Editorial

Setting the Stage for the Second Decade of the Era of Patient Safety: Contributions by the Agency for Healthcare Research and Quality and Grantees

This year marks the 10th anniversary of the Institute of Medicine's (IOM) *To Err Is Human* report that focused the health care community and the public on the inherent risks that patients face when they seek care. Importantly, the message made it clear that many adverse consequences were preventable if only we thoughtfully implemented systems that would prevent good people from making serious mistakes. To that end, the IOM challenged us to reduce the number of health care errors by 50 percent over 5 years.

Perhaps that goal was overly ambitious, even if we had the opportunity to benefit from lessons already learned by other high-risk, problem-prone industries such as aviation and nuclear power. Medicine is more complex and variable, with more unknowns. Yet, when there are parallels, it is surely irresponsible for us not to learn those lessons: improving the effectiveness of communication, approaching tasks when well rested, working together in multidisciplinary teams, tirelessly examining systems for latent errors, and implementing forced functions to prevent negligent acts. For a patient to lose his or her life because of an unrecognized error in medication administration is a tragedy. For a patient to suffer the same loss of life when a dozen recognized "near misses" with a similar root cause were ignored is unthinkable.

The first step in solving any problem is to recognize that there is a problem. Patient safety and quality issues know no international boundaries. I have personally had the opportunity to engage in patient safety dialogues in North America, Europe, Asia, and Africa and remain amazed at how similar the issues are despite the geographic, cultural, and language barriers.

Although perhaps even a 10-year period was overly ambitious for reducing errors by 50 percent, there is no question that important changes in

health care delivery have occurred. One can only hope, and there is reason to believe that it is true, that as a community we are reaching the “tipping point” whereby the slow gains in patient safety to date will accelerate. To reach that tipping point, it is essential that we build on, rather than repeat, the lessons learned to date.

This series, under the leadership of Donna Farley and Cheryl Damberg, documents the findings of a 4-year evaluation of one of the most ambitious patient safety initiatives to emerge from the IOM’s *To Err Is Human* report—that of the U.S. government, through the Agency for Healthcare Research and Quality (AHRQ). The Agency has served as a catalyst for energizing the health care community to generate the knowledge and experience necessary to address head-on the patient safety challenge. Perhaps more than any other effort, AHRQ’s funded research has reconfirmed that there is a problem and has facilitated some of the most thoughtful individuals, teams, and systems to move forward in addressing it. AHRQ funded 234 projects during the evaluation period, and AHRQ continues to fund additional projects.

AHRQ contracted for a program evaluation of its patient safety initiative to help it strengthen the initiative as it progressed—a form of continuous quality improvement on a national scale. The first paper in this series, by Farley and Battles, describes AHRQ’s expectations for the evaluation and documents the methodological approach taken by the Patient Safety Evaluation Center. The final paper, by Farley and Damberg, synthesizes overall evaluation results, in particular its findings on AHRQ’s process for implementing the initiative. The six other papers present results from specific analyses performed within the larger evaluation, as examples of both methods and empirical findings.

The evaluation papers in this series highlight the collective challenges and successes of projects conducted under AHRQ’s leadership. Sorbero and colleagues conclude that patient safety projects funded by AHRQ have the potential to make substantial contributions to the knowledge base on patient safety practices, and that the full value to be derived from the new knowledge will come when the project results are aggregated into common themes and their collective evidence on tested practices is judged. The assessments reported by both Taylor and colleagues and Damberg and colleagues reveal the challenges involved in implementing practices that improve patient safety, and their findings offer insights that can guide others pursuing similar actions. Taylor and colleagues report on projects that addressed a variety of patient safety practices, and Damberg and colleagues focus specifically on health information technology projects. Not surprisingly, similar implementation

issues are encountered regardless of the types of technologies or actions being pursued.

AHRQ has also been making valuable contributions to building national infrastructure to support patient safety. Teleki et al. remind us that achieving success in our quest for patient safety requires a trained workforce and that AHRQ's initial efforts, while showing success, must reach a much broader audience. One of the strongest evaluation messages, which suggests we may be approaching the tipping point, is Mendel and colleagues' findings that patient safety partnerships are growing. Improving health care safety is a journey that we must take together, and strong partnerships among individuals and organizations solidify the infrastructure from which future gains will be realized.

Greenberg and colleagues focus us on the importance of objective measurement to drive change and the challenges associated with consistency in data collection. Both the manner and the consistency with which we codify data are essential for extracting actionable information from aggregated individual events. Making sure that data can be synthesized into actionable information is the foundation for harnessing the health information technology promises that Damberg and colleagues discuss in their paper.

AHRQ must be congratulated for taking the initiative to lay the foundation for ensuring a safe health care system, in part through the projects and initiatives described in this series. As we move into the second decade of the era of patient safety, it is essential that we build on the knowledge generated from the efforts of AHRQ, its grantees, and the many other organizations and systems that have committed to reducing and ultimately eliminating the unnecessary injury and loss of life that remain part of health care today.

We must set an agenda for this second decade that focuses on what we now recognize as the key challenges. That focus will force us quickly to the patient safety tipping point. That agenda must be developed collectively through careful review and thought. The information and issues identified by the evaluation of AHRQ's patient safety initiative can help guide priorities for this agenda—its findings have implications for both AHRQ and other organizations working in this area. Priorities for action laid out by Farley and Damberg in their synthesis paper include establishing a national data network for use in monitoring trends in patient safety, updating evidence on safe practices using recent study results, disseminating key practices and tools to providers, and actively engaging in partnerships to stimulate practice adoption. I offer here a few key areas for practice improvement to begin that discussion, based on both review of the patient safety literature and personal experience:

- *Changing the culture in which care is provided.* Perhaps one of the most elusive challenges, real change requires each and every member of the team to internalize the culture of safety as an immutable value. During this second decade, no health care provider should wash her hands or mark a surgical site because an accrediting agency says she must. These actions must be done because they are the natural “right thing” to do and doing otherwise would be uncomfortable, much the same as it is unthinkable that we would leave for work in the morning without getting dressed. Achieving this goal requires each of us to “walk the talk,” avoid taking unsafe shortcuts when it “appears” safe, and ensure that each new health care professional who joins our profession is initially and consistently taught the safe way to provide care.
- *Transparency in providing care and examining risk.* The second decade must see a transformation in how we address unsafe practices. Health care providers must be rewarded for acknowledging errors, identifying hazards, and initiating examination of ways to prevent future adverse events. No patient should ever die from a medication error that also happened to dozens of others before, yet was repeatedly dismissed because no harm occurred.
- *Embrace the power of multidisciplinary teams.* Really part of the culture issue above, all members of the health care team must recognize how important it is to acknowledge the experience and contributions of other team members. This will undoubtedly require a change in the way we educate future professionals. If students and trainees from multiple health care disciplines (e.g., physicians, nurses, social workers, medical technologists) work together from the day they start training, then when they enter practice their comfort zone will be with the team and not with professional silos.
- *Realize the benefits of information technology in advancing patient safety.* Today’s information systems already have untapped capacity and we can expect capabilities to continue to double over very short periods. We must harness the technology for both real-time care delivery and retrospective care analysis to provide the data to drive change. For example, no patient should be harmed because an abnormal laboratory result among several hundred results goes unrecognized. Scanning through large volumes of data is something that computers, with the right instruction, do better than people.

- *Approach every issue through the patient's eyes.* Successful organizations and endeavors always put their customers first. As we wind our way through the complexities of medical care, the financing, and the oversight, it is easy to falsely conclude that the health care infrastructure, not our patients, is our “customer.” Real success comes when we engage our patients in their care, making them partners in safety. Leading organizations are finding that the “patients first” approach results in safer care, higher patient satisfaction, and a positive bottom line.

As we enter the second decade of the era of patient safety, let us make a commitment to quickly reach the patient safety tipping point, building on the knowledge and experience of AHRQ grantees, along with that of thousands of other health care professionals (and professionals in other industries). We have the capacity and responsibility to make the editorials when we enter the third decade of the patient safety era reflect on how the IOM's challenge was actually met.

Lee H. Hilborne