

Medical News & Perspectives

Patient Safety Still Lagging

Advocates Call for National Patient Safety Monitoring Board

Bridget M. Kuehn, MSJ

Hospitals and ambulatory care centers remain risky places for US patients despite more than a decade of national efforts to improve patient safety, according to testimony at a US Senate subcommittee hearing, webcast on July 17, 2014 (<http://1.usa.gov/UaVr7g>).

This sobering assessment comes at the 15-year anniversary of the release of a seminal report from the Institute of Medicine (IOM) on patient safety (*To Err Is Human: Building a Safer Health System*. Washington, DC: Institute of Medicine; 1999).

The report estimated that 98 000 patients died each year as a result of medical errors. Ashish Jha, MD, MPH, a professor of health policy and management at the Harvard School of Public Health, testified that evidence suggests that the IOM likely underestimated patient harm. A more recent estimate suggests the number of US deaths as a result of medical error may top 400 000 per year, more than 1000 each day (James JT. *J Patient Saf*. 2013;9[3]:122-128).

"If I walk into a hospital today, would I be safer than 15 years ago?" said Jha. "The answer is 'no.'"

There have been some advances. One area where substantial progress has been made is in reducing central line-associated bloodstream infections, an effort led by Peter Pronovost, MD, PhD, senior vice president for patient safety and quality at Johns Hopkins Medicine in Baltimore. Pronovost created a program to reduce central line-associated infections by empowering nurses to use checklists to ensure precautions are taken. The checklist helped Michigan intensive care units reduce central line-associated bloodstream infections by 66% and allowed 65% of the participating units to eliminate these infections (Kuehn BM. *JAMA*. 2012;308[16]:1617-1618).

The program, which has been expanded nationwide, is successful because it counters the conventional wisdom that cen-



Despite some advances in patient safety in the United States, such as reductions in central line-associated bloodstream infections, medical errors remain a major problem, a new report says.

tral line infections are inevitable with robust, transparent data, said Pronovost.

In testimony at the hearing, Pronovost said that one of the biggest barriers to improved patient safety is the lack of a robust national system for tracking patient safety data. He said the US Centers for Disease Control and Prevention (CDC) has a good system for tracking health care-acquired infections. That system, he argued, should be expanded to track other types of patient harm.

The consumer advocacy organization Consumers Union supports more CDC data monitoring and greater data transparency, testified Lisa McGiffert, director of Consumers Union's Safe Patient Project. She said that 31 states and the District of Columbia require public reporting of health care-associated infections. In addition, a national patient safety monitoring board should be created to provide regulatory oversight of patient safety in the medical system, she said.

Greater sanctions are also needed against facilities that are failing to improve

safety, Pronovost said. He noted that several hundred US hospitals have infection rates 10 times higher than the national average, yet they do not face sanctions from Medicare or any other regulatory body.

Better systems of care are also needed, several of the speakers testified. Joanne Disch, PhD, RN, past president of the American Academy of Nursing, explained that a host of factors—such as the complexity of hospital systems, time pressures, growing use of technology, and financial incentives that reward hospitals by paying them to care for patients' complications—all contribute to poor patient outcomes.

Hospital cultures that discourage nurses from speaking up when they identify safety issues or that fail to give nurses a say in bedside staffing levels also increase the likelihood of patient harm. "Nurses are often the last line of defense," Disch explained. She argued that it's time to shift away from bureaucratic, patriarchal leadership models and toward "high-reliability organization" models used in aviation and other industries.

Greater attention is also needed to patient safety outside of hospitals, said Tejal Gandhi, MD, MPH, president of the National Patient Safety Foundation and associate professor of medicine at Harvard Medical School. She noted that most care is delivered in nonhospital settings, such as primary care clinics, nursing homes, and ambulatory surgical centers, yet most patient safety efforts focus on hospitals.

Better data and monitoring of patient harms in these settings are needed, she said. Patient handoffs from one facility to another can be particularly perilous. For example, patients are often transferred to a new facility only with their medical record and no discussion between caregivers. She said clinician-to-clinician discussions alone can help pass on vital information.

Jha noted that better integration between facilities and smarter use of tech-

nology can help improve patient safety. For example, he noted that currently many nursing homes and rehabilitation facilities do not have electronic health records, in part because federal incentives haven't been extended to them. This means rec-

ords for the sickest, most complicated patients must be faxed, he said.

Ultimately, improving patient safety will require that the US health system realign financial incentives, said Jha. He and other speakers noted that a hospi-

tal chief executive officer's (CEO's) compensation is often not tied to quality of care.

"Until hospital CEOs are lying awake at night worrying about safety, it's not going to happen," he said. ■