MAKING A LIST CHECKING IT TWICE

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In 1999, the Institute of Medicine published "To Err Is Human: Building a Safer Health System," which emphasized the dramatic number of preventable medical problems in the U.S. As a result, Congress mandated federal health care facilities to focus on preventing medical errors which led to the establishment of DoD Instruction 6025.17, Military Health System Patient Safety Program, to implement patient safety programs in the military.

All military treatment facilities are required to collect and analyze information on medical events that may or may not have caused harm to the patient, to include "close call" errors. Health care systems have adopted a non-punitive approach in managing unintentional errors in order to encourage reporting. The information is generated from staff reports and suggestions, customer comment cards, patient complaints, and patient surveys. With this data, the facility initiates actions intended to improve patient safety followed by evaluations of the actions effectiveness.

> "I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them."
>
> *—excerpt from The Doctor's (Hippocratic) Oath*

The DoD Instruction also regulates safety education. Medics participate in ongoing patient safety training, which is required annually. In addition, on-the-job patient education is provided in cases where the patient voices a concern. The health care team routinely advises patients on their role in facilitating the safe delivery of health care. DoD health care staff members currently wear "Ask Me" buttons in order to promote a dialog between the patient and the health care provider.

Building a culture of safety is achievable through understanding the underlying causes in medical incidents. "Experience is the best teacher" but the price is high. In order to reduce this expense, it behooves the medical community to learn from "close calls" where no harm is done, rather than learning from an incident that causes harm. Establishing a culture of safety where individuals are comfortable in disclosing both undesirable events and close calls is the key to establishing patient safety.

In order to improve patient safety, it is important to target specific items of emphasis: a core body of general knowledge; mediums for applying knowledge; develop a culture of accessibility to patient safety; raise public awareness; foster communications about patient safety; and improve the status of patient safety and its ability to meet the needs of the public.

Patient safety programs closely mirror Operational Risk Management (ORM) in that it proactively identifies risks, or potential risks, to patient safety. They assess risks using a "probability of severity" matrix and initiate structured actions to reduce risks that focus on processes and systems, not individuals. This way finger pointing at individuals for unintentional errors is avoided. Instead, the focus is to fix system flaws over which individuals have no control. But, patient safety is also committed to holding individual medical providers accountable for their job responsibilities.

An important part of patient safety is fully empowering patients to be involved in their medical treatment plan. This has been a part of "Patient Rights and

Photo by MSgt Mark Bucher

THE AIM OF PAITENT SAFETY

> "Into whosever house I enter, I will do so to help the sick, keeping myself free from all intentional wrong-doing and harm..."
>
> *—excerpt from The Doctor's (Hippocratic) Oath*

Responsibilities" for many years. The governing publication (DoDD 6000.14) states: "Beneficiaries have the right and responsibility to fully participate in all decisions related to their health care". The medical treatment facility is responsible for providing high-quality health care. At the same time, patients are expected and encouraged to assume reasonable responsibility for their own health care.

In the same manner that physicians perform early health screenings to prevent illness, the health care system proactively looks at patient care processes and recommends early improvements as a preventive measure. The goal is to avoid "bad" outcomes but, more importantly, to reduce or eliminate problems recognized as harmful to the patient prior to an incident.

Patient safety initiatives are beneficial for both the patient and the health system. The patient benefits from the constant improvement of safety in the health care environment and is encouraged to become an informed and active "partner" in managing their health. The health system benefits from the "culture of safety," ultimately resulting in safer care, as well as increased satisfaction for both the patients and the health care team by continually reviewing processes for eliminating errors or potential errors.

Medical reports show that as many as 180,000 deaths occur in the U.S. every year due to errors in medical care, many of which are preventable. Throughout the U.S. and the military, the health care system has dedicated itself to improving the safety of all patients. The level of errors acceptable in the past, are no longer accepted. Public demands, ORM, and new regulatory requirements are forcing hospitals and physicians to reevaluate their systems and practices in order to ensure the safety of their patients.

ORM	& Patient Safety
Identify the Hazards	Speak up if you have questions of concerns
Assess the Risk	Know your medical procedure options
Analyze Control Measures	Make sure you get the results of any test or procedure
Make Control Decisions	Talk with your doctor and health care team about your options in treatment
Implement Risk Controls	Keep a list of all the medicines you take
Supervise and Review	Make sure you understand your plan of treatment