Safe Practices for Better Healthcare

Why Implement Practices to Improve Safety in Healthcare?

Just the Facts

- Preventable medical errors have been estimated to cost the United States $17 billion to $29 billion per year in healthcare expenses, lost worker productivity, lost income and disability. [IOM, 1999]

- One in five patients discharged from the hospital ends up sicker within 30 days, over half of these cases are medication related. [Denham, 2008]

- One out of 10 inpatients suffers as a result of a mistake with medication, frequently causing a significant injury and death among hospital patients. [Bates 2008]

- It is estimated that 1 of every 10-20 hospitalized patients in the US develops a healthcare-associated infection accounting for nearly 2 million infections and 99,000 associated deaths each year. [Klevens 2007, Yokoe DS 2008]

The Practices

(Full list of all 34 Safe Practices available at www.qualityforum.org)

Practice # 7 Disclosure- Provide open and clear communication with patients and families about serious unanticipated outcomes.

- The frequency of disclosure of harmful events is one in four [Fein, 2007] even though patients want disclosure from clinicians each time a harmful medical errors occur. [Sheridan, 2008]

- The University of Michigan reported that, after implementation of a full disclosure program, the number of pending lawsuits decreased by half and reduced litigation costs per case fell from $65,000 to $35,000. This resulted in an annual savings to their organization of approximately $2 million in defense litigation bills. [Boothman, 2005; Wocieszak, 2006]

Practice #8 Care of the Caregiver – To create a culture of safety and rigorous pursuit of prevention there must be a culture of honesty. Care and support must be provided to those who make or have been involved in mistakes and bear a burden of guilt, shame and failure.

- By creating a “culture of safety” where staff are encouraged and recognized for reporting events and near misses, Sentra Norfolk General Hospital reduced Ventilator-associated pneumonia by 84 percent and device-associated bloodstream infection by 63 percent.vii

- Harm to caregivers can be profoundly preventable with timely, systematic, and direct action by healthcare organization leaders. [West, 2006] viii

- A 2007 multi-institutional study of almost 3,000 physicians in the U.S. and Canada revealed that 90% believe that healthcare organizations need to provide more systematic support services to them after unintentionally harming a patient. [Waterman, 2007]ix

Practice #17 Medication Reconciliation – Develop, maintain and communicate an accurate list of each patient’s medications.

- 10% to 67% of patients had at least one prescription medication history error at hospital admission. When non-prescription drugs were included the frequency was 27% to 83%; and when information on drug allergies and prior adverse events were included, the frequency was 34% to 95%. [Tam, 2005; Gleason 2004]x

- Medication errors occur in approximately 12% of patients. [Forster, 2003]xi In one study, 22% of medication errors occurred at admission, 66% occurred during transitions in care, and 12% occurred at the time of discharge. [Santell, 2006] (SP Med Rec Chapter 6)

Practices # 19- 25 Healthcare Acquired Infections – Policies and procedures such as hand washing should be in place to reduce infections.

- Approximately 14,000 deaths occur each year due to Central Line-Associated Blood Stream Infections. The total financial cost of such infections is estimated at over $9 billion annually. [Pittet, 1994; Berenholtz, 2004]xii

- Surgical site infections (SSI) occur with the second highest frequency of any adverse event occurring in hospitalized patients. According to a report from the Pennsylvania Health Care Cost Containment Council, the cost of an SSI was $135,132 compared to a hospital stay with no infection of $33,260. SSI’s in total account for up to $10 billion annually in healthcare expenditures. [Wong, 2004]xiii
• Ventilator-associated pneumonia (VAP) increases average hospitalization costs by $41,285. Adopting care practices that have been demonstrated to reduce the risk of VAP. [Rello, 1996]\textsuperscript{xiv}

• More than 126,000 hospitalized persons are infected with Multi-Drug Resistant Organisms annually at an additional cost of more than $39,000 per patient. [IHI, 2008]\textsuperscript{xv}

**Practice #34 Pediatric Imaging** – Child-size techniques should be used when imaging studies are done on children.

• There are more than 60 million CT scans performed annually in the U.S; 11% of those are children [NCI, 2008]\textsuperscript{xvi}

• A change in CT exam parameters for children could reduce the dose delivered to them from 5% to 90% while retaining diagnostic accuracy. [Brody, 2007]\textsuperscript{xvii}

\textsuperscript{vii} http://www.commonwealthfund.org/Content/Innovations/Case-Studies/2008/Sep/CASE-STUDY-- ACCELERATING-PATIENT-SAFETY-IMPROVEMENT-BY-STRENGTHENING-THE-CULTURE-OF-SAFETY---SENTARA.aspx


