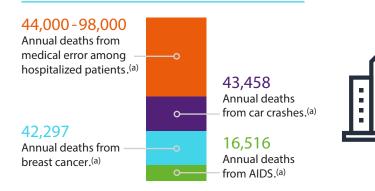
FREE FROM HARM:

ACCELERATING PATIENT SAFETY IMPROVEMENT FIFTEEN YEARS AFTER TO ERR IS HUMAN

Report of an expert panel convened by the National Patient Safety Foundation argues for looking at morbidity as well as mortality caused by medical errors and going beyond hospitals to improve safety across the continuum of care.

TO ERR IS HUMAN FRAMED PATIENT SAFETY AS A SERIOUS PUBLIC HEALTH **ISSUE (1999 ESTIMATES)**



BY SOME MEASURES, HEALTH CARE HAS GOTTEN SAFER SINCE TO ERR IS HUMAN

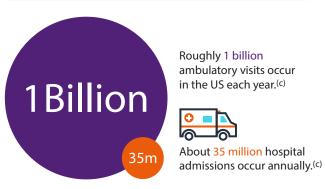


hospital-acquired conditions (2011-2013) as a result of the federal Partnership for Patients initiative.(b)

TO UNDERSTAND THE FULL IMPACT OF PATIENT SAFETY PROBLEMS, WE MUST LOOK AT BOTH MORTALITY AND MORBIDITY

1in10 patients develops a health care acquired condition (such as infection, pressure ulcer, fall, adverse drug event) during hospitalization.^(b)

BUT WE MUST LOOK BEYOND HOSPITALS TO THE FULL CARE CONTINUUM





ADVANCEMENT IN PATIENT SAFETY REQUIRES AN OVERARCHING SHIFT FROM REACTIVE, PIECEMEAL **INTERVENTIONS TO A TOTAL** SYSTEMS APPROACH TO SAFETY^(d)

- Ensure that leaders establish and 1 sustain a safety culture.
- Create centralized and coordinated 2 oversight of patient safety.
- Create a common set of safety metrics 3 that reflect meaningful outcomes.
 - Increase funding for research in patient safety and implementation science.

4

5

- Address safety across the entire care continuum.
- 6 Support the health care workforce.
- Partner with patients and families for 7 the safest care.
- Ensure that technology is safe and
- 8 optimized to improve patient safety.



To read the full report and detailed set of recommendations, visit www.npsf.org/free-from-harm

AIG

This project was made possible in part through a generous grant from AIG in support of the advancement of the patient safety mission. AIG had no influence whatsoever on report direction or its content. The views and opinions expressed herein are those of the author(s) and do not necessarily reflect those of American International Group, Inc. (AIG) or its subsidiaries, business units or affiliates. Sources: (a) Institute of Medicine. To Err Is Human: Building a Safer Health System. Washington, DC: The National Academies Press, 2000. (b) 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Death Averted From 2010 to 2013. Rockville, MD: Agency for Healthcare Research and Quality; October 2015. AHRQ Publication No. 16-0006-EF. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/index.html. (c) National Center for Health Statistics. Faststats A-Z. Ambulatory Care and Hospital Utilization Available at: http://www.cdc.gov/nchs/fastats/ (d) National Patient Safety Foundation, Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human, Boston, MA: National Patient Safety Foundation; 2015. Available at: http://www.npsf.org/free-from-harm