Table 1: Patient Safety Design Management

1. Design work so that it is easy to do it right and hard to do it wrong.
2. How to do #1
    a) Reduce reliance on memory
    b) Simplify processes (reduce steps)
    c) Standardize
    d) Utilize constraints and forcing functions
    e) Use protocols and checklists
    f) Recognize fatigue's effect on performance
    g) Require education and training for safety
    h) Promote teamwork
    i) Reduce known sources of confusion

Table 2. "Safe Practices" to Reduce Medical Errors

1. Explicitly educate patients and family members about their medications
2. Implement reminder/recall interventions and other mechanisms to ensure follow-up
3. Prominently display critical, patient-specific information on every patient record
4. Ensure appropriate dose adjustment in children and elderly persons
5. Limit accessibility to and control the use of high-hazard drugs (concentrated KCl, epi, etc.)
6. Insist on the use of protocols and checklists for highly toxic drugs, drugs with a narrow therapeutic range, procedures
7. Utilize pharmacy-based IV admixture programs
8. Avoid use of abbreviations (or at least standardize them)
9. Avoid verbal orders; use repeat back when done
10. Standardize approaches and processes for drug storage locations, internal packaging or labeling and delivery
11. Utilize unit dosing
12. Use automated pharmacy dispensing systems
13. Implement electronic medical record and prescriber order entry
14. Utilize automated/bar code medication administration control systems
15. Use weight-based heparin protocols
16. Insist on pharmacist availability 24/7/365
17. Use pre-printed orders
18. Limit the number of kinds of commonly used equipment (e.g., infusion pumps, defibrillators, etc.)
19. Use clinical guidelines and critical pathways (including checklists)
20. Utilize bar coding for transfusions
21. Implement a restraint-free policy
22. Preferentially purchase and utilize "unit of use" packaged drugs
23. Preferentially purchase IV solutions with contents and concentration prominently displayed on both sides of container
24. Require machine-readable labeling (bar coding) for all pharmaceuticals
25. Preferentially purchase pharmaceuticals products that have labels with name, strength and warnings prominently displayed and that otherwise incorporate human factors evaluation

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TO ERR IS HUMAN: REDUCING MEDICAL ERRORS

Kenneth W. Kizer, M.D., M.P.H.
President and CEO
The National Quality Forum

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The Paradox of American Healthcare Quality

- **Highly trained practitioners, wide spread state-of-the-art technology, unparalled biomedical research, unequaled expenditures**
- **Overuse, underuse and misuse problems are common, serious and systemic in nature—and largely preventable**

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QUALITY IS THE ESSENTIAL HEALTHCARE BUSINESS STRATEGY FOR THE 21ST CENTURY

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Key Trends

- **Rising healthcare expenditures**
- **New technology/drugs**
- **Changing purchaser attitudes**
- **Consumer demand**
- **Patient safety concerns**

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Healthcare Quality

Healthcare quality begins with patient safety!

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What is Patient Safety?

Patient safety is freedom from injury or illness resulting from the processes of healthcare.

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Terminology

Code Words for Medical Errors

- **Adverse event, adverse clinical event**
- **Adverse outcome, adverse clinical outcome**
- **Medical mishap; sentinel events**
- **Unplanned clinical occurrence; unexpected occurrence; untoward incident**
- **Therapeutic misadventure**
- **Peri-therapeutic accident**
- **Iatrogenic complication/ injury**
- **Hospital acquired complication**

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What are Healthcare Errors?

- **Failure to diagnose/incorrect diagnosis**
- **Failure to utilize or act on diagnostic tests**
- **Use of inappropriate or outmoded diagnostic tests or treatments**
- **Failure to provide follow-up**
- **Medication errors/adverse drug events**
- **Wrong-site surgery; surgical errors**
- **Transfusion mistakes**

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What are Healthcare Errors?

- **Hospital-acquired infections**
- **Burns/fires**
- **Falls**
- **Pressure ulcers**
- **Phlebitis associated with intravenous lines**
- **Restraint-related strangulation**
- **Preventable suicides**
- **Failure to provide prophylaxis**

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Healthcare Errors – How Big is the Problem?

- 3-38% of hospitalized patients affected by iatrogenic injury or illness
- 44,000-98,000 hospital deaths/year (IOM)
- 2-35% of hospitalized patients suffer adverse drug events (average 7%)
- >7,000 ADE deaths/year
- 2 million nosocomial infections/year

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Role of NQF in Patient Safety

- **Endorsed "Patient Safety: Call to Action"**
- **To standardize hospital performance measures**
- **To develop compendium of "best practices"**
- **To develop list of "never events" and design national state-based reporting system**

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A Strategic Priority

Improving patient safety should be a key strategic priority for every healthcare provider in the country

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Patient Safety – Recommended Actions

- **Make patient safety improvement a leadership priority**
- **Make a clear organizational commitment to patient safety**

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Patient Safety – Recommended Actions

- **Initiate routine patient safety audits**
- **Create a healthcare culture of safety**

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Patient Safety – Recommended Actions

- **Implement known "safe practices"**

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Patient Safety – Recommended Actions

- **Incorporate patient safety into all healthcare professional training**
- **Be accountable for patient safety**

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Patient Safety – Recommended Actions

- **Promptly and decisively deal with professional misconduct**
- **Make patient safety research a priority**

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Patient Safety – Recommended Actions

- **Support efforts to create a non-punitive environment for healthcare error reporting**

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Conclusion

Quality and quality improvement will be the holy grail for healthcare in the 21st century