Prologue

Blueprints for Action

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In 1999, the Institute of Medicine report *To Err Is Human: Building a Safer Health System*[1] advanced a clear challenge to create safer environments in health care. The message of the report has resonated ever since, from the halls of Congress to the hallways of health care facilities across the nation. Less clear, however, was when and how the concern about unsafe systems would be translated into action, and who would own the challenge. The work reflected in this volume illustrates that, in fact, the responsibility for improving patient safety is being shouldered in varied settings, supported by multiple disciplines, and at times using alternative approaches to address similar problems. The lesson of this volume is that those concerned about patient safety are many in number, and they have moved beyond an evidence-based problem description to advance a replicable cascade of actions. Whether the reader is a novice asking where to start, or an expert considering what to do next, the answers may well be found here.

To deliver high quality, safe care, health care stakeholders benefit from a set of approaches at their disposal. The approaches incorporated in this volume—representing programs, tools, and products to improve patient safety—cluster in five different areas: programs and collaborations, tools and procedures, simulation, education and training, and surveillance tools. Characterizing the attributes reflected in these papers illustrates the breadth of effort underway.

Across the five categories, one finds lessons extracted from local to international experience, and representing macro- to micro-level efforts. Macro-level efforts are reflected in papers describing far-reaching programs hailing from such organizations as the Agency for Healthcare Research and Quality, the National Quality Forum, and the U.S. Air Force. Micro-level efforts often reflect small team sweat equity in focused point-of-service initiatives. The types of activities are quite diverse, ranging from the development of tools and products to ensuring safe venous access through clinician education to approaches for discerning which clinicians are likely to adopt PDAs with safety information prior to their implementation.

Some of the papers examine cutting-edge technology applications, including the use of simulation by physicians learning highly technical skills such as sinus surgery, to focusing on complex decisionmaking processes in the context of physician-diabetic patient encounters. Other papers incorporate low-technology efforts, including important survey efforts directed at ascertaining the safety climate, with even more focused application of climate considerations to critical processes, such as medication administration.

Throughout this volume, the practicality of the initiatives that focus on point-of-service safety strategies stands out. Incorporated in most of the papers are detailed blueprints of the essential elements needed to undertake similar

initiatives. The authors provide not just the tools, but—in many cases—the equivalent of an instruction manual for assembling, using, and ultimately achieving the results the product, tool, or program is designed to achieve. Additionally, many of the authors provide significant details about barriers that need to be overcome to achieve success, and thereby prepare the reader to anticipate and plan to address similar obstacles. The inclusion of this information is especially valuable given the many examples nationwide of failed attempts to institute change without adequately understanding and constructing approaches that position the system and people for success. Some of the papers describe in detail activities designed to improve patient safety that appear, on the face of it, to be simple in their execution (e.g., executive walkarounds). However, the authors richly note the complexity in the architecture of the strategy and fully explore how to construct the strategy to maximize the likelihood of success and ultimately accomplish meaningful change.

Also noteworthy in this volume is the array of health care settings in which safety efforts are underway. While the majority of programs, tools, and products in this volume are designed for inpatient hospital care, a number of them address other environments, ranging from nursing homes to outpatient surgery to communities. And, while the human resources that tend to be targeted are generally health care providers or executives, some of the papers incorporate a special focus on the patient's role in enhancing their own safety. With an eye toward the future, a few papers address educational efforts underway in academic settings to better prepare the next generation of providers for safe practice.

With all the strengths of this volume, there are also cautionary notes that merit mention. First, while these papers present scores of approaches to a wide range of safety issues, given the complexity and multiple layers of health care there will always be new tools, products, and programs needed to address both old and new safety challenges. Patient safety is as much about managing the complexity in our contemporary health care environments as it is about planning for the management of iterative change in those same environments. The evolving mix of technology, pharmacotherapeutics, human resources, and other environmental changes require vigilance and new levels of situational awareness to ensure protection of every patient moving through health care settings. The approaches detailed here are meaningful efforts geared to today's health care settings; settings that may look quite different 10 years from now. So, the set of approaches is substantive, but not exhaustive, and will require ongoing assessment to determine whether they fit meaningfully within the current health care context or if they require retooling.

Second, some of the initiatives are works in progress, with full evaluations yet to be completed. Evidence of effectiveness is established in some of the papers but not in others, where more remains to be learned by the originators of the work and/or the people who adopt the strategies. Also missing from this volume is any discussion of the financial cost associated with the introduction and maintenance of the new effort. Sustainability, while a serious concern, also is rarely addressed. And a cautionary note is always in order with the introduction of any new

program, process, or tool: New efforts designed to improve patient safety carry the potential to trigger unintended adverse consequences in their adoption. Mindful of all these concerns, the intellectual energy and commitment to advancing patient safety is richly embedded in these projects. The authors of these efforts are clearly dedicated to making a difference.

In summary, what might one make of all the efforts that are represented in this volume? It is to see creation of sorts. One after the other, the focus and activities represented in the papers largely define themselves rather than being defined. The papers provide the reader with an exquisite sense of how to do the work that we collectively know we must do. The work in this volume clearly signals that the ecosystem of the health care safety effort is thriving and robust. The projects and the people behind them give voice to strategies and, ultimately, solutions to achieve the most fundamental promise. Through a myriad of efforts and sustained commitment we can collectively deliver on the promise of ensuring that people in American health care settings are kept as safe as they can be—to the extent humanly possible, that they are removed from harm's way.

References

1. Kohn LT, Corrigan JM, Donaldson MS, editors. To err is human: building a safer health system. A report of the Committee on Quality of Health Care in America, Institute of Medicine. Washington, DC: National Academy Press; 2000.