

## 10 Years After To Err is Human: Are Hospitals Safer?

*Cheryl Clark, for HealthLeaders Media, November 30, 2009*

November marks the 10-year anniversary of the Institute of Medicine's "[To Err Is Human](#)," the first of its 11-volume "Quality Chasm" series on improving patient care and avoiding mistakes.

Since the landmark report, health providers have been chagrined by the revelation that they were killing "a jumbo jet" full of passengers every day, about 98,000 preventable deaths a year. And many of them reacted to the allegation by launching a broad spectrum of efforts to reduce medical mistakes.

But are we really better today at preventing mistakes and safeguarding our systems from causing harm than we were 10 years ago?

"We're safer in many more places, and more of the time," says James Conway, senior vice president of the [Institute for Healthcare Improvement](#) in Cambridge, MA.

"We're seeing very courageous people in many organizations doing exceptional work. We're seeing sobering discussions about the circumstances in which patients died unnecessarily, confronting the reality of the patient who was harmed with graphic detail, using the name of the patient, and their age."

There is in many places, Conway says, more accountability and more responsibility. There is more acknowledgment that mistakes are preventable, and not just part of the background noise that says it's OK because bad things happen in medicine sometimes.

But on a national level, he's not so sure. He's concerned that in many regions, facilities have not become "expert at looking for trouble. We're just learning to identify what harm is," he says.

First the good news.

- Many states now require reporting of adverse events and some require public reporting of hospital-acquired infections, patient falls or pressure ulcers. In some states, health officials hold press conferences to publicize hospital errors that caused, or had the potential to cause serious patient harm or death. At least one state, California, imposes hospital fines and publishes the incident report in all its excruciating detail on the Web.
- Medical residents' hours are now restricted to prevent errors caused by fatigue.
- Providers in many hospitals that normally compete have joined hands to unify how they label high-risk intravenous medications, to avoid a new doctor or nurse from misusing a potentially lethal drug because the facility's coding or storage system was not the same as their previous hospital.
- The Institute for Healthcare Improvement launched a number of safety strategies, including its "100,000 Lives Campaign." Following that campaign, the IHI launched its "5 Million Lives Campaign" to understand and address those medical mistakes, an estimated 40,000 per day, that injure patients and take a toll on their quality of life.

Providers are setting goals for their communities. Hospitals are starting to use the IHI "global trigger tool" to more accurately measure areas of care that might be causing avoidable harm, including the 28 adverse events now required to be reported.

- Facilities were urged to adopt a "no-blame" system to encourage providers to report their own missteps, in the chance the practice or situation might be easily repeated by a colleague. Disclosure of those mistakes and transparency has become acceptable at many facilities as well.
- Central Line Associated Bloodstream Infections have been reduced.
- Many facilities are using "checklists" before beginning surgery or a complex procedure.
- The Centers for Medicare and Medicaid Services will no longer reimburse health facilities for the cost of caring for a patient with a preventable hospital-acquired infection.

- More attention is being paid to physicians' diagnostic errors, and the importance of being candid with patients and patients' families when preventable errors occur.

But many significant challenges remain.

### **Hospital mistakes**

On the negative side, lots of serious mistakes are still happening. Earlier this month for example, Rhode Island Hospital, the state's largest, was fined \$150,000 for performing its fifth wrong-site surgery since 2007. The latest incident prompted the state to order the facility to install video cameras in all its operating rooms.

Foreign bodies, such as sponges, clamps, hemostats, and towels, are too often left inside patients during surgery, because surgical teams don't take seriously enough requirements that they count and record all such items incoming and outgoing.

### **Infection control lapses**

Kathy Warye, chief executive officer of the [Association for Professionals in Infection Control and Epidemiology](#), said a major issue is lack of scientific information about bacterial, viral, and fungal infections that are so frequently transmitted in healthcare settings.

"We don't understand some of these infections, like *C. difficile*, well enough to know whether they can be prevented," she says. "Science hasn't yet filled the gaps."

Aside from that, she says, another stumbling block is the lack of healthcare executives' support to control preventable infections.

Health executives, she says, "still aren't fully cognizant of what infections ultimately cost," Wayre says. "They look at infection control as a cost center, and in the last economic downturn, 20% of respondents [to a survey] said they had to cut back on surveillance, and 41% said their resources were cut across the board.

Today, 29 states require some public reporting of healthcare infections. And if the current House version of health reform bill passes, it will be 100%.

"Transparency leads to improved outcome, and in many states there is evidence that it's played a key role," Wayre says.

Hospitals need to conduct comprehensive risk assessments to determine if they should be screening patients on admission for infections they may have acquired in their communities, but which could pose serious health issues for other patients, adds Wayre.

### **Medication errors**

It was just two years ago that actor Dennis Quaid's twins were given Heparin in an adult dose that was 1,000 times stronger—rather than the proper dosage of Hep-lock.

Allen Vaida, a pharmacist and executive vice president of the [Institute for Safe Medication Practices](#), says "we have made great strides in understanding that medication errors are an issue, but we still have a long way to go."

Vaida says hospitals should implement barcoding of medications. "Only 5-20% of hospitals now do it. We should be striving for 100%," he says.

Second, he says, "we have to do a better job learning from others." Too many hospitals see tragic mistakes that happen elsewhere and say, "That happened in California. I'm in Ohio. It doesn't happen here.

"We need to realize we're in a risky business, and ask the question 'Could that happen here?' "

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*Cheryl Clark is a senior editor and California correspondent for HealthLeaders Media Online. She can be reached at [cclark@healthleadersmedia.com](mailto:cclark@healthleadersmedia.com).*

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