PATIENT SAFETY

Five years after the groundbreaking report *To Err is Human* was released by the Institute of Medicine (IoM), the Commonwealth Fund has highlighted the continued need to improve patient safety in a series of articles released in August 2005.[1] Patient safety in hospitals has improved little in the five years since the IoM report, according to the articles. The initial IoM report found that 44,000-98,000 unnecessary deaths per year were caused by human mistakes such as medication errors, wrong-site surgeries, incorrect patient identification, and the transmission of infection from staff to patients.[2] In the follow-up articles, doctors, researchers and advocates highlight changes catalyzed by *To Err Is Human*, and show that many challenges remain:

PROGRESS

- Patient safety and human error has become a central concern for many hospitals.
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (www.jcaho.org) includes patient safety measures as a part of its accreditation process. Information is available at http://www.jcipatientsafety.org/, including JCAHO's 2005 Hospital Patient Safety goals.
- Residents are required to work a shorter number of hours in an effort to reduce fatigue, a factor that often contributes to human error.

PROBLEMS

- The culture of medicine still places blame on individuals, rather than on faulty systems that do not incorporate redundancies to help reduce human error. This often leads to reluctance to fully disclose errors, which could help others learn from past mistakes. Concerns of malpractice liability often heighten these problems.

[1] David, Karen and Lucian L. Leape. "To Err is Human; to Fail to Improve is Unconscionable." The Commonwealth Fund. August 2005. Available at http://www.cmwf.org/aboutus/aboutus_show.htm?doc_id=287032; Leape, Lucian and Donald Berwick. "Five Years After *To Err Is Human*: What Have We Learned?" The Commonwealth Fund *In the Litterature*. May 2005; Wachter, Robert M. "The End of the Beginning: Patient Safety Five Years After 'To Err Is Human'." *Health Affairs Web Exclusive*. 30 November 2004.

[2] Patient safety is one of several aspects of quality health care. More information about the IoM report, patient safety, quality standards and reporting, and payment systems is available on our Quality of Care (link to http://www.medicareadvocacy.org/FAQ_QualityOfCare.htm#quality%20chasm) page.

- Though more hospitals are collecting data on errors, many are not using this information to review systemic problems and create new protocols. Simply reporting data does not mean that safety is improving.
- Reimbursement systems pay for care based on quantity of services, even if those services are needed because of medical errors. Refusing to pay may be an incentive for hospitals to implement better safety practices.
- Many hospitals do not use electronic records, which have built in systems to help doctors catch errors such as incorrect medications.
- Care teams often are not trained on safety concerns related to multiple providers treating one patient.
- There is no "business case" for safety. Regulation and payment systems may be the catalyst that forces safety improvement to become financially attractive to hospitals in order for change to take place.

Though patient safety often focuses on the care providers, patients too can take affirmative steps to assure they are receiving safe, quality care. JCAHO's Speak Up™ (http://www.jcaho.org/general+public/gp+speak+up/speak+up.htm) campaign educates patients on their role in assuring the care they receive is safe. Safety is especially important for Medicare beneficiaries, who often have multiple, complex conditions that require close monitoring, and who may have multiple physicians and specialists whose care instructions must be coordinated.

Resources: In April 2005 the Agency for Healthcare Research and Quality (AHRQ) launched the Patient Safety Network, a website with patient safety resources, available at http://psnet.ahrq.gov. AHRQ also maintains Morbidity and Mortality Rounds on the Web, a site where physicians can anonymously report and discuss medical errors, available at http://www.webmm.ahrq.gov/. The National Committee for Quality Assurance has also made efforts to incorporate patient safety into its health plan accreditation standards (link to http://www.ncqa.org/Programs/Accreditation/MCO/mcostdsoverview.htm).