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Patient safety: Do nursing and medical curricula address this theme?

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Summary In this literature review, we examine to what extent patient safety is addressed within medical and nursing curricula. Patient safety is the foundation of healthcare practice and education both in the UK and internationally. Recent research and policy initiatives have highlighted this issue. The paper highlights the significance of this topic as an aspect of study in its own right by examining not only the fiscal but also the human costs such events invite.

In the United Kingdom patient safety issues feature prominently in the (Department of Health, 2000a. An organisation with a memory. The report of an expert group on learning from adverse events. The Stationery Office, London, Department of Health, 2000b. Handling complaints: monitoring the NHS complaints procedures (England, Financial year 1998–99). The Stationery Office, London.) policy documentation but this is not reflected within the formal curricula guidelines issued by the NMC and GMC. Yet if healthcare educational curricula were to recognise the value of learning from errors, such events could become part of a wider educational resource enabling both students and facilitators to prevent threats to patient safety. For this reason, the paper attempts to articulate why patient safety should be afforded greater prominence within medical and nursing curricula. We argue that learning how to manage errors effectively would enable trainee practitioners to improve patient care, reduce the burden on an overstretched health care system and engage in dynamic as opposed to defensive practice.

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Introduction

Everyday more than one million people are treated safely and successfully in the NHS. But ... in complex health care systems things will and do go wrong, no matter how dedicated and professional the staff. The effects of harming a patient are widespread ... devastating consequences can ensue and staff can become demoralised and disaffected

(National Patient Safety Agency, 2003a, p. 3)

According to the Chief Medical Officer's Report, the vast majority of NHS care meets the high clinical standards expected by the public (Department of Health, 2000a; National Patient Safety Agency, 2003a). Although the vast majority of health professionals are committed to attaining excellence when caring for patients, enquiries into adverse events have too often shown that failure is largely tolerated by medical/nursing staff (Department of Health, 2000a; Lester and Tritter, 2001; Maddox et al., 2001; Neale et al., 2001; The Bristol Infirmary Inquiry 2001). The notion of failure when used in this context denotes an adverse event or error, which the Department of Health (2000a) defines as *an event or omission arising during clinical care and causing physical or psychological injury to a patient*. Thus, patient safety is defined as *freedom from accidental injury* of any kind (Kohn et al., 1999; Weinger et al., 2003, p. 106).

Within the literature, there is a lack of a common definition for the terms error, adverse event and patient safety. While the Department of Health (2000a) do not distinguish between adverse events or errors, Kohn et al. (1999, p. 3) have attempted to distinguish between them by defining errors as the *failure of a planned action to be completed as intended (an error of execution) or the use of the wrong plan to achieve an aim (an error of planning*). For the purpose of this review, we define an adverse event as any occurrence leading to iatrogenic injury. When there are operational and organisational breakdowns, whatever their cause and however they are defined, devastating and distressing consequences can ensue not only for patients and their families, but also for staff (Houston and Allt, 1997; National Patient Safety Agency, 2003a). In particular, the psychological impact of failure exerts additional pressure upon organisations that are already challenged, given that such events have the potential to demoralise staff and undermine public confidence (Aron and Headrick, 2002; Department of Health, 2000a; Department of Health, 2001a; National Patient Safety Agency, 2003a; The Bristol Infirmary Inquiry, 2001). Nevertheless, the delivery of top quality evidence-based care ultimately depends on the competence of practitioners and the nature of the organisational milieu supporting their work (Ziv et al., 2000).

Patient safety: the extent of the problem, policy relevance and related research

The cumulative financial burdens incurred by organisations such as the United Kingdom National Health Service (NHS) following adverse events are enormous. For example, in 1998/1999 the Department of Health paid out an estimated £400 million to settle its clinical negligence claims (National Audit Office, 2000a). This is in addition to having to set aside a further £2.4 billion to meet existing and expected liability claims. A further £2 billion per year was also required to fund extra hospital bed days caused by adverse events (Department of Health, 2000a); with another £1 billion earmarked to fund the cost of hospital acquired infections (Vincent et al., 2001). Reinforcing this bleak representation of the status of the NHS, the best available research-based evidence suggests that in NHS hospitals alone adverse events or errors may occur in around 10% of admissions, a figure equating to over 850,000 patients with an additional:

- 400 people dying or being seriously injured by adverse events involving medical devices (Medical Devices Agency, 2000).
- 10,000 people reported as having experienced serious adverse reactions to drugs.
- 1150 people in recent contact with mental health services having committed suicide.
- 28,000 written complaints being made about aspects of hospital treatment (National Audit Office, 2000b; Department of Health, 2000b).
- 38,000 complaints received relating to family health services (National Audit Office, 2000b; Department of Health, 2000a).

Although these figures appear alarming they are not unique to the NHS, given that research undertaken in the United States by Kohn et al. (1999), and the Institute of Medicine (2001) as well as that carried out in Australia by Runciman and Moller (1999) reports similar findings. In particular, the Harvard Medical Practice Study, which extrapolated retrospective data from hospital case records, painted an equally depressing picture highlighting that 3.7% of hospital admissions culminated in an adverse event (Brennan et al., 1991; Leape, 1991).