PATSAFE TOOLBOX No. 13

Definitions of patient safety, adverse events and errors

Patient safety

- **Kohn, Corrigan & Donaldson, 2000**: Patient safety relates to the reduction of risk and is defined as "freedom from accidental injury due to medical care, or medical errors".
- **Emanuel et al., 2008**: Patient safety is a discipline in the healthcare sector that applies safety science methods towards the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.
- **Slawomirski, Auraaen & Klazinga, 2017**: Patient safety is the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum; [this minimum is defined based on] the collective notions of current knowledge, resources available and the context in which care was delivered and weighed against the risk of non-treatment or alternative treatment.

Errors and adverse events (from Kohn, Corrigan & Donaldson, 2000; see also Walshe, 2000)

- An error is defined as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning) (Reason, 1990).
- An adverse event is an injury caused by medical management rather than the underlying condition of the patient. An adverse event attributable to error is a "preventable adverse event" (Brennan et al., 1991). Negligent adverse events represent a subset of preventable adverse events that satisfy legal criteria used in determining negligence (i.e., whether the care provided failed to meet the standard of care reasonably expected of an average physician qualified to take care of the patient in question) (Leape et al., 1991).

Examples of adverse events related to level of care and generic possible causes

Level of care	Adverse event related to level of care	General drivers of adverse events (unrelated)
Primary care	• Adverse drug events • Medication errors • Diagnostic error • Delayed diagnosis	• Communication and information deficits • Insufficient skills/knowledge • Inadequate organizational culture and misaligned incentives
Long-term care	• Adverse drug events • Pressure injury • Falls	
Hospital care	• Healthcare-associated infections • Venous thromboembolism • Adverse drug events • Pressure injury • Wrong site surgery	

References

Extracted from:

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Original source:

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Kohn LT, Corrigan JM, Donaldson MS (eds.) (2000). To Err is Human: Building a Safer Health System. Washington, DC: National Academies Press

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Brennan TA et al. (1991). Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I. New England Journal of Medicine, 324:370–7.

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