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The Language of (Patient) Safety

'The limits of my language mean the limits of my world'
—Ludwig Wittgenstein, *Tractatus Logico-Philosophicus*, 1921.

- Language is central to our understanding and to the communication of ideas and information
- Becoming accustomed to the language of patient safety is important for understanding patient safety theories and methodologies

What is the Difference Between an Adverse Event and a Patient Safety Incident?

This question sounds a bit like the start of a very niche joke, but it demonstrates an important point: both terms are used widely in the literature, but it is difficult to know from the outside what the difference is between them, or indeed if they are describing the same thing.

Delving into a new subject can be confusing, as it comes not only with new concepts to understand but also a new vocabulary to describe these concepts. In any subject, an agreed common language (a set of words and terms with associated definitions) allows effective communication between individuals and groups and helps develop a shared understanding. On the other hand, inconsistent use of language can compromise understanding and can lead to confusion and mixed messages.

Patient safety is a relatively new subject in medicine, with the term only entering the literature regularly in the 1990s (McCulloch 2024). This has meant, unlike more established scientific subjects, patient safety has not been able to agree on a universal set of terms and definitions (Runciman et al. 2009). This has led to several problems. A single concept can be associated with multiple different terms, e.g., close call and near miss can both be used to describe an incident which had the potential to cause harm, but which did not reach the patient. In addition, a single term can be used to describe several different concepts, e.g., the term medical error can include human errors, system failures and violations. This lack of consistency has been identified as a key factor compromising the understanding of patient safety within healthcare (Runciman et al. 2009).

What is more, there is considerable controversy regarding some of the most basic terms (Aven 2022). Even the term "safety" can be defined, and therefore approached, in multiple different ways. Classically, safety has been considered "the absence of accidents and incidents", e.g., safety means ensuring that as few things as possible go wrong. However, in this view, driving a car

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over the speed limit and without wearing a seatbelt would be considered safe, provided the destination was reached without accident. This definition has since been expanded to include the "freedom from unacceptable risk", recognising safety should be defined not merely by outcome but also by the risks introduced via the processes or systems involved. Using this definition, our example of driving a speeding car while not wearing a seatbelt would be considered unsafe, even if the driver and car arrived at their destination unscathed, because the method of getting there introduced significant risk to persons and the vehicle.

Recently, an alternative definition of safety was proposed, which considers the ability of a system to succeed under varying conditions, thus ensuring "as many things as possible go right" (Hollnagel et al. 2015). Hollnagel has coined the two opposing views of safety as ***Safety I**** and ***Safety II****. ***Safety I*** focusses on failures, accidents and losses, while ***Safety II*** focusses on success and the effect of variation and resilience on outcome. While this can be confusing enough, it doesn't end here. A third view on safety (***Safety III****) has recently been proposed by Aven (2022). Safety in this context is achieved through pre-emptively eliminating, mitigating or controlling ***hazards****, which are states in the system that can potentially lead to losses.

You may ask, why is describing and discussing definitions and language in this detail relevant or important for understanding the practicalities of patient safety in the veterinary profession? Isn't this simply an academic argument? My response would be this: understanding there are different meanings to words like "safety" is important as it not only helps with communication but starts us on the way to understanding that there are multiple different perspectives involved in all aspects of patient safety. You will notice when reading this book that differing perceptions and meanings are something that regularly arise when discussing patient safety. These differing perspectives can include the definitions of key terms, the best way to investigate problems and analyse data, and even that a single incident can be perceived in different ways by different people involved in it. These are important concepts to recognise. There is no single truth or right way to do things, but rather multiple often overlapping perspectives and methodologies.

Fundamentally, going forward, we need to use a shared language with precise, unambiguous meanings to allow the consistent, accurate and effective sharing of information and ideas. Unfortunately, there is no consensus regarding language and approach to patient safety in human or veterinary healthcare. However, for consistency's sake, throughout this book I have tried to utilise a modified version of the **International Classification for Patient Safety** terms proposed by Runciman et al. (2009) for the **World Health Organisation's World Alliance for Patient Safety**. This includes a preferred set of terms and definitions, which have been adapted and expanded slightly to ensure their relevance to veterinary medicine (Box 1.1). A larger glossary of terms is provided at the back of the book, in which all words italicised and in bold are included, and generally these are terms relating to concepts which span multiple sections and chapters in the book.

Acronyms and Abbreviations

A quick note on acronyms and abbreviations is required before we progress further into understanding patient safety. Our professional lives are littered with acronyms and abbreviations; on the day I started to write this chapter, the hospital's procedure scheduling board read amongst others: TPLO, TIVA, PDA, CXR, AUS, CRI, MTZ and ACP. These relate to procedures, medications and methods of medication administration.

Box 1.1 Suggested terms for veterinary patient safety and their definitions based upon the list of preferred terms and definitions for key concepts adapted from the World Health Organisation's International Classification for Patient Safety (Source: Adapted from Runciman et al. 2009). †Adapted from other sources

***Patient*:** the recipient of healthcare.

***Healthcare*:** the provision of services to patients with the goal of maintaining, monitoring or restoring health.

Health: the state of a patient's physical, physiological and psychological wellbeing.

Disease: a physical, physiological or psychological dysfunction.

Injury: damage to tissues caused by an external agent or event.

***Suffering*:** any unpleasant experience, including pain, anxiety, depression, stress, nausea, disorientation or fear.

Harm: the deleterious effects of impairment of the structure or function of the body.

***Patient safety*:** the reduction of risk of unnecessary harm associated with veterinary healthcare to an acceptable minimum and optimising healthcare's ability to function successfully over varying conditions.

***Healthcare-associated harm*:** harm arising from or associated with plans or actions taken during the provision of healthcare, rather than an underlying disease or injury.

***Patient safety incident*:** an event, hazard or circumstance which could have resulted or did result in unnecessary harm to a patient.

***Event*:** something which happens or involves a patient.

***Hazard*:** a circumstance, agent or action with the potential to cause harm.

***Risk*:** the probability of a hazard reaching a patient and causing an incident.

***Circumstance*:** a situation or factor which may influence an event, agent or person.

Near miss: an incident which did not reach the patient.

No harm incident: an incident which reached the patient but did not result in discernible harm.

Harmful incident (accident, adverse event): an incident which resulted in harm to a patient.

***Error*:** failure to carry out a planned action as intended or application of an incorrect plan. Includes slips, lapses and mistakes.

***Slip*:** a memory failure, includes omitting planned items, losing place in a process and forgetting intentions.

***Lapse*:** a failure of attention, includes omission, intrusion, reversal, misordering and mistiming, e.g., forgetting to open an adjustable pressure limiting valve.

***Mistake*:** a rule-based or knowledge-based error. Rule-based mistakes include the misapplication of a good rule or the application of a bad rule. Knowledge-based mistakes are many and varied.

Violation: deliberate deviation from an operating procedure, standard or rule. These can be routine, exceptional or sabotage.

***Contributing factor*:** a circumstance, action or influence which is thought to have played a part in the origin or development of an incident or to increase the risk of an incident.

***Mitigating factor*:** an action or circumstance that prevents or moderates the progression of an incident towards harming a patient.

***Preventable*:** accepted by peers as being avoidable in a given set of circumstances.

***Detection*:** an action or circumstance which results in the discovery of an incident.

***Resilience*:** the degree to which a system continues to function effectively and safely in the face of varying conditions, e.g., demands and pressures. Includes the prevention, detection, mitigation and amelioration of hazards or incidents.

***Accountable*:** being held responsible for something.

Healthcare quality: the degree to which the outcomes of healthcare systems are consistent with goals for efficacy, safety, timeliness, efficiency, equitability, affordability and sustainability.

†***System:*** a set of interdependent components interacting to achieve a common goal, e.g., a hospital is a system set up to deliver healthcare.

†***System components:*** the elements which make up a system, e.g., in healthcare systems, it relates to an organisation's operational methods, tasks and processes, its infrastructure, including the people, tools and technology and working environments within it.

†***Control measures:*** design features within a system's processes and procedures which help eliminate or manage hazards. These can be barrier controls, escalation controls, mitigation controls or recovery controls.

†***Human factors*:** cognitive, psychological, physical, social and environmental factors influencing human performance and capabilities and the scientific study of these factors.

***Patient safety investigation*:** a systematic approach to examining the circumstances and contributing factors associated with an incident or assessing a process or task in terms of outcomes, hazards, control measures and performance variation.

Acronyms and abbreviations are used to save time, to take up less space and for ease of spelling. If an acronym or abbreviation relates to our everyday work, we can generally understand exactly what it means as we have prior knowledge of its meaning and can generally understand the context in which it is being used. However, different clinics, and sometimes different teams within the same clinic, have often developed their own language, which is not necessarily shared with others from outside that clinic or team. Worse, many acronyms and abbreviations we use have more than one potential meaning, which can lead to them becoming ambiguous and occasionally contradictory. This means they can commonly be misunderstood, misread or misinterpreted if their context isn't clear. Studies suggest misunderstandings and errors commonly arise when abbreviations are used in medical communications (Brunetti et al. 2007; Parvaiz et al. 2008; Kilshaw et al. 2010; Sinha et al. 2011). Take the three-letter acronym "AUS" as an example; this could stand for "Abdominal UltraSound", which it did for the internal medicine service in one hospital I worked in. However, it could also stand for "Artificial Urethral Sphincter", which it did for the surgeon who performed the urological surgeries in the same hospital. To understand what "AUS" meant on the procedure scheduling board of this hospital required the gathering of more information about the context of the message; we would need to find out the name of the clinician (an abbreviation of the first letters of their forename and surname) or the medical specialty (also an abbreviation e.g., STS for Soft Tissue Surgery or IM for Internal Medicine). From this you can see the meaning of AUS is obvious to the person posting the information on the board, however to the person reading the board, at least for the first time that day, the meaning is unclear without further investigation. This can lead to a lack of clarity which can cause miscommunications and lead to problems.

Having recently moved country, I can attest to how difficult it can be to learn a new set of acronyms. Imagine my surprise on my first day in clinics in Munich when a DSH, an acronym I

was accustomed to using for Domestic Short Hair cat, was presented for anaesthesia and it turned out to be a German shepherd dog (DSH = Deutscher Schäfer Hund).

As this book is aimed at all specialties and walks of veterinary medicine, I will attempt to avoid the use of acronyms throughout this book. I apologise if any NIBP, MAP or BPM sneak into the text.

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