

## A Brave New World

*Imagining error-free health care.*

Hospitals, health care coalitions, the National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and other entities in the health care arena have put into action ambitious plans to stanch the flow of health care errors—with some success. Unfortunately, to borrow from Shakespeare: “There is nothing either good or bad, but thinking makes it so.” In this case, that means that public perception of the problem with errors in health care delivery is that the situation has grown worse instead of better. And for them, that makes it so.

In its landmark 2000 report *To Err Is Human: Building a Safer Health System*, the Institute of Medicine (IOM), borrowing from Shakespeare for its title, described a problem of health care errors in the United States that seems to have the proportions of a Shakespearean tragedy. The IOM estimated that between 44,000 and 98,000 people die each year because of preventable hospital-based errors (see *Editorial*, page 11).

The most likely patients to perceive that the quality of health care has declined are those with chronic health conditions and therefore more exposure to health care providers, hospitals, and other care settings where errors could occur. Of these people with chronic conditions, 50% reported that they or a family member have been on the receiving end of a health care error.

In its report, the IOM defined patient safety as “freedom from

accidental injury; ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them when they occur.”

But Barbara Blakeney, MS, RN, president of the ANA, thinks patient safety should mean more. “It is not enough to have patients leave hospitals and other care settings relieved that they’ve suffered no harm,” she says. “It is as important they leave knowing they have received superb, high-quality care.”

### ROOTS OF THE PROBLEM

Blakeney blames the ever-changing environment of the health care delivery system—at least in part. “We have seen market forces, reimbursement changes, and new technologies revolutionize health care,” she says. “Unfortunately, these changes have not always resulted in better patient care.

“Throughout the 1990s, new models of health care delivery were implemented or reemployed. As registered nurses typically represent the largest single expenditure for hospitals and health systems, we were among the first to feel the pinch through downsizing and layoffs.

“Today’s RNs are engaged in the delivery of highly sophisticated and labor-intensive care for an aging and increasingly vulnerable patient population. The time allotted for care is shorter than before—whether because of length of stay or increasing case loads. And complicating all of this, the nurse works longer hours with fewer support mechanisms and increasing administrative duties.”

According to a November 2004 survey from the Kaiser Family Foundation, about 74% of consumers polled agree that workload and inadequate staffing issues are at the heart of the problem, along with the fact that physicians are now spending less time with their patients.

Recent studies back up these assumptions. In July 2004 researchers at the University of Pennsylvania School of Nursing found in their study *The Working Hours of Hospital Staff Nurses and Patient Safety* that the risk of making an error increased significantly when a nurse worked shifts longer than 12 hours, worked significant overtime, or worked more than 40 hours per week. Since nurses are on the front line of direct patient care, the potential impact on patients is enormous.

Nurse researcher Mary Blegen, PhD, RN, in her 2001 study *Organizational Culture: Continuous Quality Improvement and Medication Administration Error Reporting*, polled 1,200 U.S. nurses and found that the top reasons nurses gave for errors—apart from illegible physician handwriting or transcription errors—were distractions and interruptions. They also cited too few nurses per patient and the administration of numerous medications to many of their patients. They also expressed concern about the time that lapses between a medication being prescribed and its delivery to a unit.

### NURSES RESPOND

In response, Blakeney and the ANA have identified four changes that they feel must take place to improve the

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work environment and patient outcomes:

**1. Nurses must have decision-making authority and professional autonomy at the point of care delivery and in all arenas where decisions related to care delivery are made.**

Research has demonstrated that hospitals providing nurses with professional autonomy and control over nursing practice not only have better retention rates for nursing staff but also have better outcomes for patients.

**2. Health care facilities must provide safe and appropriate nurse staffing levels.**

Determining appropriate staffing levels (the mix of licensed and unlicensed staff) has been difficult because of the absence of comprehensive guidelines. To address this issue, the ANA released in

2000 *The Principles for Nurse Staffing*, which outlines its recommendations along three levels: the patient care unit, the nursing staff, and the organization.

**3. All health care facilities and agencies should be required to participate in the collection and external reporting of standardized nursing-sensitive data, both to assess the sufficiency of staffing and to quantify the safety and quality of care for consumer and payers.**

Consumers want information on the rate of health care errors, and hospital staff want an environment in which reprisal-free reporting of errors is encouraged in the spirit of patient safety. Therefore, the ANA established the National Database for Nursing Quality Indicators (NDNQI), which provides

education on quality measurement, develops nursing-sensitive indicators and establishes a national database for them, provides database participants with useful and timely benchmarks, and informs public policy about the quality of patient care and the working environment for nurses.

**4. Research around staffing, fatigue, safety, and outcomes must be engaged in actively.**

The ANA supports further investigation into the issues of fatigue and safety and believes that definitive safe limits on work time need to be determined for all health care workers.

## FRUITS OF THEIR LABORS

Despite the perceptions of the public as revealed in the Kaiser Foundation study, some progress has been made in the area of improving patient safety and

reducing medical errors. JCAHO now includes patient safety goals in its accreditation process, hospitals nationwide have developed written policies for informing patients and their families of preventable medical errors, the use of computerized physician order entry has more than doubled, and successful implementation of bar code technology in Veterans Administration and other hospitals has already had a measurable effect on patient safety.

Along similar lines, the Institute for HealthCare Improvement is proposing six clinical initiatives to save 100,000 lives between now and June 2006, and every year thereafter. The ANA is a partner in this campaign and now is working on implementing it. The plan includes recommendations to

- deliver reliable evidence-based care for acute myocardial

infarctions to prevent deaths from heart attacks.

- prevent adverse drug events by implementing medication reconciliation.
- prevent central line infections by implementing a series of steps called the “Central Line Bundle.”
- prevent surgical site infections by reliably delivering the correct perioperative antibiotics at the proper time.
- prevent ventilator-associated pneumonia by implementing a series of steps called the “Ventilator Bundle.”

According to Blegen, the nursing shortage has eased slightly since the IOM report in 2000, although working conditions have shown little or no improvement.

“System change is slow to happen—changing processes, cultures, and emphases takes a long while,” she says. “The

actual rate of safety problems perceived by consumers may not have changed in the interim period. On the other hand, consumer awareness of health care safety problems has greatly increased.”

And while technology, such as bar codes on medications, reporting systems for patient safety, automated medication cabinets, and robots for dispensing medications, promises to lift some of the burden on health care providers, Blegen warns that it’s no silver bullet: “Nurses and others must continue their vigilance, assessment, and critical thinking to maintain safety,” she says.

For more information on NDNQI, go to <http://nursingworld.org/quality/database.htm>. To read *The Principles for Nurse Staffing*, go to <http://nursingworld.org/readroom/stffprnc.htm>. ▼