Medical Errors and Patient Safety—What Do We Know and What's Being Done?

Date and Time

Monday, March 14, 4 p.m.
The Universities at Shady Grove
The Camille Kendall Academic Center
Building III, Room 3241
9636 Gudelsky Drive
Rockville, MD 20850
Directions | Map

The Issue

While modern medicine continues to come up with new treatments and technologies, it has been less successful in finding ways to reduce medical errors and prevent complications. Problems like infections, medication errors, bedsores, medication mistakes, surgical complications, and patient falls continue to endanger lives and undermine the quality of health care. Learn about initiatives led by Federal agencies and innovative health care organizations to track and reduce medical errors, improve patient safety, and ensure quality of care.

Background

The main goal of patient safety can be summarized in the statement attributed to Hippocrates, "…first, do no harm." Today, the complexity and depth of medical knowledge gives practitioners great power to not only cure but also increase the opportunity for mistakes. Importantly, much of health care is delivered by teams of practitioners working across departments and organizations, further increasing the possibility of miscommunication and poor transitions of care. Many studies have confirmed the pervasive prevalence of medication errors, procedural errors, health care-associated infections, and other medical errors, with significant consequences for patient health and health care costs.

Training and specialization alone cannot solve these systemic challenges. Lessons on organizational approaches to safety can be drawn from other industries such as nuclear power and aviation. Many health care organizations are now developing approaches to improving patient safety culture, processes, and incentives. Government agencies are developing the infrastructure to support research and analysis into the causes of errors in health care, and providing technical assistance and tools for improving patient safety. These efforts are beginning to show results.

Assessing Patient Safety Culture in Hospitals

Patient safety is a critical component of health care quality, and there is growing recognition of the importance of establishing a culture of safety. Achieving a culture of safety requires an understanding of the values, beliefs, and norms about what is important in an organization and what attitudes and behaviors related to patient safety are expected and appropriate. The Agency for Healthcare Research and Quality (AHRQ) sponsored the development of a hospital patient safety culture survey to enable hospitals to assess staff perceptions about patient safety issues and error reporting. The survey results are used by

hospitals as the foundation for patient safety improvement efforts. Patient safety culture survey results from a national database of 1,000 U.S. hospitals and 470,000 staff will be presented, as well as lessons learned from these results.

Using a Patient Safety Culture Survey as a Driver for Change

Children's National Medical Center is committed to pediatric patient safety across its departments and programs. The hospital has implemented the AHRQ Survey on Patient Safety Culture several times and will present their survey results and describe several patient safety improvement initiatives they have undertaken. Hear about the initiatives, challenges, and successes in patient safety at this leading medical center.

Presenters

Russ Mardon, Ph.D., is a Senior Study Director at Westat who works on approaches to measure and improve quality and safety in health care. He is project director for AHRQ's Network of Patient Safety Databases, part of AHRQ's effort to develop a national analysis center for medical errors and patient safety events.

Joann Sorra, Ph.D., is a Senior Study Director at Westat with 20 years of experience in organizational and survey research. She is an expert on organizational culture and its impact on medical errors and patient safety. She is the Westat project director for two AHRQ survey programs:

- AHRQ Surveys on Patient Safety Culture (www.ahrq.gov/qual/patientsafetyculture)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS™) (www.cahps.ahrq.gov)

David Stockwell, M.D., M.B.A., is the Executive Director for Improvement Science, and Medical Director of Patient Safety as well as the Pediatric Intensive Care Unit at Children's National Medical Center in Washington, DC. Dr. Stockwell has directed his research efforts toward examination of the physician as a leader and manager of the clinical team as well as investigating strategies toward improving patient safety.