

### **340: HOW SAFE IS THE SAFETY PARADIGM?**

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#### **Objective:**

To explore the mechanisms and potential implications of patient safety responses in four advanced health systems which have performance measurement initiatives

#### **Methods:**

We explored the patterns and instruments of national safety initiatives, safety agencies, and performance frameworks of the United Kingdom, Canada, Australia, and the United States. Using their supporting literature, we also critically appraised their safety indicators for strengths, weaknesses and implications for healthcare safety. Subsequently, we raised and explored several questions regarding the concepts, contents, and context (as well as the unwanted but potential impact) of the revealed healthcare safety initiatives.

#### **Results:**

Commonest responses to patient safety in these four health systems are the use of adverse events reporting, creation of safety agencies, and routine performance monitoring via safety indicators. All have active national or public-private mechanisms that analyze and feedback anonymous reportable adverse events and errors to encourage learning, and to prevent recurrence. All but Canada have a national government-initiated patient safety agency which coordinates adverse events reporting or safety improvement projects or both. All four systems focus more on patient safety but less so on staff and environmental safety. The context needs to address litigation, and encourage disclosure and learning. Patient safety indicators are most developed in the United States, whereas Canada and Australia each have only one safety indicator in their performance measurement frameworks. The United States Patient Safety Indicators from the Agency for Healthcare Research and Quality are designed to use hospital discharge administrative data, and cover a broad range of mostly surgical and obstetric topics, but less of medical conditions.

#### **Conclusions:**

Several conceptual, content and contextual issues need to be addressed in national patient safety initiatives.

Disparities in terminology and taxonomy obstruct cross-national comparisons and learning. The underlying no-fault rationale may not be very realistic in so far as medicine is not an exact science but an art with an increasing emphasis on patient-centeredness. There are little expectable minimum levels of adverse events unlike in the industry that gave rise to this thinking. Moreover, healthcare safety is much more than just patient safety, but includes safety of staff and environment. Non-acute care, non-hospital settings receive less attention in the current healthcare safety paradigm.

Measurable impact of adverse events reporting mechanisms remains elusive. Potential downsides to these mechanisms include unforeseen bureaucratic shortcomings, decreased professional innovation, decreased individualization of patient care, and reduced clinical effectiveness. Patient-centeredness implies individualized, responsive care.

Safety indicators from the United States are practical and use routine inpatient data. Major drawbacks include underreporting, unknown validity, unspecific denominators, case-mix bias, variable condition definition, perverse influence, and probable non-preventability of some of the conditions. There are fewer internal medicine related indicators because of the co-morbidities and severity heterogeneity issues seen in medical cases.

A combination of reporting, safety promotion agencies, and indicators may be more fruitful than just any one of these. Nonetheless, we must avoid creating new bureaucracies and deterrent jargons and protocols which hinder good medicine. Medicine does not need more regulation but a new psycho-cultural alignment. In line with the Hippocratic oath, we must balance the "doing good" (i.e. quality and effectiveness) with the "doing no harm" (i.e. safety).