adverse events, CPSI clearly discourages the use of this term in conjunction with patient safety. Patients surveyed did not understand the difference between a ‘true error’ in care and an adverse event or complication of care. In addition, while they often understood the term ‘medical’, it is important to note that medical events and adverse events are not the same.

Although the use of the term ‘error’ in conjunction with patient safety is not popular, Turnbull (2000) does relate that errors are a result of complicated interactions between providers and technology, providers and the system, and/or complex dealings among the many different healthcare providers.

Given the critical nature of patient safety, the regulatory bodies authoring this joint statement agree that it must be addressed through a collaborative effort. Patient safety is a responsibility to be shared by individual healthcare professionals and their agencies/organizations, as well as by regulatory bodies and governments. This joint position statement underscores the commitment shared by the regulatory bodies to continue to make improvements in patient safety in Nova Scotia.

**POSITION**

In their quest to assist individuals achieve an optimum level of health, healthcare professionals also take action to prevent or minimize harm. Patient safety is a fundamental responsibility of healthcare professionals across all settings and sectors because they all share a moral and ethical imperative to provide safe, competent care.

- Improving patient safety is a responsibility shared among individual healthcare professionals and others, including interdisciplinary teams, regulatory and accrediting organizations, educational institutions, unions, healthcare organizations, and governments. It also requires involvement of the public.
- Responsibilities and accountabilities for patient safety should be clearly delineated in the governance, management, and clinical processes of an organization.
- Visionary and courageous leadership is required to create a culture of safety in which most adverse events are recognized as system issues, requiring system analysis and system solutions.
- A culture of safety should include teamwork, involvement of patients, and an ongoing commitment to review, investigate and analyze adverse events to determine improvements in systems, processes and products.
- Clear, respectful communications, and effective teamwork and collaboration among healthcare professionals, are needed to remove barriers to safe care.
• Appropriate reporting and monitoring mechanisms should be established that ensure privacy and confidentiality of personal information.

• System or other changes impacting on patient safety, including health human resource issues, must be evidence-based and addressed on a systems level.

• Efforts to analyse and reduce adverse events are most effective when these events are viewed as system failures.

• Patient safety cannot be achieved without system accountability and competence, which must include reviews of adverse events and near misses. These reviews must incorporate thorough analyses, as well as consideration of the need for policy development, resources, information technology systems, communications and education.

• Actions to improve patient safety must include adequate supports for healthcare professionals (e.g., appropriate and adequate workloads and staffing).

• Improvements in patient safety, both internally (within an organization) and externally, should be effectively communicated to all patients, staff and stakeholders.

• Data should be collected at both the provincial and national level: to support research on best practices in patient safety.

• Consumers should be included in adverse event prevention activities, to enable them to learn from the perspectives of healthcare professionals as well as from the experiences themselves. Considering consumers as true partners requires a commitment to transparency within healthcare settings and by healthcare providers.

• The implementation of clear agency policies on the reporting of adverse events and near misses should be supported, as should the disclosure of adverse events to patients and families.

ROLE OF INDIVIDUAL HEALTHCARE PROFESSIONALS

Healthcare professionals in all practice settings are:

• responsible and accountable to maintain their own competence and fitness to practise, and by taking appropriate action at the organizational or system level.

• responsible to identify and report actual or potential unsafe situations, including near misses, errors and adverse events.

• expected to support organizational efforts to fully investigate near misses and adverse events: to identify the root causes of unsafe situations, with the goal of improving the system.

• expected to assist their organizations to evaluate, select and implement products, systems and technologies that will make it easier to provide safe care.

• expected to support research on patient safety and to apply existing evidence to their practice: to reduce adverse events and improve patient outcomes.

• expected to participate in reporting programs that foster lifelong learning, the creation of a supportive environment where open communication is respected and valued, and performance that is focused on the system rather than the individual.

NOTE: The American Society of Healthcare Risk Management [2006], notes that attempts to institute ‘non-punitive’ policies presents significant issues for patient safety programs. Staff surveys demonstrate that promoting a ‘non-punitive’ approach leads employees, staff and physicians to believe there will be no punishment or discipline whatsoever as long as they report
an event. In relation ‘non-punitive’ approaches, staff members often react inappropriately in the belief that reckless behaviour will not be dealt with. A ‘just’ culture promotes fair and equitable investigation, review and/or follow-up, but clearly delineates behaviour that is acceptable and unacceptable.

**ROLE OF HEALTHCARE PROFESSIONAL REGULATORS**

Regulatory bodies are responsible and accountable for:
- regulating the practice of individual healthcare professionals
- establishing continuing competence programs establishing processes and taking action when the incompetent, incapacitated or unethical behaviour of any one of its members jeopardizes the provision of safe care.

In addition, regulatory bodies have a role in:

1. **Policy Development**
   To collaborate with:
   - councils, members of multidisciplinary healthcare teams, healthcare consumers, and external partners (e.g., academic institutions, provincial governments, national and provincial accreditation bodies) to promote a culture of safety and environments that improve patient safety practices.
   - other regulatory bodies to develop policies/positions on patient safety that reflect and support the development of reporting mechanisms and disclosure of adverse events.

2. **Promotion and Advocacy**
   To:
   - support patient safety projects/programs;
   - advocate for multidisciplinary approaches that foster a culture of teamwork and systems improvement.

3. **Professional Development**
   To:
   - collaborate in the development of multidisciplinary educational programs on patient safety.
   - adopt professional regulation links to quality care that strengthen clinical practice and leadership, improve practice through educational sessions, and focus on quality practice environments.
   - ensure competent practice through continuing competence programs.

**ROLE OF AGENCIES/ORGANIZATIONS**

Provincial health agencies/organizations have an obligation to:
- demonstrate a commitment to patient safety, by encouraging and supporting involvement by staff, at all levels of care, in patient safety initiatives.
- ensure adequate numbers of healthcare professionals with appropriate competencies (appropriate skill mix) and organizational supports to provide safe care.
- utilize a variety of strategies to integrate patient perspectives, and to encourage patients to become involved as partners in the pursuit of safety.
- develop policies that promote open and honest communications and full disclosure of near misses and adverse events to patients and others, as appropriate.
• develop reporting systems that actively promote the reporting of safety concerns in the context of a fair and just culture (to encourage healthcare professionals to identify near misses and adverse events, and to take action to minimize harm in a timely fashion).

• put in place, reliable and accurate systems to identify and track the nature and types of near misses and adverse events.

• ensure that patient safety is monitored at the highest level from a variety of perspectives by regularly reporting workforce, workflow, clinical and financial data to their boards (governing bodies).

• regularly contribute appropriate patient safety information (e.g., near misses, errors, adverse events) to provincial and national data collection, while maintaining patient confidentiality.

ROLE OF GOVERNMENTS

All levels of government (federal, provincial, municipal) have a responsibility to establish policies, programs and services to improve the safety and quality of healthcare for their citizens.

ROLE OF PATIENTS/FAMILIES

Patients and families have a responsibility to be active, involved and informed members of the healthcare team. People who are involved with their care tend to do better and stay safer (Nova Scotia Health, 2005).

REFERENCES


Canadian Nurses Protective Society. (2005). Patient safety. infoLAW, 14(1)


