PriMera Scientific
Medicine and Public Health
Volume 7 Issue 1 July 2025
DOI: 10.56831/PSMPH-07-223
ISSN: 2833-5627

Impact of Learning from Organizational Patient Safety Lessons on Improving Patient Care and Quality

Type: Case Study
Received: June 16, 2025
Published: July 01, 2025

Citation:
Shaik Mohiuddin., et al. "Impact of Learning from Organizational Patient Safety Lessons on Improving Patient Care and Quality". PriMera Scientific Medicine and Public Health 7.1 (2025): 03-10.

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Abstract

Based on extensive global research into complex healthcare systems and the persistent challenge of patient safety, the prevalence of healthcare-related harm continues to be a significant concern. This study sought to identify recurring themes in organizational incidents, develop a targeted training program, and assess its efficacy in augmenting patient safety knowledge among healthcare professionals. Employing a mixed-methods approach, the study encompassed a survey to evaluate the impact of organizational training on clinicians' patient safety knowledge, alongside a comprehensive review of incident reports, which identified seven common themes for improvement. The study proposed a model emphasizing seven focus areas for improving clinical care and preventing medical malpractice, stressing the importance of evidence-based practices and organizational learning. The resulting training program comprised 13 sessions attended by 141 staff members, including physicians, nurses, allied healthcare workers, and managers. Results indicated that 71% of participants concurred that a patient safety curriculum developed from organizational scenarios could enhance clinical care and reduce instances of medical negligence. Furthermore, the study underscored inadequate communication, insufficient documentation, and failure to escalate as primary contributors to patient safety events.

The analysis of organizational incidents and case reviews was found to significantly contribute to patient safety and care quality, offering valuable insights for improvement. To bolster safety frameworks and augment care quality, it is recommended to prioritize and invest in the identified focus areas. The study also suggests replicating the research in multiple organizations to enhance generalizability and develop more robust models for patient safety.

Introduction and Background

Since the release of the influential report "To Err is Human" in 1999 by the Institute of Medicine's Committee on Quality of Health Care in America, significant efforts have been directed towards identifying, analyzing, mitigating, and learning from healthcare errors to avert similar occurrences in the future [1].

Globally, much research has been done to understand the complex healthcare systems and address patient safety issues; however, the numbers are still astounding. A report published by Maria Clark reported around 250,000 deaths per year [2], while WHO reports that one in every 10 patients is harmed while receiving healthcare [3]. Therefore, there is a need for every healthcare organization and professional to take a closer look at their hospital incidents and learn from them [4].

It is often cited that "Unless we measure, we cannot improve." However, it is equally imperative to recognize that measuring without subsequent improvement yields no real value [5].

The objectives of this study were as follows

1. Conduct an analysis of recurring themes evident in recent organizational incidents, never-never cases, and case reviews.
2. Develop and execute a training program to share knowledge and assess its effectiveness in enhancing participants' comprehension and knowledge level on safety and quality.

Materials and Methods

Various research articles provide evidence that organizations can learn from their mistakes and from other organizations [6]. The research posits that the analysis of internal incidents and errors can profoundly impact an organization's learning and development, particularly when genuine efforts are exerted to identify Opportunities for Improvement (OFI).

The organization aimed to transition into a "learning organization" focused on deriving insights from internal challenges to improve its overall effectiveness [2, 4, 7]. As per the Agency for Healthcare Research and Quality (AHRQ), 2019, a "learning health system" is described as a health system that methodically incorporates internal data and experiences with external evidence and then applies that knowledge in practice [8].

This study significantly utilized the mixed method methodology, and, in this concern, a survey was conducted to understand whether organizational curriculum on the focus areas will improve the knowledge and understanding of patient safety among clinicians. We reviewed Internal organizational reported incidents, errors, near misses, and never-events from 2021-2023. Based on an analysis of 263 incident reports, they categorized the learning areas into common themes, identifying seven common themes for improvement.

1. Practicing good medicine.
2. Maintain effective communication.
3. Set clear patient/family expectations.
4. Maintain good, and contemporaneous documentation.
5. Seek help from peers and colleagues immediately when needed (Escalation).
6. Making timely decisions (avoid delay).
7. Understand limitations (self and organizational limitations).

The training plan was meticulously developed based on the seven previously mentioned themes. This training encompassed the entire clinical workforce, including physicians, nurses, allied healthcare workers, and healthcare managers. The inclusion of a wider range of healthcare professionals was crucial in creating an environment where all members of the healthcare teams, regardless of their roles, understood the risks and engaged in a collaborative learning journey.

The training was rolled out in phases to cover as many staff as possible. A total of 13 training sessions, which were attended by 141 Staff.

It is crucial to complete the feedback loop when developing a learning strategy. We sought to evaluate the training results, receive staff viewpoints, and the identify the need for additional improvements to the training procedures in order to establish an ongoing learning loop that is driven by data, focused on practical application, and evidence-based [8, 9]. Hence, at the end of the training a

survey was sent to all the participants through email and asked to complete the survey within two days of attending the workshop.

Results

1. The study confirms that, as noted by Dickson and Tholl, leadership support is crucial for the successful implementation of any program within an organization. Facilities where hospital leadership participated in training alongside their staff and supported the agenda showed significantly higher attendance rates compared to facilities where leaders were not present in the training rooms [10].
2. Out of the 141 staff members who participated in the training, 114 completed the survey forms. Among the survey respondents, 86.84% were licensed care providers, consisting of General and Specialist physicians, nurses, allied staff, and other licensed professionals. The remaining, approximately 13%, were administrative staff members engaged in direct or indirect patient care duties.
3. Seventy-one percent (71%) of the participants agreed that a patient safety curriculum based on locally curated real-life situations for practicing clinicians will improve clinical care and reduce potential medical negligence cases. Only 2.6% answered "no," while 26.3% indicated that such programs are likely to improve clinical care.
4. The staff rated inadequate communication, insufficient documentation, and failure to escalate as the top three reasons which may lead to patient safety events and, in turn, cause medico-legal issues. The feedback also aligns with the information.

Discussion

From the era of Hippocrates, the emphasis on practicing safe medicine has been paramount. It is widely acknowledged that the exact phrase "First do no harm" (Latin: Primum non nocere), an integral part of the Hippocratic Oath, is also a fundamental aspect of practicing safe medicine.

The statement, "we collect too much and do too little" holds good even in today's modern health systems [5]. In recent decades, there has been a continual rise in medical negligence cases. The Medical Defense Union (MDU) reported a 12% increase in the number of doctors facing medicolegal claims in 2012. Clinical Practice Guidelines are gaining traction for bedside care delivery, and regulatory bodies and medical organizations such as the National Institute for Health and Care Excellence (NICE) have significantly contributed to their popularity by recommending evidence-based care for routine clinical decisions.

The authors have formulated a model delineating seven focus areas for improving clinical care and for mitigating medical malpractice cases, drawing from extensive professional experience and case analyses. These seven areas, listed in this article's materials and methods section, were denoted as fundamental focus areas for addressing patient safety and medical malpractice instances. Practicing good medicine becomes the central focus of the model, which is a core area of good clinical care.

Post-training, the attending clinicians were requested to provide their feedback through a survey, and responses were collected. Based on the proposed model, the responses are categorized under each of the seven key areas for the purposes of this article.

Each of the seven focus areas are detailed below

Focus area 1: Practice Good Medicine

The primary focus emphasized in the model is the significance of upholding high standards in medical practice. This involves healthcare professionals embracing evidence-based approaches, adhering to clinical protocols, and placing a strong emphasis on patient safety. By upholding these principles, healthcare providers can mitigate the likelihood of errors and adverse events, ultimately enhancing patient outcomes. The principles of sound medical practice are fundamentally different from those of defensive medicine [11, 12]. In fact, they directly oppose the defensive mindset. Healthcare professionals are trained to prioritize patient safety, save lives, and treat illnesses comprehensively, drawing on their clinical expertise, resources, and skills for the benefit of their patients. Research suggests that defensive medicine can lead to increased cost of healthcare delivery with low value [11].

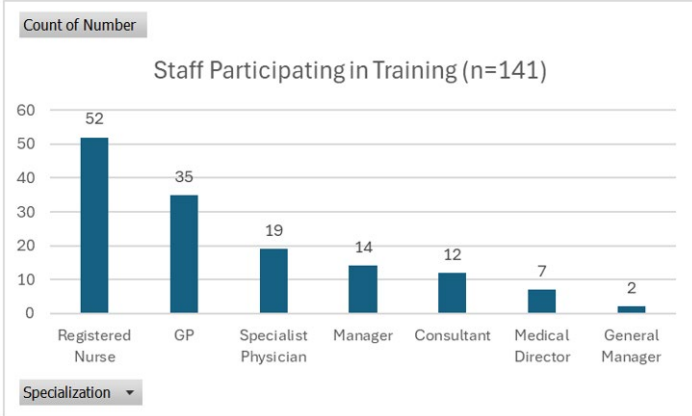

Table 1: Participation of staff.

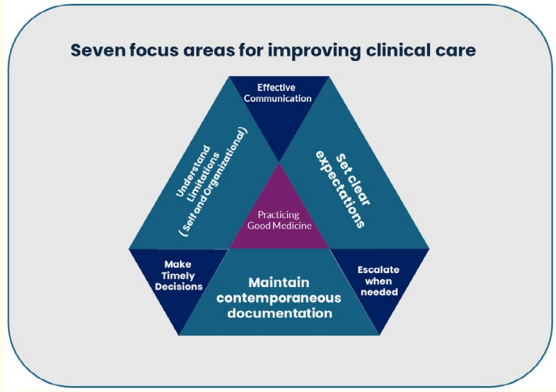

Figure 1: Seven focus areas for improving clinical care.

Upon review, it was found that 32% of cases demonstrated good clinical practice as the primary focus area. Good clinical practice encompasses the application of evidence-based medicine, the appropriate use of resources for diagnosis and treatment, and the holistic treatment of the patient rather than solely addressing the disease.

In addition, post-training feedback, which focused on the likelihood of safety issues and medical errors for clinicians not practicing evidence-based medicine, revealed a diverse distribution of responses. Of the respondents, 32% expressed a high likelihood of errors, with 13% perceiving it as very high. These findings underscore the comprehensive understanding expressed by respondents about potential issues arising when clinicians deviate from evidence-based practices.

Focus area 2: Maintaining effective communication

Poor communication has a tremendous impact cost of care and is one of the leading causes of sentinel events, poor care and outcomes [13]. Effective communication is crucial in healthcare settings to ensure seamless coordination of care and patient safety [12, 13]. The research highlighted that upholding proficient communication is crucial in preventing incidents and errors, accounting for 66.6 % of occurrences [12]. Clear and open communication among healthcare team members, patients, and their families can help prevent misunderstandings, errors, and omissions in care. Effective communication also Is a key element of good teamwork that reduces

medical errors and mistakes [13, 14]. Communication includes both between care providers and between care providers and patients. A breakdown in any of the two can lead to deficient care or potential for medico-legal claims. Douglas et al, 2021, claim almost 43% of the litigations in "Anesthesia" arise from communication failures [15].

The feedback survey revealed that 47% of participants identified poor communication as the primary factor contributing to medical negligence, with an additional 30% rating it as highly significant.

Focus area 3: Setting Clear Patient/Family Expectations

Ensuring clear expectations for patients and their families is paramount in delivering patient-centered care and averting misunderstandings. While establishing clear expectations is an essential component of effective communication, it demands heightened emphasis in the context of medico-legal claims, particularly in disciplines such as dermatology, plastic surgery, and dentistry. When patients have a precise understanding of their prognosis, treatment plan, medications, and projected outcomes, they are more likely to actively engage in their care and adhere to recommendations [16].

Healthcare providers should take the time to explain procedures, risks, and potential complications to patients in a clear and understandable manner [15, 16]. By involving patients in decision-making and setting realistic expectations, healthcare professionals can build trust, improve adherence to treatment plans, and reduce the likelihood of errors [15-17].

An important aspect of setting patient expectations is medical consent [18]. Deficient informed consent can be subjected to legal trials and may be considered a battery in the legal arena [17-20]. In our review, sixty-three (63%) cases (n-168) reviewed indicated patient and family expectation setting as an area for improvement.

Focus areas 4: Maintaining Clear, Contemporaneous Documentation

In addition to protection against lawsuits, accurate and timely documentation is critical in healthcare for maintaining continuity of care, tracking patient progress, and identifying areas for improvement [20, 21]. The study emphasized the importance of maintaining clear, contemporaneous documentation as a key theme in learning from reported incidents. A staggering 83% (n-220) cases reviewed indicated documentation as a focus area for improvement.

By documenting patient assessments, interventions, and outcomes accurately, healthcare providers can ensure that important information is accessible to all care team members. Clear documentation also facilitates communication among healthcare professionals and reduces the risk of errors due to incomplete or inaccurate information [13, 21, 22].

The chart showed that not undertaking detailed contemporaneous documentation is the primary reason that physicians are exposed to medical negligence cases. Of the participants, 70% indicated that poor documentation is the prime reason for medico-legal negligence suits.

Focus area 5: Escalate when needed (Seeking Help from Peers and Colleagues)

In healthcare, collaboration and teamwork are essential for providing safe and effective care to patients. Communication failures can lead to serious harm in healthcare [21, 23]. The study identified escalating care and seeking help from peers and colleagues as critical themes, with over 43% (n-116) of cases identified as opportunities for improvement in preventing errors and adverse events. Barriers like professional silos, as well as organizational bottlenecks such as dispersed teams, can heighten the risk of communication breakdowns, leading to potential harm to patients [23, 24]. High-reliable organizations focus on empowering professionals to seek assistance when faced with challenging situations or unfamiliar circumstances [25, 26].

By consulting with colleagues, sharing knowledge and expertise, and seeking second opinions, healthcare providers can enhance patient safety and prevent errors when necessary [23]. A culture that encourages open communication and collaboration fosters a supportive environment where healthcare professionals can learn from each other and improve patient care [25, 26].

Focus area 6: Making Timely Decisions

Timely decision-making is paramount in healthcare to address urgent situations, prevent complications, and optimize patient outcomes [27]. Timely diagnosis and treatment can enhance treatment options and also patient experience [27]. The study highlighted making timely decisions as a key theme in reducing errors and improving patient safety. Delays in decision-making can have serious consequences for patients and may lead to adverse events [24, 27].

Healthcare providers should be equipped to make quick and informed decisions based on the best available evidence and clinical judgment. By prioritizing timely decision-making, healthcare professionals can respond promptly to changes in patient status, unexpected events, and critical situations, ultimately enhancing the quality of care provided.

The study revealed that around 46% of cases (n-124) indicated timely decision-making as an opportunity for improvement.

Focus area 7: Understanding Limitations

Understanding personal and organizational limitations is paramount for healthcare professionals in providing safe and efficient care. There is a paucity of research emphasizing the necessity for physicians to comprehend and acknowledge the boundaries of their practice. Often, these limitations are interrelated with institutional resources. The study emphasized the appreciation of limitations in 45% (n-119) of cases as a key factor in preventing incidents and errors. Healthcare providers must be cognizant of their own competencies, areas of insufficient knowledge, and opportunities for enhancement.

Acknowledging their limitations, healthcare professionals can proactively pursue further training, acquire additional resources, or bolster their skills and competencies. Organizational policies and procedures must be designed to facilitate healthcare providers' identification and remedying of limitations, thereby ensuring the provision of high-quality care and safeguarding patient safety.

The analysis revealed that approximately 71% of training participants believe that learning from organizational case reviews has the potential to enhance clinical safety and address medical-related issues. This suggests that such measures could help mitigate the unique challenges present in healthcare practices.

Conclusion

In summary, the examination of organizational incidents and case reviews significantly contributes to the advancement of patient safety and quality of care, as well as the defense of physicians against medicolegal risks. The analysis of recurring themes in healthcare incidents offers valuable insights into areas necessitating improvement and enables the development of strategies to bolster patient safety.

The extraction of insights from documented incidents and engagement in cooperative endeavors with colleagues are imperative for healthcare professionals. Their continuous pursuit of excellence in patient safety and the advancement of quality is vital. The author asserts that organizations can fortify a robust safety framework for their practitioners and enhance care by giving priority to and investing in the seven focal areas expounded upon in this publication. In addition, the organizational leadership should consider investing in processes aimed at transforming the organization into a learning entity. This can be achieved by effectively utilizing the available in-house data and implementing programs focused on quality improvement and safety.

Limitations

The study, conducted within a singular organization, provides valuable insights but lacks generalizability. Due to various factors, like regional differences, industry factors, and sample size, the findings may not be readily applicable to alternative organizations or regions.

Recommendations

To overcome these limitations and improve the generalizability of the findings, future research should replicate the study in multiple organizations. This will help ascertain the findings' robustness and applicability across diverse contexts, ultimately contributing to the development of more robust and widely applicable models and theories.

References

1. Greco PM. "To err is human". Ethics in orthodontics 147.2 (2015): 165.
2. Clark M. "Medical Error Statistics: When Healthcare Can Kill You" (2020).
3. WHO. "Patient Safety" (2019).
4. St. Pierre M, Hofinger G and Simon R. "Crisis Management in Acute Care Settings Human Factors and Team Psychology in a High-Stakes Environment. 3rd ed" (2016).
5. Leistikow I., et al. "Learning from incidents in healthcare: the journey, not the arrival, matters". BMJ Qual Saf 26.3 (2017): 252-6.
6. Edmondson AC. "Learning from failure in health care: frequent opportunities, pervasive barriers". Qual Saf Health Care 13.suppl_2 (2004): ii3-9.
7. Carman KL., et al. "Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies". Health Aff 32.2 (2013): 223-31.
8. AHRQ. "About Learning Health Systems" (2019). [Internet].
9. Sirio CA., et al. "Shared Learning and the Drive to Improve Patient Safety: Lessons Learned from the Pittsburgh Regional Healthcare Initiative". Advances in Patient Safety: From Research to Implementation (Volume 3: Implementation Issues). Rockville (MD): Agency for Healthcare Research and Quality (US) (2005).
10. Dickson G and Tholl B. "Bringing Leadership to Life in Health: LEADS in a Caring Environment". London: Springer London (2014).
11. Berlin L. "Medical errors, malpractice, and defensive medicine: an ill-fated triad". Diagnosis 4.3 (2017): 133-9.
12. Sekhar Ms and Vyas N. "Defensive medicine: A bane to healthcare". Ann Med Health Sci Res 3.2 (2013): 295-6.
13. JCI. "The Joint Commission Sentinel Event Data 2023 Annual Review" (2024).
14. Costello M, Rusell K and Coventry T. "Examining the average scores of nursing teamwork subscales in an acute private medical ward". BMC Nurs 20.1 (2021): 84.
15. Douglas RN., et al. "Communication failures contributing to patient injury in anaesthesia malpractice claims". Br J Anaesth 127.3 (2021): 470-8.
16. Boyd JB., et al. "Plastic Surgery and the Malpractice Industry". Plast Reconstr Surg 147.1 (2021): 239-47.
17. Boyll P., et al. "Variables That Impact Medical Malpractice Claims Involving Plastic Surgeons in the United States". Aesthet Surg J 38.7 (2018): 785-92.
18. Cocanour CS. "Informed consent—It's more than a signature on a piece of paper". The American Journal of Surgery 214.6 (2017): 993-7.
19. Klimczak AM., et al. "Medicolegal Review: Essure Lawsuits and Legal Strategies Adverse to Gynecologists". J Minim Invasive Gynecol 24.5 (2017): 727-30.
20. Torres A., et al. "Medicolegal issues". Clin Dermatol 34.1 (2016): 106-10.
21. Raveesh B, Nayak R and Kumbar S. "Preventing medico-legal issues in clinical practice". Ann Indian Acad Neurol 19.5 (2016): S15-S20.
22. Humphrey KE., et al. "Frequency and Nature of Communication and Handoff Failures in Medical Malpractice Claims". J Patient Saf 18.2 (2022): 130-7.
23. Weller J, Boyd M and Cumin D. "Teams, tribes and patient safety: overcoming barriers to effective teamwork in healthcare". Postgrad Med J 90.1061 (2014): 149-54.
24. Leonard M. "The human factor: the critical importance of effective teamwork and communication in providing safe care". Qual Saf Health Care 13.suppl_1 (2004): i85-90.

25. Sutcliffe KM. "High reliability organizations (HROs)". Best Pract Res Clin Anaesthesiol 25.2 (2011): 133-44.
26. Cynthia A Oster and Jane S Braaten. "High reliability organizations: A healthcare handbook for patient safety & quality 2nd ed" (2021).
27. Woods B., et al. "Timely diagnosis of dementia? Family carers' experiences in 5 European countries". Int J Geriatr Psychiatry 34.1 (2019): 114-21.