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Too many avoidable errors in patient care, says report

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Avoidable harm to patients is still too high in healthcare in the UK and across the globe—making safety a top healthcare priority for providers and policy makers alike.

These are the findings of two reports launched today by researchers from Imperial College London. Both reports, produced by NIHR Imperial Patient Safety Translational Research Centre (PSTRC), provide evidence on the current state of patient safety and how it could be improved the future. They urge healthcare providers to embrace a more open and transparent culture to encourage continuous learning and harm reduction.

Professor Ara Darzi, Director of the NIHR Imperial PSTRC and senior author of the reports said: "For too long the mind-set has been that patient harms are inevitable, and that nothing can be done to prevent them. But keeping patients safe is a fundamental part of care. Although we currently face many changes—such as increasingly complex patient cases and limited resources - we must focus on creating safer environments for patients. This should involve a systems-based approach, and coordinating action across all levels of the political and health systems. We also must ensure patients and staff are integral to any solution, and not just seen as victims or culprits."

The first report focuses on the current system used by NHS staff to report patient safety incidents, called the *National Reporting and Learning System (NRLS)*. The report authors explain this system requires

refinement and renovation, so as to take advantage of new technologies and recent behavioural insights. For example app-based technologies offer a simplified platform that engages staff in the incident reporting process. This will not only improve the ease of reporting, but also the accuracy of data reported.

In particular, the report reiterates problems around under-reporting of safety incidents, and reveals structural concerns within the NRLS, that have inhibited its usefulness as a tool to drive safety improvement.

Erik Mayer, lead author of the report, from the Department of Surgery and Cancer at Imperial, explains: "The UK has one of the biggest incident reporting systems in the world. But despite this, evidence suggests that as little as 5 per cent of patient safety incidents are reported. This is often related to the culture of institutions and the culture of medicine. For instance, staff may witness an incident that should be reported, but are hesitant to do so for fear of repercussions."

Furthermore, the information produced by the system is difficult to analyse, making it hard to spot dangerous trends or problems.

"At the moment there is no standardised method to code or group the reports. So, for example, a delay in a medication being given may be recorded in a number of different ways, depending on the hospital. We need to standardise this and ensure that we have an improved approach to incident reporting."

The second report, *Patient Safety 2030*, suggests a 'toolbox' for patient safety. This would include: using digital technology to improve safety; providing robust training and education, and strengthening leadership at the political, organisational, clinical and community levels. Other points in the 'toolbox' include effective and high-quality education and training; strengthening measurement methods, including incident reporting, and

exploring new digital solutions.

However, the authors warn that interventions implemented to reduce avoidable patient harm must be engineered with the whole system in mind, and empower patients and staff to become more involved in preventing harm and improving care.

Ultimately, both reports issue a global call-to-action on patient safety: both for individual health systems to convert the evidence on how to improve patient safety into everyday practice, and for the global community of health systems to share learnings from each other's successes and failures.

Provided by Imperial College London