Alumni Exchange

MedStar Health

Knowledge and Compassion
Focused on You

Walking Across America for Patient and Health Worker Safety

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CEO Patient Safety Movement
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Patient Safety Movement Foundation

- Global organization
  - 4,756 Hospitals
  - 64 Countries
- Mission is “Zero Preventable Deaths by 2030”
- 38 Actionable Patient Safety Solutions (APSS)
- https://patientsafetymovement.org/

MedStar Health

- Largest Healthcare System in Mid-Atlantic
- Ten hospitals
- 300+ Outpatient sites of care
- 30,000 MSH Associates
- Over 1100 Residents
- MedStar Institute for Quality and Safety

Patient Safety

"Medicine used to be simple, ineffective and relatively safe. Now it is complex, effective, and potentially dangerous."

Sir Cyril Chantler,
Dean of London's Guy's Hospital

The Problem

Hundreds of thousands of people die and **millions** are harmed every year due to **preventable** medical error.

REVIEW ARTICLE

A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care

John T. James, PhD

thebmj

BMJ 2016;353:i2139 doi: 10.1136/bmj.i2139 (Published 3 May 2016) Page 1 of 5

ANALYSIS

Medical error—the third leading cause of death in the US

Medical error is not included on death certificates or in rankings of cause of death. **Martin Makary** and **Michael Daniel** assess its contribution to mortality and call for better reporting

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The annual list of the most common causes of death in the United States, compiled by the Centers for Disease Control and Prevention (CDC), informs public awareness and national research priorities each year. The list is created using death certificates filled out by physicians, funeral directors, medical examiners, and coroners. However, a major limitation of the death certificate is that it relies on assigning an International Classification of Disease (ICD) code to the cause of death.[1] As a result, causes of death not associated with an ICD code, such as human and system factors, are not captured. The science of safety has matured to describe how communication breakdowns, diagnostic errors, poor judgment, and inadequate skill can directly result in patient harm and death. We analyzed the scientific literature on medical error to identify its contribution to US deaths in relation to causes listed by the CDC.[2]

Death from medical care itself

Medical error has been defined as an unintended act (either of omission or commission) or one that does not achieve its intended outcome,[1] the failure of a planned action to be completed as intended (an error of execution), the use of a wrong plan to achieve an aim (an error of planning),[3] or a deviation from the process of care that may or may not cause harm to the patient.[1] Patient harm from medical error can occur at the individual or system level. The taxonomy of errors is expanding to better categorize preventable factors and events.[4] We focus on preventable lethal events to highlight the scale of potential for improvement.

The role of error can be complex. While many errors are non-consequential, an error can end the life of someone with a long life expectancy or accelerate an imminent death. The case in the box shows how error can contribute to death. Moving away from a requirement that only reasons for death with an ICD code can be used on death certificates could better inform healthcare research and awareness priorities.

How big is the problem?

The most commonly cited estimate of annual deaths from medical error in the US—a 1999 Institute of Medicine (IOM) report[5]—is limited and outdated. The report describes an incidence of 44 000-98 000 deaths annually.[1] This conclusion was not based on primary research conducted by the institute but on the 1984 Harvard Medical Practice Study and the 1992 Utah and Colorado Study.[6 7] But as early as 1993, Leape, a chief investigator in the 1984 Harvard study, published an article arguing that the study's estimate was too low, contending that 78% rather than 51% of the 180 000 iatrogenic deaths were preventable (some argue that all iatrogenic deaths are preventable).[8] This higher incidence (about 140 400 deaths due to error) has been supported by subsequent studies which suggest that the 1999 IOM report underestimates the magnitude of the problem. A 2004 report of inpatient deaths associated with the Agency for Healthcare Quality and Research Patient Safety Indicators in the Medicare population estimated that 575 000 deaths were caused by medical error between 2000 and 2002, which is about 195 000 deaths a year (table 1⇓).[1] Similarly, the US Department of Health and Human Services Office of the Inspector General examining the health records of hospital inpatients in 2008, reported 180 000 deaths due to medical error a year among Medicare beneficiaries alone.[9] Using similar methods, Classen et al described a rate of 1.13%.[10] If this rate is applied to all registered US hospital admissions in 2013[11] it translates to over 400 000 deaths a year, more than four times the IOM estimate.

Similarly, Landrigan et al reported that 0.6% of hospital admissions in a group of North Carolina hospitals over six years (2002-07) resulted in lethal adverse events and conservatively estimated that 63% were due to medical errors.[12] Extrapolated nationally, this would translate into 134 581 inpatient deaths a year from poor inpatient care. Of note, none of the studies captured deaths outside inpatient care—those resulting from errors in care at home or in nursing homes and in outpatient care such as ambulatory surgery centers.

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...men make mistakes, but a good man
...s when he knows his course is wrong,
...d repairs the evil. The only crime is
...pride."— Sophocles, Antigone"

...al care in the United States is technically complex at
...individual provider level, at the system level, and at

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the national level. The amount of new knowledge generated each year by clinical research that applies directly to patient care can easily overwhelm the individual physician trying to optimize the care of his patients.[1] Furthermore, the lack of a well-integrated and comprehensive continuing education system in the health professions is a major contributing factor to knowledge and performance deficiencies at the individual and system level.[2] Guidelines for physicians to optimize patient care are quickly out of date and can be biased by those who write the guidelines.[3–5] At the system level, hospitals struggle with staffing issues, making suitable technology available for patient care, and executing effective handoffs between shifts and also between inpatient and outpatient care.[6] Increased production demands in cost-driven institutions may increase the risk of preventable adverse events (PAEs). The United States trails behind other developed nations in implementing electronic medical records for its citizens.[7] Hence, the information a physician needs to optimize care of a patient is often unavailable.

At the national level, our country is distinguished for its patchwork of medical care subsystems that can require patients to bounce around in a complex maze of providers as they seek effective and affordable care. Because of increased production demands, providers may be expected to give care in suboptimal working conditions, with decreased staff, and a shortage of physicians, which leads to fatigue and burnout. It should be no surprise that PAEs that harm patients are frighteningly common in this highly technical, rapidly changing, and poorly integrated industry. The picture is further complicated by a lack of transparency and limited accountability for errors that harm patients.[8,9]

There are at least 3 time-based categories of PAEs recognized in patients that are or have been hospitalized. The broadest definition encompasses all unexpected and harmful experience that a patient encounters as a result of being in the care of a medical professional or system because high quality, evidence-based medical care was not delivered during hospitalization. The harmful outcomes may be realized immediately, delayed for days or months, or even delayed many years. An example of immediate harm is excess bleeding because of an overdose of an anticoagulant drug such as that which occurred to the twins born to Dennis Quaid and his wife.[10] An example of harm that is not apparent for weeks or months is infection with Hepatitis C virus as a result of contaminated chemotherapy equipment.[11] Harm that occurs years later is exemplified by a nearly lethal pneumococcal infection in a patient that had had a splenectomy many years ago, yet was never vaccinated against this infection risk as guidelines and prompts require.[12]

METHODS

The approach to the problem of identifying and enumerating PAEs was 4-fold: (1) distinguish types of PAEs that may occur in hospitals, (2) characterize preventability in the context of the Global Trigger Tool (GTT), (3) search contemporary medical literature for the prevalence and severity of PAEs that have been enumerated by credible investigators based on medical

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1. James, J. T. (2013). A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety*, *9*(3), 122-128.
2. Makary, M.A., & Daniel, M. (2016). Medical error – the third leading cause of death in the U.S. *BMJ*, 353, i2139.

...on You

MedStar Health

What Are Medical Errors?

- A medical error is an unintentional, preventable, adverse event, whether or not it is evident or harmful to the patient, and leads to unsafe care.
- Medical errors are most often made by health workers who mean well but operate in a healthcare system lacking systems and processes that are highly reliable - like aviation, nuclear power and oil.

Some examples include:

1. Your son tests positive for COVID-19 and is admitted to the hospital. Due to the lack of masks your son's caregiver isn't able to stop the spread of the infection and is also infected. ***This is preventable.***
2. Your grandmother goes into the hospital for a hip replacement and gets an infection at the site of her surgery and dies five days later. ***This is preventable.***
3. Your neighbor has an asthma attack during allergy season and goes to the emergency department for relief. The medication they give to your neighbor is 10x's stronger than it should be and he dies. ***This is preventable.***
4. Your brother is in a skateboarding accident, hits his head and becomes unconscious. In the hospital, they put a tube in his trachea, and it becomes dislodged and he dies. ***This is preventable.***

Healthcare Worker Safety

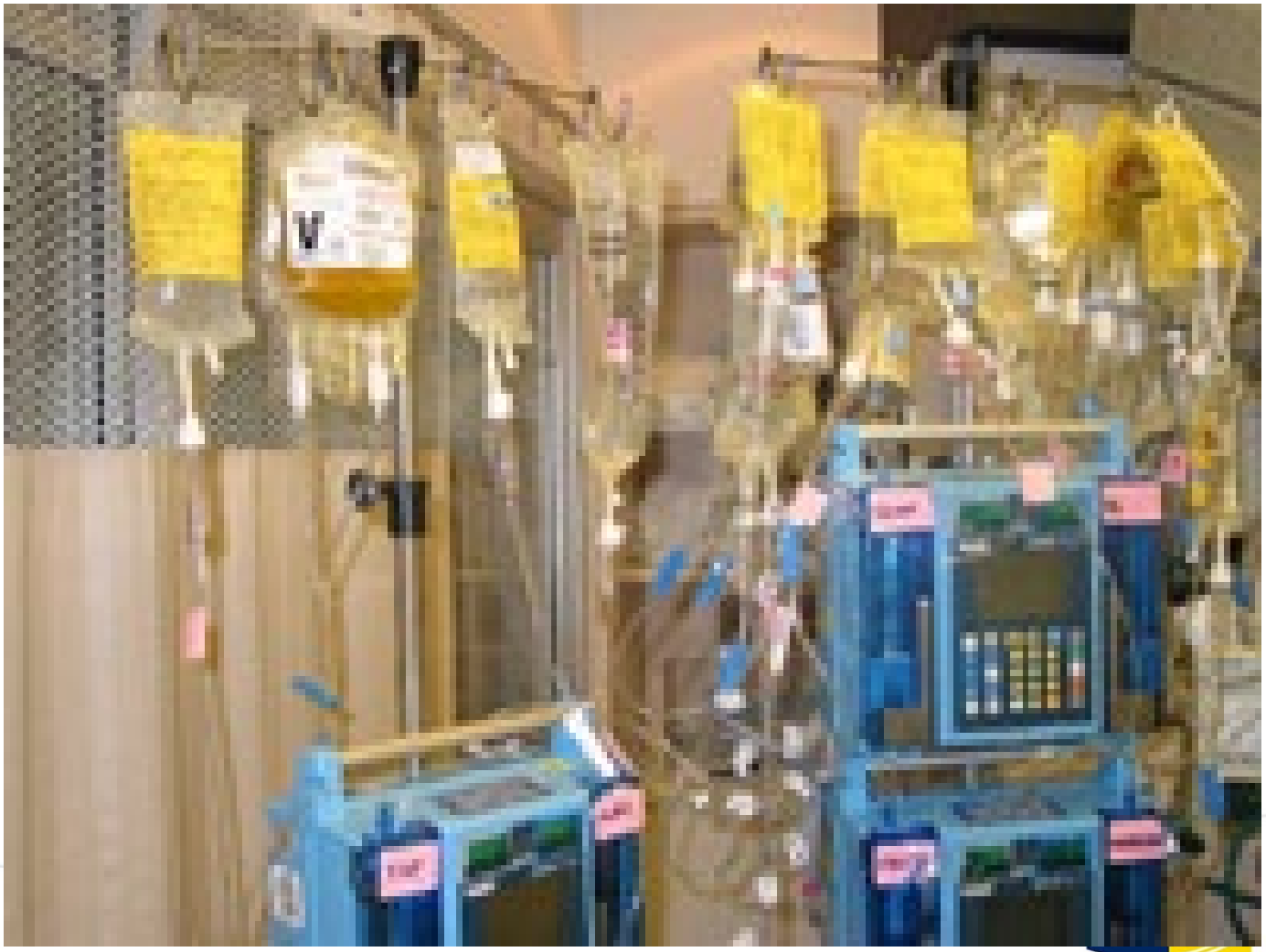
- Pandemic has exposed the gaps in safety for healthcare workers
- Thousands have died while serving patients
- High Suicide, Depression, Burnout Rates
- Frontline injuries
  - Needlesticks
  - Lifting Injuries
  - Falls and Slips
  - Workplace Violence

“To Err is Human”

Why Do We Need Human Factors in Healthcare?

Credit to Raj Ratwani

We Create Vulnerable Systems and then tell our Colleagues Not to Make a Mistake



Albert Einstein

"The definition of insanity is doing the same thing over and over again but expecting different results."

Chicago Cubs Fan

Peoria doctor walks for caregivers and patients

Peoria, AZ | peoriatimes.com | 14h

Each year, more than 200,000 people die unnecessarily in U.S. hospitals. Worldwide, 4.8 million lives are lost. The Patient Safety Movement Foundation (PSMF) is a global nonprofit organization offering free tools to help achieve zero preventable deaths from hospital errors.

74 days of driving; Over 15,000 miles driven!


WRIGLEY FIELD
HOME OF
CHICAGO CUBS
WINDY CITY LIMOUSINE
TOYOTA
Patient Safety
MOVEMENT


St. Bernards
Lt. CoL. Coffee
Judie B.

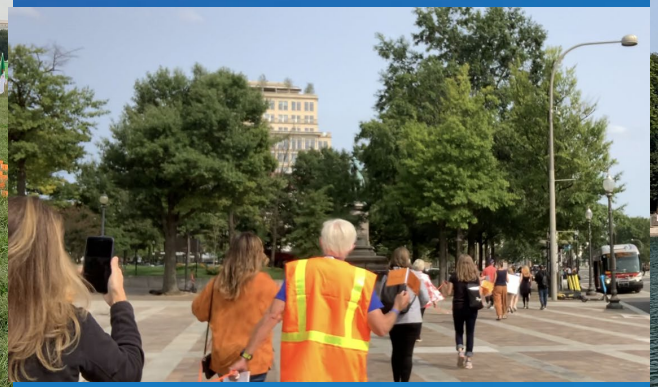

RESERVED PARKING
SLOAN
ALLEN FAMILY


SANDBERG
23

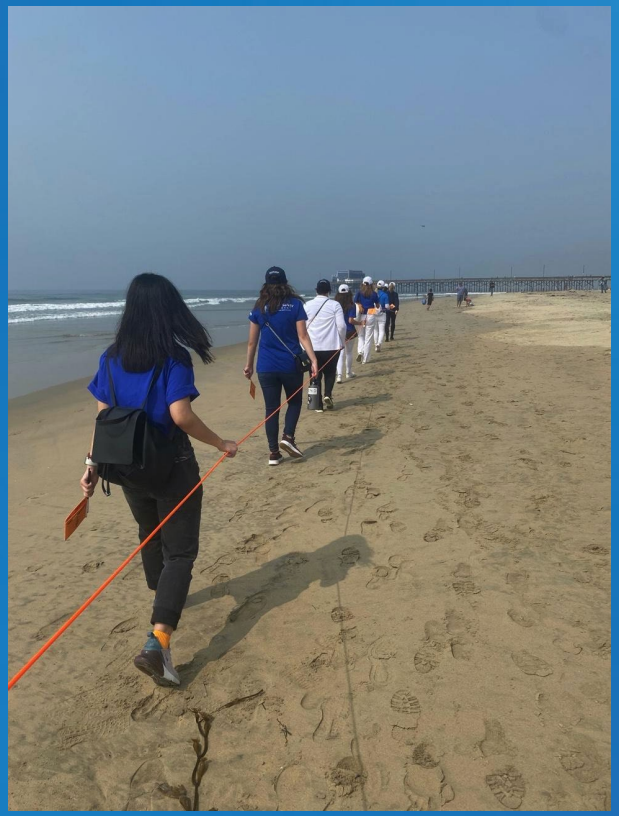

CAMELBACK
RANCH
GLENDALE
34

Total Miles Walked by Our PSMF Global Team: 238,912

Washington DC Walk



Newport Beach Walk




ZERO

During a Pandemic, Racial Injustice Riots and Polarized Elections

1. 2,460 total miles walked over 355 consecutive days
2. 15,368 miles driven over 74 days visiting 26 states.
3. Broken glass, busted out windows, protesters and physical threats
4. 75 TV, radio, newspaper and podcast interviews raising awareness about the need for better patient and healthcare worker safety.
5. 12 pairs of Brooks running shoes used.
6. 20 Major League Ballparks, 14 spring training ballparks and 3 minor league ballparks walked to despite not being allowed into them.
7. $50,000+ raised for the Patient Safety Movement Foundation.
8. Two broken toes, back spasms, frequent hip and knee pains.

- https://patientsafetymovement.org/advocacy/patients-and-families/resources/
- Download **PatientAider** free APP
- Sentinel
- Ask questions; be a partner in your care
- Get second opinions on important decisions
- Don’t be bullied or intimidated
- Medications
- Use On-line Patient Portals
- Hospital Compare, Leap Frog and other Ratings Sites

Thank You

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