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**NEW NATIONAL ACTION PLAN SEEKS TO RE-ENERGIZE PATIENT SAFETY
IMPROVEMENT AND ACCELERATE CHANGE**

*Plan reflects consensus on need for greater collaboration and greater focus on
foundational change to reduce medical errors*

Boston, MA — September 14, 2020 —The Institute for Healthcare Improvement (IHI)-convened National Steering Committee for Patient Safety (NSC) today announced the release of a National Action Plan intended to provide health systems with renewed momentum and clearer direction for eliminating preventable medical harm. [*Safer Together: A National Action Plan to Advance Patient Safety*](#) draws from evidence-based practices, widely known and effective interventions, exemplar case examples, and newer innovations. The plan is the work of [27](#) influential federal agencies, safety organizations and experts, and patient and family advocates, first brought together in 2018 by [IHI](#), a global leader in health and health care improvement worldwide.

“The way in which diverse groups and patient advocates who are interested in patient safety came together to forge the National Action Plan is unprecedented, and it underscores the necessity to work together to create the safest health care possible,” said NSC Co-Chair Jeffrey Brady, MD, MPH, who directs the Center for Quality Improvement and Patient Safety at the U.S. Agency for Healthcare Research and Quality. “Over the past 20 years, the field has amassed a tremendous body of knowledge to improve health care safety. What’s been missing is the use of this knowledge for more coordinated action. That’s what we want to rectify.”

While development of the National Action Plan was initiated prior to the onset of the COVID-19 pandemic, the core principles and recommendations are extremely relevant to the current crisis. In addition, COVID-19 has exposed the health consequences of inequities that have persisted for decades across health and health care. The National Action Plan highlights advancing health equity as a core principle of its recommendations and compiles resources to help health systems address and eliminate inequities at the point of care and in the community.

The insights and recommendations in the National Action Plan center on four foundational areas deliberately chosen because of their widespread impact on safety across the continuum of care. These areas are: Culture, Leadership, and Governance; Patient and Family Engagement; Workforce Safety; and Learning Systems. To help health care organizations immediately act on the recommendations and achieve progress across the four foundational areas, the plan provides implementation tactics, case examples, tools, and resources—including two supplementary materials:

- *Self-Assessment Tool* assists leaders and organizations in deciding where to start on their respective work and is designed to allow organizations to track progress over time.
- *Implementation Resource Guide* details tactics and supporting resources for implementing and measuring the National Action Plan recommendations

FOUR FOUNDATIONAL AREAS:

1. *Culture, Leadership, and Governance*: The imperative for leaders, governance bodies, and policymakers to demonstrate and foster deeply held professional commitments to safety as a core value and promote the development of cultures of safety.
2. *Patient and Family Engagement*: The spread of authentic patient and family engagement; the practice of co-designing and co-producing care with patients, families, and care partners to ensure their meaningful partnership in all aspects of care design, delivery, and operations.
3. *Workforce Safety*: The commitment to the safety and fortification of the health care workforce as a necessary precondition to advancing patient safety; the need to work towards a unified, total system perspective and approach to eliminate harm to both patients and the workforce.
4. *Learning System*: The establishment of networked and continuous learning; forging learning systems within and across health care organizations at the local, regional, and national levels to encourage widespread sharing, learning, and improvement.

“With so many competing priorities and requirements that health systems face, it has become difficult to focus on key areas that are foundational for improving across the board,” stated Tejal K. Gandhi, MD, MPH, CPPS, NSC Co-Chair, IHI Senior Fellow, and Chief Safety and Transformation Officer at Press Ganey. “The Action Plan helps direct attention to these interdependent areas, which have substantial, wide-ranging influence on many aspects of patient safety. Accelerating improvement in each of these areas will mutually support improvement in others and create the fertile soil that allows broader safety initiatives to take root and be cultivated.”

One foundational area, Workforce Safety, is the focus of this year’s World Patient Safety Day, organized by the World Health Organization and taking place September 17. The theme recognizes the risks to health and safety which frontline caregivers and workers have faced while taking care of patients before and during the COVID-19 pandemic. Per the National Action Plan, Workforce Safety encompasses the physical and psychological safety of the entire health care workforce: nurses, physicians, medical assistants, pharmacists, technicians, patient and family advisors, volunteers, and others who work tirelessly to care for patients in an industry with one of the highest rates of work-related illnesses and injuries. It’s possible to rectify this, according to the National Action Plan, if workforce and patient safety are advanced together using tried and true improvement methods, in concert with other foundational areas.

“IHI joins with the 26 other organizations who have contributed to this National Action Plan and pledges to help health care leaders take advantage of the new guidance to catalyze the patient safety agenda and continue to drive meaningful change,” stated Kedar Mate, MD, IHI President & CEO. “We urge everyone across health and health care to embrace this same pledge, stand with the NSC, and take decisive action to advance these recommendations.”

In the 20 years since the publication of the Institute of Medicine’s seminal report, *To Err Is Human: Building a Safer Health System*, patient safety experts agree and studies show that the efforts of thousands of health systems and state, regional, and national programs have led to progress on patient safety. But there’s acknowledged ‘project fatigue’ in the field. And, nationwide resolve to bring about and sustain widespread improvement in patient safety has become complacent. The result, observers say, is that medical errors remain too frequent, and improvement tends to target particular types of harm in isolation of one another, not as part of a total system of safety. Without greater attention to the foundational factors that impact workforce and patient safety, more substantial and lasting change is impossible, according to NSC members.

About the Institute for Healthcare Improvement (IHI)

The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization based in Boston, Massachusetts, USA. For more than 25 years, IHI has used improvement science to advance and sustain better outcomes in health and health systems across the world. IHI brings awareness of safety and quality to millions, catalyzes learning and the systematic improvement of care, develops solutions to previously intractable challenges, and mobilizes health systems, communities, regions, and nations to reduce harm and deaths. IHI collaborates with a growing community to spark bold, inventive ways to improve the health of individuals and populations. IHI generates optimism, harvests fresh ideas, and supports anyone, anywhere who wants to profoundly change health and health care for the better. Learn more at ihi.org.

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