Definitions of Quality and Patient Safety in Health Care

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Achieving quality outcomes for patients served is the primary goal of health care organizations. The role of the board is to keep an organization accountable for meeting that goal. For the board to be effective, they need to understand the concepts of quality and safety in health care, including why they are such vitally important issues. This resource provides an overview of the basic definitions of quality and patient safety.

WHAT IS QUALITY?

Quality is a concept used in many industries to describe the attributes or characteristics of a product or service. The National Academy of Medicine defines quality as:

***The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.*[1]**

Health care quality is further defined by its multidimensional attributes. Six domains are frequently used to describe quality. These domains are used as a framework to define and measure quality of care. These six domains are often referred to by the acronym STEEEP: Safety, Timeliness, Efficiency, Effectiveness, Equity and Patient- (or Person) centered care.[1] Based on the STEEEP framework, the focus of quality should incorporate all six domains.

- **S** — **Safety:** Avoiding harm to patients from the care, treatment, and services that are intended to help them
- **T** — **Timeliness** (or Accessibility or Affordability): Reducing barriers to care, treatment, and services that may be caused by time delays, accessibility, or affordability
- **E** — **Efficiency:** Avoiding waste, including waste of all resources (human, equipment, supplies, finances, energy)
- **E** — **Effectiveness:** Avoiding overuse of inappropriate care, treatment, and services and underuse of effective care, treatment, and services
- **E** — **Equity:** Removing variation in the quality of care, treatment, and services that may be based on patient characteristics such as gender, ethnicity, race, or socioeconomic status
- **P** — **Person-centeredness:** Providing care, treatment, and services that are respectful of and responsive to individual preferences, needs, and values

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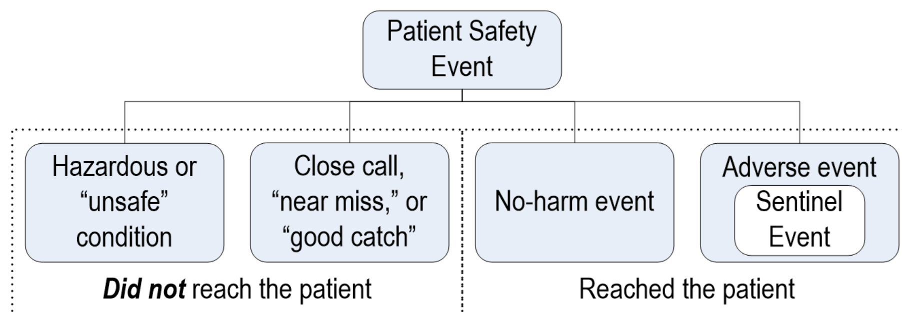
WHAT IS PATIENT SAFETY?

Although included as one of the six dimensions of quality, safety has emerged as a central, and separate, aim. The discipline of patient safety has evolved to focus on preventable harm. The World Health Organization describes patient safety as:

The cultures, processes, procedures, behaviours, technologies, and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce its impact when it does occur. [2]

Patient safety was brought to the forefront with the watershed report To Err Is Human: Building a Safer Health System, which reported that approximately 100,000 patients die each year due to harm that was caused by the medical system.[3] Unfortunately, the current state of patient safety continues to be a problem. In fact, more recent studies have projected that over 400,00 patients die each year and medical errors may be the third leading cause of death. [4]

In the delivery of everyday health care, things can go wrong that put patients at increased risk of harm. These incidents are referred to as patient safety events. A patient safety event is any event, incident, or condition that could have resulted, or did result, in harm to a patient, including "errors". Patient safety events are broken down into categories that include the following:



- **Adverse event:** A patient safety event that results in harm to a patient.
- **Close call** (sometimes called "near miss" or "good catch"): A patient safety event that did not reach the patient.
- **Hazardous condition** (sometimes called "unsafe condition"): A circumstance (unrelated to the patient's disease process or condition) that increases the probability of an adverse event.
- **No-harm event:** A patient safety event that reaches the patient but does not cause harm.
- **Sentinel event:** A type of adverse event in which the patient suffers death, permanent harm, or severe temporary harm that is not primarily related to the natural course of the patient's illness or an underlying condition; the term sentinel event is used because it signals the need for immediate investigation and response.

Patient safety is a complex challenge for all health care organizations, and many factors contribute to adverse events. The traditional approach to managing safety has been to identify the individuals involved in the event and then "blame and shame" them for their errors. Based on the scientific study of accidents in other industries, health care has learned that most safety events are the result of underlying problems in the systems or processes of delivering care or a breakdown in communication. Organizational culture, communication and teamwork, and the physical environment—factors that influence how staff perform their work—need to be developed in a way that supports staff so they can effectively perform their jobs.

The goal of patient safety is not to prevent human errors; human limitations prevent us from ever being error free. Rather, the challenge is to fix the conditions in which humans work so that it is easy for staff to do the right thing and hard for them to make a mistake—or to prevent their mistakes from reaching the patient.

References

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