Patient Safety

Overview

The concept of safety culture originated outside health care, in studies of high-reliability organizations, organizations that consistently minimize adverse events despite carrying out intrinsically complex and hazardous work. High-reliability organizations maintain a commitment to safety at all levels, from frontline providers to managers and executives. This commitment establishes a "culture of safety" that encompasses these key features:

- acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations
- a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment
- encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems
- organizational commitment of resources to address safety concerns

Improving the culture of safety within health care is an essential component of preventing or reducing errors and improving overall health care quality.
Source: AHRQ

Resources

Centers for Disease Control and Prevention (CDC)

- Current HAI Progress Report

Agency for Healthcare Research and Quality (AHRQ)

- Patient Safety Network

World Health Organization (WHO)

- Patient Safety
- Multi-professional Patient Safety Curriculum Guide

American Academy of Pediatric Dentistry (AAPD)

- Policy on Patient Safety

The Joint Commission

- Patient Safety

Institute for Healthcare Improvement (IHI)

- National Action Plan to Advance Patient Safety

Fact Sheets & Information

World Health Organization (WHO)

- Patient Safety

Articles

- *Patient safety and dentistry: what do we need to know? Fundamentals of patient safety, the safety culture and implementation of patient safety measures in dental practice*
- *Developing patient safety in dentistry*
- *Systematic review of patient safety interventions in dentistry*

- *First, do no harm*
- *From good to better*

Patient Information

MedlinePlus

- Patient Safety

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