

Refocusing on Patient Safety

G. Ross Baker

Patient safety provides an important foundation for high-quality care. Research in Canada and elsewhere has identified substantial levels of harm in hospitals and other settings; these results spurred the development and spread of safety practices, along with strategies to strengthen organizational training, incident reporting and analysis and a host of resources intended to reduce the burden of harm. Yet, despite these efforts, 20 years after the publication of the Canadian Adverse Event study (Baker et al. 2004) and other studies, many leaders believe progress in patient safety has stalled (NEJM Catalyst 2023). Indeed, some recent studies indicate that the levels of harm have increased. One notable study by David Bates and colleagues (2023), building on approaches used in earlier studies, identified at least one adverse event in 23.6% of a random sample of patients in Massachusetts hospitals in 2018. Among 978 events, 22.7% were judged preventable and one-third required at least substantial intervention or prolonged recovery.

Not surprisingly, these trends have been further exacerbated by the COVID-19 pandemic. The pandemic heightened pressures on healthcare systems globally with surges of infected patients admitted for care, and the transmission of the virus within and across hospitals, long-term care and other sites. The COVID-19 pandemic disrupted systems and processes of care, sickened providers and, in its aftermath, accelerated exits from the healthcare workforce, limiting the capacity of health systems to deliver essential health services and threatening the well-being of those needing care (WHO 2022).

In many organizations, pandemic pressures have shifted attention from addressing patient safety challenges beyond infection control to securing adequate human resources. Yet

these two issues are intimately related. Understaffed organizations rely on temporary staff, overtime shifts and the assignment of staff to different settings where they must cope with new care needs and practices. These staff work with unfamiliar teams and types of patients, which can create safety challenges. In this issue of *Healthcare Quarterly*, Campbell et al. (2024) analyze the CIHI data on the Canadian health workforce and hospital harms to illustrate the relationship between staffing trends and safety events in hospitals. The correlation between these measures illustrates the need for supportive human resources policies, not only to create a positive work environment enabling recruitment and retention but also to secure a safer care environment for patients.

There are many ways in which human resources strategies and care environments influence safety. Experienced teams working in familiar environments are better equipped to provide safer care and to react effectively to challenges such as deteriorating patients. More broadly, leaders who support psychological safety and team learning help to foster work cultures that encourage staff to ask questions when they are uncertain about a patient and to rely on their colleagues for backup and support. Individual knowledge and skills are valuable assets, but safe healthcare relies on resilient teams that can manage despite adverse circumstances and unanticipated events.

Safer care also results from learning about past safety events. Every healthcare organization experiences failures; good organizations learn from those failures and act to close existing safety gaps to minimize the repetition of these events. In this issue, Harvey et al. (2024) at Unity Health in Toronto outline the serious harm event review process at that

organization. Key elements of that process include (1) reporting events with enough detail to allow them to be classified, allowing the identification of frequent events and their incidence over time; (2) collection of sufficient data to determine what happened and what circumstances influenced the event; (3) analysis of event data using root cause analysis and other tools; and (4) identification of actions to improve systems and practices that contributed to these events to avoid reoccurrence.

Critical event analysis and learning require important technical skills and the insights of front-line staff as well as clinical leaders and patient safety specialists. Support from senior leaders and resources to conduct the inquiries, analyses and recommendations are also prerequisites for effective critical incident reviews. Healthcare boards hold a fiduciary duty to be aware of the types of events that occur in organizations they oversee, and to ensure that resources are available to collect, analyze and act on the knowledge gained from these activities.

Healthcare organizations across Canada have learned a lot from the patient harm that occurred in them, and some organizations are much safer as a result. But considerable gaps still remain. Tight budgets have squeezed patient safety resources. Learning across organizations is still difficult in many environments and for many types of patient safety events. Moreover, the implementation of recommendations from critical incident reviews depends on local commitment and resources, with limited system oversight. Current pressures likely diminish learning from incident analysis and the improvements that emerge.

Despite the work of many committed individuals, teams and organizations, we cannot say that Canadian healthcare is safer today than it was 20 years ago. Healthcare Excellence Canada in their recent report, *Rethinking Patient Safety* (HEC and Patients for Patient Safety Canada 2023), has identified some paths forward. We need to focus on more than just past harms, to be more proactive in learning how to create safe environments that support teamwork and to involve patients in improving safety. Identifying harm is still an important step for improving safety. But we need to broaden our definition of “harm” beyond physical harms to include psychological and cultural harm, as well as other forms of harm. In addition, we must make safety events and their analysis more transparent, with more information available to healthcare leaders and providers, to the family and caregivers of those harmed and to the broader public. In addition, we must invest more in developing, adapting and sharing safety practices – learning lessons within and across organizations. The COVID-19 pandemic provided key lessons on effective responses in a healthcare emergency. We need to invest further to strengthen the resilience of our healthcare system, including embedding safety practices and reporting more fulsome data that reveal the performance of the Canadian healthcare system and its vulnerabilities. Above all, we need to follow the advice of Don Berwick, who in a recent editorial in the *New England Journal of Medicine* urged us to push safety “back to strategic prominence” (Berwick 2023: 182).

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About the Author

G. Ross Baker, PhD, is professor emeritus at the Institute of Health Policy, Management and Evaluation in the Dalla Lana School of Public Health, University of Toronto in Toronto, ON. Ross can be reached by e-mail at ross.baker@utoronto.ca.