

**Chapter 1 : Ambulatory Care Safety | AHRQ Patient Safety Network**

*The Patient Safety Initiative at America's Public Hospitals: The Year One Overview. Research Brief. Washington, DC: National Association of Public Hospitals and Health Systems; January*

The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. The advantages of health information technology IT include facilitating communication between health care providers; improving medication safety, tracking, and reporting; and promoting quality of care through optimized access to and adherence to guidelines. Health IT systems permit the collection of data for use for quality management, outcome reporting, and public health disease surveillance and reporting. However, improvement is needed with all health IT, especially regarding design, implementation, and integration between platforms within the work environment. Robust interoperability is critical for safe care, but this goal has proved elusive. Significant patient safety concerns already have been recognized; it is important to keep patient safety and quality as the primary focus. Benefits of Health Information Technology

Most obstetrician-gynecologists are now using electronic health records. They have rapidly moved into use because of the recognition of their potential benefits and government programs that incentivize their use. The benefits of health information technology IT include its ability to store and retrieve data; the ability to rapidly communicate patient information in a legible format; improved medication safety through increased legibility, which potentially decreases the risk of medication errors; and the ease of retrieval of patient information. The potential to improve patient safety exists through the use of medication alerts, clinical flags and reminders, better tracking and reporting of consultations and diagnostic testing, clinical decision support, and the availability of complete patient data. Data gathered through the use of health IT can be used to evaluate the efficacy of therapeutic interventions and have been demonstrated to lead to improvements in the practice of medicine

1. Alerts can optimize adherence to guidelines and evidence-based care
2. Record uniformity can be designed to reduce practice variations, conduct systematic audits for quality assurance, and optimize evidenced-based care for common conditions
3. Health IT is increasing patient engagement as consumers of health care. It allows patients access to their medical records, which helps them to feel more knowledgeable about their conditions and encourages them to actively participate in shared decision making. Outside the patient encounter, it can improve follow-up for missed appointments, consultations, and diagnostic testing. A health care provider can search for specific cohorts of patients within a practice to monitor and improve adherence to indicated health care such as mammograms, Pap tests, or measurement of hemoglobin A1c levels. The use of alerts to warn health care providers of potential problems is a powerful tool. However, alerts top the list of health IT hazards because the sheer volume of them is causing alert fatigue. This issue is complex and requires individualization within each facility. Developing systems to manage alerts, establish levels of importance, and make them unambiguous is a critical patient safety priority. Computerized Physician Order Entry has improved legibility and order processing times, and lowered the risk of medical errors; however, safety concerns have been raised. The time needed to place an order has increased, the ordering process may disrupt the work flow of the health care provider, and some formatting can create new opportunities for errors. Patient engagement tools, while improving patient involvement, also introduce reliability concerns regarding data. Use of portable devices that are not password protected makes the patient record vulnerable to invasion of privacy
5. Mismatches can also occur with paper charting. However, as the amount of data being transferred between different systems increases, the potential for mass mismatch exists and must be evaluated. The exchange of data across all health care settings and health care providers would reduce errors and improve patient safety. However, the marketplace continues to sell products that use proprietary code and, thus, are not easily integrated with other systems for the exchange of data. Automated and self-populating templates designed to save time can inadvertently cause inaccuracy in the medical record. Health care providers must review and edit these templates to ensure that they accurately reflect the encounter. There are many barriers to addressing patient safety concerns within health IT systems. There is an absence of mandatory reporting for medical errors related to health IT systems.

Conclusion Health IT has become an

integral part of the practice of medicine. As with any new technology, health IT brings many potential benefits and as well as potential concerns. The current literature to date, reflects outcomes at single sites or institutions. National estimates are extrapolations from these single-site studies. As the implementation and use of health IT systems increase, it is important to keep patient safety and quality as a major focus 6. Resource The following resource is for information purposes only. Referral to this web site does not imply the endorsement of the American College of Obstetricians and Gynecologists. This resource is not meant to be comprehensive. The exclusion of a source or web site does not reflect the quality of that source or web site. Please note that web sites are subject to change without notice. References Institute of Medicine. Health IT and patient safety: The National Academies Press; Meaningful use of computerized prescriber order entry. J Patient Saf ;6: Redesigning care processes using an electronic health record: Safely implementing health information and converging technologies. Sentinel Event Alert Issue No. Retrieved August 13, Creating an oversight infrastructure for electronic health record-related patient safety hazards. J Patient Saf ;7: American College of Obstetricians and Gynecologists.

## Chapter 2 : WHO/Europe | Patient safety

*Tips for preventing medical errors and promoting patient safety, measuring health care quality, consumer assessment of health plans, evaluation software, report tools, and case studies. Resource Links.*

Holmes was at the bedside when the procedure went horribly, perhaps predictably, wrong, and the patient quickly died. Horrified, she quit that job the next day. Today Holmes devotes her career to improving patient safety and the quality of care. It should be a given that the health care system makes people healthier but, in practice, often that is not the case. Building a Safer Health System , stunning many with the conclusion that as many as 98,000 people die in U.S. The consensus view is that improvement since then has been slow at best. In announcing a patient safety initiative this month, the U.S. For nurses, the issue is fraught with challenges. As front-line providers, nurses stop errors, feel powerless to stop errors, make errors, and may at times be blamed for errors they did not commit. The kinds of errors that both involve nurses in some way and endanger patients cover broad territory. Some errors can be traced to shifts that are too long and leave providers fatigued; some result from flawed systems that do not allow for adequate checks; some are caused by interruptions to nurses while they are trying to administer medications or provide other care. Many, experts say, come from a culture that can leave nurses powerless to intervene when doctors or others commit errors. We have to look closely at what is happening to providers of care in environments that put patients at risk. You are vulnerable when you blow the whistle. Leading Change, Advancing Health , addresses patient safety in myriad ways. For instance, if implemented, its leadership recommendationâ€”that nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United Statesâ€”would help empower nurses at all levels to contribute to improvements in patient safety. The report calls for more advanced practice registered nurses APRNs and more nurse-led research into ways to improve the quality of care. Everyone needs to be heard. Holmes says nurses need to push themselves as well. They need to focus on quality and safety, and bring nurses into those conversations. Her study will contribute to an understanding of the relationship between nurse staffing characteristics, interruptions and discontinuities of care, and patient outcomes. Talsma is part of a new generation of nurses who feel they have a mandate to evaluate data, learn from it and improve systems. Nurses with advanced degrees are in a position to focus on improving patient safety. She may be right. Nurse-led solutions have broad support. A Gallup poll commissioned by RWJF and released in found that large majorities of opinion leaders would like to see nurses exert more influence in a number of areas, with reducing medical errors and improving patient safety 90 percent , and improving quality of care 89 percent topping the list.

**Chapter 3 : 4 Ways Technology Is Improving Patient Safety**

*Medical errors and patient safety fact sheets Health Care Simulation to Advance Safety: Responding to Ebola and Other Threats This issue brief underscores the helpful role simulation can serve in response to the Ebola virus disease, other emergent epidemic challenges, provider and patient safety, and quality of care in general.*

Errors, Injuries, Accidents, Infections In some hospitals, patient safety is a top priority. Strong health care teams reduce infection rates, put checks in place to prevent mistakes, and ensure strong lines of communication between hospital staff, patients, and families. Patients can experience dangerous complications, recovery is slower, and some patients even die unnecessarily. For example, an air or gas bubble in the blood air embolism is a serious medical error. An air or gas bubble stops blood from flowing through the body. This serious mistake can happen during surgery or other procedures. If blood flow is blocked, a patient can suffer a stroke or die. The statistics are alarming: Hospitals need to work hard every day to protect their patients from errors, injuries, accidents, and infections. What should I do if I see an error made in the hospital? If you are concerned, feel like something might go wrong, or if you actually see an error made in a hospital, you should: Talk to someone immediately. The closer this individual is to your personal care, the better. Your bedside nurse is a good place to start. Do not wait to report the incident if no one you know is around. All health care staff members “ from physicians to the custodial crew ” are there to make your care as safe as possible. Discuss the issue in a respectful, yet assertive manner. No one wants to make a mistake, so let the caregiver know so he or she can address the problem quickly. If the error happens to you, talk to a hospital employee who can investigate and resolve the problem. Be clear that you expect to hear back about the issue, and that you would like to see something done to address the error. You or a family member should follow up after reporting. Each hospital may have different titles for these groups. If you are uncomfortable asking someone directly within the unit you or a family member was in, seek out a neutral party like a hospital librarian who can help you identify another group to contact. Many hospitals have an established system for reporting errors, such as a suggestion box or a hot line. The problem will not be addressed if it is not reported. What is the difference between patient safety and quality? Patient safety is an important element of an effective, efficient health care system where quality prevails. Safety has to do with lack of harm. Quality has to do with efficient, effective, purposeful care that gets the job done at the right time. Safety focuses on avoiding bad events. Quality focuses on doing things well. Safety makes it less likely that mistakes happen. Quality raises the ceiling so the overall care experience is a better one. Your nurses, doctors and loved ones all want the same outcome: As the patient, you too are part of the health care team. You will observe and interpret activities and conversations differently from your health care team. You can help the team do a better, safer job. As members of the care team, you and your family can hold other team members accountable. You should speak up immediately if you see something that is not right or safe. To ensure safe care, it is important to be an active member of the health care team. But the public deserves this information so they can make informed choices about where to receive care. The purpose of the Leapfrog Hospital Safety Grade is to bring this information to light in a way that is easy for you “ the consumer ” to use. Some people do more research on what car to buy than what hospital to go to for medical care. The Leapfrog Hospital Safety Grade provides data and research to help you make informed decisions about a critical aspect of your hospital stay “ safety. A hospital may have the best surgeons and greatest technology in the world, but unless it is preventing infections and eliminating errors, it is not delivering on a very basic premise: The Leapfrog Hospital Safety Grade is a public service provided by The Leapfrog Group, an independent nonprofit organization committed to driving quality, safety, and transparency in the U.

**Chapter 4 : Nurses Are Key to Improving Patient Safety - RWJF**

*The patient's role in preventing errors and promoting safety. Health care errors and the media. The many advantages and some disadvantages of a no-blame.*

At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS. Medical errors can be defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Among the problems that commonly occur during the course of providing health care are adverse drug events and improper transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries or death, falls, burns, pressure ulcers, and mistaken patient identities. High error rates with serious consequences are most likely to occur in intensive care units, operating rooms, and emergency departments. Beyond their cost in human lives, preventable medical errors exact other significant tolls. One oft-cited problem arises from the decentralized and fragmented nature of the health care delivery system - or "nonsystem," to some observers. When patients see multiple providers in different settings, none of whom has access to complete information, it becomes easier for things to go wrong. From Institute of Medicine report "To Err is Human - Building a Safer Health System"

Medical information is becoming increasingly complex and for various reasons time constraints, stress of multitasking, too many patients, not enough staff, learning curve with health IT, lack of awareness, etc. Health care professionals may not even know when patients do not understand, nor do patients ask their providers to explain complicated information perhaps due to embarrassment or fear of questioning the "experts".

Types of Medical Errors

- Error or delay in diagnosis
- Failure to employ indicated tests
- Use of outmoded tests or therapy
- Failure to act on results of monitoring or testing
- Treatment Error in the performance of an operation, procedure, or test
- Error in administering the treatment
- Error in the dose or method of using a drug
- Avoidable delay in treatment or in responding to an abnormal test
- Inappropriate not indicated care
- Failure to provide prophylactic treatment
- Inadequate monitoring or follow-up of treatment
- Other Equipment failure
- Other system failure

SOURCE: Leape, Lucian; Lawthers, Ann G. A few Developments in Process

Improvement: In response to findings of small area variations, various professional groups, MCOs, and the government have embarked on the development of standardized practice guidelines

Cost-Efficiency: This occurs when the benefit received is greater than the cost incurred in providing the service

Critical Pathways: These are outcome-based and patient-centered case management tools that are interdisciplinary and that facilitate coordination of care among multiple clinical departments and caregivers

Risk Management: This is a proactive effort to prevent adverse events related to clinical care and facilities operations, and is frequently focused on avoiding medical malpractice. Practitioners predict that quality will "trump finances" in communities throughout the US. Many believe that "zero tolerance" will be used instead of basing goals on average industry standards. Many also expect that hospitals will adopt programs developed by the aviation and manufacturing industries to improve communication and reduce medical errors, and that senior management bonuses will be determined by achievement of quality outcomes over achievement of financial goals. The pay-for-performance model of reimbursement will make patient care safer. Accountability Watch the following video on patient safety to put human faces into the maze of technology, critical pathways, clinical guidelines, and cost efficiency initiatives. Consider where carefully framed theories, rules, and regulations wane and reality takes over.

Joint Commission Speak Up: Launched in December, the initiative brings together leaders of major hospitals, employers, physicians, nurses, and patient advocates along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. Human error is bound to happen. We have systems in place to minimize error, but they are not enough to prevent all mistakes. No one goes to work wanting to harm a patient. In this installment of the Narrative Matters series from Health Affairs she presents her experience with a medical error and related this to disclosure, apology and the role of shame. Click the source link below to view the links to the podcasts. To listen to the podcast

click: Andamp after seeing the impact of time and staff shortages, cost reductions, tougher regulations, etc. Consider the connection between health literacy, patient safety, and medical errors. Patients who know how to ask questions of providers, and providers who know how to answer patients in plain language, can go a very long way to improving the health care of our population.

**Chapter 5 : Patient Safety and Health Information Technology - ACOG**

*Medical Errors and Patient Safety "Health care in the United States is not as safe as it should be - and can be. At least 44, people, and perhaps as many as 98, people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies.*

A substantial body of evidence points to medical errors as a leading cause of death and injury. Sizable numbers of Americans are harmed as a result of medical errors. Two studies of large samples of hospital admissions, one in New York using data and another in Colorado and Utah using data, found that the proportion of hospital admissions experiencing an adverse event, defined as injuries caused by medical management, were 2. The proportion of adverse events attributable to errors i. When extrapolated to the over Even when using the lower estimates, the total national costs associated with adverse events and preventable adverse events represent approximately 4 percent and 2 percent, respectively, of national health expenditures in Although more than 6, Americans die from workplace injuries every year, 9 , 10 in medication errors are estimated to have accounted for about 7, deaths. Medication-related errors occur frequently in hospitals; not all result in actual harm, but those that do are costly. Hospital patients represent only a fraction of the total population at risk of experiencing a medication-related error. In , nearly 2. This chapter provides a summary of findings in the literature on the frequency and cost of health care errors and the factors that contribute to their occurrence. Introduction Although the literature pertaining to errors in health care has grown steadily over the last decade and some notable studies are particularly strong methodologically, we do not yet have a complete picture of the epidemiology of errors. Many studies focus on patients experiencing injury and provide valuable insight into the magnitude of harm resulting from errors. More is known about errors that occur in hospitals than in other health care delivery settings. Synthesizing and interpreting the findings in the literature pertaining to errors in health care is complicated due to the absence of standardized nomenclature. For purposes of this report, the terms error and adverse event are defined as follows: An error is defined as the failure of a planned action to be completed as intended i. An adverse event attributable to error is a "preventable adverse event. Medication-related error has been studied extensively for several reasons: There are probably other areas of health care delivery that have been studied to a lesser degree but may offer equal or greater opportunity for improvement in safety. Efforts to assess the importance of various types of errors are currently hampered by the lack of a standardized taxonomy for reporting adverse events, errors, and risk factors. How frequently do errors occur? What factors contribute to errors? What are the costs of errors? Are public perceptions of safety in health care consistent with the evidence? How Frequently do Errors Occur? For the most part, studies that provide insight into the incidence and prevalence of errors fall into two categories: General studies of patients experiencing adverse events. These are studies of adverse events in general, not studies limited to medication-related events. These studies are limited in number, but some represent large-scale, multi-institutional analyses. Virtually all studies in this category focus on hospitalized patients. With the exception of medication-related events discussed in the second category, little if any research has focused on errors or adverse events occurring outside of hospital settings, for example, in ambulatory care clinics, surgicenters, office practices, home health, or care administered by patients, their family, and friends at home. Studies of patients experiencing medication-related errors. There is an abundance of studies that fall into this category. Although many focus on errors and adverse events associated with ordering and administering medication to hospitalized patients, some studies focus on patients in ambulatory settings. Adverse Events An adverse event is defined as an injury caused by medical management rather than by the underlying disease or condition of the patient. Numerous studies have looked at the proportion of adverse events attributable to medical error. Due to methodologic challenges, far fewer studies focus on the full range of errorâ€”namely, those that result in injury and those that expose the patient to risk but do not result in injury. The most extensive study of adverse events is the Harvard Medical Practice Study, a study of more than 30, randomly selected discharges from 51 randomly selected hospitals in New York State in Although most of these adverse events gave rise to disability lasting less than six months, Drug complications were the

most common type of adverse event 19 percent, followed by wound infections 14 percent and technical complications 13 percent. Adverse events occurred in 2. The proportion of adverse events due to negligence was 19 percent. But the study in New York found that in New York, about one in four negligent adverse events led to death, while in Colorado and Utah, death resulted in about 1 out of every 11 negligent adverse events. Factors that might explain the differences between the two studies include: It is important to note that although some of these cases may stem from incompetent or impaired providers, the committee believes that many could likely have been avoided had better systems of care been in place. Extrapolation of the results of the Colorado and Utah study to the over 100 million patients admitted to two intensive care units and one surgical unit at a large teaching hospital, The likelihood of experiencing an adverse event increased about six percent for each day of hospital stay. Some information on errors can also be gleaned from studies that focus on inpatients who died or experienced a myocardial infarction or postsurgical complication. In a study of deaths in 12 hospitals from three conditions cerebrovascular accident, pneumonia, or myocardial infarction, it was found that at least 14 percent and possibly as many as 27 percent of the deaths might have been prevented. In a study of 44, patients who underwent surgery between and at a large medical center, 2, patients 5. Patients who died during surgery requiring general anesthesia have been the focus of many studies over the last few decades. Anesthesia is an area in which very impressive improvements in safety have been made. As more and more attention has been focused on understanding the factors that contribute to error and on the design of safer systems, preventable mishaps have declined. For example, in Australia, general practitioners participating voluntarily in an incident reporting system reported a total of incidents during October through June, of which 76 percent were preventable and 27 percent had the potential for severe harm. Medication-Related Errors Even though medication errors that result in death or serious injury occur infrequently, sizable and increasing numbers of people are affected because of the extensive use of drugs in both out-of-hospital and in-hospital settings. Medication Errors in Hospitals Medication errors occur frequently in hospitals. Numerous studies have assessed the incidence of adverse drug events ADEs, defined as an injury resulting from medical intervention related to a drug. For example, a patient with no history of allergic reactions to drugs, who experiences an allergic reaction to an antibiotic, has suffered an ADE, but this ADE would not be attributable to error. However, an error would have occurred if an antibiotic was prescribed to a patient with a history of documented allergic reactions, because the medical record was unavailable or not consulted. In an analysis of 1,000 medication orders written during one year in a tertiary-care teaching hospital, the overall error rate was estimated to be 3. In a study of patients admitted to coronary intensive care, medical, surgical, and obstetric units in an urban tertiary care hospital over a day period, the rate of drug-related incidents was 73 in 2, patient-days: Of the 27 ADEs, 15 56 percent were judged definitely or probably preventable. In a study of prescribing errors detected and averted by pharmacists in a bed tertiary care teaching hospital between July and June, the estimated overall rate of errors was 3. The error rate per patient-days was greater in the pediatric intensive care units PICUs than in the pediatric ward or neonatal intensive care units, and the authors attribute this to the greater heterogeneity of patients cared for in PICUs and the broad range of drugs and dosages used. In a four-year prospective quality assurance study, medication errors resulting in injury were reported among the 2, neonatal and pediatric intensive care admissions, an error rate of one per 6. Not surprisingly, the potential for medication-related error increases as the average number of drugs administered increases. In a prospective cohort study of 4, adult admissions to 11 medical and surgical units in two tertiary care hospitals including two medical and three surgical ICUs, the rate of preventable ADEs and preventable potential ADEs in ICUs was 19 events per 1, patient-days, nearly twice the rate of non-ICUs. Current estimates of the incidence of medication errors are undoubtedly low because many errors go undocumented and unreported. In a study of 36, hospitalized patients, Classen et al. Medication Errors in Ambulatory Settings There is evidence indicating that ADEs account for a sizable number of admissions to inpatient facilities, but we do not know what proportion of these ADE-related admissions are attributable to errors. One study found that between three and 11 percent of hospital admissions were attributable to ADEs. Drug groups most commonly involved were cytotoxics, cardiovascular agents, antihypertensives, anticoagulants, and nonsteroidal anti-inflammatory drugs. In an analysis of 1, patients drawn from a community of-rice-based medical practice who were

observed for adverse drug reactions, adverse effects were recorded in 42.4%. In a meta-analysis of seven studies, Sullivan et al. Factors that Contribute to Errors Studies of Adverse Events Patient safety problems of many kinds occur during the course of providing health care. They include transfusion errors and adverse drug events; wrong-site surgery and surgical injuries; preventable suicides; restraint-related injuries or death; hospital-acquired or other treatment-related infections; and falls, burns, pressure ulcers, and mistaken identity. Diagnostic Error or delay in diagnosis More than two-thirds (70 percent) of the adverse events found in this study were thought to be preventable, with the most common types of preventable errors being technical errors (44 percent), diagnosis (17 percent), failure to prevent injury (12 percent) and errors in the use of a drug (10 percent). The contributions of complexity and technology to such error rates is highlighted by the higher rates of events that occur in the highly technical surgical specialties of vascular surgery, cardiac surgery, and neurosurgery. In hospitals, high error rates with serious consequences are most likely in intensive care units, operating rooms and emergency departments. The authors note the complexity inherent in emergency medical care and point to the need to improve teamwork and standardize work procedures. Other studies have made similar attempts to classify errors. Dubois and Brook studied 49 preventable deaths from 12 hospitals, and found that for those who died of a myocardial infarction, preventable deaths reflected errors in management; for cerebrovascular accident, most deaths reflected errors in diagnosis; and for pneumonia, some deaths reflected errors in management and some reflected errors in diagnosis. As shown in Box 2. Some errors are errors of commission e. Prescribing Assessing the need for and selecting the correct drug Medication errors are often preventable, although reducing the error rate significantly will require multiple interventions. In the study of prescribing errors conducted by Lesar et al. The most common groups of factors associated with errors were those related to knowledge and the application of knowledge regarding drug therapy (30 percent); knowledge and use of knowledge regarding patient factors that affect drug therapy. Many studies have identified inappropriate prescribing as a particularly important factor in accounting for medication errors. In an analysis of National Medical Expenditure Survey data, it was found that physicians prescribe potentially inappropriate medications for nearly a quarter of all older people living in the community. Physicians do not routinely screen for potential drug interactions, even when medication history information is readily available. In an analysis of randomly selected visits to a hospital emergency department, 47 percent led to added medication, and in 10 percent of the visits in which at least one medication was added, the new medication added a potential adverse interaction. Errors can occur in the dispensing of drugs by pharmacists. In a recent investigation of pharmacists, the Massachusetts State Board of Registration in Pharmacy estimated that 2. Errors in the ordering and administration of medications are common in hospitals. Davis and Cohen (88) in their review of the literature and other evidence on errors report an error rate of 12 percent to be common in the preparation and administration of medications in hospitals. Patients make errors too.

**Chapter 6 : Health Care Provider Patient Safety- Health Cost Containment**

*Patient Safety Equals Lower Health Care Costs Recognizing the potential savings that could be accrued by reducing hospital-based medical errors, Medicare identified a number of "reasonably preventable" conditions that are common during a hospital stay.*

On a federal level, Medicaid, Medicare, etc. Medical errors are the eighth leading cause of death in the United States, higher than motor vehicle accidents, breast cancer or AIDS. Each year, between 1.5 and 1.8 million hospital stays and the cost of treating medical error-related injuries and complications are the two major expenditures associated with medical errors. Examples of patient safety initiatives that improve patient care and reduce costs exist, but evidence of overall savings is limited. State governments are among the stakeholders concerned about the human and economic toll of these events. As large purchasers, regulators, conveners, and providers of health care services, states have unique opportunities to improve patient safety and safeguard the public. One strategy in place in just more than half of states is the implementation of an adverse event reporting system. This report describes the status of and trends in state adverse event reporting systems as of November 2010. Read the full report published Jan. 2011. Hospital acquired conditions decreased. The Department of Health and Human Services announced that "new preliminary data show an overall nine percent decrease in hospital acquired conditions nationally during 2010 and 2011. The Affordable Care Act is also helping reduce hospital readmissions. After holding constant at 19 percent from 2007 to 2009 and decreasing to 17 percent in 2010. This translates into an 8 percent reduction in the rate and an estimated 1.5 million fewer hospital readmissions among Medicare beneficiaries between January and December 2010. For bariatric surgery treating morbid obesity, about two-thirds of the readmissions are preventable; with the most common reasons for readmission are dietary indiscretions and medication reconciliation. But central line-associated bloodstream infections are the most expensive, researchers report, in Healthcare-Associated Infection Costs Detailed. Surgical complications are something that neither patients nor hospitals want. Published in Health Affairs, October 2010. The rule prohibits federal payments to states for any amounts expended providing medical assistance for health care-acquired conditions. The rule provides incentives quality improvement at the provider-level and cost savings for states by requiring states to reduce payments at the occurrence of hospital errors and Never Events in specific health care settings. The rule became effective July 1, 2011, but CMS provided states with an additional year to meet these new requirements. In preparation for full implementation, states should have submitted a state plan amendment SPA for their Medicaid programs to institute the changes. In preparation for the approaching final implementation date of July 1, 2012, CMS is offering technical assistance, and has provided on their website basic information about the requirements, SPA pre-prints and instructions, as well as a Frequently Asked Questions page. The survey captured details on these programs to curb readmission rates, along with the conditions most likely to trigger readmissions. States have until July 2012 to comply with the rule. What resources are available for constituents interested in learning more about patient safety? Infection Control and Hospital Epidemiology.

**Chapter 7 : Patient Safety: MedlinePlus**

*Patient safety refers to rules, practices and systems to prevent patient harm or injury, including efforts to prevent medical errors. These errors, also known as adverse events, are occurrences of unintended harm from medical care. The main categories of medical errors are treatment errors, failure.*

However, a body of research dedicated to patient safety in ambulatory care has emerged over the past few years. These efforts have identified and characterized factors that influence safety in office practice, the types of errors commonly encountered in ambulatory care, and potential strategies for improving ambulatory safety. Factors Influencing Safety in Ambulatory Care Ensuring patient safety outside of the hospital setting poses unique challenges for both providers and patients. A recent article proposed a model for patient safety in chronic disease management, modified from the original Chronic Care Model. This model broadly encompasses three concepts that influence safety in ambulatory care: The role of patient and caregiver behaviors The role of provider-patient interactions The role of the community and health system Specific types of errors can be linked to each of these three concepts. Types of Safety Events in Ambulatory Care Since face-to-face interactions between providers and patients in the ambulatory setting are limited and occur weeks to months apart, patients must assume a much greater role in and responsibility for managing their own health. This elevates the importance of including the patient as a partner and ensuring that patients understand their illnesses and treatments. The need for outpatients to self-manage their own chronic diseases requires that they monitor their symptoms and, in some cases, adjust their own lifestyle or medications. For example, a patient with diabetes must measure her own blood sugars and perhaps adjust her insulin dose based on blood sugar values and dietary intake. Patients must also understand how and when to contact their caregivers outside of routine appointments, and they must often play a role in ensuring their own care coordination e. The nature of interactions between patients and providers-and between different providers-may also be a source of adverse events. Patients consistently voice concerns about coordination of care , particularly when one patient sees multiple physicians, and indeed communication between physicians in the outpatient setting is often suboptimal. Poorly handled care transitions e. When a clinician is not immediately available-for example, after hours-patients may have to rely on telephone advice for acute illnesses, an everyday practice that has its own inherent risks. Underlying health system flaws have been documented to increase the risk for medical errors, particularly medication errors and diagnostic errors , issues that are certainly germane to ambulatory safety. Medication errors are very common in ambulatory care, with one landmark study finding that more than 4. Likewise, prescribing errors are startlingly common in ambulatory practice. To err is human: Patient misinterpretations of prescription drug label instructions. Recent data suggests that timely information availability and managing test results contribute to delayed and missed diagnoses in outpatient care. Although use of electronic health records in the ambulatory setting is growing, many practices still lack reliable systems for following up on test results -a problem that has been implicated in missed and delayed diagnoses. Finally, while an increasing amount of attention has been devoted to measuring and improving the culture of safety in acute care settings, less is known about safety culture in office practice. Burnout and work dissatisfaction, particularly among primary care physicians , may adversely affect the quality of care. Missing clinical information during primary care visits. While EHRs hold great promise for reducing medication errors and tracking test results, these systems have yet to reach their full potential. Coordinating care between different physicians remains a significant challenge, especially if the doctors do not work in the same office or share the same medical record system. Efforts are being made to increase use of EHRs in ambulatory care, and physicians believe that use of EHRs leads to higher quality and improved safety. Patient engagement in outpatient safety involves two related concepts: Success has been achieved in this area for patients taking high-risk medications , even in patients with low health literacy at baseline. Current Context Although efforts to improve safety have largely focused on hospital care, The Joint Commission now publishes National Patient Safety Goals focused on ambulatory care. The Agency for Healthcare Research and Quality is also leading efforts to improve ambulatory quality and safety through programs and research funding. A systematic review

commissioned by the World Health Organization identified missed and delayed diagnoses and medication errors as the chief safety priorities in ambulatory care, and it highlighted the need to develop clear and consistent definitions for patient safety incidents in primary care. Related Patient Safety Primers.

## Chapter 8 : What is Patient Safety?

*In some hospitals, patient safety is a top priority. Strong health care teams reduce infection rates, put checks in place to prevent mistakes, and ensure strong lines of communication between hospital staff, patients, and families.*