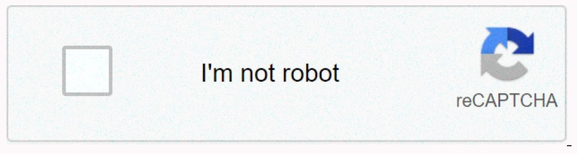

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Institute of medicine report on medical errors

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O número de pacientes hospitalares dos EUA que morrem por erros médicos a cada ano pode ser até 4,5 vezes maior do que o Instituto de Medicina estimou em seu relatório de 1999, To Err is Human, de acordo com um estudo no Journal of Patient Safety. Em 1999, o OIM publicou To Err is Human: Building a Safer Health System, que estimou que até 98.000 mortes de pacientes ocorrem nos EUA por ano devido a erros médicos. Esta estimativa é baseada em dados de 1984 de revisões médicas de prontuários de pacientes hospitalares de Nova York. O autor John T. James, PhD, toxicologista-chefe da National Aeronautics & Space Administration e fundador do grupo de advocacia Patient Safety America, teve como objetivo atualizar essa estimativa realizando uma revisão de estudos publicados de 2008 a 2011. Ele four studies they examined examined incidence of events using the Global Trigger Tool, in which medical records are reviewed for certain triggers that suggest that an adverse event has occurred. These studies included two studies by the Office of Inspectors General, one in 2008 and one in 2010, a 2011 Health Affairs study, and a 2010 New England Journal of Medicine study. A weighted average of these studies revealed that at least 210,000 deaths were associated with preventable adverse events in hospitals each year. However, the GTT does not identify misdiagnosis or mismission errors, including non-compliance with the guidelines, and medical records often do not include all adverse events, according to the study. In accounting for these missed errors, the estimated number of deaths linked to preventable adverse events rises to 440,000 —about 4.5 times the IOM estimate and approximately one-sixth of all annual Deaths in the U.S. Dr. James suggested several possible reasons for the increased estimate compared to the number of IOM, including different criteria for identifying an avoidable adverse event among studies, the potentially superior ability of GTT to identify adverse events, and an increase in the rate of adverse events over time. He concluded: In a way, it doesn't matter if the deaths of 100,000, 200,000, or 400,000 Americans each year are associated with [preventable adverse events] in hospitals. Any of the estimates requires assertive action by providers, legislators and people who will one day become patient. He wrote that he hopes the present study will encourage a faster improvement in patient safety. More articles on patient safety: SHEA releases the first infection prevention guidelines from Ronald McDonald House Home Lessons from high-risk industries can permanently eliminate patient damage Hospital start MRSA rates by more than 50% Drug-related injuries harm at least 1.5 million Americans each year, resulting in an additional $3.5 billion (£1.9 billion; €2.8 billion) in hospital spending, a report by the US Institute of Medicine says. The report was commissioned by the Centers for Medicare and Medicaid Services in the direction of Congress and released on 20 July.It found that drug-related errors are the most common medical errors and can occur at all stages from prescription to patient response monitoring. The report estimates that, on average, at least one drug error per hospital patient occurs every day and says the error rate varies widely between facilities. Not all mistakes, however, lead to injuries. The 1999 report of the To Err is Human Institute brought for the first time to public attention serious problems with the quality in health care provision, said J Lyle Bootman, dean of the University of Arizona School of Pharmacy, Tucson, and co-chair of the committee that wrote the most recent report. This recognition in 1999 to 1999 the beginning of implementation of changes to fix the problems, that this report continues to advance, he said. There are many paths to error at the patient level. That's why we specify, right up front, [that] the patient needs to be heavily engaged in this process, Dr. Bootman said. Better communication, including both sides of the patient-provider partnership, was crucial, he added. Patient safety in general -- and drug safety in particular -- is not part of the curriculum in most professional schools, said one committee member, Albert Wu, professor of health policy and management at Johns Hopkins University in Baltimore. He called it a central competency that doctors should have been receiving since the beginning of medical school. The report recommends that by 2008 all healthcare providers should have plans to write prescriptions electronically. And it set a date from 2010 until when all health care providers should be using electronic prescription systems and all pharmacies should be able to receive prescriptions electronically, to reduce the scope of error. The committee lamented the limited amount of data on operational aspects of drug delivery. He has called for more funding for research in this area, from the few million dollars a year that are currently spent for a minimum annual investment of $100 million. Dr. Wu said: If medication errors were a single disease, we would be investing more heavily. Research funding for cancer is in the billions, but the proportion of people suffering from medication errors is much higher than those with cancer. Prevention of medication errors can be purchased in www.nap.edu/catalog/11623.html.Articles from the BMJ are provided here courtesy of BMJ Publishing Group Errors occur in health care as well as in all other very complex systems involving humans. The message in To Err is Human is that preventing death and injury from medical errors requires dramatic, system-throughout changes.1 Among three important strategies —preventing, recognizing, and mitigating the damage of error—the first strategy (recognizing and implementing actions to prevent errors) has the greatest potential effect, as well as on preventive public health efforts. The IOM committee acknowledged that simply calling on individuals to improve security would be as wrong as blaming individuals for specific mistakes. Health professionals have seen errors as a sign of an individual's incompetence or recklessness. As a result, instead of learning from such events and using information to improve safety and prevent new events, health professionals have had difficulty admitting or even discussing adverse events or near mistakes, often because they fear professional censorship, administrative guilt, lawsuits or personal of shame. Recognizing this, the report presented a four-part plan that applies to all who are or will be at the forefront of patient care; clinical administrators; regulation, accreditation and licensing groups; licensing; directors; industry; and government agencies. He also suggested actions that patients and their families could take to improve safety. The committee understood that it is necessary to develop a new field of health research, a new taxonomy of error and new tools to face problems. It also understood that the responsibility for taking action could not be borne by any group or individual and had to be addressed by health organizations and groups that influence regulation, payment, legal responsibility, education and training, as well as patients and their families. The report called on Congress to create a National Center for Patient Safety within the Health Research and Quality Agency to develop new patient care tools and systems that facilitate the right and most difficult things to do the wrong things. This manual is a direct result of the implementation of these recommendations. Every day, doctors, nurses, nurses, pharmacists and other hospital staff recognize and correct errors and generally prevent harm. Errors, defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve a goal, 1 do not result in injury or damage. Errors that cause injury or damage are sometimes called preventable adverse events —that is, the injury is believed to be due to medical intervention, not the patient's underlying condition. Errors resulting in serious injury or death, considered sentinel events by the Joint Committee (formerly the Joint Accreditation Committee of Health Organizations [JCAHO]), 5 signal the need for immediate response, analysis to identify all factors contributing to the error, and reports to appropriate individuals and organizations7 to guide improvements in the system. The key issue for the IOM, as for many health professionals now, was what could be done to improve safety. To differentiate between individual factors and system factors, the report distinguished between the sharp end of a process in which the event occurs (e.g., administration of the wrong dose of medication that is fatal, an accident during surgery) and the blunt end in which many factors (called latent conditions), which may have appeared minor, interacted and led to an error.6 These latent conditions may be attributable to the design or maintenance of the equipment. , working conditions, design of processes for many handoffs, communication failures, and so on.7-9Leape8 greatly improved our understanding of errors, distinguishing between two types of cognitive tasks that can result in errors in medicine. The first type of task occurs when people engage in well-known and repeated processes, such as driving to work or making a pot of coffee. Errors can occur while performing these tasks due to interruptions, pressure, anger, distraction, anxiety, fear or boredom. In contrast, tasks that require troubleshooting are done more slowly and and are perceived as more difficult, and require conscious attention. Examples include making a differential diagnosis and preparing various types of surgical equipment made by different manufacturers. The errors here are due to the misinterpretation of the problem that must be solved and the lack of knowledge. Keep in mind these two different types of tasks is useful for understanding the multiple reasons for errors and is the first step in preventing them. People make mistakes for a variety of reasons that have little to do with lack of good intention or knowledge. Humans have many intellectual forces (e.g., large memory capacity and an ability to react creatively and effectively to the unexpected) and limitations (e.g., difficulty in carefully attending to various things at the same time and generally poor computational capacity, especially when tired).12 Improving safety requires respecting human skills when designing processes that recognize human strengths and weaknesses. There are many opportunities for individuals to avoid mistakes. Some actions are clinically oriented and evidence-based: communicating clearly with other team members, even when hierarchies and authority gradients seem to discourage you; requesting and giving feedback for all verbal orders; and be alert for accidents waiting to happen. Other opportunities are broader in focus or address the work environment and may require clinical leadership and changing workplace culture: simplifying processes to reduce hands and standardize protocols; development and participation in multidisciplinary team training; involving patients in their care; and be receptive to discussions about near errors and mistakes, paying respectful attention when any team member challenges the security of a plan or care process. However, large and complex problems require thoughtful and multifaceted responses by individuals, teams, and organizations. That is, preventing errors and improving security require a systems approach to dedesign processes, tasks, training, and working conditions in order to modify the conditions that contribute to errors. Fortunately, there's no need to start from scratch. The IOM report included some guidance based on what was known at the time, and other specific evidence has accumulated since then that can be put into practice today. Designing for safety requires a commitment to security, a thorough knowledge of technical care processes, an understanding of the likely sources of error, and effective ways to reduce errors. Nurses sometimes say: We're really short-staffed. Sometimes I'm so busy and distracted that I'm sure I should make mistakes when calculating the doses of meds. I didn't kill anyone, but I know when I made a mistake. How can I be sure i don't make mistakes? I should chemotherapy to a patient. Even though I struggled, I couldn't figure out from the chart what kind of cancer the patient had. What can I do to make sure of this kind of thing happen again? There's equipment in our unit that's an accident waiting to happen. The experienced staff knows this and has learned to work around it, but what happens when new employees are assigned? These kinds of questions are not uncommon. Partly because of its complexity and the number of different individuals with different trainings and approaches, health care is likely to undermine errors —especially in operating rooms, intensive care units (ICUs), and emergency services where there is little time to react to unexpected events —and the consequences can be very serious. Although most initial studies have focused on the hospital environment, medical errors present a problem in all environments, including outpatient surgical centers, medical and clinic offices, nursing homes, and homes, especially when patients and families are asked to use increasingly complicated equipment. Patients should not be harmed by the health system that should help them, but the solution is not to assign blame or to urge health professionals to be more careful. In what appears to be a simple example, an ICU nurse was taking a patient on a stretcher to radiology when his knee hit a fire extinguisher hanging from the wall, resulting in the need for extra patient care. In response, the nurse may have been reprimanded by the supervisor and told to be more careful, or punished in some other way; everyone would feel that the problem had been solved. However, would that make the hospital safer? Would it prevent other similar but slightly different events from happening to other employees and patients in other units? The answer is an emphatic non- Improving safety arises from attention to often multiple latent factors that contribute to errors and, in some cases, to injuries. In the example above, these factors included: 1) the nurse having to move her own patient because the transport had never arrived; 2) a change in hospital policy, so that only one instead of two people guide stretchers; 3) the failure to mount the fire extinguisher in a lowered niche; 4) the decision to transport a critically ill patient instead of having mobile equipment reach him, requiring extra deliveries and injury opportunities; and 5) bad litter design, making it difficult to steering, and possibly even other factors. The IOM committee sought what could be learned from other disciplines and applied in health care by clinical and administrative leadership. He described actions that healthcare professionals can now take in their own institutions, be they new interns, experienced clinical leaders or instructors. The main impetus of the report was a four-part plan to create financial and regulatory incentives for the creation of a more and a systematic way to integrate security into the care process (the focus of this chapter). The four parts of the IOM recommendations are described below:♦ Part 1: National Centre for Safety – The IOM recommended the creation of a National Center for Patient Safety at the U.S. Department of Health and Human Services's Health Research and Quality Agency (AHRQ), because health care is a decade or more behind other high-risk industries in its care to ensure basic safety, set national safety goals , track progress in meeting them and invest in research to learn more about error prevention. This center would also serve as a clearing and source of effective practices that would be shared broadly.♦ Part 2: Mandatory and Voluntary Reporting Systems – To learn about medical care associated with serious injury or death and to prevent future occurrences, the IOM recommended the creation of a national and mandatory public notification system, where federal law would protect the confidentiality of certain information (for example. errors that have no serious consequences). The intention was to encourage the growth of voluntary and confidential reporting systems so that health professionals and organizations could learn and correct problems before serious harm occurs.♦ Part 3: Role of Consumers, Professionals and Accreditation Groups – The IOM believed that fundamental changes would require pressure and incentives from many directions, including public and private buyers of health insurance , regulators (including the Food and Drug Administration), and licensing and certification groups. A direct result was the announcement of new safety standards from the Joint Committee and a report, Safe Practices for Better Health Care. A Consensus Report from the National Quality Forum.10♦ Part 4: Building a Safety Culture – The IOM called on health organizations to create an environment in which safety becomes a top priority. This report underscored the need for leadership by executives and physicians and accountability for patient safety by the trustees. In particular, it called for known safety principles in other industries to be adopted, such as the design of jobs and working conditions for safety; standardization and simplification of equipment, supplies and processes; and avoiding memory dependency. The report highlighted the safety of medicines in part because drug errors are so frequent11 and, in part, because a number of evidence-based practices were already known and needed broader adoption. Although at the time of publication, the levels of evidence for each category varied, committee members believed that all were important places to start improving security. The committee acknowledged that some actions could be taken at the national level, as described in the recommendations contained in Parts 1-3. However, if patient safety were to really improve, the committee knew it would take much more than reporting requirements and regulations. It is necessary to create and sustain a culture of safety (Part 4), which would require the continuity of local action by thousands of health organizations and working on these settings at all levels of authority. Hospital leadership should provide resources and time to improve safety and foster an organizational culture that encourages recognition and learning from mistakes. A safety culture cannot develop without trust, keen observation and broad knowledge of care processes at all levels, from those at the forefront of health care to those in leadership and management positions. Positions.