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Hospitals fall short of patient safety goals 20 years after 'To Err is Human'

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"Patient safety is uniquely the responsibility of the C-suite, but CEOs haven't paid attention to it or acquired the necessary knowledge."

Kim Hollon, CEO
Signature Health

CEOs, not frontline staff, are at the root of the hospital industry shortfall in improving patient safety in the 20 years since the problem was highlighted by the landmark study *To Err is Human*.

At Signature Health, a safety-net hospital in Brockton, Mass., daily huddles take place at every staff shift change to discuss mistakes and near-misses. The goal is to raise awareness and anxiety about errors.

In 2010, CEO Kim Hollon implemented the Lean method of process improvement throughout his organization. He added a safety-management system three years ago to improve how staffers think while performing potentially dangerous tasks, to protect both patients and themselves from harm. Among other things, that led to staff more consistently using patient bar codes during medication dispensing, which they would sometimes skip to save time.

Over 10 years, Signature has reduced its serious safety event rate for patients by more than 85%, Hollon said. Its employee injury rate fell by 90%. Workers' compensation and medical malpractice costs dropped. He believes the cost of care in his system also has decreased due to a reduction in infections, pressure ulcers and patient falls.

The safety work, he acknowledged, has been "time-consuming and exhausting, has taken tremendous focus, and is very invasive to the organization." But he rejected the argument that it's too difficult or expensive for most healthcare organizations to implement.

"If you can do that in a safety net system, with a lot of Medicaid patients and low commercial rates, it's not about money, it's about how you manage," Hollon said.

Signature's example is a call to action for the healthcare industry, which has been far too complacent in the 20 years since the Institute of Medicine attempted to spark action on improving patient safety by reporting that at least 44,000 and perhaps as many as 98,000 people die in U.S. hospitals each year as a result of preventable medical errors. It estimated the cost in additional care, lost income and disability at $17 billion to $29 billion a year.

"Everyone sat up and said: 'Wow, we're not very good. Not only are we very expensive, we kill a lot of people,' " recalled Dr. Robert Wachter, chair of the department of medicine at University of California at San Francisco, who started writing about patient safety at that time. "If you were a hospital CEO or board member, you had to talk about patient safety and tell stories about terrible errors."

That landmark report, *To Err is Human: Building a Safer Health System*, set a goal of reducing preventable errors by at least 50% within five years. It recommended creating a new federal agency to set national safety goals and track progress; establishing a nationwide and public mandatory-reporting system for adverse events leading to death or serious injury; and developing robust safety systems in all healthcare organizations.

But many of the report's ambitious goals, such as creating a reliable system of measuring errors, were never realized.

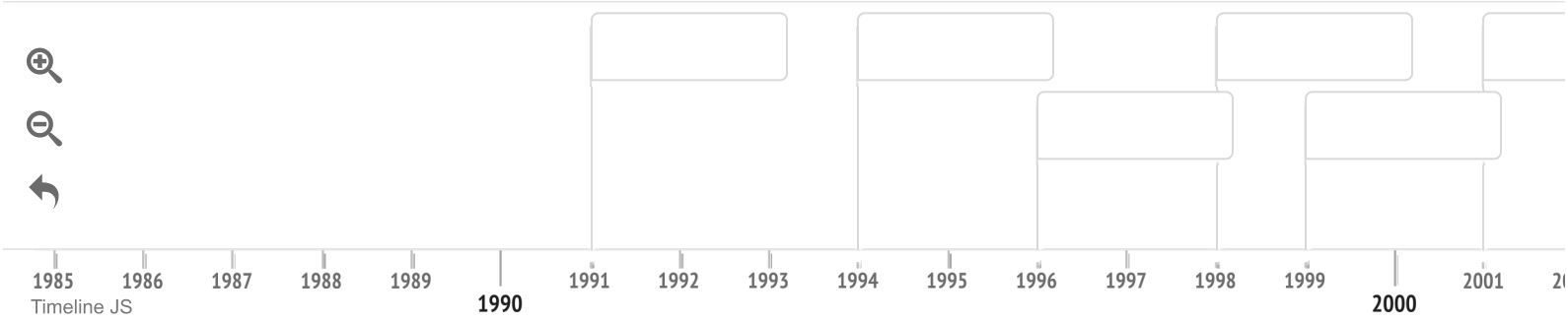
The biggest hurdle? CEOs have not made safety and quality a top priority.

“Patient safety is uniquely the responsibility of the C-suite, but CEOs haven’t paid attention to it or acquired the necessary knowledge,” Hollon said.

The main roadblock, he added, isn’t front-line staff, who are eager to improve patient safety. “The problem is getting management at all levels to believe they have to change the way they manage,” he said. “We have to believe that if we change, we’ll see better results. It’s painful and difficult to change.”

TIMELINE OF THE PATIENT SAFETY MOVEMENT

By Harris Meyer and Maria Castellucci



Source: Modern Healthcare staff research

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Changing the culture

The continuing safety problems were highlighted by investigative news reports over the past year and a half documenting chronic safety problems leading to patient deaths and injuries at prestigious hospitals such as Baylor St. Luke’s Medical Center, Johns Hopkins All Children’s Hospital, UNC Health Care System, and University of Texas MD Anderson Cancer Center. In some

cases, system leaders knew of the problems while they were occurring but did little until details were published in the news reports.

When adverse events occur, a common problem is a lack of accountability to patients. Hospital staff often don't talk to patients and their families about what caused the error or how they plan to address the problem, according to a survey of Massachusetts patients by the **Betsy Lehman Center for Patient Safety** published in June. That's despite the growing movement to openly communicate with families about adverse events, apologize and resolve the issues quickly.

Too often, no one analyzes the errors or designs solutions to prevent them from happening again. **Even healthcare professionals**, when they or family members are patients, struggle to dodge hazards in a fragmented, uncoordinated system.

"We've made some progress and prevented some deaths, but there are still overwhelming safety problems in hospitals," said Leah Binder, CEO of the Leapfrog Group, which publishes an **annual safety scorecard** on hospitals.

In any human enterprise, mistakes happen. To prevent them, hospitals have established safety programs, with varying levels of resources and rigor. But such efforts are far less common in **outpatient and post-acute settings**, where a growing amount of care is being delivered.

But even in hospitals, systemwide safety procedures have not become standard practice as they have in high-reliability industries like airlines and nuclear power. Healthcare organizations have launched many projects to reduce particular risks such as sepsis, but far fewer have made safety and quality their core mission and developed robust learning and improvement systems.

That's a deep disappointment to safety and quality leaders, who hoped their industry would be much further along by now.

> I'm especially disappointed that quality improvement hasn't risen to the strategic center of healthcare."

DR. DON BERWICK, PRESIDENT EMERITUS
INSTITUTE FOR HEALTHCARE IMPROVEMENT

"I'm happy that the problem is now recognized," said Dr. Don Berwick, president emeritus of the Institute for Healthcare Improvement and one of the IOM report's authors. "But I'm especially disappointed that quality improvement hasn't risen to the strategic center of healthcare. It is what we should be about."

He and other safety experts lament that too many healthcare organizations still have not built a culture in which physicians, nurses and other staff feel confident that they can raise quality of care concerns without suffering retribution and that their concerns will be addressed. Inseparable from that, organizations haven't concentrated on enhancing the physical safety and emotional well-being of their staffs.

"Is the culture of an organization one that genuinely cares about the people who care for patients?" said Dr. Stephen Swenson, former medical director for leadership and organization development at the Mayo Clinic. "This is not widespread. But if we're serious about creating safety, we have to change the culture of organizations, and that's largely leadership actions."

A **study published in Health Affairs** last year found that nearly 30% of nurses surveyed in four large states graded their hospitals unfavorably on patient safety and infection prevention. Half said their mistakes are held against them, and more than a third said staff do not feel free to question authority.

No one denies there have been successes in the 20 years since the IOM report was released, particularly following the passage of the Affordable Care Act in 2010. Partly as a result of quality and safety provisions and financial incentives and penalties in the law, the hospital industry reduced hospital-acquired conditions such as adverse drug events, infections and injuries from falls.

The federal Agency for Healthcare Research and Quality reported in January that public and private efforts helped prevent more than 20,000 hospital deaths and saved $7.7 billion in healthcare costs from 2014 to 2017.

But federal funding for safety and quality research has dropped 9% since 2011, from $372 million to $338 million. There's still no national error-reporting system, and no evidence that the IOM's goal of cutting medical errors in half has been achieved. Without a reliable system for detecting errors, experts say it's difficult to improve safety.

Indeed, researchers in recent years have estimated that the IOM's mortality estimates were too low, and that anywhere from **160,000 to more than 400,000** people die each year from preventable harms in healthcare settings. Some say it's the **third-leading cause of death** in the U.S., ahead of respiratory disease and strokes.

A **survey last year** by the Commonwealth Fund, the New York Times, and the Harvard T.H. Chan School of Public Health found that 23% of seriously ill patients reported experiencing a serious medical error, including 14% at a hospital and 7% at a doctor's office or clinic.

Hospital-acquired condition rates per 1,000 discharges

For patients 18 or older. A lower number is better.

The chart below is interactive: click or touch to see more.

Total HACs Preliminary 2017 data shows the total rate of hospital acquired conditions is still 6.9 per 1,000 higher than the 2019 goal.

What will it take to change?

Greater external pressure to reduce medical errors may be needed, either through regulation or market mechanisms. The shift from fee-for-service payment to value-based models that hold providers financially accountable for achieving high-quality outcomes for patients will help, many experts believe.

“The payment system is a big driver,” said Dr. Tejal Gandhi, chief clinical and safety officer at the Institute for Healthcare Improvement, which is working with 27 stakeholder groups on a national safety action plan. “Everything should be aligned to drive high-quality, safe care.”

That alone may not be enough, however. “You’ll probably need to mandate better safety reporting and measurement,” said Dr. David Bates, a health policy professor at Harvard University. “Organizations are unlikely to assign resources to that without additional regulation.”

It also may be necessary to convince people that getting close to zero patient harm is doable.

“It’s countering the sense of fatalism that people make mistakes, and we’re not going to be able to take quantum leaps forward,” said Barbara Fain, executive director of the Betsy Lehman Center for Patient Safety, who has organized a new multi-stakeholder consortium in Massachusetts to re-invigorate patient safety efforts. “Just because it’s complicated and hard, there’s a lot that can be accomplished.”

Observers agree that the focus on patient safety has waned, however, as other issues such as financial performance, growth, competition, and regulatory and payment changes have captured the attention of healthcare leaders and policymakers. Getting healthcare CEOs to prioritize patient and staff safety has been difficult at least partly because it involves a major organizational commitment of time and resources.

“There’s a business case for investing in safety, but it’s been a bit of a hard sell,” Fain said.

CEO surveys conducted by the American College of Healthcare Executives for the past five years have found CEOs consistently rank patient safety below financial challenges, and about equal to government mandates and personnel shortages, on their list of priorities.

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DR. DAVID BATES, HEALTH POLICY PROFESSOR
HARVARD UNIVERSITY

Still, a survey of hospital CEOs by ACHE in 2017 found that two-thirds of hospitals had adopted 75% or more of 38 recommended safety practices, with adoption highest on response to patient-safety events and lowest on physician education and engagement.

Another big challenge is the widespread shift of care out of the hospital. Protecting patients from errors in settings such as physicians' offices, ambulatory surgery centers, diagnostic facilities, skilled-nursing facilities, and home health is harder because the safety infrastructure is much less developed than in hospitals.

Plus, the most common errors in those settings, such as diagnostic mistakes and failure to provide recommended preventive care, may be harder to detect and prevent than hospital-based harms.

"We don't have an easy solution yet to extending this work into the clinics of private-practice pediatricians and helping them understand the factors influencing safety," said Marcy Doderer, CEO of Arkansas Children's in Little Rock, which has implemented a comprehensive safety program.

UCSF's Wachter said that while much work remains to be done, he sees substantial improvement, especially compared with the chaos and egregious errors he saw 20 years ago. He bases that judgment on observing hospital care for his elderly parents, Murray and Bernice.

Now, there's a "reasonably good chance" the physician will have washed his hands, he said. Staff will ask the patient's name and check the bar codes. Prescriptions and lab tests are speedily transmitted digitally. Physicians can read each others' notes through the EHR.

On the other hand, he said, when patients get care from multiple specialists or health systems, "it seems like the right hand doesn't know what the left hand is doing. We haven't nailed that problem at all."

Many say that such hazards will only be corrected when top leaders of healthcare organizations are held responsible for creating a culture where safety and quality is the core mission. Signature's Hollon hopes his state's new safety and quality consortium will focus on that, along with pushing executives to learn the science of safety management.

"I don't think executives see patient harm close enough to see the human impact," he said. "They believe it's someone else's failure. I'm hoping the coalition will have the gumption to hold industry

leaders more accountable.”

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Inline Play