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Free from Harm

Accelerating Patient Safety Improvement Fifteen Years after *To Err Is Human*

Report of an Expert Panel Convened by
The National Patient Safety Foundation

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Executive Summary

Patient safety is a serious public health issue. Like obesity, motor vehicle crashes, and breast cancer, harms caused during care have significant mortality, morbidity, and quality-of-life implications, and adversely affect patients in every care setting. Although patient safety has advanced in important ways since the Institute of Medicine released *To Err Is Human: Building a Safer Health System* in 1999, work to make care safer for patients has progressed at a rate much slower than anticipated.

Despite demonstrated improvement in specific problem areas, such as hospital-acquired infections, the scale of improvement in patient safety has been limited. Though many interventions have proven effective, many more have been ineffective, and some promising interventions have important questions still unresolved. The health care system continues to operate with a low degree of reliability, meaning that patients frequently experience harms that could have been prevented or mitigated.

While the release of *To Err Is Human* significantly heightened the focus on patient safety, the expectation at the time was that expanded data sharing and implementing interventions to solve specific concerns would result in substantial, permanent improvement. In the intervening decade and a half, it has become increasingly clear that safety issues are far more complex—and pervasive—than initially appreciated. Patient safety comprises more than just mortality; it also encompasses morbidity and more subtle forms of harm, such as loss of dignity and respect. It involves more than inpatient care; it includes safety in every care setting: ambulatory care clinics, freestanding surgical and diagnostic centers, long-term care facilities, and patients' homes as well as hospitals and other locations.

Although our understanding of the problem of patient harm has deepened and matured, this progress has been accompanied by a lessening intensity of focus on the issue. Patient safety must not be relegated to the backseat, proceeding haphazardly toward only those specific harms currently being measured and targeted for improvement by incentives. Advancement in patient safety requires an overarching shift from reactive, piecemeal interventions to a total systems approach to safety. Adopting such an

approach would mean leadership consistently prioritizing safety culture and the well-being and safety of the health care workforce. It means more complete development of the science, measurement, and tools of patient safety. To ensure maximal impact, moving from competition on safety to coordination and collaboration across organizations will be important. Such an approach also means thinking about safety in all aspects of care across the continuum, not just in hospitals. To ensure that the patient voice is heard, it must also include partnering with patients and families at all points along the journey.

This report recognizes areas of progress, highlights remaining gaps, and most importantly, details specific recommendations to accelerate progress. These recommendations are based on the establishment of a total systems approach and a culture of safety:

1. **Ensure that leaders establish and sustain a safety culture**
2. **Create centralized and coordinated oversight of patient safety**
3. **Create a common set of safety metrics that reflect meaningful outcomes**
4. **Increase funding for research in patient safety and implementation science**
5. **Address safety across the entire care continuum**
6. **Support the health care workforce**
7. **Partner with patients and families for the safest care**
8. **Ensure that technology is safe and optimized to improve patient safety**

Success in these actions will require active involvement of every player in the health care system: boards and governing bodies, leadership, government agencies, public-private partnerships, health care organizations, ambulatory practices and settings, researchers, educators, the health care workforce, and patients and their families. Our hope is that these recommendations and the accompanying specific tactics for implementation will spur broad action and prompt substantial movement towards a safer health care system. Patients deserve nothing less.

AIG

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EIGHT RECOMMENDATIONS FOR ACHIEVING TOTAL SYSTEMS SAFETY

1. ENSURE THAT LEADERS ESTABLISH AND SUSTAIN A SAFETY CULTURE

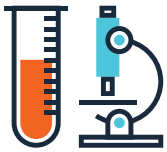
Improving safety requires an organizational culture that enables and prioritizes safety. The importance of culture change needs to be brought to the forefront, rather than taking a backseat to other safety activities.

2. CREATE CENTRALIZED AND COORDINATED OVERSIGHT OF PATIENT SAFETY

Optimization of patient safety efforts requires the involvement, coordination, and oversight of national governing bodies and other safety organizations.

3. CREATE A COMMON SET OF SAFETY METRICS THAT REFLECT MEANINGFUL OUTCOMES

Measurement is foundational to advancing improvement. To advance safety, we need to establish standard metrics across the care continuum and create ways to identify and measure risks and hazards proactively.



4. INCREASE FUNDING FOR RESEARCH IN PATIENT SAFETY AND IMPLEMENTATION SCIENCE

To make substantial advances in patient safety, both safety science and implementation science should be advanced, to more completely understand safety hazards and the best ways to prevent them.

5. ADDRESS SAFETY ACROSS THE ENTIRE CARE CONTINUUM

Patients deserve safe care in and across every setting. Health care organizations need better tools, processes, and structures to deliver care safely and to evaluate the safety of care in various settings.

6. SUPPORT THE HEALTH CARE WORKFORCE

Workforce safety, morale, and wellness are absolutely necessary to providing safe care. Nurses, physicians, medical assistants, pharmacists, technicians, and others need support to fulfill their highest potential as healers.

7. PARTNER WITH PATIENTS AND FAMILIES FOR THE SAFEST CARE

Patients and families need to be actively engaged at all levels of health care. At its core, patient engagement is about the free flow of information to and from the patient.

8. ENSURE THAT TECHNOLOGY IS SAFE AND OPTIMIZED TO IMPROVE PATIENT SAFETY

Optimizing the safety benefits and minimizing the unintended consequences of health IT is critical.

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