



Establishing a culture for patient safety – The role of education ☆

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Summary This paper argues that the process of making significant moves towards a patient safety culture requires changes in healthcare education. Improvements in patient safety are a shared international priority as too many errors and other forms of unnecessary harm are currently occurring in the process of caring for and treating patients. A description of the patient safety agenda is given followed by a brief analysis of human factors theory and its use in other safety critical industries, most notably aviation. The all too common problem of drug administration errors is used to illustrate the relevance of human factors theory to healthcare education with specific mention made of the Human Factors Analysis and Classification System (HFACS). © 2006 Elsevier Ltd. All rights reserved.

Introduction

The challenge of achieving significant improvements in patient safety is one of the key tasks facing healthcare at the start of the 21st century. There is broad international agreement on the nature of the task faced and the importance of achieving improvements to quality in this area (Kohn et al., 2000; DH, 2000, 2001, 2004; National Health Performance Committee, 2004). This paper explores an issue central to this agenda – the role of education in creating a safety cul-

ture through the inclusion of issues such as human factors theory from the outset of practitioner preparation programmes. The example of drug administration is used to illustrate the case being made. The patient safety literature referred to is from a number of different countries, but as pointed out by Scallan (2002) in a literature review of patient risk in the NHS, estimated levels of risk in the UK are broadly comparable to those found in other countries. The arguments put forward here, in terms of the relevance of human factors theory to healthcare education, are applicable at all healthcare staff but specific mention is made of nursing as that is my background. Similarly, the article focuses on the NHS as this is the main provider of care and treatment in the UK.

☆ This article was written whilst Frank Milligan was on a part-time secondment to the National Patient Safety Agency.

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Patient safety

Large numbers of people continue to be successfully cared for and treated in the National Health Service, but a significant number of errors and other forms of harm occur (Scallan, 2002; NPSA, 2005). It is calculated that around 10% of patients admitted to NHS hospitals are subject to a patient safety incident and that up to half of these incidents could have been prevented (Vincent et al., 2001; NPSA, 2004). It was estimated by the Bristol Royal Infirmary Inquiry (2001) that around 25,000 preventable deaths occur in the NHS each year due to patient safety incidents. These incidents also generate a significant financial burden that includes avoidably prolonged care, additional treatment and litigation costs. Vincent and Reason (1999) describe the latter as trivial compared to the true cost of patient safety incidents. A patient safety incident is defined by the National Patient Safety Agency (NPSA, 2004, p. 1) as:

‘‘Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care’’.

These types of incidents are also referred to in the literature as adverse events/incidents, medical error, clinical error, and include the concept of near miss. The latter is a situation in which an error or some other form of patient safety incident is averted, such as noticing and therefore avoiding giving the wrong drug to a patient. Near miss events (this term can be used in a different sense in midwifery, see Madden and Milligan, 2004) have not commonly been reported in healthcare practice, largely because the staff involved fear they may be blamed or criticised, but are an integral aspect of safety improvement in other safety critical industries (Leape, 1999). It is now common to view healthcare as a safety critical industry, hence the increasing comparisons with, for example, aviation, the rail and nuclear industries with regard to learning lessons to enhance safety. It is acknowledged that healthcare faces some unique problems (Reason, 2004), but the similarities outweigh those differences in terms of creating a safety culture.

The priority now given to patient safety in the NHS is demonstrated within the Department of Health’s ‘Standards for Better Health’ document where it is identified as the first domain (DH, 2004). The standards will structure the inspection and audit of NHS funded services further enhancing the organisational emphasis given to patient safety.

Moving towards a safety culture

Illustrating the extent of the shift required in terms of creating a safety culture is a difficult task, but the NPSA has given advice to healthcare staff by producing the Seven Steps to Patient Safety guide (NPSA, 2004; NPSA, 2005a). The seven steps described are:

1. Build a safety culture.
2. Lead and support your staff.
3. Integrate your risk management activity.
4. Promote reporting.
5. Involve and communicate with patients and the public.
6. Learn and share safety lessons.
7. Implement solutions to prevent harm.

The guide is for all staff and so the first goal, of building a safety culture, is relevant from the NHS as an organisation, right down to individual staff in ward and other practice environments. Steps 1, 6 and 7 appear to be particularly relevant to healthcare education. The primary concern of this article is the contribution healthcare education can make in creating a safety culture. The following quote from the book ‘Know the risk. Learning from errors and accidents’ (Duffy and Saull, 2003) illustrates how far the NHS has yet to go. Using examples from a range of safety critical industries, with a concluding section that focused specifically on safety issues in healthcare, the authors argue that what is required in achieving a successful safety culture is a learning environment.

‘‘What a learning environment means in practice is the existence of an ideal total work environment that strives to be safety conscious in every aspect. The whole work-related system emphasizes and pays unending attention to safety, in all aspects of design, operation, management, and rewards. Thus, the management, organizational structure, staff training, plant condition, trust, free communication, open reporting, blameless appraisal and self-criticism, awareness and readiness, and pay raises all constitute a ‘culture’ that reinforces and rewards safe operation’’ (Duffy and Saull, 2003, p. 101).

Even with such an approach, the objective of ‘zero defects’: a situation in which no errors occur, inevitably remains a desirable as opposed to an achievable goal (Duffy and Saull, 2003). The complexity of healthcare means that the learning environment described above is even more difficult to achieve, but significant improvements need to be made. Error rates of less than 0.1% are achieved in aviation compared to rates of 1% and above in

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