Healthcare Excellence Canada

Broadening our understanding of healthcare harm

The Activity

Recognizing and reducing healthcare harm matters to those receiving and delivering care in any setting. While we have made progress on reporting and learning from harm, there is still a significant gap in truly understanding and appreciating the extent of harm in healthcare. As part of championing Rethinking Patient Safety, we encourage everyone to broaden their understanding of healthcare harm. To support our efforts in understanding harm, we have designed the following activity to stimulate discussions and thoughtful reflections so that proactive actions can be taken to prevent harm and create safer care for all.

What is Healthcare Harm?

To improve patient safety, the healthcare system has traditionally focused on reducing or eliminating harm, particularly physical harm related to care, treatments and services, such as healthcare-associated infections, injury from a fall or a medication error.

The Measurement and Monitoring of Safety Framework (MMSF), an international framework for patient safety, has emphasized the limitations of focusing solely on physical harm and encourages us to widen our view of harm[1].

This infographic (Appendix A) is intended to guide us toward a broader understanding of healthcare harm. It includes five concepts:

1. Factors that can contribute to safety incidents and harm.
2. Categories of safety incidents that can potentially lead to harm.
3. The harm experienced.
4. Who was harmed.
5. The lasting impact of the harm.

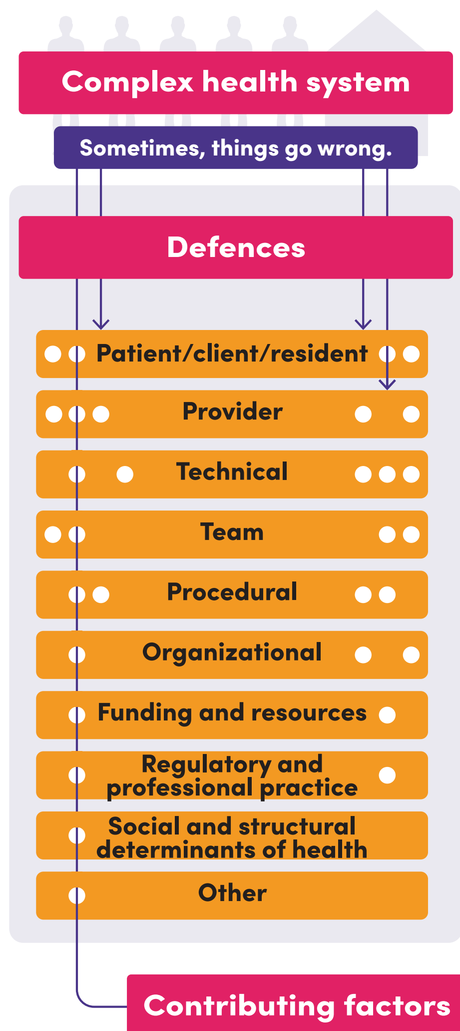
Before we dive deeper into the concepts of healthcare harm, it is important to acknowledge that the **absence of harm is not the same as the presence of safety**. Our goal in patient safety is to deliver safe, reliable healthcare. However, healthcare is complex. There are many risks associated with delivering and receiving care. Despite our best efforts, intentions and defenses, harm sometimes happens.

When things go wrong in healthcare, it is often associated with multiple, complex and interrelated **contributing factors**. Exploring and understanding these factors is an essential aspect of learning and improving. For example, contributing factors may relate to:

- **Patient, Client, Resident**: engagement in care, complexity of health and care needs.
- **Provider**: training, experience, distractions, fatigue, memory requirements.
- **Team**: staffing, teamwork, communication, handovers, staff turnover, hierarchies.

- **Technical**: design, equipment malfunction, surroundings.
- **Process**: work processes and procedures.
- **Funding and resources**: competing priorities.
- **Organizational**: safety culture, policies, staffing allocation, incentives, disincentives.
- **Regulatory and professional practice**: laws, regulations, standards.
- **Social and structural determinants of health**: inequities based on race, gender, age, socioeconomic status, colonialism and other forms of systemic oppressions.

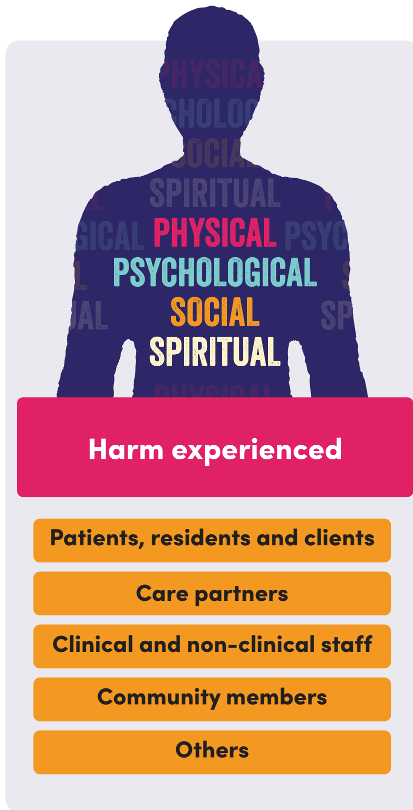
Attempts to understand contributing factors should never be confused with assigning blame. Naming, blaming, and shaming do **NOT** improve the safety of care.

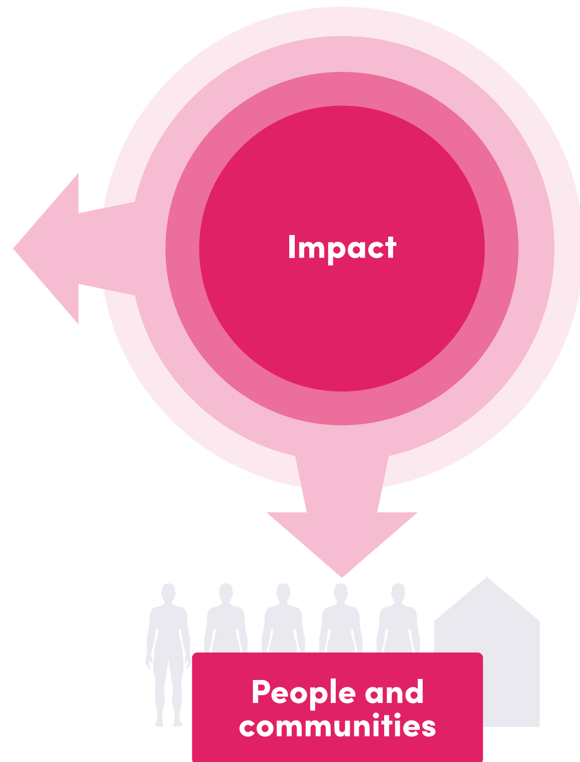


When things go wrong, **safety incidents** may occur, potentially causing harm. Safety incidents have been categorized by the authors of the MMSF and Healthcare Excellence Canada as those which result from: delayed, missed, or incorrect diagnosis; under-, over- or incorrect treatment/services; demeaning and dehumanizing incidents; treatment/service specific and general healthcare incidents; incidents arising from transitions of care; culturally unsafe care and moral distress[1].

Safety incidents can potentially cause harm and the **harm experienced** can be described as a physical, psychological, social, and/or spiritual injury resulting from delivering or receiving healthcare[2].

Healthcare harm is not limited to those receiving care. Expanding our understanding of harm must include recognizing **who can be harmed**. Healthcare harm can be experienced by patients, residents, clients, and their care partners; clinical and non-clinical staff; and community members across all care settings.





The effects of healthcare harm can have a long-lasting and cascading **impact**, potentially triggering additional harm to the individual and their community. For example, a safety incident resulting in harm can erode an individual's or community's trust in the healthcare system, which leading that person or those around them to delay any future care or treatment. Supporting those harmed by the healthcare system helps restore trust and contributes to healing and building a path to safer care[3].

The person who experiences the harm is often best positioned to define it and describe its impact on their life[3].

Why broaden our understanding of harm?

All healthcare harm matters. While the infographic in this document offers guidance toward broadening our understanding of harm, **the person who experiences the harm is often best positioned to define it and describe its impact on their life[3].**

Learning is a lifelong journey. As we work to broaden our understanding of healthcare harm, we must learn from colleagues, patients, residents, clients, care partners, and community members what healthcare harm and safety mean to them.

By asking questions, building trust, and co-creating solutions, we can deliver safer care.

Everyone contributes to patient safety. Together we must learn and act to create safer care and reduce all forms of healthcare harm[3].

How to conduct the activity

Time required:

20-30 minutes or longer, depending on the number of people involved in the activity.

Number of people:

Two or more people can collaborate.

Who to include:

- All clinical and non-clinical staff, regardless of their role and position.
- Patients, residents, clients and care partners.
- Volunteers, community partners, members of the public and board members, wherever possible.

How to plan your event

- Identify a facilitator. Their role is to create a safe and welcoming environment that encourages participants to share and learn.
- The facilitator should be prepared to support participants through difficult and sensitive conversations. Identify available resources to support participants if the need arises. Trauma-informed training resources [4,5] may be helpful as you prepare to host this activity.
- Determine the format for hosting the activity. Think about existing forums that could be leveraged to host this activity, such as safety huddles, staff meetings, lunch and learns or town halls.

Tools you will need

- A poster or slide of the infographic representing the broader understanding of healthcare harm. Ensure it is visible to all participants during the activity (see Appendix A).
- Safety Incident Cards (see Appendix B): Print and cut out the safety incident cards (e.g. delayed, missed or incorrect diagnosis; under-, over- or incorrect treatments/services; demeaning or dehumanizing incidents; treatment/service specific and general healthcare incidents; incidents arising from transitions of care ; culturally unsafe care; moral distress; and blank cards).
- Facilitation tools such as sticky notes, a flip chart, markers, a whiteboard, etc.
- Method for recording results, discussions and action items.
- With consent, be ready to take photos of those participating in the activity and the results of your card sorting so you can refer to them afterwards.

Hosting the activity

1. We recommend you open the session by emphasizing the importance of creating a non-judgmental, inclusive, safe space where all participants are confident their perspectives will be heard and where all experiences are considered. Inform participants that the topic being discussed may be sensitive and potentially triggering. Let them know that support and resources are available if they are needed during or after the session.
2. Introduce participants to the importance of broadening their understanding of harm. Depending on time and resources, this can be done by:

   A. Sharing messaging in this document.

   B. Asking participants questions such as “What comes to mind when you think of healthcare harm?” or “What does the term ‘safety’ mean to you?”

C. Asking participants to discuss the potential physical, psychological, social and/or spiritual harm resulting from delivering or receiving care.

D. Inviting people with lived experiences to share their experiences, examples and/or reflections of healthcare harm.

E. Sharing a publicly available video, podcast or article about healthcare harm and facilitating a discussion about insights gained.

3. Review the seven categories of safety incidents and:

   A. Provide examples for each (if helpful, refer to Appendix C for examples) and consider the potential harm(s) that may occur as a result of the safety incident.

   B. Use the blank cards to add other categories of safety incidents that come to mind.

4. Sort the cards, starting with the types of incidents that get the **most attention**, to the incidents that are most often **overlooked**.

5. Discuss steps that can be taken to broaden your individual understanding of harm and safety and your organization's approach to safe care.

6. Discuss what you learned and your reflections from the activity.

7. Discuss how everyone can apply the learnings as you work to create safer care and reduce healthcare harm.

Debrief

After completing this activity, you may want to debrief with a few trusted colleagues to determine its success and how to improve it.

Consider asking:

- What went well?
- Even better if...
- Next time try this...

Tips for success:

1. Create a welcoming environment that helps promote psychological safety and encourages everyone to share and learn.
2. Acknowledge that the topic of healthcare harm is sensitive and be prepared with resources to support participants' well-being.
3. For the facilitator/host, take time to reflect on how you are feeling through these discussions, as they can be difficult. Consider your own well-being, as well as others.
4. Conduct the activity with multidisciplinary groups (for example, a nurse, physiotherapist, environmental services and maintenance staff, a manager, a patient, care partners, peer support workers, etc.) as this can broaden the learning and insights gained.
5. Include patients, residents, clients and care partners in the activity to help reinforce their contributions to understanding harm and creating safety.
6. Come prepared with appropriate equipment (e.g. poster, slide, harm cards, etc.).
7. Have examples for each category of safety incidents (see Appendix C).
8. Be prepared to start a discussion with participants to generate learning and understanding of healthcare harm.
9. Encourage everyone to be creative and innovative toward developing strategies for expanding their understanding of harm and actioning safer care.

References

1. Vincent, C., Burnett, S., & Carthey, J. The measurement and monitoring of safety. The Health Foundation; 2013. Accessed November 17, 2023 from https://www.health.org.uk/publications/the-measurement-and-monitoring-of-safety

2. The National Collaborative for Restorative Initiatives in Health. (2023). He Maungarongo ki Ngā Iwi: Envisioning a Restorative Health System in Aotearoa New Zealand. The National Collaborative for Restorative Initiatives in Health. Wellington, Aotearoa NZ. Accessed May 27, 2024 from He Maungarongo ki Ngā Iwi: Envisioning a Restorative Health System in Aotearoa New Zealand (hqsc.govt.nz)

3. Gilbert R, Asselbergs M, Davis D, et al. Rethinking patient safety: A discussion guide for patients, healthcare providers and leaders. Healthcare Excellence Canada; 2023. Accessed November 17, 2023 from https://www.healthcareexcellence.ca/media/gx4l3idd/rethinking-patient-safety.pdf

4. Trauma Training Initiative | Alberta Health Services

5. Trauma- and Violence-Informed Care Foundations Curriculum - EQUIP Health Care | Research to Improve Health Equity

For more information about broadening your view of healthcare harm, visit

UnderstandHarm.ca

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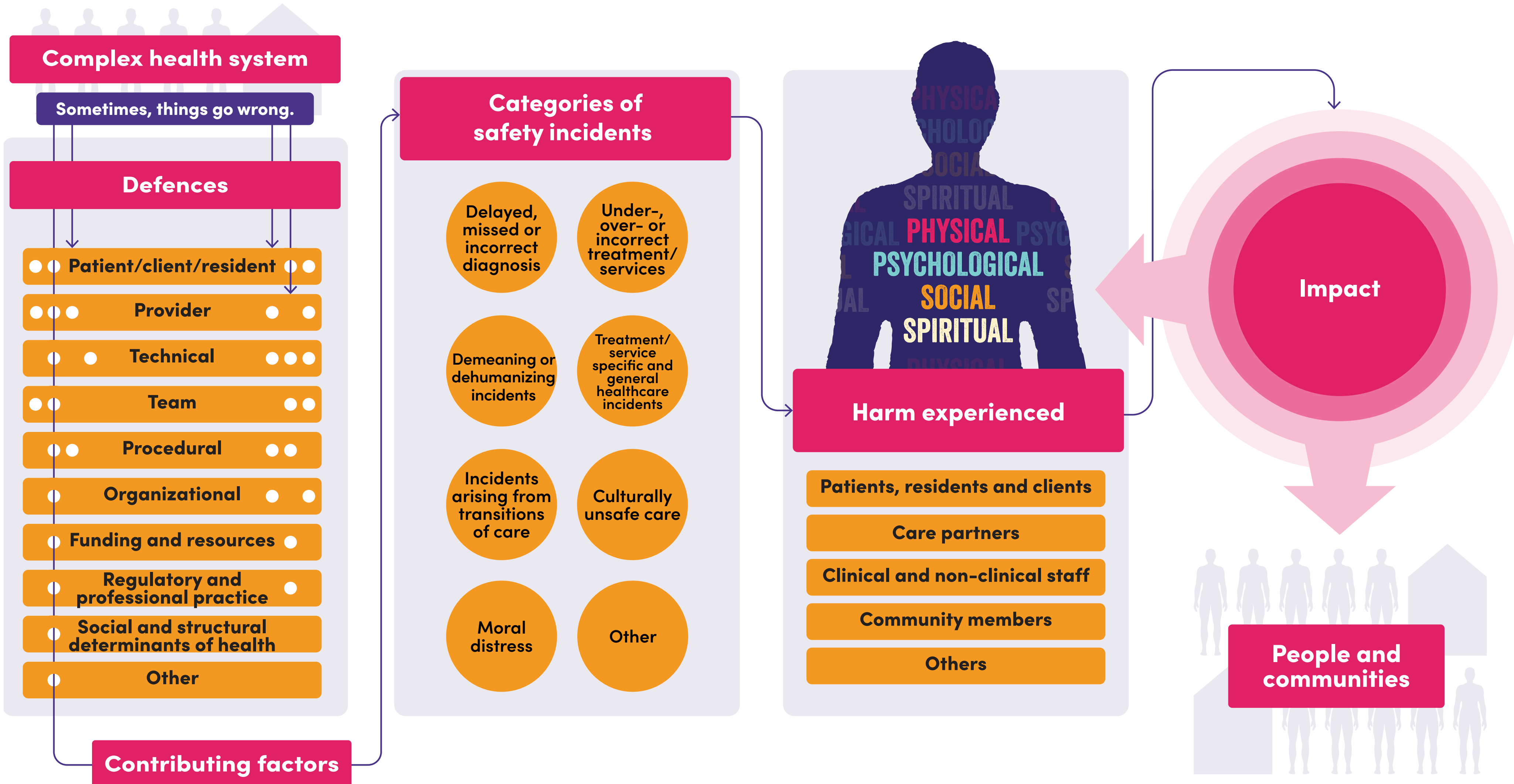
Let's broaden our understanding of harm, together



As we work together to expand our understanding of healthcare, we anticipate this infographic will continue to evolve.

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Delayed, missed or incorrect diagnosis

Under-, over- or incorrect treatment/services

Demeaning and dehumanizing incidents

Treatment/service specific and general healthcare incidents

Incidents arising from transitions of care

Culturally unsafe care

Moral distress

Appendix B

Examples of Safety Incidents

1. **Delayed, missed or incorrect diagnosis**: Misplacing biopsy results or not testing/screening for cancer, insufficient assessment, attributing symptoms to gender or racial background resulting in disregarding the need for testing or treatment.
2. **Over-, under- or incorrect treatment/services**: Over-treatment (e.g. overprescribing of antipsychotics or overuse of antibiotics leading to C. *difficile* infection); under-treatment (e.g. not providing appropriate pain control or not following evidence-informed practices, such as timely prophylactic antibiotic administration); incorrect treatment (e.g. wrong site surgery).
3. **Demeaning and dehumanizing incidents**: Calling a patient by their disease, not their name; overt racism and discrimination; lack of shared decision-making; lived experiences of disease/illness and/or care dismissed by healthcare providers; concerns ignored by others.
4. **Treatment/service specific and general healthcare incidents**: Could include a fall, pressure injury, medication error, physical aggression toward staff.
5. **Incidents arising from transitions of care**: Patient discharged home without instructions; medication changes not communicated when client transferred from hospital to residential care; critical lab values lost when patient transferred from the ER to the ICU.
6. **Culturally unsafe care**: Belittling or disrespecting different beliefs/cultural systems; making assumptions or derogatory comments related to the patient's culture.
7. **Moral distress**: Being expected/required to work in conditions that are not conducive to delivering safe care.

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