patientensicherheit schweiz
sécurité des patients suisse
sicurezza dei pazienti svizzera

Doing what counts?

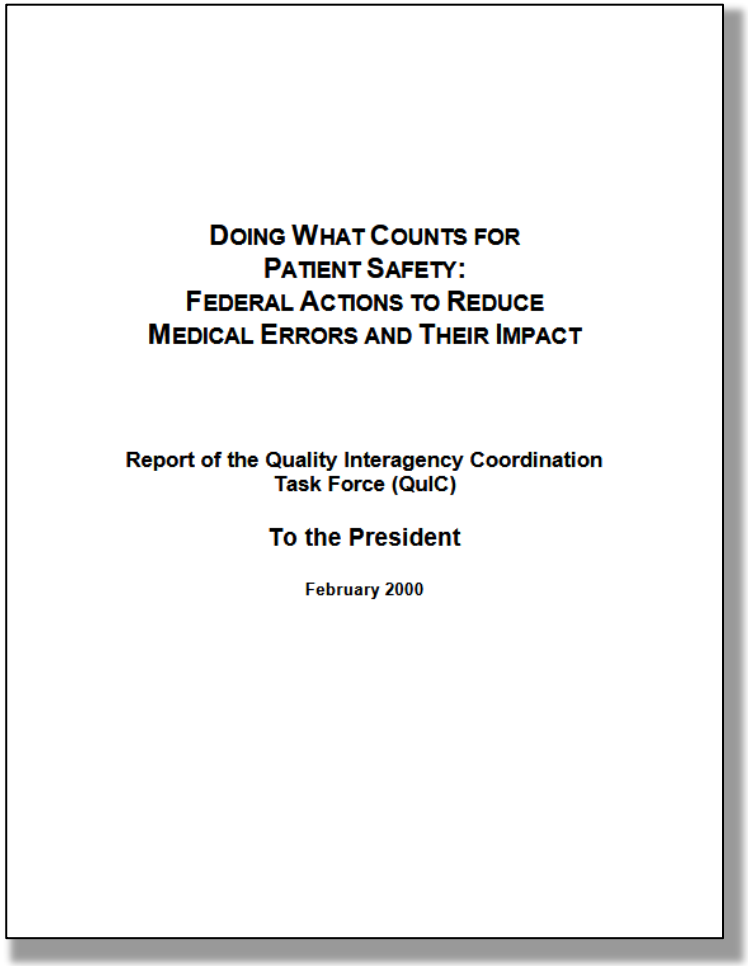
CIRRNET-Tagung

13. November 2025

Helmut Paula

Leiter CIRRNET, Stiftung Patientensicherheit Schweiz

Doing what counts?



DOING WHAT COUNTS FOR PATIENT SAFETY: FEDERAL ACTIONS TO REDUCE MEDICAL ERRORS AND THEIR IMPACT

Report of the Quality Interagency Coordination Task Force (QuIC)

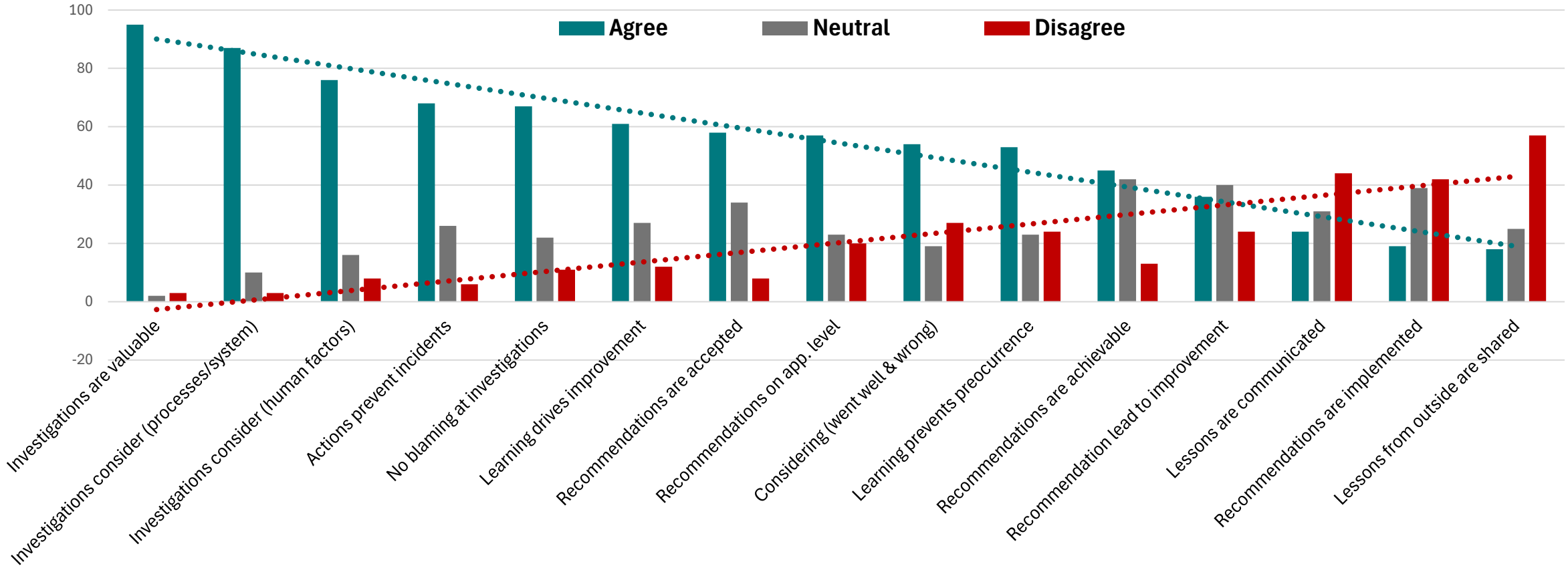
To the President

February 2000

https://archive.ahrq.gov/quic/report/errors6.pdf

"While both the public and private sectors have made notable contributions to reducing preventable medical errors, additional and aggressive efforts are needed in and outside of the Federal government to further reduce these mistakes."

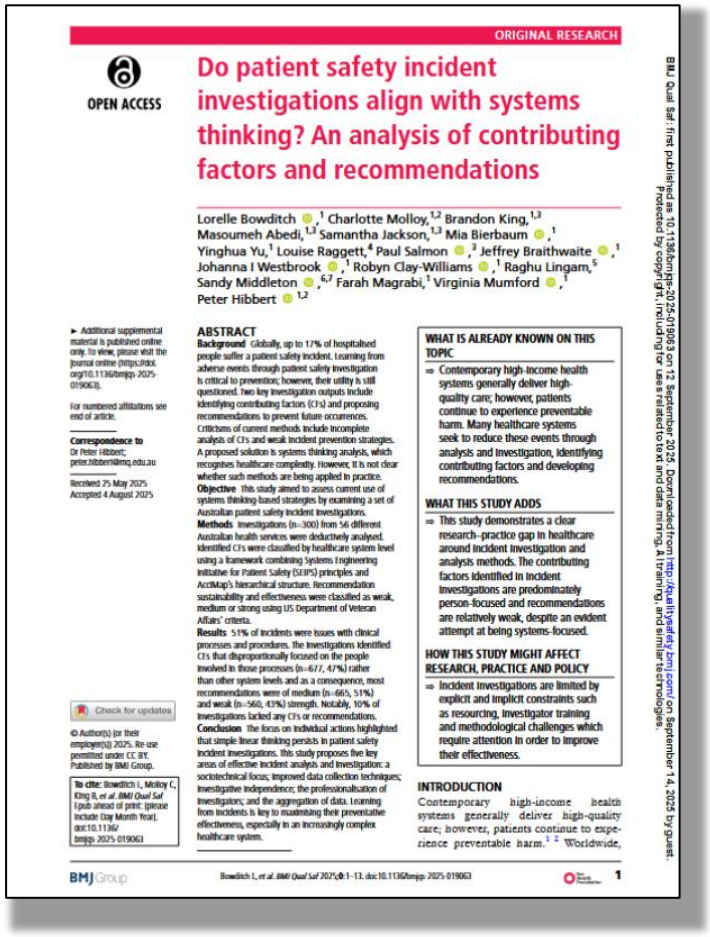
Doing what counts?



Decades of failure to prevent harm to patients - where are we going wrong?

Front. Health Serv., 02 September 2025 (Ergebnisse vereinfacht dargestellt)

Doing what counts?



ORIGINAL RESEARCH

OPEN ACCESS

Do patient safety incident investigations align with systems thinking? An analysis of contributing factors and recommendations

Lorelle Bowditch,[1] Charlotte Molloy,[1,2] Brandon King,[1,3] Masoumeh Abedi,[1,3] Samantha Jackson,[1,3] Mia Bierbaum,[1] Yinghua Yu,[1] Louise Raggett,[4] Paul Salmon,[3] Jeffrey Braithwaite,[1] Johanna I Westbrook,[1] Robyn Clay-Williams,[1] Raghu Lingam,[5] Sandy Middleton,[6,7] Farah Magrabi,[1] Virginia Mumford,[1] Peter Hibbert[1,2]

ABSTRACT

Background Globally, up to 17% of hospitalised people suffer a patient safety incident. Learning from adverse events through patient safety investigation is critical to prevention; however, their utility is still questioned. Two key investigation outputs include identifying contributing factors (CFs) and proposing recommendations to prevent future occurrences. Criticisms of current methods include incomplete analysis of CFs and weak incident prevention strategies. A proposed solution is systems thinking analysis, which recognises healthcare complexity. However, it is not clear whether such methods are being applied in practice.

Objective This study aimed to assess current use of systems thinking-based strategies by examining a set of Australian patient safety incident investigations.

Methods Investigations (n=300) from 56 different Australian health services were deductively analysed. Identified CFs were classified by healthcare system level using a framework combining Systems Engineering Initiative for Patient Safety (SEIPS) principles and ACcHAgS's hierarchical structure. Recommendation sustainability and effectiveness were classified as weak, medium or strong using US Department of Veteran Affairs' criteria.

Results 51% of incidents were issues with clinical processes and procedures. The investigations identified CFs that disproportionally focused on the people involved in those processes (n=677, 47%) rather than other system levels and as a consequence, most recommendations were of medium (n=665, 51%) and weak (n=560, 43%) strength. Notably, 10% of investigations lacked any CFs or recommendations.

Conclusion The focus on individual actions highlighted that simple linear thinking persists in patient safety incident investigations. This study proposes five key areas of effective incident analysis and investigation: a sociotechnical focus; improved data collection techniques; investigative independence; the professionalisation of investigators; and the aggregation of data. Learning from incidents is key to maximising their preventative effectiveness, especially in an increasingly complex healthcare system.

WHAT IS ALREADY KNOWN ON THIS TOPIC

- Contemporary high-income health systems generally deliver high-quality care; however, patients continue to experience preventable harm. Many healthcare systems seek to reduce these events through analysis and investigation, identifying contributing factors and developing recommendations.

WHAT THIS STUDY ADDS

- This study demonstrates a clear research-practice gap in healthcare around incident investigation and analysis methods. The contributing factors identified in incident investigations are predominately person-focused and recommendations are relatively weak, despite an evident attempt at being systems-focused.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE AND POLICY

- Incident investigations are limited by explicit and implicit constraints such as resourcing, investigator training and methodological challenges which require attention in order to improve their effectiveness.

INTRODUCTION

Contemporary high-income health systems generally deliver high-quality care; however, patients continue to experience preventable harm.[1 2] Worldwide,

► Additional supplemental material is published online only. To view, please visit the journal online (https://doi.org/10.1136/bmjqs-2025-019063).

For numbered affiliations see end of article.

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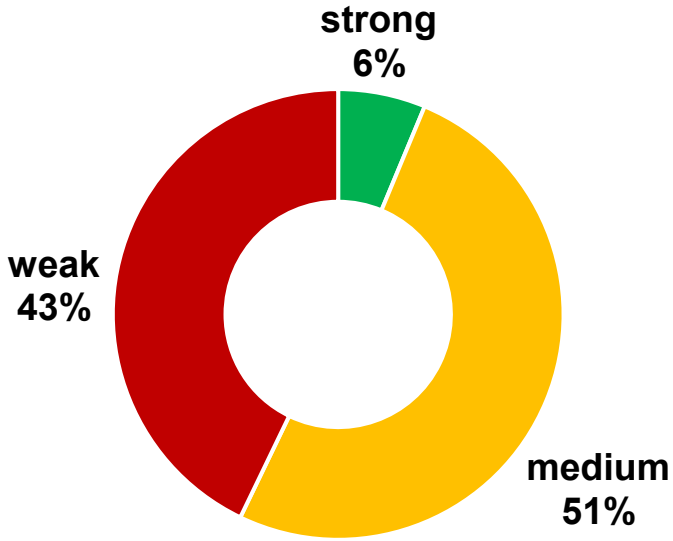
Stärke von empfohlenen Massnahmen:

Force de la recommandation de mesures:

Forza delle misure raccomandate:



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https://qualitysafety.bmj.com/content/early/2025/09/11/bmjqs-2025-019063

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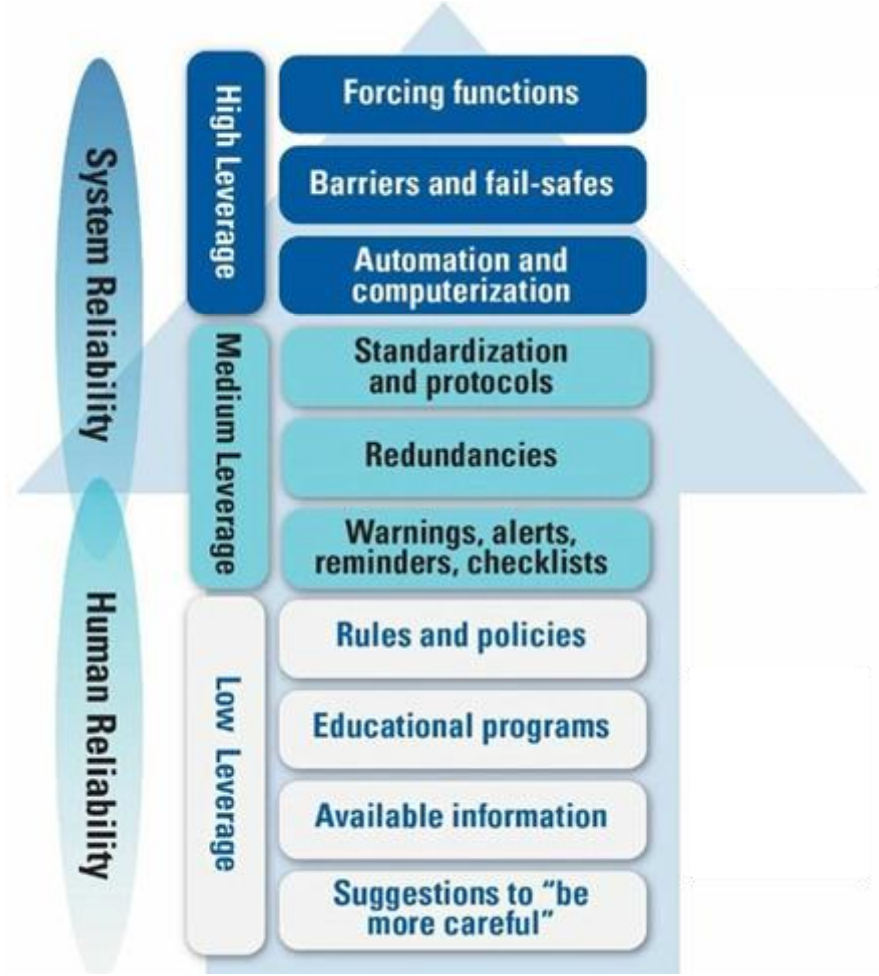
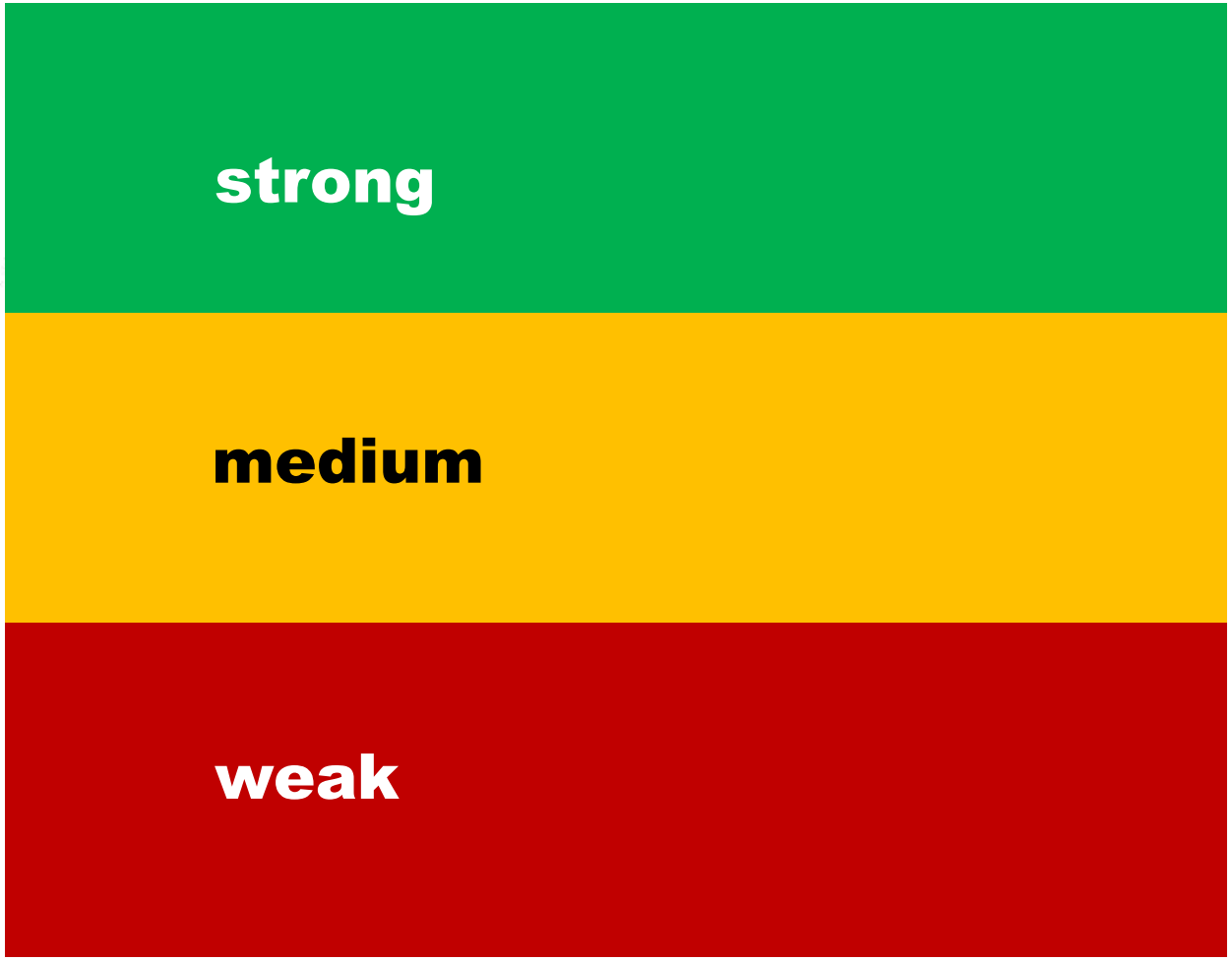




ISMP's hierarchy of effectiveness of risk-reduction strategies (2022)

Doing what counts?

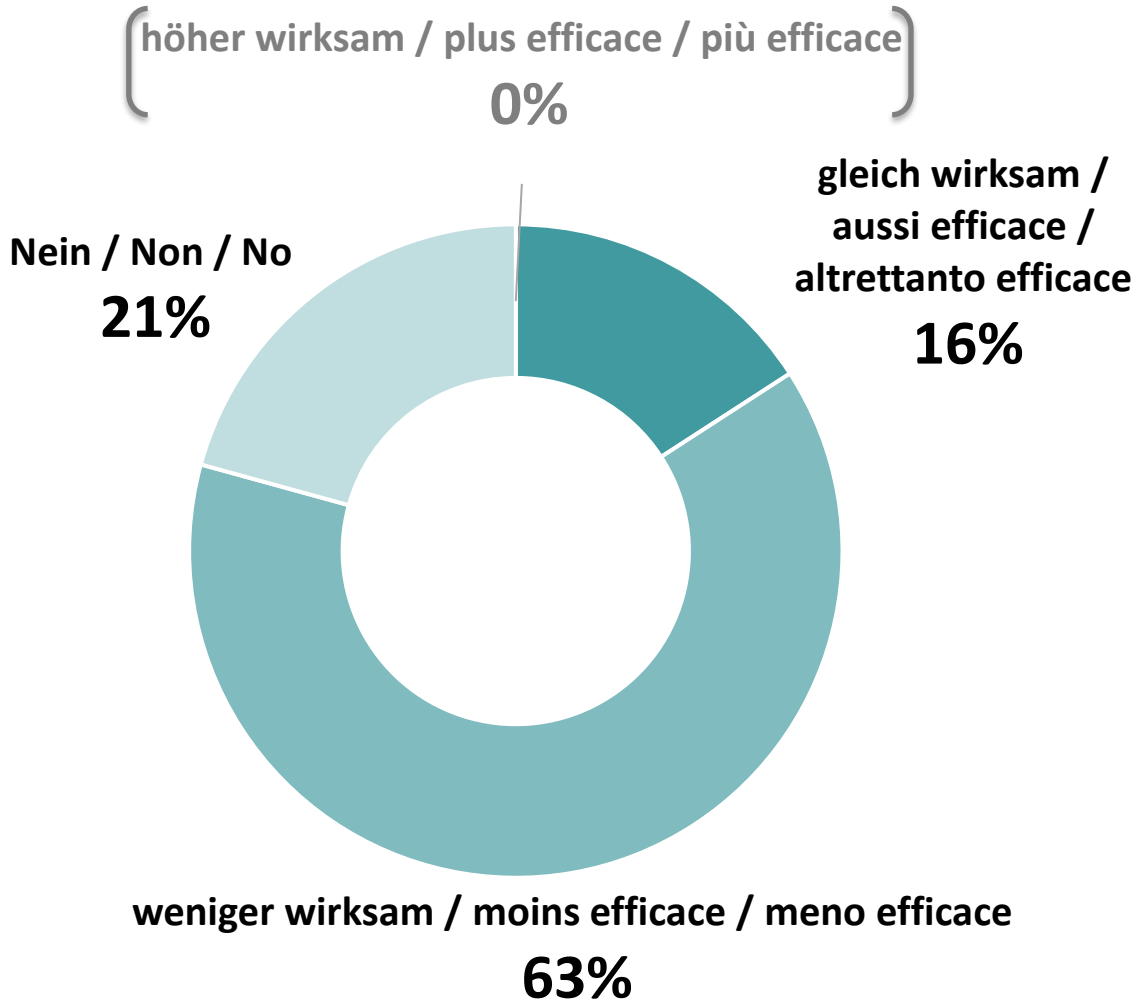
ISMP's hierarchy of effectiveness of risk-reduction strategies (2022)

Doing what counts?

Bei Nicht-Umsetzung: Konnten andere Massnahmen eingeführt werden?

En cas de non-mise en œuvre : d'autres mesures ont-elles pu être introduites ?

In caso di mancata attuazione: è stato possibile introdurre altre misure?



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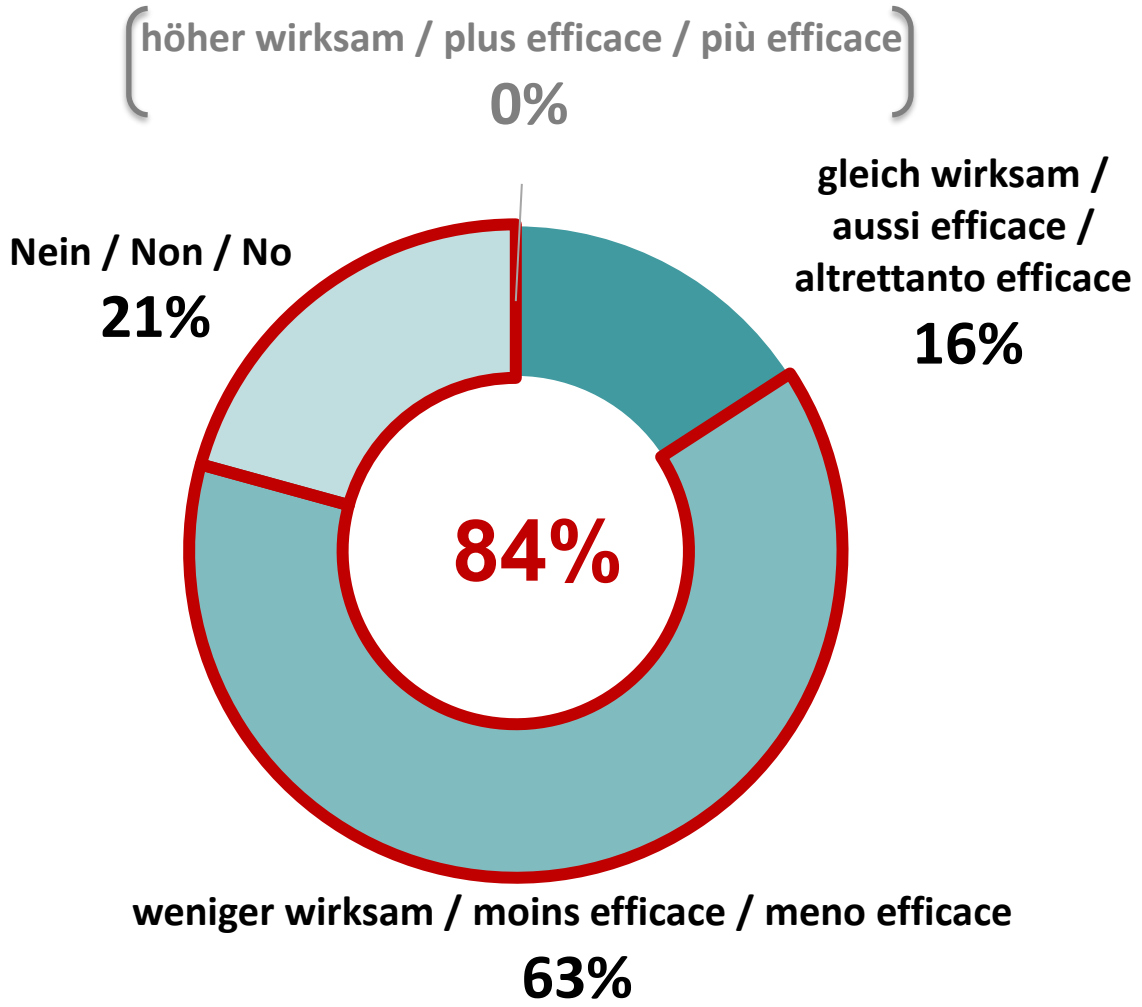

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fr.
La règle des **6 B** de l'administration des médicaments

it.
La regola delle **6 G** della somministrazione dei farmaci

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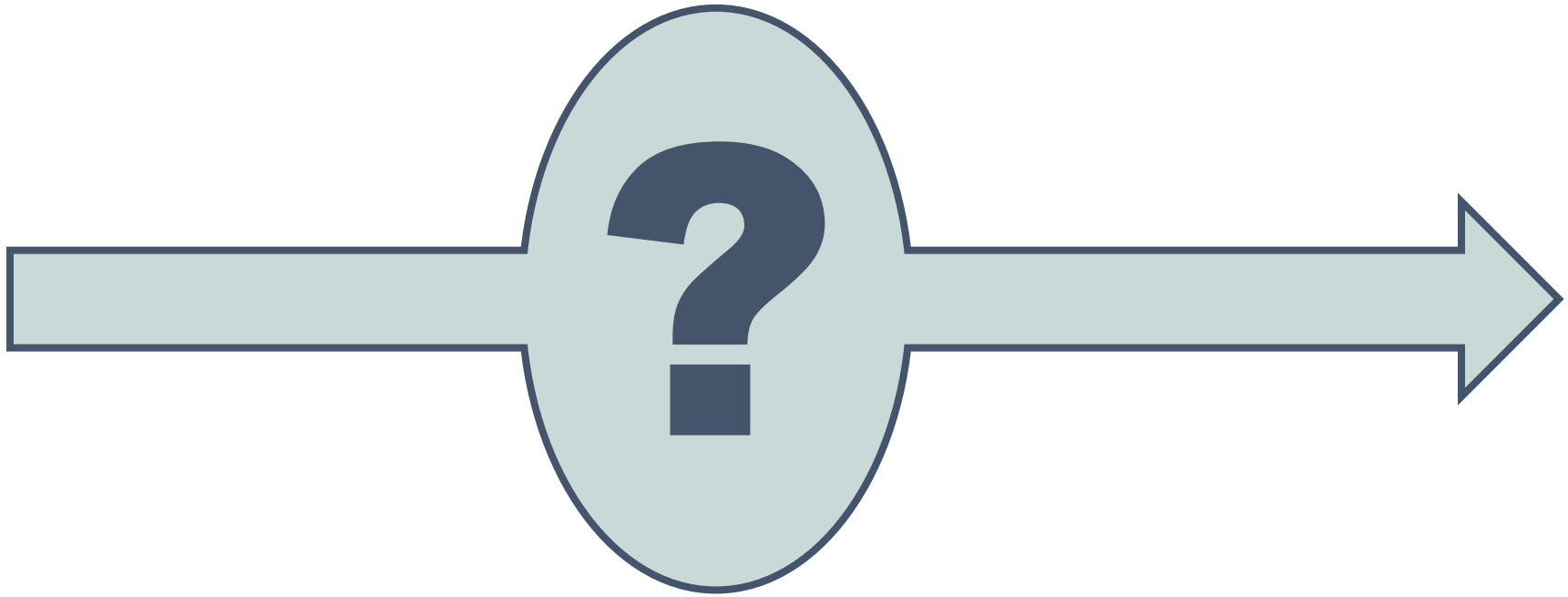

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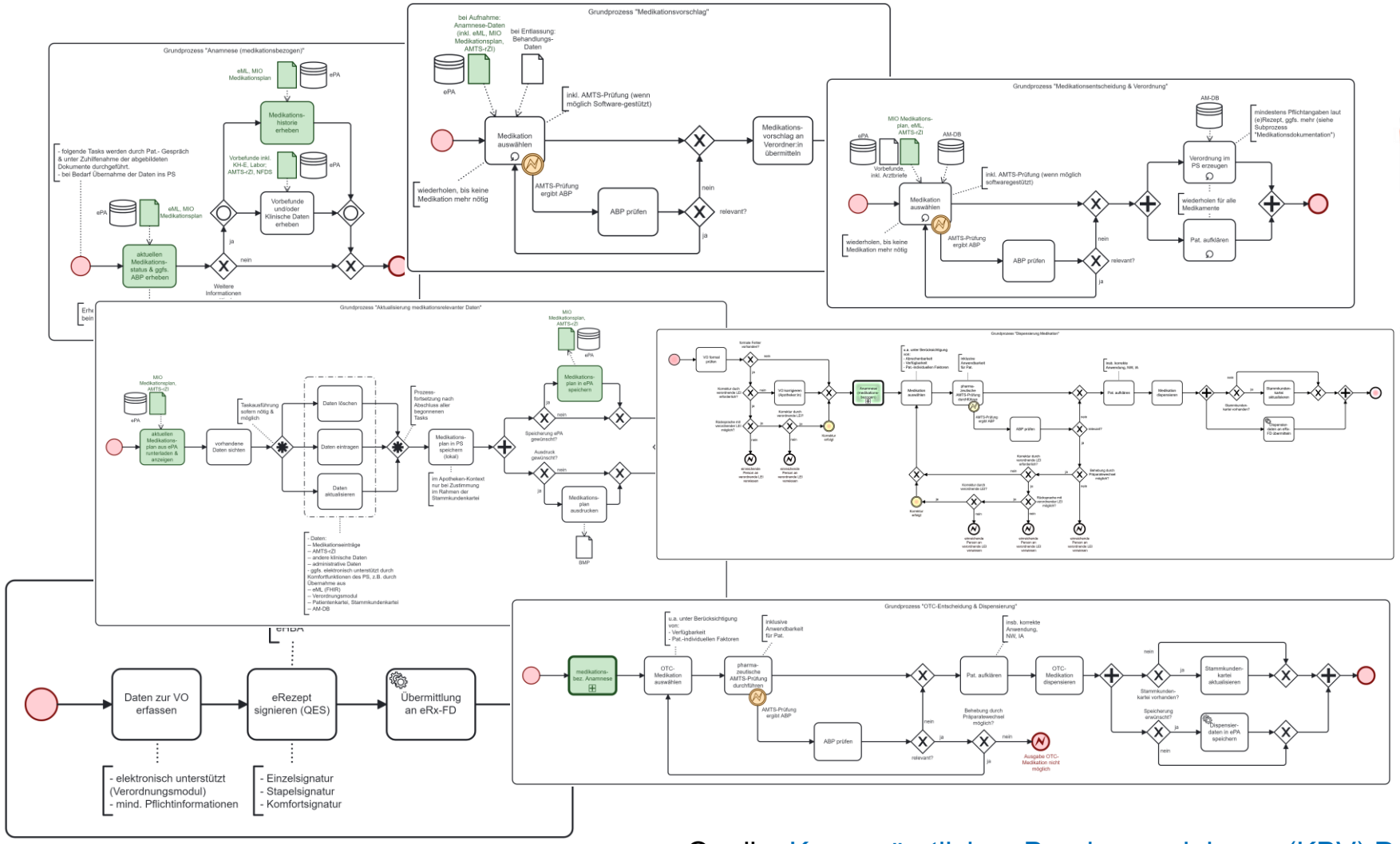

Quelle: Kassenärztlichen Bundesvereinigung (KBV) Deutschland

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