Ten years after the Institute of Medicine (IOM) report To Err is Human, a million lives have been lost and billions of dollars wasted. Our progress deserves an overall grade of B-minus. Is patient care safer 10 years after that landmark report? The widely divergent responses to this question are all partially accurate, yet missing something essential.

The progress made since the IOM report is positive and necessary, but is not accelerating on pace with the growing complexity of patient care. Efforts to improve the reliability of highly complicated care across multiple transitions have enhanced the easier-to-change aspects of care. But when the easier solutions are accomplished, the more difficult work remains—that of assuring safety in complex systems. These systems do not respond to single-source solutions, as shown by recent patient safety efforts: regulatory requirements, education, public reporting, or pay for performance.

“Patients and families are the only source of information about complex healthcare systems across all settings and are best equipped, if carefully listened to, to identify the unknowable aspects of unsafe systems.”

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Viewing each problem as a learning source

Steven Spear’s studies of very complex, yet highly reliable organizations offer a different and more productive approach. Rather than applying broad, large-scale solutions to highly complex systems, Spear recommends acknowledging that such systems are highly interdependent and unknowable.

This premise leads to treating each problem, no matter how small, as something not known about the system and an essential source of learning. Rather than striving to move from 80% to 90% performance in a process, each instance of something not working as expected is treated as a gift to be immediately learned from and corrected.

What’s often missing: Learning from patients and families

When safety reporting systems are consistently ineffective, how do organizations immediately identify instances of the system not working as expected? They turn to those who know the most about unsafe systems: patients and their families. To accelerate safety, clinicians and healthcare leaders must rely on these experts to supply the missing pieces of knowledge.

LLI identifies 5 transformational concepts

NPSF’s Lucian Leape Institute (LLI) has articulated 5 concepts for healthcare transformation:

1. Transparency
2. Integrated care
3. Consumer engagement
4. Joy and meaning in work
5. Medical education reform.

Of the 5 concepts, consumer engagement, or “nothing about me, without me,” provides information about the problems in healthcare systems and helps transform healthcare. Engaging consumers in care partnerships is essential to achieving healthcare quality and safety.

Patients and families are the only source of information about complex healthcare systems across all settings and are best equipped, if carefully listened to, to identify the unknowable aspects of unsafe systems. They provide untold sources of information about how to accelerate safety outcomes:

- The inability to understand healthcare information (healthcare illiteracy)
- Lack of partnerships on the care team

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10 Years After To Err Is Human CONTINUED FROM PAGE 1

• Intolerable waits and delays
• Minimal understanding of the system’s function from the patient’s view
• Gaps in care transitions

Patients and families help transform care
Some healthcare organizations committed to patient- and family-centered care are making gains faster through an intense commitment to consumer engagement; they find it is the missing piece in their safety efforts. Spectrum Healthcare in Michigan offers several examples of their patient- and family-centered care values in action:
• Nearly 100 patient and family advisors participate in improving the quality and safety of care, from front-line design and improvement to board committees.
• The Patient and Family Advisory Council (PFAC) created a video, Partners in Care, viewed by newly hospitalized patients and their families. It immediately sets the tone with real examples of how partnerships of clinicians, patients and families can ensure safety, quality, and an exceptional experience. The video also shows patients and families what to do when gaps occur.
• Frank Dopkiss, chair of the Executive Patient and Family Advisory Council, is a full member of the Board Quality and Safety Committee.
• A patient/family advisor is a member of the medication safety team. This advisor recently spent 2 hours rounding with the medication safety officer to bring the unique view a clinician would not have.
• Patients are engaged in their efforts to reduce avoidable re-hospitalizations.
• The PFAC led to using a very different approach to discharge phone calls than that found in the literature. Calls are linked to the discharge instructions to ensure patients’ understanding of the instructions, answer any questions or worries, and learn what could have been improved on throughout their stay.
• With the help of patients/families describing what the first 24–48 hours post-discharge are really like—not what clinicians expected—these discharge calls have become safety-enhancing rather than simply courtesy calls.
• The PFAC has addressed health literacy by helping the hospital communicate more clearly with patients. PFAC members continually challenge clinicians to “put it in English” or “quit speaking medical.” They have helped translate information into terms patients can easily understand.

Iowa Health System models Spear’s studies
Another example of involving patients and families to improve patient care comes from Iowa Health System.
• As part of their intense health literacy focus, clinicians partner with patients—especially new adult readers—to develop patient education materials useful for readers at all levels of literacy. Patients’ helpful red-pencil reviews of materials have provided more-effective content.

How has Spectrum Health’s PFAC improved patient safety?
By Frank Dopkiss, Chair, Executive Patient and Family Advisory Council, Spectrum Healthcare

From a patient and family advisor perspective, none of the PFAC’s accomplishments would have been possible without the strong partnership Spectrum Health developed with patients and their families. It is one thing to want to improve the patient experience, but quite another to make it happen. Spectrum Health has demonstrated its commitment to raising the bar on the patient experience. In many ways, the advisory council has been the voice of that initiative.

What drove my wife and me to become involved with the hospital was directly fueled by our experiences—some great, some not so great. The hospital environment can be extremely intimidating. Patients and families tend to believe anything said by a person wearing a white coat and stethoscope. Repeated admissions, unfortunate as they were, essentially armed us with information. The experience made us more comfortable in the hospital environment, certainly less intimidated. In many ways, this filled us with confidence—and in some cases, skepticism.

Without really realizing it, we became untrained observers of hospital procedures. What makes this important is that Spectrum Health was willing to listen and open to suggestions. Without that willingness to listen to families and patients, I don’t believe it is possible for a hospital to make great strides in improving quality, safety, and patient experience. Patients and families need to be involved in the score-keeping. It is too easy for the hospital to give itself a passing grade if it is not asking the right group to help interpret the grade.

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Clinical Simulations: Engaging an Entire Organization in Improving Patient Safety

BY DONNA FRYE, RN, MN, CLINICAL DIRECTOR, WOMEN’S AND CHILDREN’S CLINICAL SERVICES, HOSPITAL CORPORATION OF AMERICA (HCA)

Perinatal clinicians have come to expect simulations in the rudimentary form of mega-codes for adult cardiopulmonary life support (ACLS) and the neonatal resuscitation program (NRP). In 2004, the Hospital Corporation of America’s (HCA) Perinatal Safety Initiative (now the Women’s and Children’s Clinical Services Group or WCCSG) took a step beyond these basic simulations to improve maternal newborn outcomes.

Applying an enterprise approach to perinatal clinical simulation

The challenge for the WCCSG leadership team and clinical work groups was to implement designated clinical simulations in the 111 diverse HCA perinatal services. HCA hospitals with perinatal units span from New Hampshire to South Florida, and from Southern California to Alaska. They include basic, intermediate, and tertiary perinatal services.

Some university medical centers have state-of-the-art simulation laboratories with professional, technical leadership and support. Other units collaborated with sister facilities in their market to establish learning centers with simulation capabilities. Some smaller, community facilities have no access to such resources.

Moving beyond basic simulations

As noted, traditional simulations for perinatal clinicians have included ACLS and NRP. Simulation is also included in

10 Years After To Err Is Human

• Care improvement involves direct observation of patients’ care first, before any change is made. Involving patients and their families in this observation is key. What do they see? What does it mean to them? What can be done better right now for this patient? Valuable input from patients and families provides rich information to improve other patients’ care. Iowa Health System believes in making no assumptions about patients’ care and how the system actually works.

These examples illustrate what is missing in most patient safety initiatives, and perhaps what limits their results: the clear, compelling voice of the patient and family. The National Quality Forum’s Safe Practices, 2009 Update offers important practices and implies patient/family partnerships. Yet it falls short by not naming a proven strategy in safety improvement—explicit consumer engagement. Healthcare organizations committed to accelerating safety outcomes will tap into the missing link: patients and families.

References