

Ten-Year Retrospective Review

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A bit more than a decade ago, the country was bombarded by a series of headlines announcing tragic medical errors that caused pain, increased costs, and even death to the patients involved. As president of the American Medical Association (AMA), I was asked repeatedly about how “the best health care system in the world” could allow mistakes like the ones being reported to occur. The kinds of responses that might have been provided in the past did not seem acceptable . . . “physicians are only human, mistakes happen, it is relatively uncommon for mistakes to occur when put in the context of the number of interactions that occur across the country each day in health care.”

Perhaps the sequence of several serious events triggered the subsequent activities, or perhaps they would have occurred anyway. In any case, the issues of errors in health care attained center stage, and many organizations, clinicians, researchers, and policy works began to address the problems of errors in health care delivery. The AMA committed to form the National Patient Safety Foundation (NPSF), which brought together an astounding array of persons and entities committed to improving the safety of the health care delivery system—nurses and physicians, attorneys and aviation specialists, practitioners and investigators, pharmaceutical companies, and insurance companies, as well as patients. Through the formation of the NPSF, the AMA committed to helping fund research and dissemination of information about how to make care safer. More than a decade later, the NPSF is a vibrant contributor to the safety environment. The Institute of Medicine (IOM) published its report, *To Err is Human*¹—a report that transformed much of the discussion about quality and safety. A follow-up report, *Crossing the Quality Chasm*,² kept the momentum moving forward.

But the NPSF and IOM are not alone. Many activities and organizations have arisen, with goals of improving the quality and safety of the care for U.S. patients. This journal, the *Journal of Patient Safety*, was created by Lippincott as a demonstration of its belief that the arena of safe patient care was, and would continue to be, a major focus of health care delivery and research for the foreseeable future. During the 5 years since its inception (and 3 years of publication), the journal has put cutting-edge research in the hands of hospitals, physicians, nurses, pharmacists, and others on the team. It has moved the bar in patient safety.

Another substantially contributing organization is the National Quality Forum (NQF). The NQF has identified cross-cutting patient safety measures across conditions, populations, and settings of care and has worked to continually update those measures as research and data gathering provide additional insights and opportunities. This volume of the *Journal of Patient Safety* includes several articles about the activities of the NQF and the Safe Practices program that outline the various activities that are important to the eradication of preventable error. The articles included in this volume, and others that can be found in the online publication, provide updates on already widespread practices and insights into new areas that can contribute to safety.

JANET M. CORRIGAN, PHD, MBA

Improving the safety of health care delivery saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Now, 10 years since the IOM’s report, *To Err Is Human*,¹ issued a call to action, uniformly reliable safety in health care has not yet been achieved. Change is gradually occurring, and numerous successes have been recognized, yet there is clear consensus that much still needs to be accomplished before safety in health care reaches a stage where improvement is consistently recognized across all sectors of the industry.

Every day, in health care organizations across the country, people are harmed, or nearly harmed. This harm is not intentional; however, it can usually be avoided. It is now better appreciated that the errors that can create harm often stem back to organizational system failures, leadership shortfalls, and predictable human behavioral factors. As well, the issue of delays or errors in diagnosis is beginning to

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receive increased recognition as a potential contributor of harm, and further work is needed. Within this improved understanding of medical error, however, the often-touted call for development and instillation of a “culture of safety” is proving difficult to initiate and sustain at all levels of health care. Further learning and ongoing improvements are needed on how to sustain changes in the workforce values, beliefs, and behaviors that will ultimately contribute to the desired change in culture.

In an effort to help create sustainable change, the NQF, during its first decade of existence, has completed and continually updated a number of initiatives that focus directly on patient safety. For example, the NQF Serious Reportable Events (SREs) and NQF Safe Practices are 2 programs that were developed early in this decade and have been updated on a regular basis. There are 28 NQF SREs³ that have been adopted or adapted by the federal Department of Health and Human Services and numerous state-based health care reporting agencies that are also being used within a large number of health care organizations as a basis for performance improvement activity. These SREs are currently being reviewed and updated with a view toward how best to expand the concept into other environments of care beyond traditional hospital settings. The resonance for this program is such that similar programs are being initiated in several countries around the world.

The NQF Safe Practices program⁴ now embraces 34 evidence-based practices that are generalizable across a wide spectrum of focus areas in health care and are proven to help improve patient safety and quality of care. These Safe Practices are not prioritized or weighted within or across focus areas, but they do provide actionable suggestions and direction for all types of health care providers. The ongoing implementation of these practices will continue to improve patient safety, and their uptake by numerous organizations in this country is proving to be a valuable national resource—and an example program for other countries.

In addition, NQF now has more than 500 endorsed Performance Measures,⁵ and approximately 20% of these measures are focused on topics related to patient safety. Moving forward, there will be ongoing expansion of patient safety measures that will provide further insights for performance on numerous levels of health care and within numerous environments of care. A concerted effort is underway to create improved synergy among these NQF-endorsed Performance Measures, the NQF SREs, and the NQF Safe Practices. This effort will develop a tighter weave across all 3 programs and will result in a broad-based complement of overlapping actionable activities that organizations will be able to use for creating sustainable improvements. Helping to bring this concept together is another NQF initiative, which is already in progress, to develop a framework report that will outline the constellation of issues related to measuring, evaluating, and publicly reporting health care and patient safety events.

Up from the eighth leading cause in 1999 to the third leading cause of patient harm this past year, there is a growing recognition that health care–associated infections (HAIs) are, for the most part, preventable and that zero infections is the target number that can be achieved for many situations.^{6,7} Recently, NQF completed a consensus project related to the assessment and prevention of HAIs, and this report highlights the need for additional practices and measures focused on HAI prevention.⁸ To support this recommendation, NQF continues with specific calls for new HAI-focused safe measures and practices that harmonize with other national, state-level, and federal agency HAI initiatives.

Harmonization of efforts is a pivotal strategy for creating simplification and uniformity of approaches when improving

patient safety and health care quality. One such example is the National Priorities Partnership—a consortium of 32 organizations convened by NQF—which includes a strong focus on patient safety as 1 of the 6 priorities emerging from this initiative.⁹ Specifically, there is an initial focus by this initiative on perioperative patient care and the prevention of HAI, prevention of SREs, and improvement of cross-disciplinary team functions. The overarching goal is to improve patient safety and the culture of care for every organization’s perioperative environments.

In essence, every health care stakeholder group should insist that provider organizations demonstrate their commitment to reducing health care error and to improving safety. This includes promoting an environment of effective reporting and learning from errors or mistakes within a blame-free culture. Collective reporting and learning from the mistakes of others is also an essential component of this process to improve health care safety. And importantly, health care organization leaders and governance boards must be explicitly called upon to proactively review the safety of their organizations and to take action to continually improve the safety and thus the quality of care they provide.

We can, and must, continue to do better.

Every individual who seeks medical care should be able to expect and receive safe, reliable care, every time, under all conditions.

CHARLES R. DENHAM, MD

This issue of the *Journal of Patient Safety* addresses the subject matter covered by the *NQF Safe Practices for Better Healthcare – 2010 Update*.¹⁰

Now, 10 years after the IOM report, *To Err is Human*,¹ we have acquired a great deal of knowledge about how to make patients safe. We know a tremendous amount about the what, why, when, where, and how we need to improve patient safety. It is, however, the “who” that is now most important. Who will step up and lead at the local level, and how can we equip them to inspire those who need to follow them.

Although never perfect and continually being updated, the NQF Safe Practices are the most evidence-based set of safety activities ever created. They have been harmonized across the major certifying, quality, and purchasing organizations down to the specification level. Some safe practices, such as those that target HAIs, which cost as many as 100,000 lives a year,¹¹ have been harmonized across virtually all of the professional associations involved in preventing and treating such infections. The evidence has been graded and tied to individual safe practices specifications. The 2010 update of the Safe Practices has been carefully prepared with the very latest evidence. As such, articles in this issue would be redundant if they repeated what has already been provided in the *NQF Safe Practices for Better Healthcare – 2010 Update*. Hence, this issue concentrates on leadership because this is the area that will make or break the success of the practices in saving lives, saving money, and increasing the value that caregivers can provide to the communities they serve.

There are certain themes that are consistent across the collection of articles in this issue. They include overcoming adoption barriers, a thirst for advice, and new disruptive opportunities.

The greatest barriers we face are human issues: fear and habit. Leaders are fearful of taking action—including the fear of the financial impact of investing in patient safety and fear of blame for prior, less safety-centered care. Habit and inertia are huge issues. In times of crisis, the tendency to embrace change is

lessened, despite the fact that history has shown that the path of least resistance often leads to failure.

There is a thirst for advice and learning by patient safety and midlevel leaders who believe they are in crisis. There is also a refreshing energy from health care students who want to learn safety and impact care, even during their training.

The opportunities include those related to new funding incentives for health care information technologies that impact adoption of updated safe practices, opportunities to involve patients and families by health care organizations, and grassroots initiatives by health care students who can create a bottom-up activation of change.

ARTICLES IN THIS ISSUE

Story Power

The article “Story Power: The Secret Weapon” addresses the extraordinary untapped power that leaders can use to activate the passions and energy of their teams and organizations. Bringing forth best practices from other industries, it addresses the science and art of storytelling and provides preliminary results of story impact through an international program that has disseminated the story of a child who lost her life through “people systems failure.”

Computerized Prescriber Order Entry

Computerized prescriber order entry (CPOE) is the virtual capstone to the health information technology systems of a hospital or health care organization. “Meaningful Use of Computerized Prescriber Order Entry” addresses the concept of “meaningful use” that spells new federal financial incentives for organizations adopting CPOE. This article is a careful review of the literature that ties meaning to meaningful use for safety leaders. Intended to complement the CPOE safe practice for 2010, it also addresses the potential updates that should be considered for 2011.

Greenlight

The Chief Financial Officer (CFO) and the team he represents should be the first vital vote for investments in safety—to be won before we embark to the board room. Unfortunately, the financial climate is stormy, and the CFO is often the vote that kills a plan after a full administrative team meeting because he has to protect the budget. The article, “Green Light Issues for the CFO: Investing in Patient Safety,” will help prepare patient safety officers and quality leaders build their argument for discussions that has to be undertaken before a group can vote “up or down.” The term “greenlight” comes from the movie industry and signifies that a movie is fully approved to start production. This article is intended to help translate the safety impact, from the bedside to the boardroom, and to help win the vital resources necessary for improvement.

Leadership in Crisis

“Leading in Crisis: Lessons for Safety Leaders” provides midlevel and safety leaders with practical lessons on how to lead through the crises they are experiencing today. Again, not a dry analytical piece, it addresses practical leadership issues and the fact that there is a real and unanticipated thirst for leadership advice. This article is, in part, a summary of proceedings from a webinar, led by an international business guru, that is complemented by a crosswalk application to specific NQF Safe Practices addressing leadership. The extraordinary response to the webinar demanded further development of content, in that our midlevel managers and safety leaders expressed the fact that they are in crisis and need help now.

Students—Check a Box. Save a Life

“Check a Box. Save a Life: How Student Leadership Is Shaking Up Health Care and Driving a Revolution in Patient Safety” is an exciting article written by medical students who are embarking on their health care careers. It is exciting because the students are not waiting to be taught patient safety—they have formulated an international approach to teaching each other through the Institute for Healthcare Improvement Open School. Unfettered by having to defend their treatment of the past and not yet dulled by the repetitive cadence and grind of the practice of medicine, they are harnessing great core values to launch a program that will empower a grassroots initiative to save lives from the bottom up. The article addresses a student-led program that provides a mechanism allowing students to become disruptive innovators during their surgery rotations in training. If nothing else, the program provides role model servant leadership that will inspire us to act in our own microsystem of care. This article offers us a refreshing conversation with the future.

Integrative Medicine and Pain Management

More than 50 million Americans suffer from pain. It is 1 of the top 3 reasons that patients seek health care and the leading cause of disability. “Everyone owns it and no one owns it”—this phrase captures the essence of the pain dilemma. Everyone treats it, and most rather poorly, because no one owns it as a systems problem. Integrative care, which brings to bear the best evidence-based complimentary care, coupled with the best conventional pharmaceutical and procedural care, may offer a new window on safer and more high-performance pain management. The article, “The Impact of Integrative Medicine on Pain Management in a Tertiary Care Hospital,” pulls back the shades of traditional fragmented approaches to pain and introduces a new view on integrative care.

Pharmacy Leadership

All of the NQF Safe Practices are trending in design to address leadership issues since this has been recognized as the critical ingredient to adoption. The Safe Practice addressing pharmacy leadership was completely new for 2009. It was received with enormous support from the industry, and the article, “A New Leadership Role for Pharmacists: A Prescription for Change,” provides supportive content to empower pharmacy leaders to embrace and leverage their newfound leadership opportunities to improve care far beyond the walls of the pharmacy.

Involving Families

It is only a matter of time before consumers will demand to be part of the operations of our health care organizations. “Patient and Family Involvement in Contemporary Healthcare” is a complementary piece to the NQF Safe Practice elements that sets forth opportunities to engage and, in fact, leverage the great opportunities for partnership in improvement. Meant to be a complement to the chapter entitled *Opportunities for Patient and Family Involvement* from the *National Quality Forum Safe Practices – 2010 Update*,¹⁰ the article helps provide context to truly making our care patient-centered through their input.

Readers of this issue of the journal will find the articles more narrative than analytical. This is by design. Our knowledge of patient safety is woefully incomplete, with real need for evidence for action; yet, the *NQF Safe Practices for Better Healthcare – 2010 Update*¹⁰ represents the most carefully prepared and all-inclusive set of activities in patient safety ever created, representing input from more than 500 experts in as many pages.

In the end, the practices have no value if leaders do not step up and own adopting them. Therefore, this issue centers on leaders. Success in patient safety begins with leadership, ends with leadership, and is all about leadership.

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Dear Healthcare Leader:

We are delighted to announce that the Journal of Patient Safety has graciously given us permission to distribute copies of recently published articles to you in the interest of helping you adopt the National Quality Forum Safe Practices for Better Healthcare – 2009 Update and 2010 Update.

The Journal of Patient Safety is dedicated to presenting research advances and field applications in every area of patient safety and we give our highest recommendation for them as a valuable resource toward patient safety from hospital bedside to boardroom. It is in the fulfillment of this mission that they make the gift of these articles to you in your pursuit of your quality journey.

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We want to acknowledge you and your institution for your current efforts in patient safety. We hope you enjoy this article and find it useful in your future work.

Sincerely,

Charles R. Denham, M.D.
Chairman