Patient Safety in 2005: *The End of the Beginning*

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A National Patient Safety Resource

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A continuously updated, annotated, and carefully selected collection of patient safety news, literature, tools, and resources.

What's New This Week

05/25/05

View More of What's New

Legislation/Regulations

21st Century Health Information Act of 2005.
H.R.2234, 109th Cong., 1st Sess. (2005).

Prohibition of Excessive Overtime for Nurses Act.
The General Assembly of Pennsylvania. HB957 (2005).

Books/Reports

Health Information Technology Leadership Panel: Final Report.
Falls Church, VA: The Lewin Group, Inc.; 2005.

Journal Articles

High rates of adverse drug events in a highly computerized hospital.
Nebeker JR, Hoffman JM, Weir CR, Bennett CL, Hurdle JF. Arch Intern Med. 2005;165:1111-1116.

Surgical skill is predicted by the ability to detect errors.
Bann S, Khan M, Datta V, Darzi A. Am J Surg. 2005;189:412-415.

Adherence to simple and effective measures reduces the incidence of ventilator-associated pneumonia: [L'observation de mesures simples et efficaces reduit l'incidence de pneumonie associee a la ventilation mecanique].
Baxter AD, Allan J, Bedard J, et al. Can J Anaesth. 2005;52:535-541.

The investigation and analysis of critical incidents and adverse events in healthcare.
Woloshynowych M, Rogers S, Taylor-Adams S, Vincent C. Health Technol Assess. May 2005;9:1-158.

Building a framework for trust: critical event analysis of deaths in surgical care.
Thompson AM, Stonebridge PA. BMJ. 2005;330:1139-1142.

Browse the Collection

Browse by Resource Type

Journal articles, Books and reports, Tools and toolkits, Upcoming meetings, **More...**

Browse by Subject

Safety Target
Medication errors, Diagnostic errors, Nosocomial infections, Post-operative surgical complications, **More...**

Approach to Improving Safety
Human factors engineering, Error reporting, Teamwork training, Culture of safety, Nurse staffing ratios, Regulation, **More...**

Error Types
Cognitive errors ("mistakes"), Non-cognitive errors ("slips & lapses"), Latent errors, **More...**

Clinical Area
Anesthesiology, Emergency medicine, Critical care nursing, Community pharmacy, **More...**

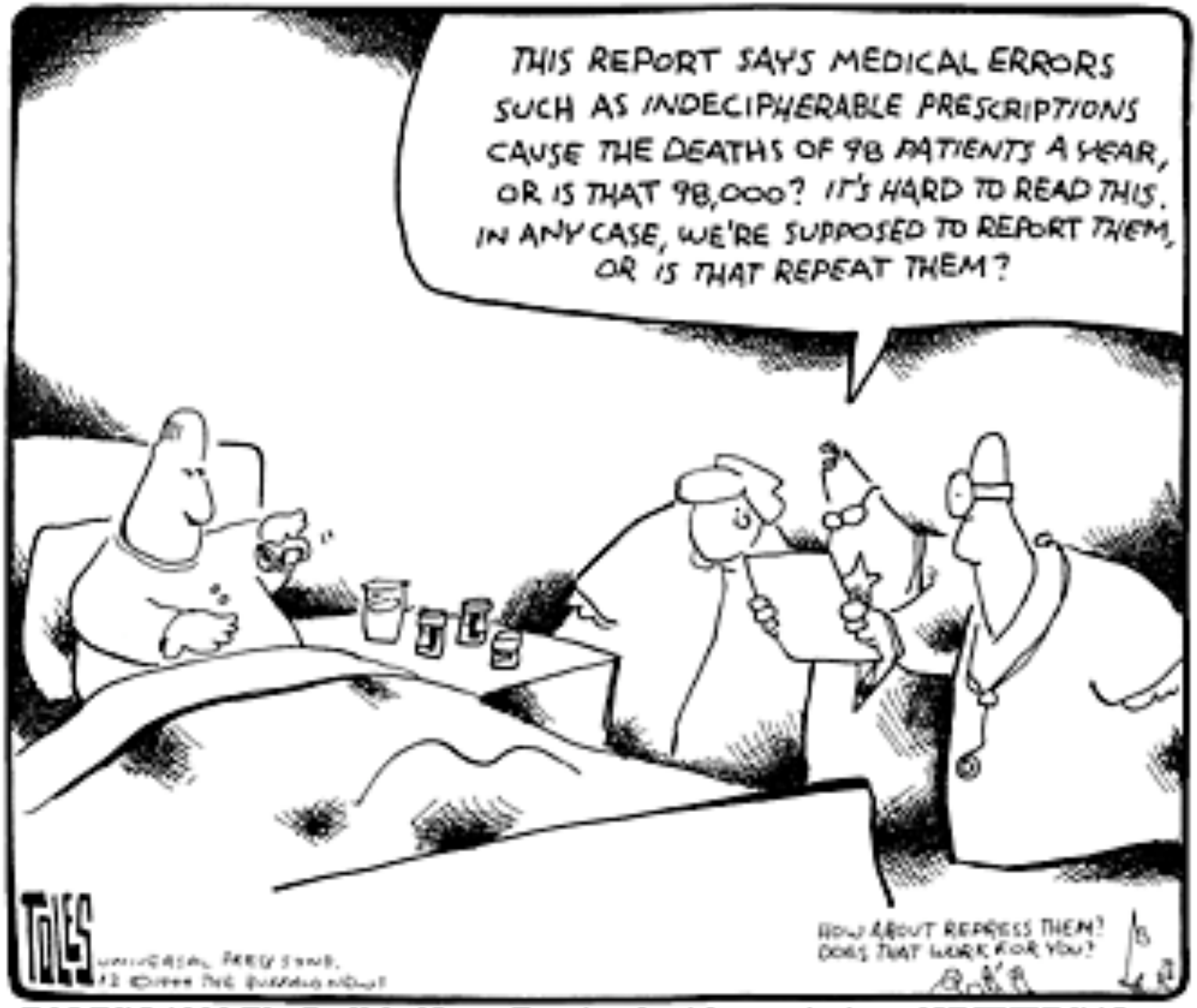
Target Audience
Physicians, Nurses, Risk managers, Educators, Policymakers, **More...**

Setting of Care
Intensive care units, Operating room, Children's hospitals, Ambulatory clinic or office, Residential facilities, **More...**

Patient Safety *CLASSICS*

The most influential, frequently cited articles, books, and resources in patient safety. View *CLASSICS*

"The IOM Report"
December, 1999



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How Did Health Care Become So Unsafe?

Medical Progress Over Half a Century

Problem Goes Beyond Complexity

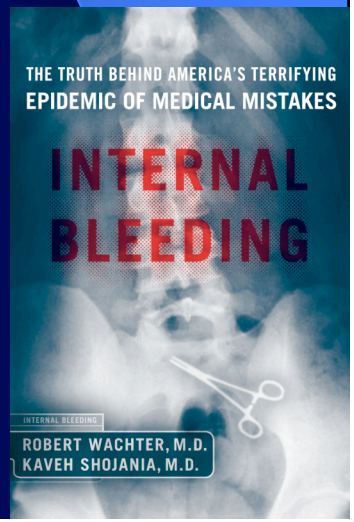
- A flawed mental model
- The bizarre organizational dichotomy of American medicine
- The absence of an incentive system
  - Business, academic, marketing… anything

Predictors of robust safety commitment:

- *MDs and organization are unified (VA, KP) or*
- *You've made it to 60 Minutes or the NY Times (Hopkins, Duke, Dana Farber)*

…our cases are less horror stories of malfeasance or incompetence than cautionary tales about misguided priorities, mixed signals, and mass denial. From Congressional decisions about what kinds of research to fund, to choices by hospitals about where to focus their attention and dollars, to judgments by medical and nursing schools about how to train the healers of tomorrow--safety has always been an afterthought. It is the problem you tackled after all the high-tech, profitable and sexy stuff was taken care of (which, of course, it never was)…

… We all know that [we] maim and kill the patients we aim to heal with shocking regularity, but our profession has reacted to this knowledge mostly with a collective shrug of its shoulders. We have become inured to and paralyzed by it, coming to think of medical errors as the unavoidable collateral damage of a heroic, high-tech war we otherwise seem to be winning. It's as if we spent the last 30 years building a really souped-up sports car, but barely a dime or a moment making sure it has bumpers, seat belts, and airbags.



What Has Worked?

- Regulations
- Reporting Systems
- Teamwork Training and Simulation
- Clinical Information Technology
- Malpractice and Other Venues for Accountability
- Workforce Issues

Regulations: A-

- Why regulation?
  - "Let me read your order back to you…"
  - Sign your site: "X" marks the spot
  - The pilots in the OR
- JCAHO gets real
- But will probably run out of gas
  - Awfully hard to regulate culture
  - Regulation often oversteps

Reporting Systems: C

- Flawed notion that reporting has any intrinsic value
  - Create stories
  - Generate action
  - A feedback loop
- Huge opportunity to waste time, money, and promote wrong paradigm
  - "We could stop reporting tomorrow…"
- Some successes

WebMM.ahrq.gov

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web M&M

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Cases & Commentaries: MAY 2005

Emergency Medicine

Mistaken Impressions

SPOTLIGHT CASE
Using past WebM&M cases, the authors discuss the challenges inherent in classifying diagnostic mistakes as medical errors.

Commentary by **Robert McNutt, MD; Richard Abrams, MD; Scott Hasler, MD**

CME/CEU available

Medicine

Discharge AMA

A man admitted with alcoholic dementia and a broken upper arm refuses surgery and decides to leave the hospital in the middle of the night.

Commentary by **Stephen W. Hwang, MD, MPH**

Ob/Gyn

Pregnant with Danger

A woman who was 38 weeks pregnant came to the emergency department (ED) complaining of left leg pain. Ruled out for DVT, she was sent home, only to die the following morning.

Commentary by **Mark D. Pearlman, MD; Jeffrey S. Desmond, MD**

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Perspectives on Safety

View All

- **Organizational Change in the Face of Highly Public Errors—I. The Dana-Farber Cancer Institute Experience**
  by James B. Conway; Saul N. Weingart, MD, PhD
- **Organizational Change in the Face of Highly Public Errors—II. The Duke Experience**
  by Karen Frush, MD

Submit your Perspective

AHRQ PSNet Patient Safety Network

What's New: Proposed legislation would support implementation of Regional Health Information Organizations (RHIOs).

Visit AHRQ PSNet for more patient safety news and information

Did You Know?

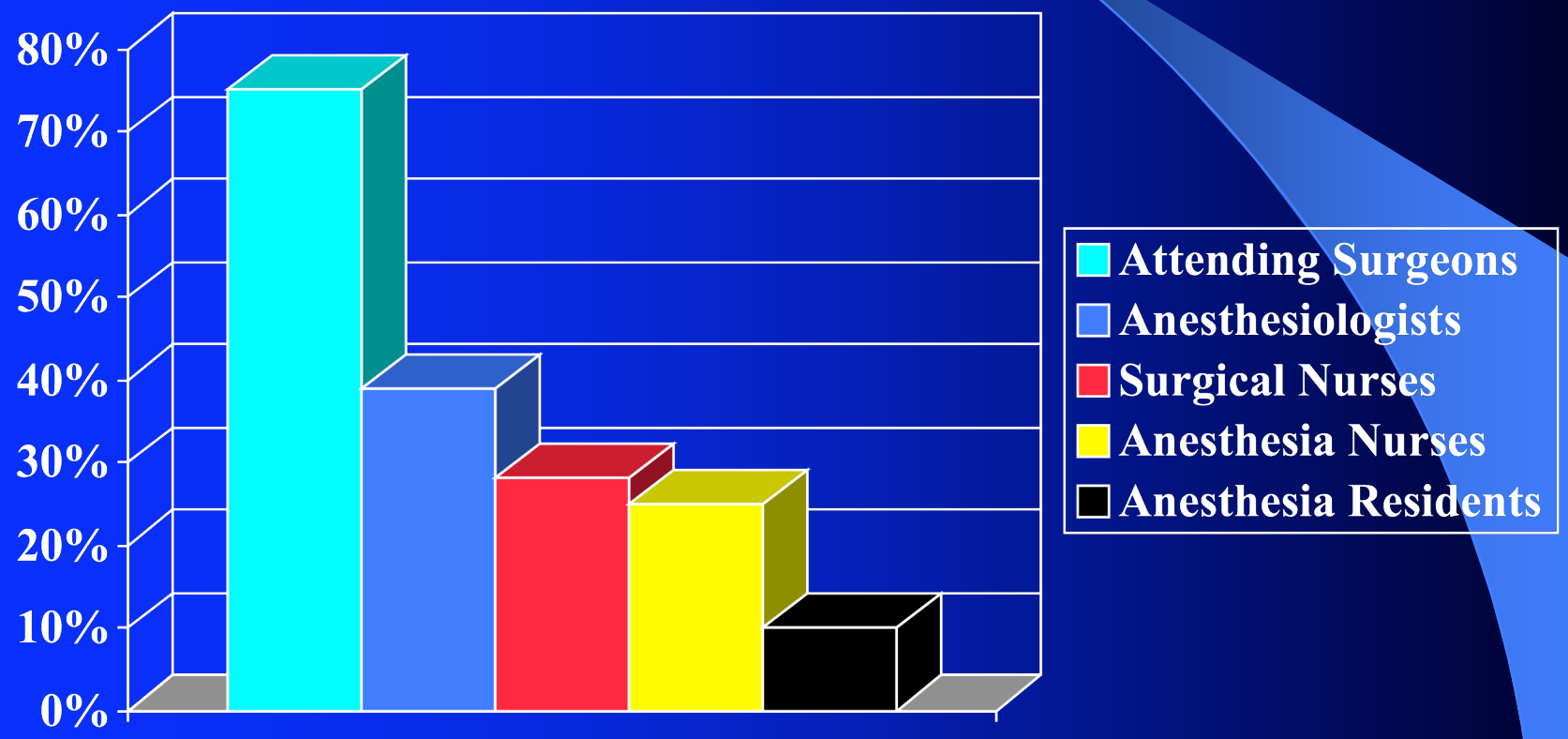
Some hospitals asking patients to remove or cover rubber wristbands

As some hospitals have turned to color-coded wristbands to indicate their patients' resuscitation (DNR) status, patients with yellow wristbands may face a new safety hazard. In the past 2 years, nearly 30 million people have purchased Lance Armstrong **"LiveStrong"** rubber wristbands to support cancer research. Some

Teamwork Training & Simulation: C+

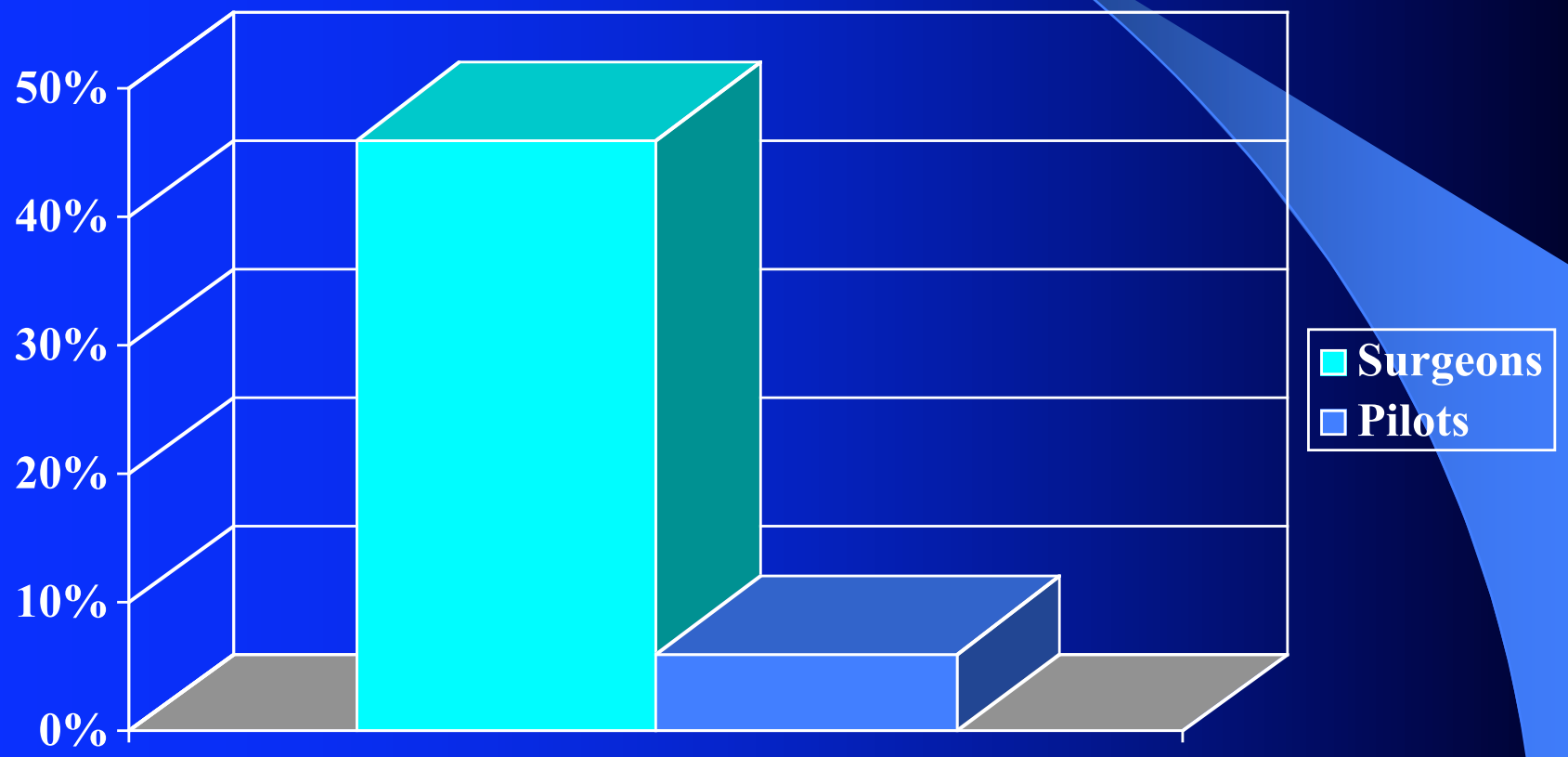
- Emerging evidence is hopeful
- Lots of targets
  - Improve procedures
  - Standardize communications
  - Dampen down hierarchies
- Where is the money?

Teamwork level felt to be "high"



Sexton, *British Medical Journal*, 2000

Believe that decisions of the "leader" should *not* be questioned



Sexton, BMJ, 2000

Clinical Information Technology: B-

- Benefits may be overstated, ?generalizable
- Costs far more than anybody budgets
  - Risk that it will consume every safety resource
- Expect "unforeseen" consequences
  - Cedars, BI-Deaconess are only the most prominent examples
  - Emerging literature re: problems

But in 2004 we passed the tipping point

The Malpractice System and Other Venues for Accountability: D

- Malpractice system: overrated impact on patient safety
  - It has plenty of baggage, but not the root cause of our safety problem
- Lack of accountability: a big problem
  - There are some bad doctors and nurses, notwithstanding "no blame" paradigm
  - Now, not just competence, but some ignore sensible safety rules

Three Fundamental Tensions

1. How to promote no blame culture for innocent slips or mistakes while holding persistent rule violators or incompetent providers accountable;
2. How to compensate patients for harm without necessarily invoking the heavy hand of tort law;
3. How to hold institutions accountable for allowing unsafe conditions without hammering them in the newspaper or the courts when they acknowledge their flaws.

I believe we have made essentially no progress grappling with these questions since 1999

Workforce Issues: B+

- New care models: hospitalists, intensivists
  - New roles for a "coordinative generalist"
  - Can primary care docs do this in the outpt. world?
- Nursing: connecting workforce issues with safety (with real data)
  - Need comparable data for physicians
- Graduate education: A new frontier
  - ACGME duty-hours limits important
  - Still not tackling the big issue…

The Right Stuff

"In fact, considerable attention had been given to a plan to anesthetize or tranquilize the astronauts, not to keep them from panicking but just to make sure they would lie there peacefully with their sensors on and not *do something* that would ruin the flight."

Tom Wolfe, *The Right Stuff*

Overall Grade: Patient Safety Five Years After the IOM Report

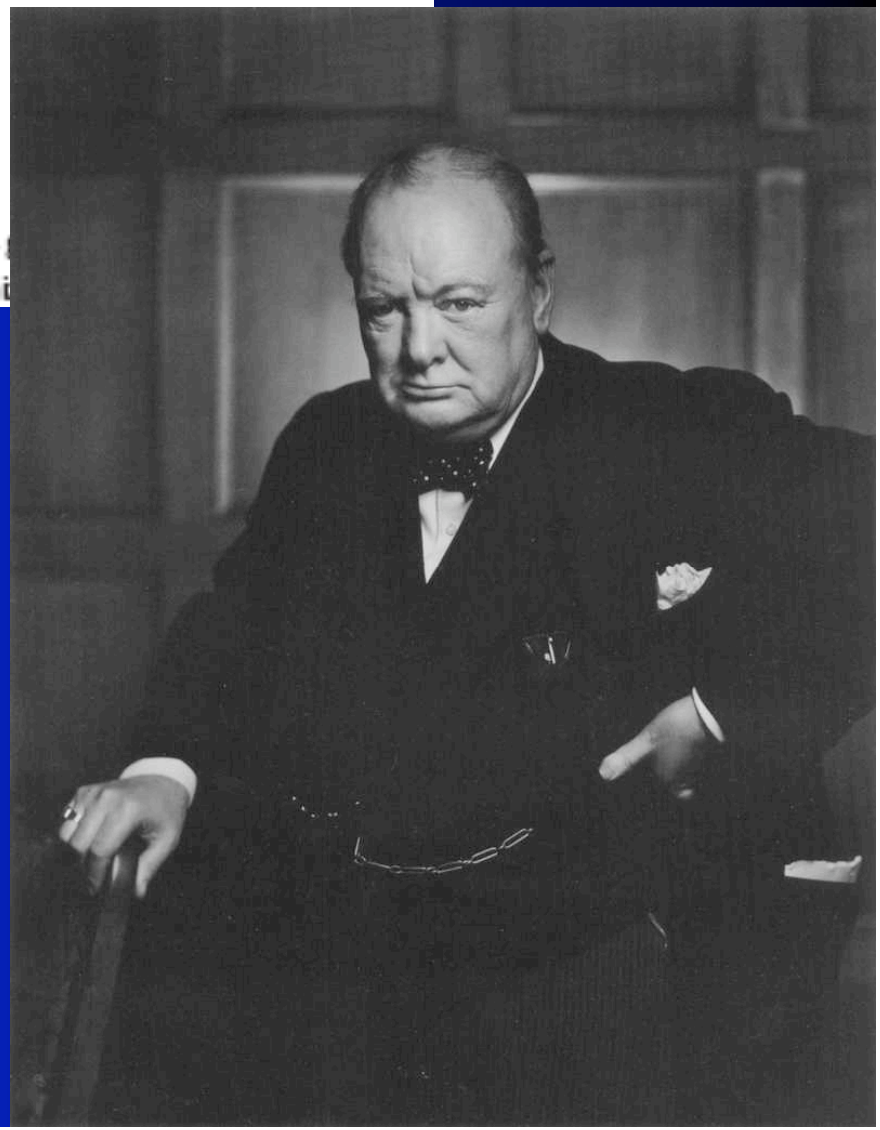
The End Of The Beginning: Patient Safety Five Years After 'To Err Is Human'

Amid signs of progress, there is still a long way to go.

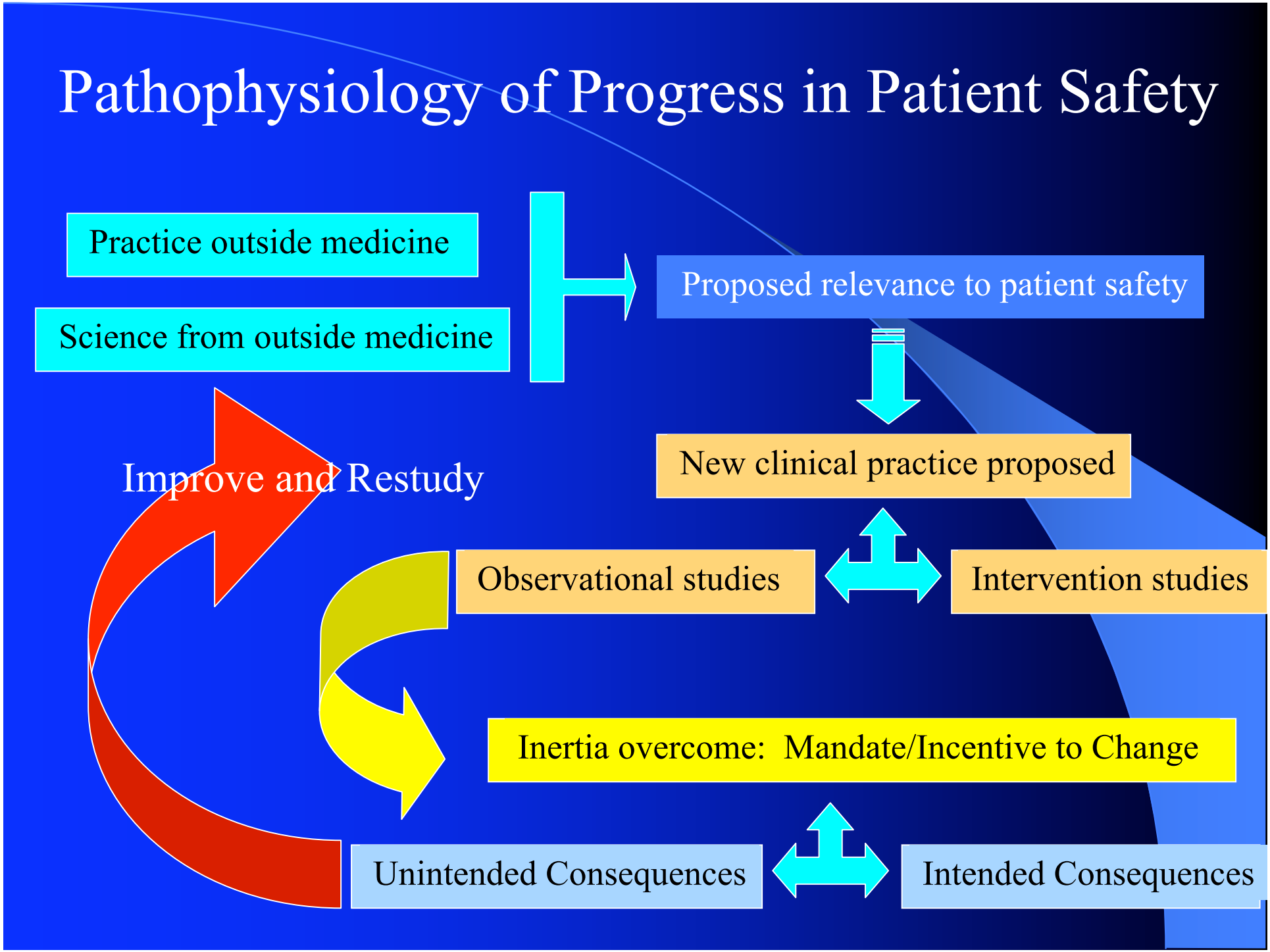
by Robert M. Wachter

ABSTRACT: The Institute of Medicine's 1999 report on medical errors
lic and health professionals. Before then, providers, health care organi

Health Affairs, November 2004



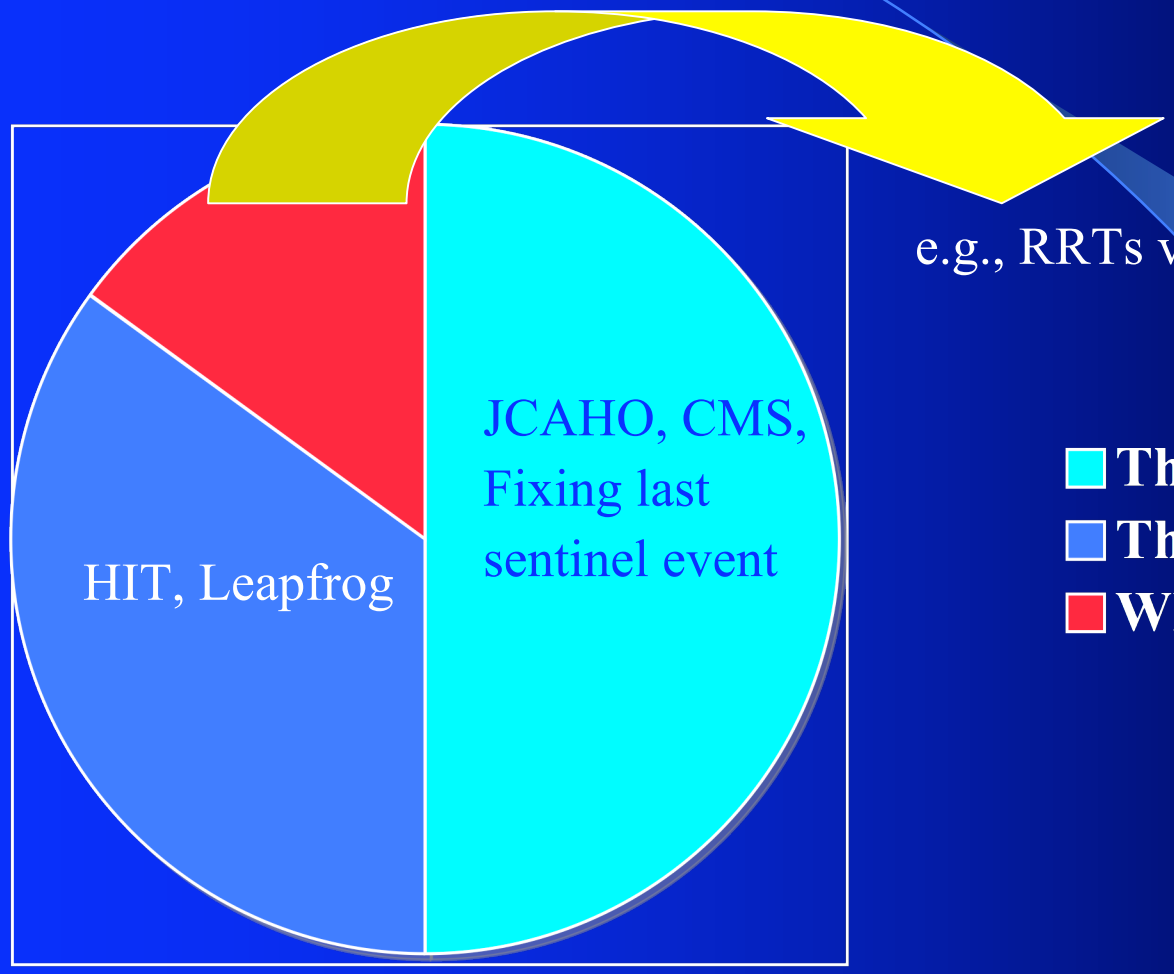
Pathophysiology of Progress in Patient Safety



A Brief Sampler

Ratios (e.g. class size)	Aiken, *JAMA,* 2002	CA legislation, other pressure
Fatigue (e.g. truck drivers)	Landrigan, *NEJM*, 2004	ACGME regs, more coming
EBM (clinical medicine)	AHRQ Evidence Rept 2001, NQF	Some JCAHO regs, 100K Lives
IT (everywhere but medicine)	Bates, *JAMA*, 1998 (& others)	Leapfrog, Proposed legis.
Crew Resource Mgmt (aviation)	Morey, *HSR*, 2002 (more soon)	Nothing yet, but just wait

The Safety Pie



e.g., RRTs vs. Teamwork Training

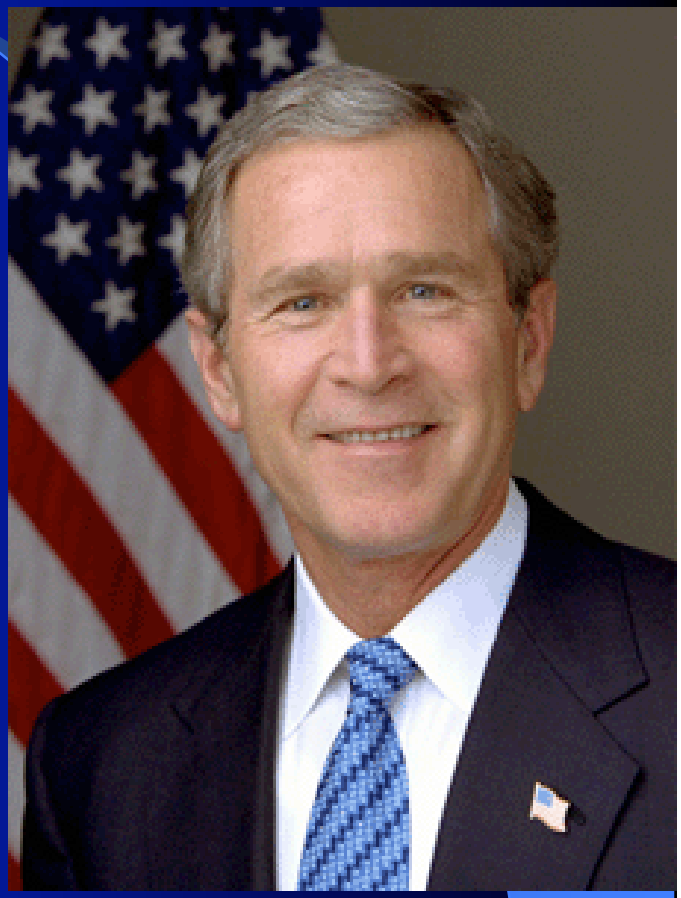
- That Ye Must Do
- That Ye Sorta Must Do
- What's Left

Pre-IOM Era

- Patient safety not in the vocabulary
- Little understanding of nature of problem
- Providers: Kubler-Ross stages I/II
- No business case for change
- No significant IT infrastructure
- Weak regulations and enforcement
- No research to inform decision-making

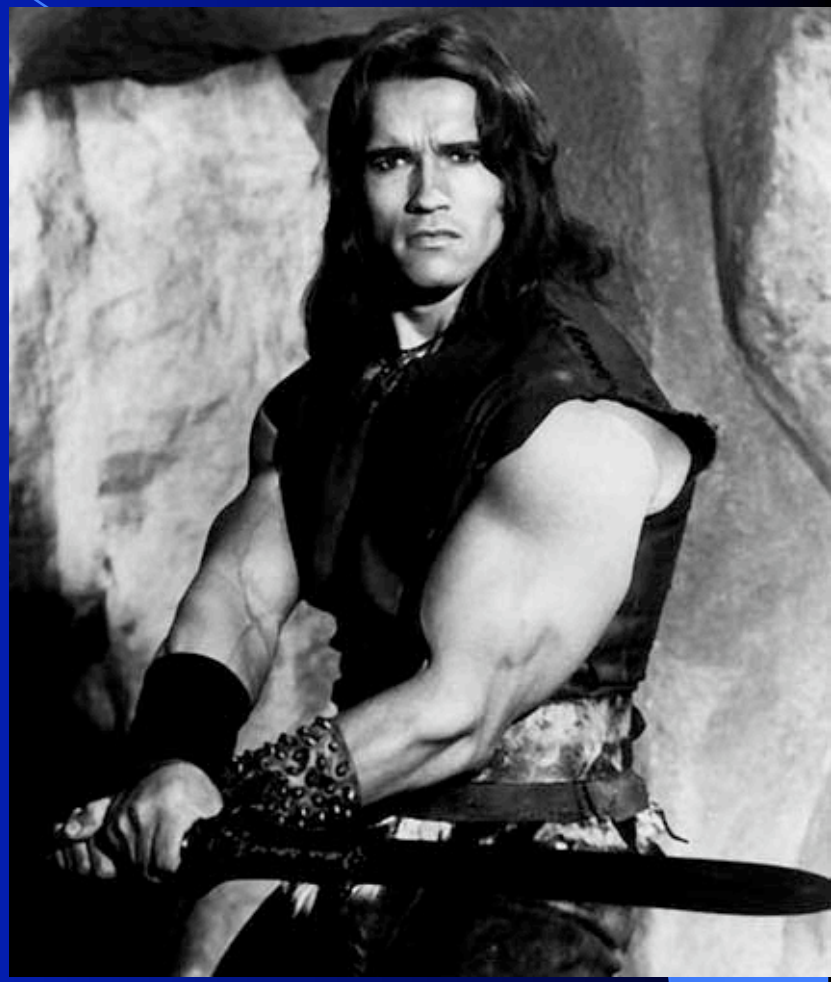
Patient Safety in 2005

- “Changed the conversation”
- Many “get” systems thinking
- Providers now at acceptance stage (mostly)
- Growing business case
- Early IT adoption, improving systems
- Much more robust regulation
- Impressive research progress



Patient Safety in 2010

- Core value of system
- Virtually everybody “gets it”
- Embedded in curriculum
- Moderately powerful business case
- IT a “must have”
- Regulation marches on
- Research continues to drive change



Lessons of the Post-IOM Era

- Pt. safety is too complicated for it to be "one thing"
  - Diverse research techniques/agenda
  - Diverse set of drivers of change
  - Nothing can work in isolation (e.g. IT and safety culture)
- Watch out for squeezed balloons
- Expect unexpected consequences
  - Workarounds, fudging, IT-induced glitches to be expected
- No point in doing the research unless it drives change
  - In practice, understanding, funding… something real