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- the IOM report “To Err is Human” launched the modern patient-safety movement on December 1, 2000
- over the decade following the report, a variety of pressures (e.g., more robust accreditation standards and increasing error-reporting requirements) have created a stronger business case for hospitals to focus on patient safety
- relatively few healthcare systems have fully implemented information technology
- we are grappling with balancing “no blame” and accountability
- the research pipeline is maturing
- funding remains inadequate
- limited ability to measure progress in safety is a substantial impediment

**Regulation and accreditation**

- National Patient Safety Goals
- tracer methodology: talking to patients and caregivers around the organization during site inspections instead of focusing on reviewing meeting records and policies
- low-hanging fruits have been picked, difficult to drive progress in complex, nuanced areas
- earlier initiatives: “sign your site”; eliminating high-risk abbreviations
more recent goals: require hospitals to have a process in place to identify and respond to caregivers who are disruptive or create a negative culture; improving hospital leadership; promoting patient involvement in safety

several goals released before robust evidence to guide implementation, leading to major missteps and wasted motion

large gap between comparatively stringent accreditation standards for hospitals and nursing homes and lax environment for clinics, doctors’ offices and surgical centers

Reporting systems

based on the successes of the Aviation Safety Reporting System, reporting systems have been created for medical errors

first, too many events were reported, but now we have a list of “never events”

most reporting is not public

Health information technology

IT can be useful in reducing errors, but its uptake is very low

health IT is harder than it looks, systems have been faulty or failed

there is now some federal engagement in this area

The malpractice system and accountability

virtually no movement to modify the US tort system

interest in balancing a systems-oriented focus with accountability

earlier models of “no blame” are now more nuanced and recognize the problems with disregard for unreasonable risk and other blameworthy actions

enforcement remains lax

Workforce and training issues

physicians’ involvement is crucial for patient safety, many practicing physicians remain unengaged
• physician engagement is best in large integrated organizations because the organization’s accountability is felt by employed or aligned physicians
• in less integrated organizations, some groups, such as hospitalists have been leaders in patient safety because they receive compensation from hospitals and partly share hospitals' accountability
• sparse progress in nursing safety
• slowdown in research linking nursing characteristics and staffing to safety
• public reporting of some nursing-sensitive problems provides a focus for nursing safety
• nursing shortage has eased, primary care physician shortage has worsened creating challenges around outpatient safety and coordination

Research in patient safety
• research can drive safety improvement
• great example: checklists
  - implemented by researchers in 100 Michigan ICUs
  - 66% drop in central line-associated bloodstream infection rates
  - saved 1,500 lives and $100 million
• some researchers think that traditional evidence standards are required for assessing safety and quality interventions
• other researchers argue that traditional research methods (like RCTs) are inappropriate or set too high a bar for research on quality and patient safety

Patient engagement and involvement
• there are now some patient-safety advocacy groups
• “What can patients do to prevent medical mistakes?” movement
• momentum to support error disclosure to patients

Engagement of provider organizations’ leadership
• crucial because patient safety flows from decisions made by leaders of hospitals, groups practices, and healthcare systems
• more direct pressure on boards and top executives
• business and regulatory case for safety is likely to grow
Interventions by national and international organizations

- many agencies and organizations involved:
  - Agency for Healthcare Research and Quality (AHRQ)
  - World Health Organization (WHO)
  - Institute for Healthcare Improvement (IHI)
  - National Quality Forum (NQF)
- these organizations have had some successful programs
- need to harmonize their activities

Payment system interventions

- there is interest in pay-for-performance (P4P)
- there is some evidence that P4P can drive quality improvements
- use of P4P in safety is limited by measurement problems
- increased numbers of report (“reporting culture”) and decreased numbers of reports (“fewer errors”) can both be evidence of progress
- Medicare has introduced a “no pay for errors” policy