Shared health Soins communs Manitoba

Widening our Views of Healthcare Harm

Safety Huddle Tool

Everyone contributes to patient safety and together we can learn and act to create safer care. This year we are encouraging teams to start thinking and talking about different types of healthcare harm.

We hope this huddle tool will help you host safety conversations and broaden the discussion of the types of harm patients/clients and their care-providers experience when receiving health care services.

Open the discussion with staff by making them aware that if anything discussed during today's huddle is upsetting to them, to connect with you after the huddle so you can discuss resources available to them.

In your huddle ask one of more of the following questions, (or have a poster/cards up on the wall for staff to write their thoughts):

What comes to mind when you think of Healthcare Harm?

- **Culturally Unsafe Care –** example, belittling or disrespecting different belief/cultural system
- **Moral Distress –** example, working conditions that prevent delivering high quality of care
- **Harm at transitions of care –** example, med changes not communicated to patient, not confirming they can follow discharge instructions
- **Over, Under, or Incorrect treatment –** example, wrong type/delayed/overuse of antibiotics
- **Dehumanization –** example calling a patient by their disease
- **Delayed, Missed or Incorrect Diagnosis –** example, misplaced biopsy results
- **Treatment specific and general healthcare harm –** example, falls, medication error
- **Other –** what other forms of harm come to mind? Example – financial or psychological harm

What is one action our team could take to reduce one of these kinds of harm?

All forms of harm matter and by discussing them, it helps to identify and broaden our understanding of harm and its impact on patients/clients, their families and us!

The person who experienced harm is often best positioned to define it and describe its impact on their life (HEC, 2024).

Here are some additional reflection questions:

Are we safe, or just lucky?

How do we invite patients/clients/care providers and families to partner with us in their safety?

How can action on health inequities help to improve patient safety? *Health inequities are inequalities in health that are unfair or unjust, and can be changed. Which underserved groups might be most impacted by patient safety issues in your work environment? What action could we take?*

How do we identify and understand new or emerging safety issues?

Huddle tool adapted from Healthcare Excellence Canada, for full resources on the webpage