

Stop the Preventable Medical Error Crisis

How many more patients must die before we decide enough is enough?

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LOOK IN THE MIRROR It's time for all healthcare professionals to seriously consider what they can do to promote safe patient care.

No one would disagree that every life is precious. Need proof? People from all walks of life dash into burning buildings, dig through rubble and plunge into raging waters just for the chance to pull someone back from the brink. And yet this shared societal commitment to preserving life seemingly doesn't extend to health care. If we *truly* value every life, why is the news that an estimated quarter of a million patients die each year from preventable medical errors met with a shrug? There's more outrage generated when a popular *Dancing with the Stars* contestant is voted off the show than when we find out that the population of Orlando perishes each year because healthcare professionals don't follow infection prevention protocols, forgo safety checklists, overprescribe deadly amounts of medication or mark the wrong surgical site. How much longer will you let that apathy continue?

Problems persist

Medical errors are the third leading cause of death in the United States, behind only heart disease and cancer, according to a recent study in *The BMJ* (see "[It's Time for Honest Discussions About Medical Care Gone Wrong](#)" on p. 40 for insights from the study's author). Certain aspects of heart disease and cancer remain a mystery, but that's not the case with medical errors. We already know how to prevent them, and doing so doesn't require singular acts of heroism. It simply requires leadership, accountability and a culture

of safety. Healthcare economics and clinical advances are shifting more surgeries into the outpatient arena. The rise in both the number and complexity of outpatient procedures increases the potential for life-threatening mistakes and puts facilities like yours on the front line in the battle against medical errors.

Unfortunately, patients are continually put in jeopardy. In 2010, for example, CMS piloted an infection control audit tool in 70 ASCs throughout 3 states to assess practices related to hand hygiene, injection safety, medication handling, environmental cleaning, equipment sterilization and disinfection, and the handling of blood glucose equipment. The findings? More than two-thirds of the ASCs had at least a single infection control oversight, and about one-fifth had more than 3 lapses. That's alarming, especially when you consider ASCs often outperform hospitals when it comes to following infection control guidelines.

Wrong-site, wrong-procedure, and wrong-patient surgeries—appropriately (or ironically) dubbed “never” events—are perhaps the lowest-hanging fruit in terms of addressing our medical error crisis. There are an estimated 1,300 to 2,700 “never” events each year in the U.S. (including inpatient and outpatient settings), according to a 2006 study published in JAMA Surgery that examined mandatory and voluntary reporting systems. The authors concluded that many of these mistakes are caused by communication breakdowns and a lack of adequate safety systems. These are glaring, preventable errors that go on and on.

Accountable Care

Rapid, dramatic progress in improving patient safety is possible if you achieve buy-in from the executive level to the front line. The Pittsburgh Regional Health Initiative (PRHI), one of the Jewish Healthcare Foundation's (JHF) supporting organizations, recruited more than 30 hospitals in southwestern Pennsylvania and partnered with the CDC to systematically attack central-line associated bloodstream infections. Together, these institutions reduced [central-line infections among intensive care unit patients by 68 percent](#). PRHI also guided the VA Pittsburgh Healthcare System in developing a Methicillin-resistant Staphylococcus aureus (MRSA) prevention protocol and interventions that led to an [85 percent reduction in MRSA infections](#) in a post-surgical unit. The MRSA prevention protocol became standard practice across the national VA Healthcare Veterans Health Administration system.

Such breakthroughs require a culture in which all healthcare team members feel accountable for patient safety, and empowered to speak up if they see something that endangers safety. The hallmarks of such a culture include exploring common causes of errors, implementing reporting systems for near-misses and adverse events, and having an inviolate checklist for procedures. It also includes ongoing, job-specific infection prevention education and training, doggedly tracking progress, spreading best practices far and wide, and acknowledging standout employees.

Here at JHF, we're committed to creating champions of quality and safety across the continuum of care. We have trained over 9,000 healthcare professionals across the globe in our Lean-based Perfecting Patient CareSM methodology. In partnership with the Fine Foundation, JHF created the [Fine Awards for Teamwork Excellence in Health Care](#) to recognize and reward groups that demonstrate innovative, exceptional performance around patient safety and quality improvement within their organizations.

We also run and support a series of [multidisciplinary graduate student fellowships](#) centered upon patient safety and systems redesign, which have more than 800 alumni. Through our new [Health Activist Network](#), we are establishing an online hub for physicians and other health professionals who want to advance health reform, patient safety, and quality improvement.

At long last, our healthcare system is incentivizing value-based care and penalizing providers for high rates of medical errors. The sort of quality and safety champs that JHF cultivates, the kind that can help you thrive in this environment, may well be in your organization. Are they recognized and supported? Do they feel comfortable pointing out unsafe practices? Does everyone who steps foot in the building share their no-excuses mentality? Until the answer to all of these questions is yes, a not-so-silent killer will continue to prowl with impunity.