IHI Open School Course Summary Sheet

PS 101: Introduction to Patient Safety

Lesson 1: Understanding Medical Error and Patient Safety

- Why should we study the field of patient safety?
  - According to the World Health Organization, patient safety means “freedom from unnecessary harm or potential harm associated with health care.”
  - According to Institute of Medicine’s 1999 report *To Err Is Human*, between 44,000 and 98,000 Americans die in hospitals each year due to errors in their care.

- Why is health care so dangerous?
  - Diagnosing and treating patients is incredibly complex.
  - Practitioners are often inadequately trained to deliver care as a well-integrated team.
  - The culture of safety — the attitudes, beliefs, perceptions, and values that employees share in relation to safety — that exists in most health care organizations is weak compared to many other high-risk, complex businesses.

- Making dramatic improvements in patient safety will require the following commitments from both individuals and the organizations working in health care:
  - Acknowledge the scope of the problem of medical errors, and make a clear commitment to redesign systems to achieve unprecedented levels of safety.
  - Recognize that most patient harm is caused by bad systems and not bad people, and therefore we must end our historic response to medical error, which has been saddled with finger-pointing and shame.
  - Acknowledge that individuals alone cannot improve safety; it requires everyone on the care team to work in partnership with one another and with patients and families.
Lesson 2: Responding to Error

- Blaming and punishing an individual does not address the underlying issues that led to an event and does not prevent a recurrence.
  - A small minority of harm is caused by incompetent or poorly intended care.
  - The aviation industry learned that blaming and punishing individuals would not make transportation safer in 1977 through the Tenerife crash, which killed 583 people in aviation’s deadliest accident.
  - Adverse events cause psychological harm to health care providers.
- Although blaming and punishing individuals for errors are not appropriate responses, individuals should still be accountable for their actions.
  - James Reason’s decision tree for determining culpability of unsafe acts can help you determine whether an individual is to blame in an adverse event.
- Sorrel King, whose daughter Josie died at Johns Hopkins Hospital as a result of medical error, chose not to blame individuals but instead work for systems solutions.

Lesson 3: A Call to Action — What YOU Can Do

- Here are four behaviors any practitioner can do to improve safety for patients:
  - Follow written safety protocols. For example: Sanitize and wash your hands to reduce the spread of infection.
  - Speak up when you have concerns. For example: Report unsafe conditions, close calls, and adverse events.
  - Listen to patients, colleagues, and mentors. For example: Encourage patients and families to participate in decision-making.
  - Take care of yourself. For example: Get an appropriate amount of sleep and control your stress.