



Patient Safety Research

The US Perspective

Agenda for Canadian Patient Safety Research

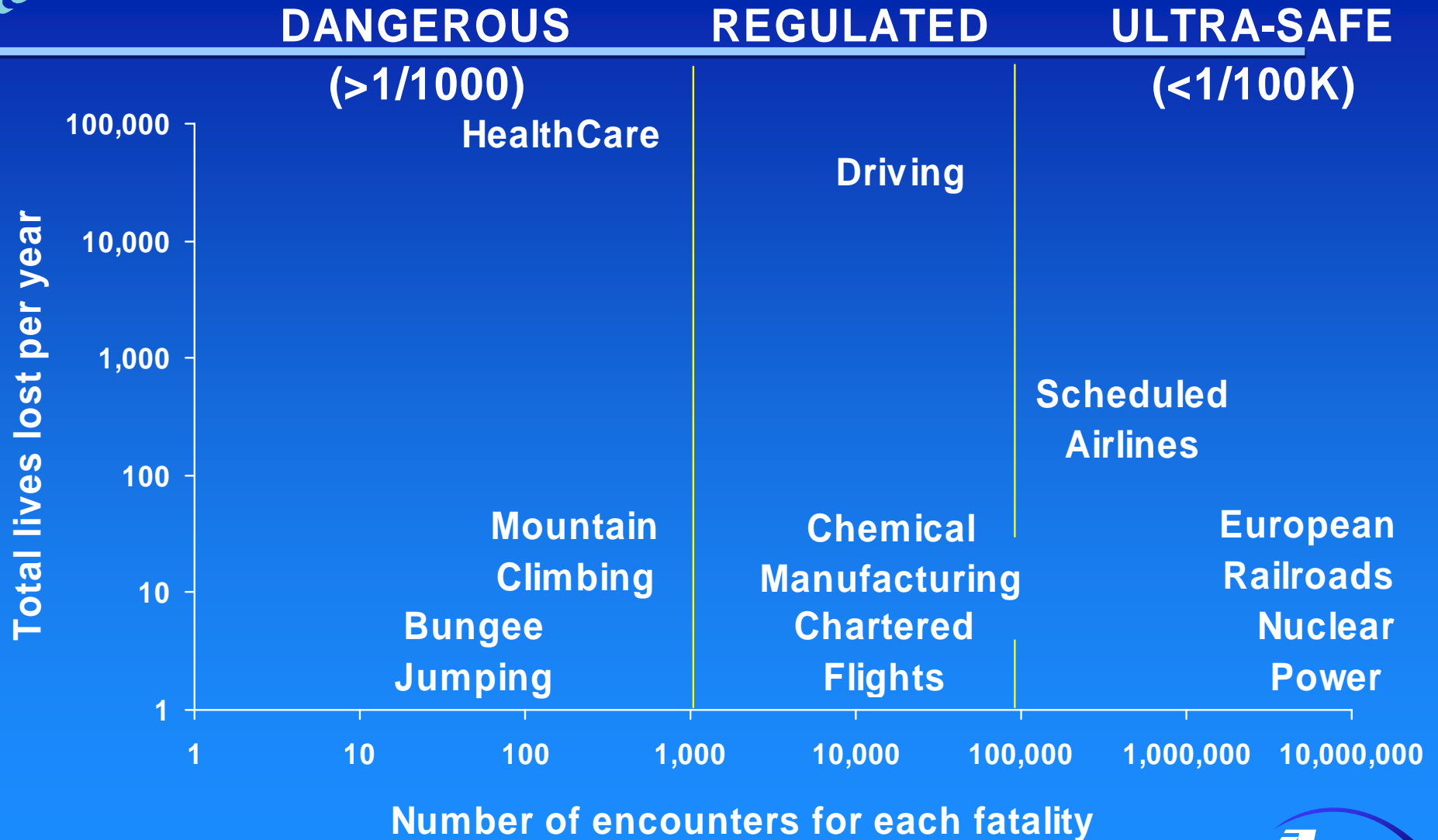
Toronto

February 28 – March 1, 2005





How Hazardous Is Health Care?





Health Care Associated Injury

- An injury or harm to a patient attributed to the process of care rather than underlying physiological conditions



Hazard

- Anything which has the potential to cause harm

Risk

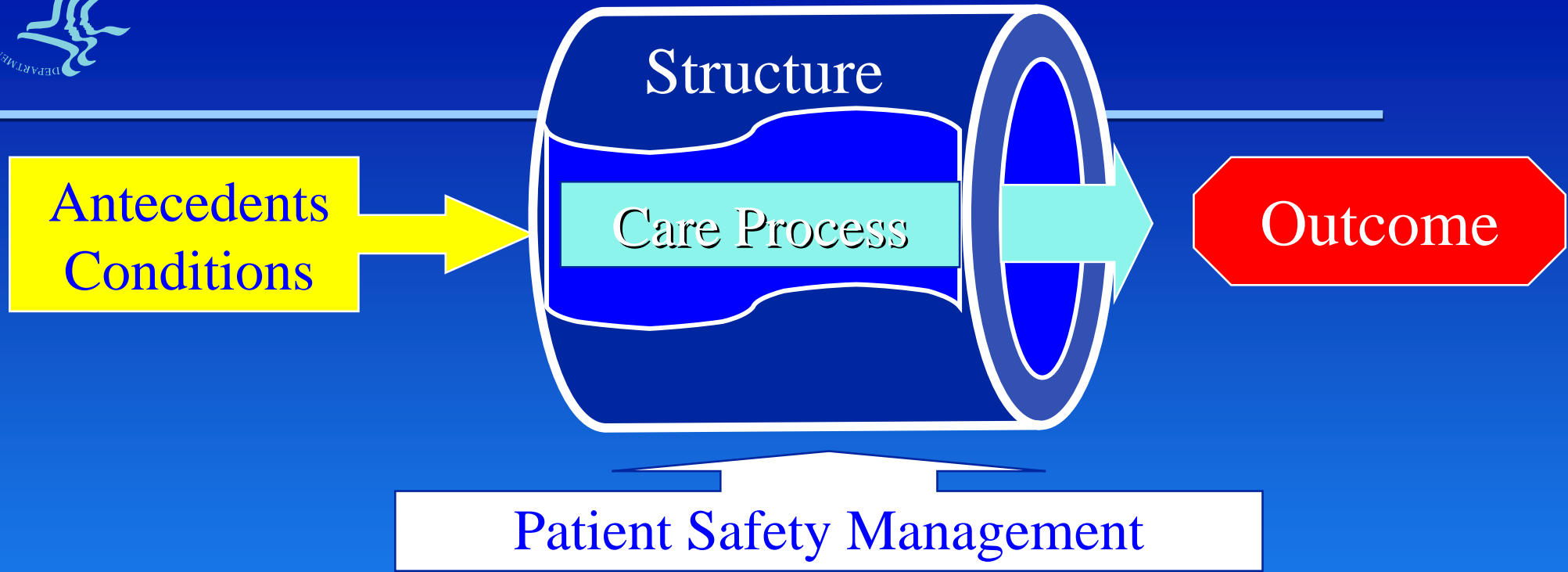
- The likelihood that somebody or something will be harmed by a hazard, multiplied by the severity of the potential harm



Goals of Patient Safety

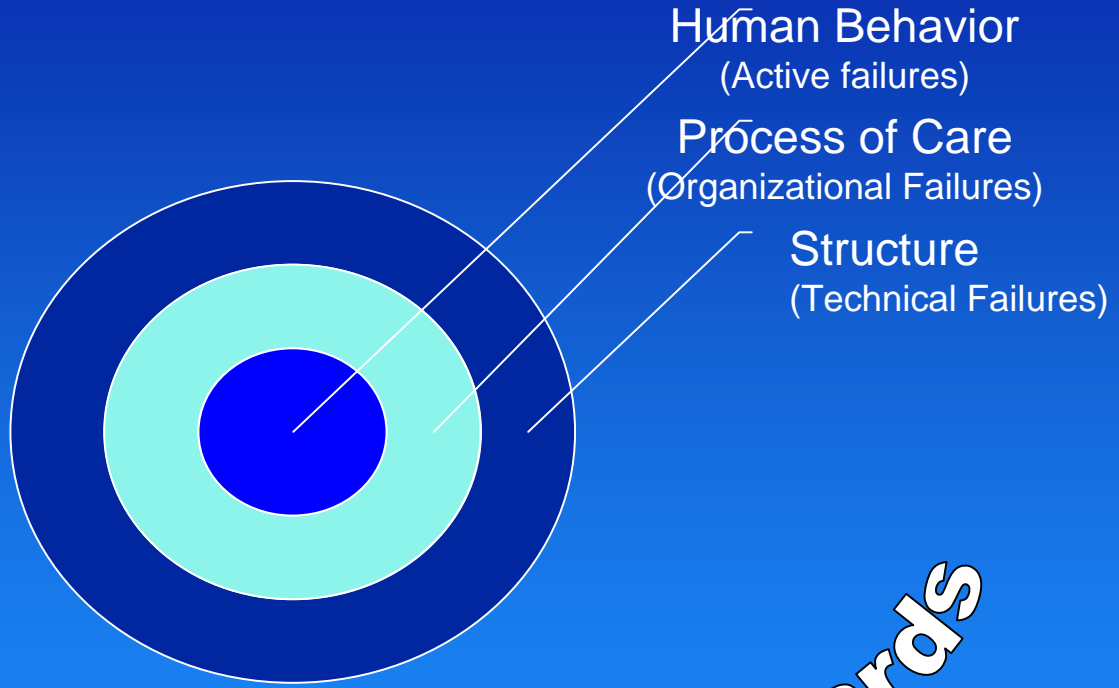
- Reduce the risk of healthcare associated (caused by treatment) injury to patients
- Remove or minimize hazards which increase risk of healthcare associated injury to patients





Adjust structure and process to eliminate or minimize risks and hazards of health care associated injuries before they have an adverse impact on the outcomes of care





Nested Risks and Hazards



AHRQ's Congressional Mandate

The director shall conduct and support research and build private-public partnerships to

- *identify* the causes of preventable health care errors and patient injury in health care delivery;
- *develop*, demonstrate, and evaluate strategies for reducing error and improving patient safety; and
- *disseminate* such effective strategies throughout the health care industry.





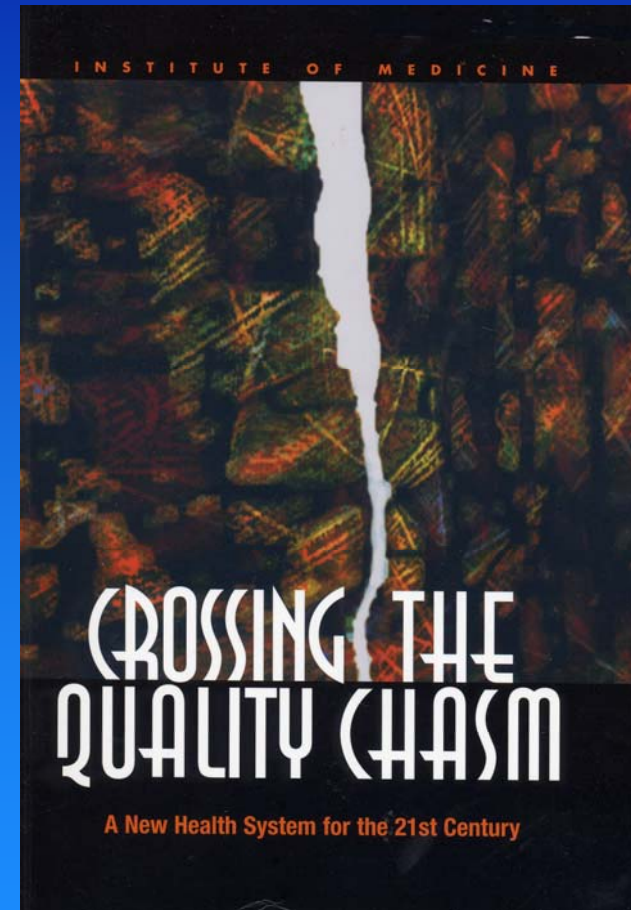
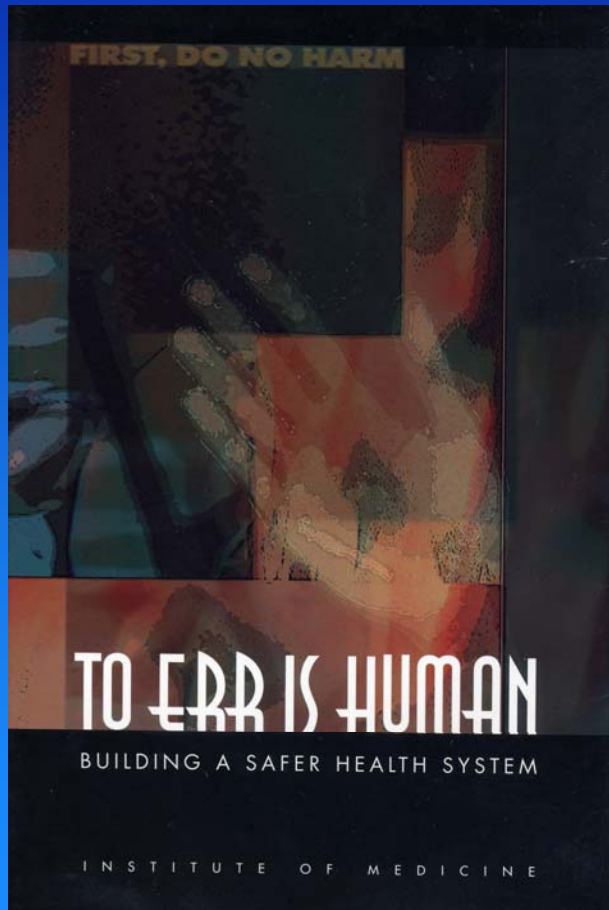
Congressional Funding for Patient Safety

- FY 01 \$50 Million
- FY 02 \$55 Million
- FY 03 \$55 Million
- FY 04 \$79.5 Million
- FY 05 \$84 Million
- FY 06 \$84 Million (Proposed)





Patient Safety and Quality Road Maps





An Epidemic

- Medical Error is an epidemic of world wide proportion
- We should declare war on medical error
John Eisenberg, MD Director, AHRQ (September 11, 2000)
- This war needs to be fought as coalition warfare with allies from other countries and other disciplines outside of medicine





Epidemic Stage One

- Identification of risks and hazards that patients at risk for harm or injury from the process of care
- Raise awareness that patients are at risk for iatrogenic injury and harm
- Build capacity for research and development





Epidemic Stage Two

- Eliminate hazardous conditions, and practices and policies that lead to iatrogenic injury
- Design, test and implement practices and process that eliminate hazards and reduce the risk of iatrogenic injury
- Develop a positive patient safety culture



Epidemic Stage Three

- Maintain vigilance and a constant state of unease
- Maintain a positive safety culture





Funding Program Areas

- Identifying risk and hazards
 - Reporting System Demonstrations (16 projects)
 - Working Conditions (22 projects)





Funding Program Areas

- Raising awareness
 - Dissemination and education (6 grants)
 - User Liaison Program with states
 - Conferences and workshops
- Identify proven patient safety practices
 - System best practices (6 projects)
 - Computer application (11 projects)





Funding Program Areas

■ Building Capacity

- Centers of excellence in patient safety research (3 centers)
- Developing centers of excellence in patient safety research (18 projects)
- Patient Safety Improvement Corps





What Have We Learned

- There is no single best method
- Need multiple methods
 - Active spontaneous event reporting
 - Patient Safety Indicators (PSI) from Administrative Data
 - Triggers of harm from medical records
- Need international standards on patient safety data
- Rather than a 1,000 blooming we will get a weed garden



Recommendations for Standards

PATIENT SAFETY

ACHIEVING A NEW STANDARD FOR CARE



QUALITY CHASM SERIES

- National Quality Forum consensus progress for Patient Safety Taxonomy
- WHO alliance for patient safety taxonomy standards





Moving from Retrospective to Prospective

- All event reporting and surveillance systems are retrospective
- Health care is a target risk environment
- Can we move to a more prospective environment



Shifting the Paradigm

- JCACO requires hospitals to perform one failure mode effects analysis (FMEA) per year as part of its patient safety goals
- IOM recommends that AHRQ conduct research on prospective hazard/risk analysis
- AHRQ funds risk assessment projects
 - FMEA
 - PRA
 - ST-PRA





Risk Assessment Projects

- Risk Modeling in Transitions of Care
- Risk and Recovery in Labor and Delivery
- Re-Engineering the Hospital Discharge System
- Risk Modeling to Improve Long-Term Care Medication Safety
- Risk Analysis of Pediatric Chemotherapy
- Conducting a PRA for the Transplantation Process
- Risk Assessment of Medication Errors in Medication with COPE





Risk Modeling

- We need to begin to develop risk model to match major risk areas in health care
- Validate or up date risk models with event reporting and surveillance data





Safety By Design

- Risk models should inform about areas for intervention
- Can risk be mitigated by existing patient safety practices or off the shelf mistake proofing
- Design interventions if none are acceptable
- Risk informed design
- Safety by Design Special Issue of QSHC coming soon



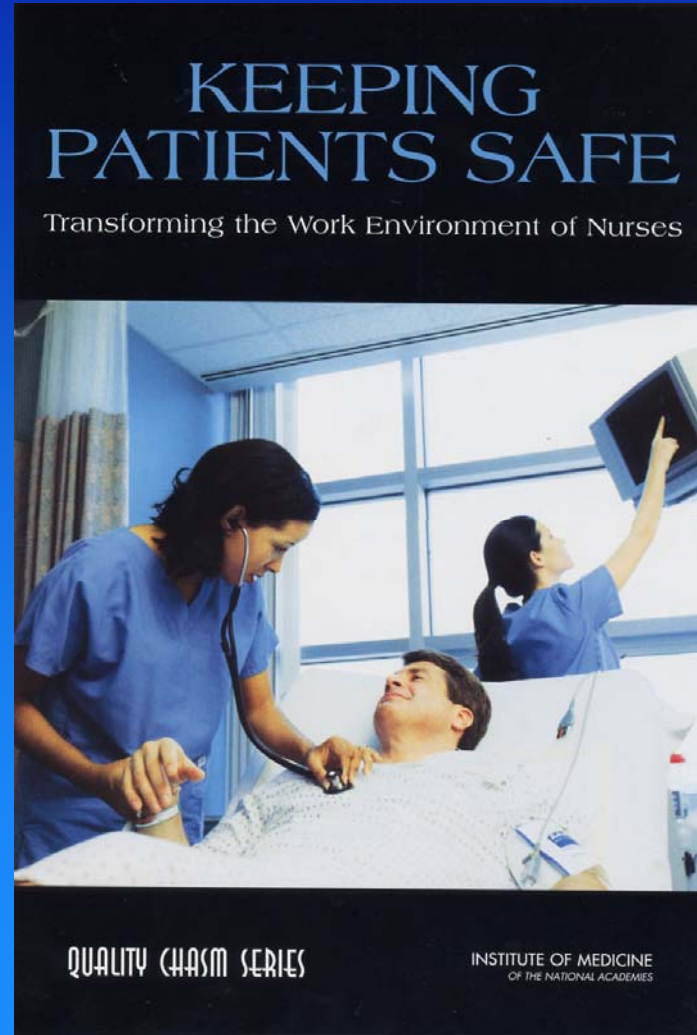
A Way Forward





Working Conditions

- Need to redesign clinical work
- Need for greater team work
- DoD/AHRQ team work initiative
- You can design clinical work



Achieving a Culture of Safety





Implementing Safe Practices Challenge Grants – FY 05/05

Evidence Report/Technology Assessment
Number 43

Making Health Care Safer: A Critical Analysis of Patient Safety Practices



Agency for Healthcare Research and Quality
www.ahrq.gov

1. Assess risks and known hazards to patient in the process of care and devise intervention strategies - 6 projects
2. Implement safe practices that show evidence of eliminating or reducing the known risks and hazards associated with the process of care – 7 projects
3. Partners in Patient Safety RFA for FY 05





Health Information Technology (HIT)

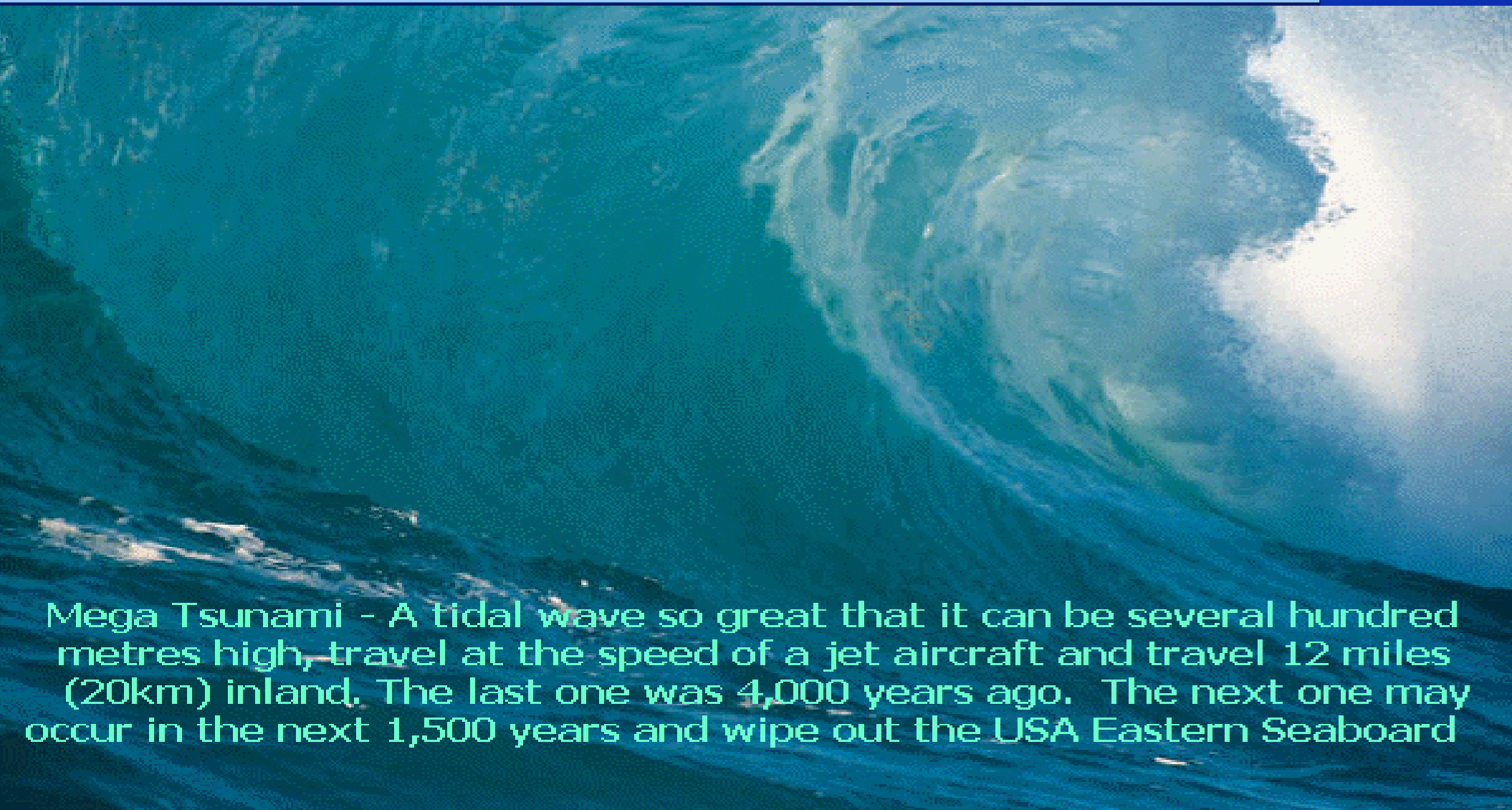
FY 04 – FY06

- AHRQ's major patient safety activities are center on HIT
 - HIT Planning grants
 - HIT Value grants
 - HIT implementation
 - State/regional HIT initiatives
- Improving the nation's IT infrastructure is a major national priority of the present administration





A Tsunami of Results



Mega Tsunami - A tidal wave so great that it can be several hundred metres high, travel at the speed of a jet aircraft and travel 12 miles (20km) inland. The last one was 4,000 years ago. The next one may occur in the next 1,500 years and wipe out the USA Eastern Seaboard



Building Buckets to Hold the Tsunamis of Research Findings

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Quality & Safety in Health Care

www.qshc.com

Patient safety methodology

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Simulation and team training

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ADVANCES IN PATIENT SAFETY: FROM RESEARCH TO IMPLEMENTATION





What is Next

- Continue basic research in areas of need
- Support more proactive risk assessment
- Reduce risk and hazards by risk informed design – safety by design both built environment and work process
- Continue to improve the IT infrastructure for safety
- Implement safe practices
- Concentrate on Diffusion of Patient Safety Innovations





Thank You

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