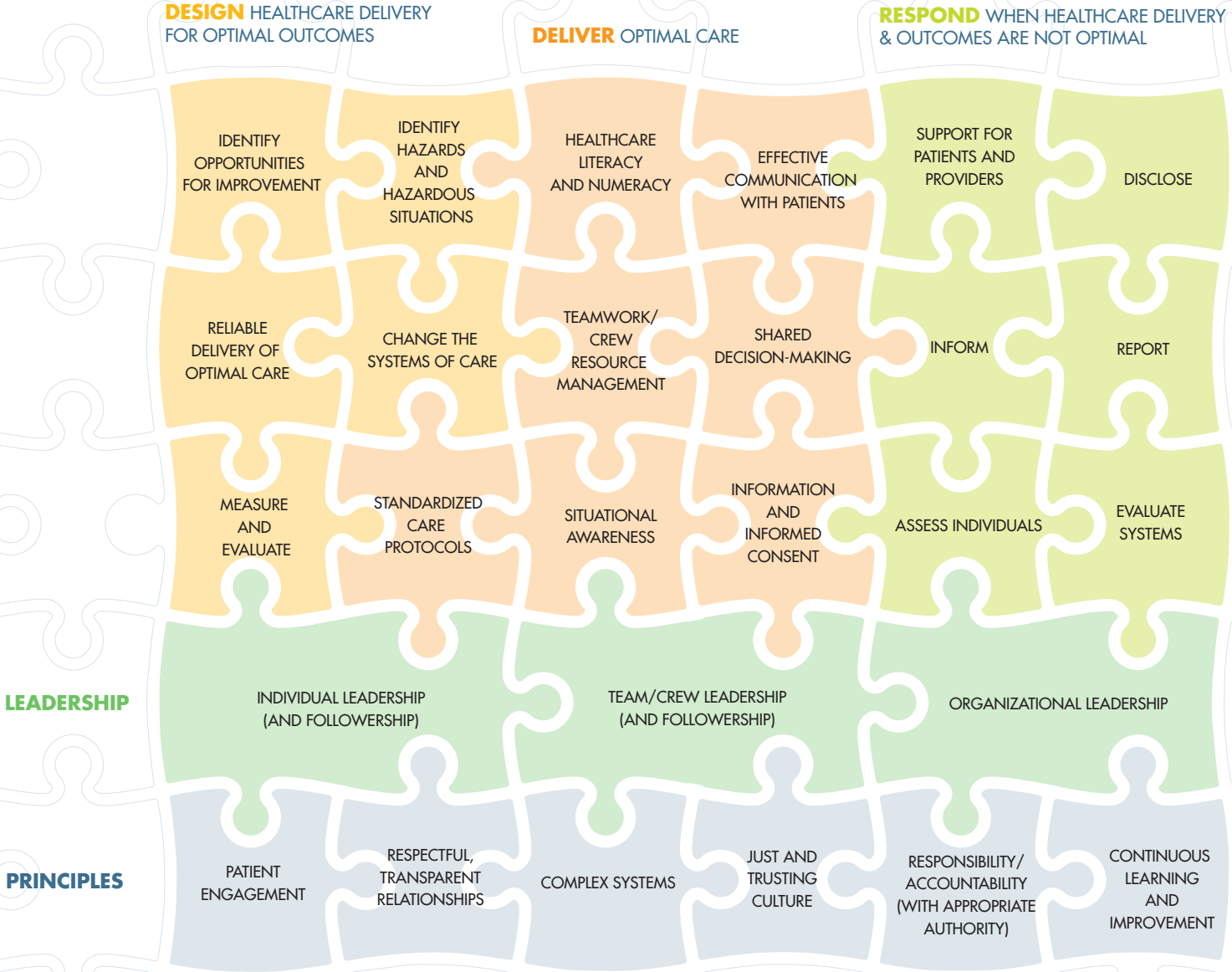
Blueprint Project
Transforming Patient Safety Education in Alberta

The Patient Safety Conundrum:
How Can Healthcare Be Made Safer?



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"Medicine used to be simple, ineffective and relatively safe; now it is complex, effective and potentially dangerous".[1]

Patients can suffer harm as a result of failures in the delivery of care. The Canadian Adverse Events Study (CAES)[2] quantified the magnitude of the Canadian problem and showed that it was similar to rates elsewhere in the world. An obvious question that arises from studies like the CAES is: *"how can healthcare be made safer?"* Task force reports have addressed this issue and made recommendations for changes to our healthcare systems. Strategies for addressing the patient safety conundrum abound but few are grounded in a theory of healthcare system structure and function. The Health Quality Council of Alberta Blueprint Project's mission is to develop a theory-based, patient safety educational framework that includes a comprehensive list of learning topics organized into key concepts that answers the question raised above.

The *Healthcare Encounter Safety and Quality Model* (HESQM)[3] was developed in response to the question: *"what do people at all levels of the system need to understand and do to make healthcare safer?"* In addition to the 'players' in the healthcare system (both providers and receivers), the HESQM highlights three critical functions that need to take place to realize safer healthcare:

1) **design** healthcare delivery for optimal outcomes;
2) **deliver** optimal care;
3) **respond** when healthcare delivery and outcomes are not optimal.

The HESQM includes two other critical components for safer care: **leadership** (at all levels) and **principles**.

It is important for healthcare to evolve a safety and quality culture; this requires leaders with a common vision who make principle-based decisions that focus on design, deliver and respond. The HESQM serves as the theoretical model underlying the Blueprint Project's Learning Topics Framework (Table 1). The framework presents 27 topics organized according to the five key concepts derived from the critical functions and components underlying safe healthcare. These learning topics represent key actions and attitudes that healthcare providers/leaders can take or adopt to make care safer, and are the focus for creating learning outcome and objective statements that will drive educational activities. By focusing their efforts on these 27 topics, educators can help healthcare providers find a solution to the patient safety conundrum.

[1] Sir Cyril Chantler. BMJ 1998; 317:1666.

[2] Baker GR, Norton PG, Flintoft V, et al. The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. CMAJ 2004; 170:1678-88.

[3] Flemons W, Davies J, Wright D, et al. 2010. Patient safety principles: definitions, descriptions index.php?id=215.

Table 1 A framework and learning concepts/topics for healthcare safety and quality

Concept	Topic
Design HEALTHCARE DELIVERY FOR OPTIMAL OUTCOMES	Identify (and prioritize) opportunities for improvement Identify hazards and hazardous situations (and prioritize strategies to minimize harm) Develop reliable methods to deliver optimal care Change systems of care to incorporate improvements Measure and evaluate improvements
Deliver OPTIMAL CARE	Use standardized care protocols Maintain situational awareness Provide information and informed consent to patients Engage patients in shared decision-making Effectively communicate with patients Consider healthcare literacy and numeracy issues Use teamwork (crew) resource management practices
Respond WHEN HEALTHCARE DELIVERY & OUTCOMES ARE NOT OPTIMAL	Support patients and healthcare providers Disclose information and apologize Report event details to allow for organizational learning Inform important stakeholders Evaluate systems of care to make improvements Assess individual's performance fairly
Leadership	Individual leadership Team leadership Organizational leadership
Principles	1. Patient engagement 2. Respectful, transparent relationships 3. Complex systems 4. Just and trusting culture 5. Responsibility/accountability (with appropriate authority) 6. Continuous learning and improvement

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Citation

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