

Harm-free care or harm-free environments: Expanding our definitions and understandings of safety in health care.

In recent decades there has been no shortage of attention to the hazards and risks of healthcare. The sustained attention to prevent, or at least minimize, harm to patients has seen an international drive for 'cultures of safety' and 'harm-free care'. These approaches place emphasis on reducing harm, rather than individual blame and disciplinary measures for staff (HQ 2015, ACSQH 2015, NHS 2014), with attention to organisational structures, clinical competence and communication to prevent harm.

While concerted effort has been given to reducing patient harm, what remains unclear is the definition of harm, what types of harm are preventable, and the scale of preventable harms. While some harms are clear and easy to identify; the field is growing in complexity, and the concept of harm, and who has the legitimate authority to define harm are becoming increasingly problematised. Is harm merely the absence of actual visible damage or injury? Or are patients able to be harmed in ways and through means we have not yet clearly recognised or articulated?

Highlighting the lack of clarity on what constitutes patient harm, the Institute of Medicine defined patient safety as freedom from accidental injury (Kohn *et al.* 2000); while the World Health Organisation (WHO) provided a more encompassing definition. The WHO definition of harm includes temporary or permanent impairment, suffering, disability or loss in function or structure, which can be physical, emotional, financial or psychological, and also includes death (WHO 2009).

Reflecting the absence of clarity around the concept of preventable harm, a systematic review of the healthcare literature (n=127) noted a high level of variability in the definitions employed (Nabhan *et al.* 2012). In this review, most definitions of preventable harm were author derived, and the most common theme for preventable harm was an identifiable modifiable cause (Nabhan *et al.* 2012). This understanding of preventable harm highlights a recurring tension within the healthcare harm discourses; whether healthcare institutions and providers should be accountable for harms believed non-preventable, or whether attention

should be given to all causes of harm (Parry *et al.* 2012). It also further problematizes our understandings of harm and raises further challenging questions. Are harms that are not preventable or not from modifiable causes, not harm? Does the safety agenda risk further solidifying a tolerance of harm and iatrogenia? Do patients and clinicians agree on what constitutes preventable harm?

It is important to problematize the dominance of expert knowledge in existing models of harm reduction and the marginalisation of patient perspectives. Doing so raises questions about who should participate in ascertaining harm or deliberating on the acceptability, inevitability and preventability of harms. It is now more than a decade since Berwick called for listening to patients and more actively involving them in finding the gaps and issues that matter (Berwick 2013), yet patients are only given a passive and marginal role in the safety and harm prevention agenda. Though patients are present in the own care, and many will be aware of impending harm or risk of harm, acknowledging patients' presence in this dynamic is a missing element in safety programs. Indeed, much of the patient perspective on harm sit outside of professional discourses – these are more likely to be found in blogs and in accounts reported in blogs and other forms of non-academic literature (Hutchinson & Jackson 2014).

When considering the challenges of actively involving patients in harm prevention, one UK study of hospital handwashing infection prevention programs reported no clear support from programme coordinators to encourage patients to ask healthcare workers to wash their hands (Pittet *et al.* 2011). These findings suggest that, even with preventive programs that are widespread and commonplace, active patient involvement in mitigating harm remains marginalised. Further highlighting the difficulties patients face in openly acknowledging their concern for risk of harm, a systematic review of patients' willingness to participate actively in reducing clinical errors noted that patients feared being labelled as “difficult”, and therefore assumed a passive and subordinate role with clinicians (Doherty & Stavropoulou 2012).

If patients are to take a more active role in harm prevention, it is important to consider the elements that would help or hinder this. Evidence from the United Kingdom suggests that patients are more likely to ask challenging questions if the healthcare provider has openly invited questioning, even so, patients are more likely to ask challenging questions of nurses

than doctors (Davis *et al.* 2011). For patients, a sense of freedom from harm evolves from a sense of trust, security, being cared for, and presence and knowledge (Mollon 2014). A recent systematic review of patients' experiences of adverse events reported that, patient distress after an adverse event is exacerbated by receiving inadequate information (Harrison *et al.* 2015).

Another issue to consider when reflecting on the discourses around harm-free environments is the invisible harms experienced by clinicians and the flow-on effect to patient care. Inadequate staffing and a perceived or real lack of support within an organisation, that may often include bullying and other forms of incivility, impact on safe nursing practice (Hutchinson & Jackson 2013). Similarly, physical and psychological stress factors such as increased workload or work intensity, continuous workplace reform and change, and conflict between care priorities and financial/managerial priorities create a backdrop of risk of harm.

The organisational culture and climate in which nurse's work, along with nurses' attitudes and responses to their perceived responsibilities have been directly linked to effective care and reduction in harm to patients (West *et al.* 2011). Better outcomes for patient and institutions occur when nurses critically consider what factors cause potential harm to patients. If these factors go unacknowledged, it is likely they will prevent nurses from undertaking the work they know should be done for patients, their families or carers.

Creating resilient points of care, and creating resilience within teams and the capacity to respond to adversity is important in the capacity to sustain safe practice. Hart *et al.* (2014) suggest a feeling of optimism and hopeful outlook are common characteristics of resilient nurses. Resilience includes being able to recognise, reframe, adapt and be future orientated despite adversity. Resilient nurses and leaders employ strategies in their every-day-practice to identify potential harm and enable patient safety, despite frequent interruptions and a sense of dissonance in their workplaces (Jackson & Daly 2011).

Positive communication and feeling part of a team reduces a sense of isolation among nurses and fosters the ability to bounce back and recover (McDonald *et al.* 2012). Developing resilient team communication helps nurses to prioritise their work, better foresee decline in a patients condition, and minimise errors occurring during care (Gaston *et al.* 2016). Challenging clinical and workplace risks are unlikely to reduce so developing awareness of the relationship between empathy and the perspectives of others and the impact of invisible harm experienced by clinical staff can reduce nurse's vulnerability and foster emotional

regulation in nurse-patient and nurse-team interactions. Support for each other is crucial to developing resilience and reducing harm. Furthermore, when nurses are supported to feel capable, active attempts to overcome adverse situations are made which open up the possibility of achieving resilience.

Clearly, there are complexities around harm that have not been fully explored in the nursing literature. In the complexities of healthcare, risk of harm is inescapable, although harm is not necessarily unavoidable.

According to Johnstone (2015), the principle of 'do no harm' includes protecting persons from harm, not harming them, and providing benefits to them. Avoidance of harm is enshrined in all codes of ethics for nurses. A social contract exists between nursing and society in which society permits nursing the authority to practice in return for nursing's commitment to society regarding matters related to health and the public good. Currently, the way in which risk of harm is conceptualized, and the dominant discourses on risk management perpetuate a limited and partial conception. To date the voices of patients, different ways of knowing and forms of knowledge have been largely excluded.

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