Patient safety

ICN Position:

Patient safety is fundamental to quality health and nursing care. The International Council of Nurses (ICN) believes that the enhancement of patient safety involves a wide range of actions in the recruitment, training and retention of health care professionals, performance improvement, environmental safety and risk management, including infection control, safe use of medicines, equipment safety, safe clinical practice, safe environment of care, and accumulating an integrated body of scientific knowledge focused on patient safety and the infrastructure to support its development.

Nurses address patient safety in all aspects of care. This includes informing patients and others about risk and risk reduction, advocating for patient safety and reporting adverse events.

A lack of accurate and current health information is a serious threat to patient safety and quality of care. ICN strongly believes that health outcomes are improved through the provision of high quality evidence-based health information to all health care providers, patients and the public.[1]

Early identification of risk is key to preventing patient injuries, and depends on maintaining a culture of trust, honesty, integrity and open communication among patients and providers in the health care system. ICN strongly supports a system-wide approach, based on a philosophy of transparency and reporting – not on blaming and shaming the individual care provider – and incorporating measures that address human and system factors in adverse events.

ICN is deeply concerned about the serious threat to the safety of patients and quality of health care resulting from insufficient numbers of appropriately trained human resources. The current global nursing shortage represents such a threat. Also contributing to the threat to patient safety and quality of care are the maldistribution of health workers, the lack of health human resource strategies, inadequately resourced and maintained care settings and decreasing health care budgets in some countries and regions.

ICN believes nurses and national nurses associations (NNAs) have a responsibility to:

- Inform patients and families of potential risks.
- Report adverse events to the appropriate authorities promptly.
- Take an active role in assessing the safety and quality of care.
- Improve communication with patients and other health care professionals.
- Advocate for positive practice environments.
- Promote rigorous infection prevention and control programmes.

- Lobby for standardised treatment policies and protocols that minimise errors.
- Liaise with the professional bodies representing pharmacists, physicians and others to improve packaging and labelling of medications.
- Lobby for adequate staffing levels, appropriate skill mixes and sufficient material resources to provide safe care.
- Support measures that improve patient safety including education and research.
- Participate in the development and implementation of clear policies on the reporting of adverse events and disclosure to patients and their families.
- Collaborate with national reporting systems to record, analyse and learn from adverse events.
- Develop mechanisms, for example through accreditation, to recognise the characteristics of health care providers that offer a benchmark for excellence in patient safety.

Background

While health care interventions are intended to benefit the public, there is an element of risk that errors and adverse events will occur due to the complex combination of processes, technologies and human factors related to health care. An adverse event is an event that results in unintended harm to the patient and is related to the care and/or services provided to the patient rather than to the patient's underlying condition.[2] Common threats to patient safety include medication errors, hospital acquired infections, patient falls, exposure to high doses of radiation and use of counterfeit medicines.

Although human errors play a role in serious adverse events, there are usually inherent system factors, which if addressed properly would have prevented the errors or reduced the likelihood of their occurrence. The fundamental role of patient safety reporting systems is to enhance patient safety by learning from failures of the health care system.[3]

There is growing evidence that inadequate institutional staffing levels are correlated with increase in adverse events such as patient falls, bed sores, medication errors, nosocomial infections and readmission rates that can lead to longer hospital stays and increased hospital mortality rates.[4] Staff shortages and poor performance of personnel because of low motivation or insufficient skills are also important determinants of patient safety.

Poor quality health care causes substantial number of adverse events with serious financial impact on health care expenditures.

Adopted in 2002
Reviewed and revised in 2012

Related ICN Positions:	ICN Publications:
▪ Protection of the title "nurse" ▪ Nursing regulation ▪ Scope of nursing practice ▪ Assistive nursing personnel ▪ Occupational health and safety for nurses ▪ Informed patients	▪ Nursing Matters, Medication errors ▪ Nursing Matters, Adverse Events Following Immunization (AEFI) ▪ Nursing Matters, First do no harm: Auto-disable syringes for immunization safety ▪ Nursing Matters, ICN on selecting safer needle devices ▪ Nursing Matters, Immunisation safety: An essential nursing function ▪ Nursing Matters, Immunisation Safety. Safe Waste Disposal Practices Save Lives ▪ Nursing Matters, Infection Control ▪ Nursing Matters, Nurse: Patient ratios ▪ Nursing Matters, ICN on disinfectants and sterilants ▪ Nursing Matters, Counterfeit Medical Devices ▪ Patient Safety, WHPA, Fact Sheet ▪ Medication Use and the Ageing Population, WHPA, Fact Sheet

The International Council of Nurses is a federation of more than 130 national nurses associations representing the millions of nurses worldwide. Operated by nurses and leading nursing internationally, ICN works to ensure quality nursing care for all and sound health policies globally.

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[1] Healthcare Information for All by 2015 (HIFA2015). A Global Campaign launched in 2006 with the goal: By 2015, every person worldwide will have access to an informed healthcare provider. www.hifa2015.org

[2] Canadian Patient Safety Institute (2008). Canadian disclosure guidelines. www.chirofed.ca/english/pdf/CPSI_Canadian_Disclosure_Guidelines_EN.pdf.

[3] World Alliance for Patient Safety (2005). WHO Draft Guidelines for Adverse Event Reporting and Learning Systems, From information to action. www.who.int/patientsafety/events/05_Reporting_Guidelines.pdf

[4] Clarke SP & Aiken LH (2008). An international hospital outcomes research agenda focused on nursing: lessons from a decade of collaboration. Journal of Clinical Nursing, 17(24), 3317.