



INSTITUTE FOR
HEALTHCARE
IMPROVEMENT

Could It Happen Here?

Learning from other organizations' safety errors.

Thousands of individuals and organizations have joined the Institute for Healthcare Improvement (IHI) in the 5 Million Lives Campaign. More than 2,000 hospitals have committed to the Boards on Board intervention. To improve quality and reduce safety errors, it recommends that hospital boards of trustees become actively engaged in: setting aims; gathering data and hearing stories; establishing and monitoring system-level measures; changing the environment, policies and culture; learning; and establishing executive accountability.

Establishing a culture of quality is an essential element of the board's accountability and responsibility. This culture includes a relentless commitment to learning, when all staff possesses the willingness and competence to draw responsible conclusions from internal and external safety information systems and make substantial changes when necessary. During educational sessions about the Boards on Board intervention, trustees and executive leaders routinely ask "Could it happen at my organization?" and "How do we learn from this?" For instance, a headline is suddenly all over the news: A tragic medication error has killed a young child. Increasingly, high-profile tragedies become prevalent through 24-hour electronic media

because of the expansive transparency and disclosure practices of hospitals, patients and families, public reporting (required and not), probing reporters, anonymous tips from within and outside of the healthcare industry and an accelerating emphasis on accountability. Many other industry sources also play a role in publicizing the events.

Yet, the message is not often received. Those who actually *want* to know if this could happen at their organizations are often frustrated that the learning from one or two hospitals—as in the recent cases of serious harm and death of infants due to heparin overdoses—hasn't spread immediately and reliably across the healthcare industry. Conversely, at times confusion exists over whether it is worth paying attention to external tragic events.

Organizations must focus on their own facilities' vulnerability to causing harm to patients, using their own data that is measured against internal aims for improvement. However, this also can prevent "stepping back," which is an important way to obtain a much broader view of where there are opportunities to improve patient safety. Staying alert to high-profile, tragic, serious and reportable events provides an additional powerful tool to inform learning in support of safe care for patients, families and staff.

One study suggests that it is rare for healthcare organizations to effectively learn from patient safety errors. The Institute for Safe Medication Practices (ISMP) found in 2004 that only 50 percent of the 1,600 hospitals studied use published error experiences to improve medication safety (up from 29 percent in 2000). ISMP also noted that hospitals only tend to look for evidence of safe practices, not hazards, and may not recognize the value of external stories of error and risk. In a soon-to-be-released 2007 study of hospital-based medical librarians, 58 percent provided targeted alerts on patient safety issues to staff, yet there was no evidence that this information was used to further enhance an organization's patient safety strategy.

Steps to Ongoing Learning

In an era of increased focus on patient safety, a checklist for ongoing learning from tragic medical events is beginning to materialize:

1. **Set expectations.** Leaders should convey to their staff that high-profile, outside events offer necessary learning for any institution's quality and safety programs, and the essential facts should be reviewed. The focus of the review should be in two areas: the actual event and how the impacted organization responded.

2. **Establish a system.** Models exist ranging from a systematic review of external alerts and using news scans conducted by the hospital's medical librarians, to using the regular quality/safety staff or committee meeting for shared learning and reserving a spot on the agenda for discussing external events. There should be an individual or group responsible for systematically collecting data on high-profile events.
3. **Agree on the focus.** The National Quality Forum's (NQF) list and definitions of serious reportable events provides an excellent starting place for framing the types of incidents you should monitor and know about.
4. **Develop reliable sources and get the facts straight.** A growing number of tools are available that include The Joint Commission's Sentinel Event Alerts, the Institute for Safe Medicine Practice's *Quarterly Action Agenda*, the FDA, Pennsylvania Patient Safety Authority and NQF. Google Alert also allows you to stay tuned to breaking news about medical errors around the world. When you first find out about the events, keep in mind that initial media coverage is sometimes inaccurate because of deadline pressures, the inability to get information from the parties involved, misunderstandings or a general absence of fact.
5. **Ask yourself, "Could it happen here?"** It is easy to perform a desktop exercise simulating an event happening, combined with visits to care delivery areas when using a tool such as the Failure Modes Effect Analysis to probe this question.
6. **Ask yourself again, "Could it happen here?"** This step is repeated because it is easy to say "Such a sad story, but it couldn't happen here." Organizations on a rigorous patient safety journey consistently report that as they become "experts in looking

for trouble” their serious event reporting goes up before it goes down.

7. Listen and learn. Stay tuned for updated reports, read them and keep asking the tough questions. Also, monitor the affected organization’s response. The way it handles the situation can help you modify your existing guidelines for how management responds to and supports patients, families and staff if something serious occurs. External events are great tests of your own plans.

8. Inform those who should know what happened. Stories are powerful, persuasive tools to drive improvement around your organization. Make it a routine part of your report to your board or board quality committee to discuss these stories that happened elsewhere. And, remember that your patients and their families are reading the papers and watching the TV, too!

9. Tell the story to those outside your organization. When 2 or 10 or 100 organizations respond back and say, “That could have happened here,” this informs a community or a nation of both the “clear and present danger” to their own facilities and the opportunity for learning.

Organizations on the Right Track

IHI and others are continually trying to identify hospitals that are leading the industry toward improved patient safety:

Medication focused:

- Catholic Health Partners (Wayne Bohenek, wsbohenek@health-partners.org)

- Lehigh Valley Health Network (Bob Begliomini, robert.begliomini@lvh.com)
- St. Rita’s Medical Center (Ronda Lehman, rklehman@health-partners.org)

Organizational approach:

- OSF Healthcare System (Kathy Haig, Kathy.M.Haig@osfhealthcare.org)
- Catholic Healthcare West (Heather Gocke, hgocke@chw.edu)
- Winnipeg Regional Health Authority (Rob Robson, RRobson@wrha.mb.ca)
- New York Presbyterian Health Care System (Joseph Cooke, jcooke@med.cornell.edu)

Executive leaders and boards of trustees should set a clear expectation that the lessons learned from major safety failures are translated into recommendations for changes in practice. It is essential that all of us in leadership seize the power of this additional source of information to take our organizations to a dramatically better place for our patients, families and staff. On balance, an organization’s ability to improve is measured by how it deals with both large and small failures—those that happen on home turf and those that happen elsewhere. ▲

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