The concept of ‘first do no harm’ is taught to every medical and nursing student. This phrase means that, as professionals, our first duty is to make sure that patients are not harmed as a result of their care. Unfortunately, we know that many patients are harmed when receiving medical care. The World Health Organization (WHO) estimates that up to 10% of patients in high-income countries are harmed in such ‘adverse events’ or ‘critical incidents’ – events or incidents that caused harm to patients and could have been avoided.1

There are many costs associated with harm – costs to the patient in pain, discomfort or distress, financial costs to the patient (e.g. through increased visits to the hospital) and financial costs to the health care system, with patients staying in hospital longer and/or requiring more—and different—treatments. There is also the emergence of legal costs as increasing numbers of patients are suing the hospital or clinician following a critical incident.

The large numbers of patients harmed and the resultant costs make a focus on patient safety incredibly important. There are two ways of approaching patient safety:

1 Preventing critical incidents.  
2 Learning from critical incidents that have occurred and changing practice so that it does not happen again.

1 Preventing critical incidents

This is a focus on preventing harm. It involves the introduction of processes and procedures that reduce the risk of harm to patients. For example; everyone who conducts surgery changes clothes and washes their hands before they start which is a way of preventing harm. By washing hands (‘scrubbing’) and changing clothes before surgery the risk of passing infection to the patient is reduced. Other examples of prevention activities include the WHO safe surgical checklist (which aims to ensure that the correct surgery is being performed on the correct patient using the correct methods and provides a formal method to check this), staff double-checking doses of drugs, making sure that all equipment is regularly maintained, sterilising instruments, plus many others.

Two of the key factors about these procedures are that they are routine (i.e. everybody does them every time the event occurs) and that they can be documented (e.g. the WHO Safe Surgical Checklist is completed and kept with the patient notes) so that it can be shown that the procedure was followed. If the procedures and protocols are only followed by some of the people, some of the time, then they are less effective. A good example of this is hand hygiene practice amongst staff:

There are ways of approaching patient safety:
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