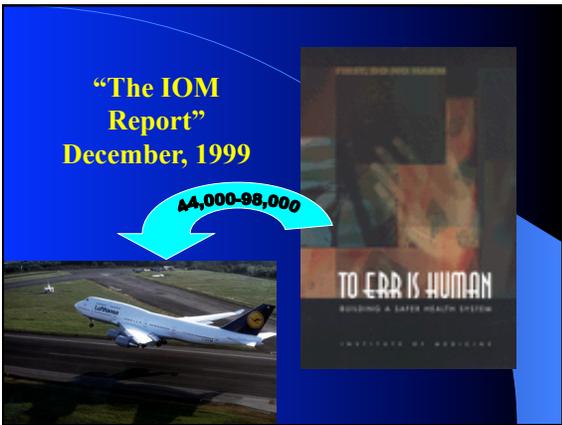


Patient Safety Ten Years After the IOM Report on Medical Errors: *Unmistakable Progress and Troubling Gaps*

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**“The IOM Report”
December, 1999**

44,000-98,000



The BBC’s “Wrong Guy”



Guy Goma Guy Kewney

<http://news.bbc.co.uk/1/hi/entertainment/4774429.stm> 3



Anchor: “Guy Kewney is the editor of the technology website ‘Music Online’... were you surprised by today’s verdict?”

The Wrong Guy: “I was very surprised...”

What Were the Problems?

- Wrong mental model: all about individual fault
- No expertise: how to analyze errors and fix systems, how other industries do safety
- No infrastructure: IT, national standards, transparency, robust local org chart
- Little research: evidence-based practices that work, implementation science
- Absolutely no business case to invest in/focus on patient safety

What *Has* Worked?

- Regulations/ Accreditation
- Reporting Systems
- Clinical IT
- Balancing “No Blame” and Accountability



Regulations/Accreditation: B+ * (down from A- in 2004**)

- Why regulation/accreditation?
 - Sign your site: “X” marks the spot
- The Joint Commission gets real
- But beginning to run out of gas
 - One size fits all
 - Hard to regulate culture (leadership standards, disruptive behavior)
 - Limited knowledge base (med rec)

* Wachter RM, *Health Affairs*, 2010.
** Wachter RM, *Health Affairs*, 2004.



Reporting Systems: B+ (up from C)

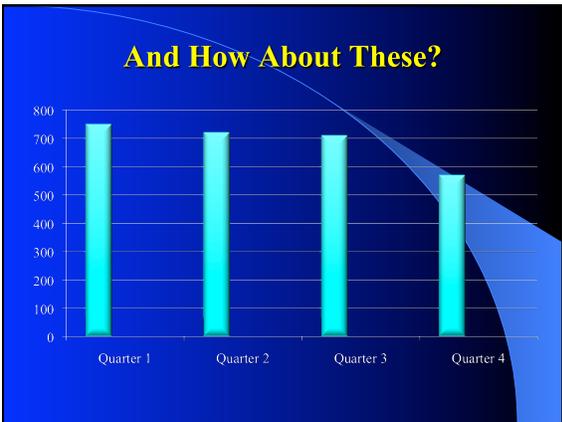
- Flawed notion that reporting has any intrinsic value *by itself*
- Huge opportunity to waste time, money, and squander caregiver good will
 - Admonition to “report everything” was silly and naïve (and a mis-analogy from aviation)



Public Reporting

- Biggest surprise of *quality* revolution
 - Simple reporting leads to major improvements
 - Mechanism is shame/pride, not public scrutiny
- Problem viz medical errors: measuring safety
 - Medicare public measures all quality, not safety
 - Processes (beta blockers, aspirin, flu shots), outcome (risk-adjusted mortality)
 - At this point, measuring safety mostly depends on self reports
 - Except for certain healthcare-associated infections





Why Reporting Systems Are Gaining Mojo

- Key was to develop a manageable list of topics (NQF “never events”)
- 27 states now require reports of NQF list
- Key is internal change, not outside analysis
 - CA’s required reporting of “never events” has transformed UCSF’s RCA process
- New: efforts by CMS to use “never events” to create “non-pay for non-performance” pressure

Healthcare IT: C+ (down from B-)

- Not *worse* than it was, but juxtaposition with IT in the rest of our lives is even more jarring
- Early glowing studies were not generalizable to vendor-built systems
- Expect unforeseen consequences
 - Emerging literature re: problems



But \$19B says we've now passed the tipping point

Is IT The Path To Improvement? What I Learned At Residents' Report



Balancing "No Blame" and Accountability: C+ (up from D+)

- The "No Blame," "It's the System Stupid" approach has been crucial
 - Most errors *are* "slips" – expected behavior by humans, particularly when engaged in "automatic behaviors"
 - Can only be fixed by improving systems (checklists, double-checks, standardization, IT, other new technology...)

Why We Needed a Systems Approach



Two Disconnected Conversations

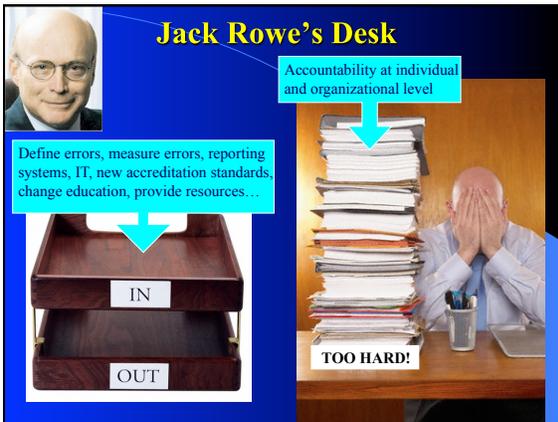


At the Junction, the Message Gets a Little Garbled...



In Summary, We Struggle With Two Competing Epiphanies

- Most errors are committed by caring, competent people who are trying hard to get it right
- Therefore, finger-pointing, shaming and suing them doesn't help, it stifles open discussions and learning
- The system produces low quality, unsafe, unreliable care partly because there's been insufficient pressure to fix it
- Therefore, the last 10 years have seen a variety of initiatives to create accountability, which generates action, focus, and resource flow



What Does Accountability Look Like?

- Reasonable performance expectations
 - Applied fairly, expectations similar for all
 - Appropriate carrots and sticks used to drive system toward excellence
- “No blame” is the dominant front-line culture
 - For innocent slips and mistakes
- Clear demarcation of blameworthy acts
 - E.g., Gross incompetence, disruptive behavior, and now, failure to heed reasonable safety/quality rules

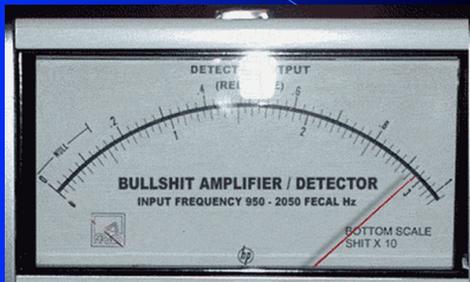
Individual Accountability: The Hand Washing Story

- Typical hand hygiene rates circa 1999: 10-30%
- Over last decade, tremendous push to improve (via transparency, social pressures, and more)
- Many organizations now at 40-70%, ***and stuck***
- “It’s a Systems Problem”:
Education, dispensers every 3 feet
- A systems problem? *Really?*



Wachter, Pronovost. NEJM 10/1/09

Who Decided that a 60% Hand Washing Rate is a “Systems Problem”?



When Is the Accountability Approach Correct?

- The practice is important and works
- The systems have been fixed
- Unintended consequences have been addressed
- Providers understand the practice, its value, the auditing strategy, and the penalties
- A single transgression has led to a warning

At that point...

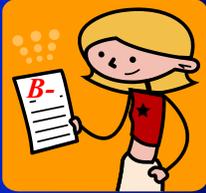


The Bottom Line: Leaders and organizations *will* be held accountable

“ ‘No blame’ is not a moral imperative (even if it seems so to providers, it most definitely does *not* to patients). Rather, it’s a tactic to achieve ends for which providers and healthcare organizations will be held accountable. ”

Wachter, Pronovost, *NEJM*, 2009

Overall Grade: Patient Safety 10 Years After the IOM Report



**Where Are We A Decade Into the
Quality and Safety Revolutions?**

This is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.