Open School

Video Activity: Why Do Errors Happen? How Can We Prevent Them?

(http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/WhyDoErrorsHappen.aspx)

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Facilitator Instructions

- Review the learning objectives and description with your group.
- Watch the video together (4 min 41 sec).
- As a group, discuss your reactions to the video, using the discussion questions as a guide.

Learning Objectives

At the end of this activity, you will be able to:

- List at least two examples of common preventable errors that occur in health care.
- Give at least one example of a health care scenario in which systems thinking could make patients safer.
- Discuss how system's thinking can help a clinician deal with the guilt of making a mistake.

Description

Millions of people suffer every year from mistakes in health care. Lucian Leape, MD, explains why those mistakes happen — and how to prevent them.

Related IHI Open School Online Courses

- PS 101: Fundamentals of Patient Safety
- PS 100: Introduction to Patient Safety
- PS 102: Human Factors and Safety

Key Topics

Quality improvement, redesign processes and systems, reliable processes, patient safety, culture of safety, medication safety.

Discussion Questions

1. Dr. Leape says "every mistake is due to a systems failure." Think about your own experiences as a clinician or patient. Have you ever spotted an error waiting to happen? If so, what could have been done to make the system safer?

2. Can you think of a time when, despite your best intentions, you made a mistake that affected someone else. (Examples can come from a health care setting or elsewhere.) What systems or processes could have kept you from making that mistake?

3. What are the main obstacles preventing hospitals from learning from one another's mistakes? Are the barriers primarily cultural? Legal? Technological? How would you design an ideal system to keep identical, fatal errors from happening in different places?