

- Make it safe for care providers to report preventable adverse events, and implement voluntary non-punitive systems for reporting and analyzing preventable adverse events.
- Assume that people don't intend to do a bad job or to make an error but, given the right set of circumstances, anyone can make a mistake: look past the easy answer that it was someone's fault to answer the tougher question as to why the error occurred — it is seldom a single reason.⁶
- Create an atmosphere where staff constantly questions if things can be done in a better, more efficient and safer manner. Never let “good enough” be good enough. Be relentless in the pursuit of finding ways to improve systems. Design systems that make it hard for people to do the wrong thing and easy to do the right thing.⁷
- Implement proven medication safety practices.
- Provide incentives to health care organizations that demonstrate continuous improvement in patient safety.
- Focus performance standards for organizations and licensing/credentialing requirements for professionals on patient safety.

Definitions

- **Adverse event:** An injury caused by medical management rather than the underlying condition of the patient.⁸
- **Health care error:** An unintended health care outcome caused by a defect in the delivery of care to a patient. Health care errors may be errors of commission (doing the wrong thing), omission (not doing the right thing) or execution (doing the right thing incorrectly). Any member of the health care team in any health care setting may make errors.⁹
- **Negligent adverse event:** A preventable adverse event that satisfies the legal criteria used to determine negligence (i.e., where the care provided failed to meet the standard of care reasonably expected of an average physician qualified to take care of the patient in question).

- **Patient safety:** The prevention, elimination or mitigation of patient injury caused by health care errors.¹⁰
- **Preventable adverse event:** An adverse event attributable to error.

¹Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington D.C.: National Academy Press. 1999.

²VA National Center for Patient Safety Mission Statement. VA NCPS Mission Statement.

³Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington D.C.: National Academy Press. 1999.

⁴Leape, Lucien; Lawthers, Ann G.; Brennan, Troyen A., et al. Preventing Medical Injury. *Qual Rev Bull.* 19(5): 144-149, 1993.

⁵VA National Center for Patient Safety Mission Statement. VA NCPS Mission Statement.

⁶VA National Center for Patient Safety Mission Statement: www.patientsafety.gov/vision.html.

⁷VA National Center for Patient Safety Mission Statement: www.patientsafety.gov/vision.html.

⁸Leape, Lucian L.; Brennan, Troyen A.; Laird, Nan M., et al. The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II. *N. Engl J Med.* 324(6): 377-384, 1991. Also, Brennan, Troyen A.; Leape, Lucian L.; Laird, Nan M., et al. Incidence of adverse events and negligence in hospitalized patients: Results of the Harvard Medical Practice Study I. *N. Engl J Med.* 324: 370-376, 1991.

⁹National Patient Safety Foundation. Approved by the NPSF® Board July 2003). www.npsf.org/html/about_npsf.html.

¹⁰National Patient Safety Foundation. Approved by the NPSF® Board July 2003). www.npsf.org/html/about_npsf.html.

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State Commission on Patient Safety



Identifying Opportunities to IMPROVE PATIENT SAFETY IN MICHIGAN



Safer health care: a shared goal

Making Michigan residents safer wherever and whenever they receive care — at hospitals, the doctor's office, the pharmacy or any other location or service — is a goal shared by most people and organizations in Michigan. To reach this goal, a major effort is underway to marshal the best information available on improving patient safety as an important first step in the development of sound, workable recommendations for the state's health care delivery system.

Who we are

In mid 2004 the Michigan Health and Safety Coalition accepted Governor Jennifer Granholm's request to serve as the State Commission on Patient Safety. MH&SC represents a diverse group of health care stakeholders who have both the interest and expertise to synthesize broad public input on patient safety.

The commission's role

The commission will gather information from a variety of sources to prepare a report with recommendations on improving patient safety for the Governor and state legislature by fall 2005. The commission is gathering information through:

- Testimony from the public, professional associations, health care organizations, academics, other organizations and experts who have an interest in patient safety.
- Existing patient safety initiatives.
- Studies of the causes of health care errors across the continuum of care, including health facilities and private practices.

Our members

- Blue Cross Blue Shield of Michigan
- DaimlerChrysler Corporation
- Ford Motor Company
- General Motors Corporation
- International Union, UAW
- Michigan Association of Health Plans
- Michigan Consumer Health Care Coalition
- Michigan Department of Community Health
- Michigan Education Special Services Association
- Michigan Health & Hospital Association

- Michigan Nurses Association
- Michigan Osteopathic Association
- MPRO
- Michigan Pharmacists Association
- Michigan State Medical Society

Why a focus on patient safety?

A 1999 report published by the Institute of Medicine estimated that between 44,000 and 98,000 people die each year in U.S. hospitals from health care errors.¹ Other estimates put the number of deaths across all health care settings at over 180,000.² Many of these deaths are preventable. In addition to the human toll, hospital health care errors cost \$17 billion to \$19 billion annually in lost income, household production, and disability and health care costs.³ Health care errors don't just occur in hospitals; errors happen in all settings, including physician offices, nursing homes and outpatient care centers. However, a good estimate about the cost of errors in those settings is not available.

Categories of preventable adverse events⁴ (errors that result in an injury not due to the underlying medical problem) include:

Diagnostic:

- Error or delay in diagnosis
- Failure to employ indicated tests
- Use of outmoded tests or therapy
- Failure to act on results of monitoring or testing

Treatment:

- Error in the performance of an operation, procedure or test
- Error in administering treatment (surgery on the wrong patient or body part)
- Error in the dose or method of using a drug
- Avoidable delay in treatment or in responding to an abnormal test
- Inappropriate (not indicated) care

Preventive

- Failure to provide preventive treatment
- Inadequate monitoring or follow-up treatment

Other

- Failure of communication
- Equipment failure
- Other system failures

These translate into transfusion errors, adverse drug events, wrong-site surgery and surgical injuries, procedures on the wrong patient, falls, hospital-acquired or other treatment-related infections, burns and pressure ulcers, among others.

Benefits of safe health care

- Patients are not injured by a preventable mistake.
- Patients get better faster.
- Patients and families better understand the care plan and are more satisfied with care.
- Health care costs are reduced.
- Job satisfaction of health care workers is improved.

Making health care safer

To improve patient safety, experts agree that a systems approach that emphasizes prevention, not punishment, is the best method. Other high-risk industries and companies such as airlines and nuclear power plants use this approach to accomplish safety improvements.⁵

To create a culture of safety within a health care organization:

- Establish patient safety programs with defined executive responsibility.
- Focus on the system of health care, not the individual care providers, as the major cause of preventable adverse events.

