

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION

Institute of Medicine Releases Report on Patient Safety

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The Institute of Medicine (IOM) of the National Academy of Sciences has issued its long-awaited report, *To Err is Human: Building a Safer Health System* (National Academy Press, 1999). Its recommendations have far-reaching implications and represent an attempt "achieve a threshold of improvement" in the next 10 years. The patient safety report represents one of the IOM's focuses for its Quality of Healthcare in America Project.

While it is difficult to get the health care community to agree on the IOM report's numerous recommendations, it can be agreed that the report has brought increased national attention to issues surrounding patient safety. While the ramifications of the report are yet to be seen, the report has stimulated action in both the legislative and executive branches of the federal government, and has received sustained media coverage.

The IOM report has caused the US government to pay closer attention to issues surrounding patient safety. The Senate Committee on Health, Education, Labor, and Pensions, chaired by Sen. James Jeffords (R-Vt.), has held two hearings on medical errors. The first hearing, held on January 26, dealt specifically with the IOM Report's recommendations; the second hearing, on February 1, emphasized adverse drug events and medication errors. Experts from many facets of the health care disciplines were involved in the testimony.

In light of the IOM report, President Clinton has asked the federal Agency for Healthcare Research and Quality (AHRQ) to study the IOM's recommendations and to report back in February with their own recommendations on the need for legislation and the feasibility of instituting measures to increase patient safety.

The IOM report appropriately positions patient safety as a component of quality of care. Safety is one of three domains of quality, the others being:

- Practice consistent with current medical knowledge—the application of current knowledge, with evidence moderated as needed by professional judgment; and

- Customization, taking into account individual values, preferences and expectations.

A complementary approach to viewing quality is to categorize quality problems as overuse, underuse and misuse.

'The release of the IOM report has caused the US government to pay closer attention to issues surrounding patient safety!'

The report highlights the need for a comprehensive approach encompassing regulatory and market drivers and engaging both the public and private sectors. Roles for accreditation and certification agencies and groups, purchasers, health care professionals and organizations and consumers are clearly defined. The report describes a model for achieving and maintaining a safe environment by comparing the spectrum of external drivers against the domains of quality care. (See chart on page 2.)

It is important to place patient safety in the conceptual framework of quality before considering the IOM's specific recommendations for action. The recommendations are not self-implementing; public and private sector leadership and action will be required.

The report outlines five major goals, each with a set of recommendations:

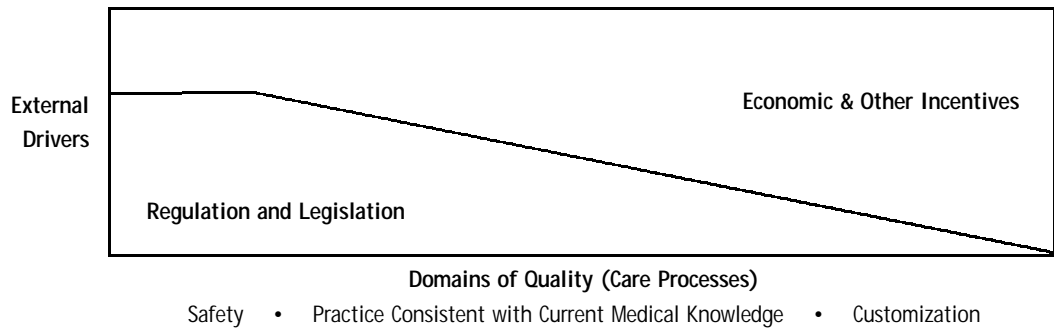
- Establish a national focus for leadership and knowledge.
- Identify and learn from errors.
- Pass legislation to protect a voluntary reporting system.
- Set performance standards and expectations for safety.
- Implement safety systems in health care organizations.

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To Err is Human is available as an Adobe Acrobat document at http://books.nap.edu/html/to_err_is_human.

The Influence of External Drivers on Quality



The report cites the need to establish a national focus for leadership and knowledge as a critical success factor, as did the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. That 1998 report, *Quality First—Better Health Care for All Americans*, not only identified the need for national leadership, but identified patient safety as one of six national goals. The vehicle for this national focus is to create a patient safety center at the AHRQ.

The report urged developing voluntary reporting efforts by designating a Center for Patient Safety to:

- Convene states to share information and expertise.
- Receive aggregate reports.
- Describe voluntary reporting efforts.
- Convene sponsors and users.
- Identify information gaps.
- Fund pilot projects.

Identifying and learning from errors can be accomplished by establishing mandatory and voluntary reporting systems integrated with creating an environment, culture and systems for learning. The scope, pros and cons and interrelationship are well summarized in the IOM effort. Also needed: appropriate protection from discovery and litigation through federal legislation.

'The IOM has once again provided a road map for dealing with a critically important issue. It is now up to organizations such as the NPSF and its affiliated groups to carry the ball!'

The report urges action by all stakeholders, including health care organizations and professionals purchasers, accreditors, professional associations and the FDA. It also highlights the importance of taking necessary steps to raise awareness, set professional and organizational performance standards and articulate expectations for achieving patient safety.

The IOM report also recommends setting performance standards and expectations for safety by:

- Requiring regulatory and accreditation organizations to require patient safety programs.
- Private and public purchasers providing incentives to health care organizations.
- Licensing bodies implementing re-examination and relicensure of professionals.
- Developing patient safety curricula.
- Disseminating information on patient safety.
- Incorporating into clinical practice guidelines (CPGs).
- Establishing community-based collaborative initiatives.
- Redesigning drug packaging and labeling.
- Modifying drug naming.
- Establishing post-marketing surveillance.

The report urges implementing safety systems in health care organizations, including an emphasis on proven medications' safe use. Specific recommendations include:

- Provide visible attention to safety.
- Implement non-punitive systems.
- Establish team-training programs.
- Incorporate well-understood safety principles.
- Implement proven medication safety practices.

The IOM has once again provided a road map for dealing with a critically important issue. It is now up to organizations such as the NPSF and its affiliated groups to carry the ball. There are few quick fixes. The road is long, but the goal of improved patient safety is achievable. **NPSF**

Medical Mishaps: Pieces of the Puzzle

EDITED BY MARILYN M. ROSENTHAL, LINDA MULCAHY AND SALLY LLOYD-BOSTOCK

REVIEWED BY DONI HAAS, RN, LHRM

book review

Medical education and culture impart a feeling of knowing everything, says *Medical Mishaps: Pieces of the Puzzle*. (Open University Press; 1999. ISBN 0-335-20258-6). Result: an environment where error must be hidden to preserve the revered culture and avoid admitting any possibility of less-than-perfect knowledge or performance.

Medical Mishaps offers a collection of error experiences and practitioners' responses—often remorse and self-flagellation—and sets the stage for examining error in a cultural context. The editors artfully use the insight of authors from many disciplines, some outside of medicine, to give the reader an illuminated picture of error—perhaps one even physicians can accept.

Part I focuses on mapping and understanding medical mishaps. Medical culture, according to editors Mulcahy and Rosenthal, needs to incorporate a deep commitment to authentic, lifelong learning and self-scrutiny in professional practice. Learning from mistakes must replace rationalization. An environment where doctors can be honest about their mistakes is a common thread in the reflections of the disciplines contributing to this insightful text.

This section includes Lucian Leape's 1994 classic *JAMA* article, "Error in Medicine," which still rings true. Leape contends that a high error rate may not be surprising considering the many interventions patients receive. As professionals internalize feelings of fear, guilt and humiliation and adjust their own practice to prevent a recurrence, they fail to share the lessons and contribute to profession-wide learning. Physicians and nurses have all experienced error; collectively the errors are buried in the suppressive memories of the individual. There is little, if any, attempt to hold error up to the light of day, enabling all who examine it to apply their unique perspective and brainstorm to achieve a global learning experience.

Vincent and Reason cite two case studies revealing the underlying causes of error. If the traditional blame culture changes to one examining causes of error beyond the control of an individual, then an emphasis on system failure will replace the traditional focus on human or individual error. The authors examine root-cause analysis of the

near-miss in detail to allow readers to appreciate professionals' ability to be more open and to participate in shared learning. This openness can expose unsafe systems or organizational precursors to near-misses before a serious incident occurs. System deficiencies can then be understood and changes implemented to enhance safety and reduce the chances of a real disaster. Airline and nuclear power studies lend their valuable insight here. However, human factor analysis—specifically, a basic active/latent failure analysis—must be streamlined to be useful in studying medical error.

Part II presents worldwide perspectives. The United Kingdom has several systems for error analysis, but no effective mechanism for learning from medical error, translating the learning into changes in clinical or organizational practice and achieving lasting quality improvements from the change. Noteworthy in the UK is the 40-year-old "confidential inquiries" process of confidential, anonymous reporting on maternal deaths. Reports from the data collected are published every three years as recommendations to the profession.

Confidential inquiries—for example, of surgical deaths within 30 days of operation—led to a reduction in the number of operations performed by UK junior doctors without supervision, as well as better control over surgeons and anesthesiologists with adult practices working on children. Risk management, introduced in the UK in the early '90s, has steadily become more formalized as litigation threats and the cost of medical error increase.

As in the States, medical negligence claims in the UK fall far short of the number that could be filed. Also, many claims arise from cases where there is absolutely no negligence. Many patients do not sue because they are not aware that they have suffered a preventable medical accident, because they are not strongly motivated to seek financial recompense due to a greater desire for an explanation, apology or assurance that such an incident will not happen again, or because they cannot afford the legal system. Notably unsatisfactory is the UK's availability of legal recourse to only the very poor, the very rich and the exceptionally motivated.

First Do No Harm CONTINUED FROM PAGE 5

book review

Learning from error can be implemented through openness and honesty about mishaps, increasing the trust and value of the patient-physician relationship.

Quality improvement offers a promising approach to avoiding medical mishaps. This, along with the culture changes under way, appears to foster partnership and collaboration across specialties, disciplines and sectors of care.

Disputes arising out of unpredictable outcomes require a comprehensive explanation addressing all of the patient's concerns. Proactive risk management efforts depend on understanding why and how the patient's expectations were not met, whether they might be satisfied in the future, or whether a better explanation may be offered to shape more realistic expectations. Patients need to feel that their concerns were heard and were fully considered—especially when they had a misunderstanding rather than an actual mishap. To reduce medical mishaps, all clinical services must adapt proactive risk management strategies. Learning from experience is important; otherwise, the same mistakes will continually be made.

Patients expect health care providers—as part of the caring process—to seek out and explain to patients and their families what has happened and why. Whether through the judiciary, through voluntary mediation or simply through honest compassionate communication, patients will continue to search for resolution. A good grievance procedure in the UK would provide resolution through comprehensive investigation, honest communication and, where appropriate, compensation. It could also identify ways to improve services and preserve relationships.

Health care professionals must learn to cope emotionally

with their own mistakes and those of their colleagues. This will require the culture of medicine to change, the mystique of the profession to disappear and the expectations of the public to be more realistic. Society should have more—not less—confidence in a doctor who admits to uncertainty and doubt and openly admits to having made a mistake.

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Medical Mishaps calls for effective risk management. The lesson in this important analysis of error management has relevance for a global approach to error reduction. Well-designed risk management programs can be a solution in the quest to learn from error and an effective mechanism for promoting widespread use of the lessons learned.

This book is definitely worth reading if you are looking for an informative, concise account of the work that leaders from several countries are doing to address medical error and grapple with obstacles such as the legal climate, lack of trust, and the need for accountability and open sharing of information. Health care practitioners, risk managers and those involved in medical and nursing curricula will find *Medical Mishaps* especially useful. [NPSF](#)

reminder

Request for research proposals

The deadline for Letters of Intent for projects to enhance patient safety is Wednesday, March 29, 2000. As many as four grants of \$100,000 each will be available to

researchers at educational and other non-profit institutions for studies in the United States or Canada. For more information, visit the NPSF Web site at www.npsf.org.

Focus on Patient Safety (ISSN 1097-0673) is the official quarterly publication of the not-for-profit National Patient Safety Foundation (NPSF) at the AMA, in Chicago, IL. The NPSF represents an unprecedented initiative to improve health care safety by studying why errors in the health care system occur and implementing safeguards to prevent such failures from injuring patients. NPSF board members represent every major segment of the health care system, as well as employers, medical ethicists, public health advocates and distinguished scientific research institutions.

The opinions expressed in this publication are not necessarily those of the National Patient Safety Foundation or of its board of directors.

To submit articles to, or publications for possible review in, Focus, please direct materials to: Lorri Zipperer, Managing Editor, Focus on Patient Safety, National Patient Safety Foundation at the AMA, 515 N. State Street, Chicago, Illinois 60610. Materials, inquiries and subscription requests for the publication will be accepted electronically at npsf@ama-assn.org or via fax at 312-464-4154.

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Plan Now to Attend the Patient Safety Solutions Conference in Chicago

This conference will build on the highly successful 1996 and 1998 meetings, held at the Annenberg Center for Health Sciences, that examined health care errors from a variety of professional and theoretical perspectives.

This meeting's sessions will focus on applying practical solutions that have been successfully implemented and shown to enhance patient safety and reduce error. These solutions can be effectively used by participants to implement measurable improvements in their health care organizations.

Who Should Attend:

Professionals from medicine, nursing, pharmacy, medical informatics, hospital administrators, health services

research, law, social science, medical economics, insurance, patient advocacy, mental health, risk assessment, human factor and systems analysis, accrediting and credentialing bodies and government agencies.

Where:

The Ambassador West Hotel, Chicago IL

Convened by:

The National Patient Safety Foundation and the Joint Commission for the Accreditation of Healthcare Organizations

Sponsored by:

Janssen Pharmaceuticals

National Patient Safety Foundation
515 North State Street—8th floor
Chicago, Illinois 60610

