Patient Safety

The Institute of Medicine's (IOM's) report, *To Err Is Human: Building a Safer Health System* (Kohn, Corrigan, & Donaldson, 2000), was a catalyst for a national effort to make health care safer in the United States. The IOM's goals for healthcare system reform included viewing errors as learning tools, enacting legislation to protect voluntary reporting of medical errors, setting performance standards and expectations for patient safety, and implementing safety systems in healthcare organizations (Kohn et al.). The report stimulated an array of stakeholders to engage in patient safety initiatives. Healthcare organizations instituted safer practices, agencies and professional societies issued safety guidelines and recommendations, increased funding was dedicated to patient safety research, the Joint Commission on Accreditation of Healthcare Organizations issued national patient safety goals, and patient safety legislation was introduced. However, despite these efforts, health care is not measurably safer in 2005 than it was in 2000. In fact, data suggest that the magnitude of the problem of preventable healthcare errors may be substantially underestimated. Many continue to go unreported, so the true incidence of errors is unknown. The use and effectiveness of safety measures also are unknown because reliable outcome measures are lacking. Advances to impact patient safety that are expected to occur from 2005–2010 include increased use of technology to reduce errors, wide dissemination of an array of safety practices, increased training for teamwork, and full disclosure of errors. However, barriers to progress include the culture and complexity of health care, continuing skepticism that system failures are the underlying cause of most healthcare errors, and fear of malpractice liability that inhibits the willingness to discuss or even admit errors (Leape & Berwick, 2005).

The Agency for Healthcare Research and Quality (AHRQ) described healthcare errors as mistakes made in the process of care that result in or have the potential to result in harm to patients. These errors may be ones of commission (i.e., doing the wrong thing), omission (i.e., not doing the right thing), or execution (i.e., doing the right thing incorrectly). Healthcare errors can be grouped into four general categories: diagnostic errors, treatment errors, preventive care errors, and errors involving failure, such as communication, equipment, and healthcare system failure (AHRQ, 2003).

Patient safety is defined by the National Patient Safety Foundation (2005) as "the prevention of healthcare errors and the elimination or mitigation of patient injury caused by healthcare errors." Patient safety is influenced by workplace conditions such as staffing, work flow, individual and group personal and social factors, the physical environment, and organizational factors (Page, 2004). In the field of oncology, environmental factors that impact patient safety include multiple individuals involved in the care of a single patient, the high acuity of patients with cancer, and the complexity of cancer treatment. Despite clinicians' best efforts, errors can occur inadvertently when an unfortunate confluence of individual, workplace, communication, technologic, and organizational factors occurs. The nature of cancer treatment creates a highly conducive environment for errors even with the involvement of well-intentioned, experienced, highly educated healthcare providers.

It Is the Position of ONS That

- Patients and their families have a right to safe care.
- Nurses have a duty to provide safe care, including a duty to report medical and nursing errors in a timely and appropriate manner.
- Oncology nurses should have a primary role in ensuring that patients are cared for in a safe environment. Nurses must collaborate with colleagues to establish and implement patient safety guidelines and practices in the workplace.
- Oncology nurses should create a partnership with patients to reduce healthcare errors and to provide public education on the role of the patient in preventing healthcare errors.
- Oncology nurses must obtain ongoing continuing education to enhance knowledge and skills, implement safety strategies, and identify system, process, and environmental factors that promote safety.
- Healthcare organizations should have an ethical obligation to protect the safety of patients by providing staff in sufficient numbers with adequate skills to deliver quality care.

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- Healthcare organizations should create patient safety programs that clearly communicate the importance of patient safety. These programs should focus on improving work processes and organizational culture and include strategies for leadership, management, and workforce development.
- Healthcare organizations should adopt a nonpunitive culture of safety to encourage healthcare providers to report errors and near-misses so that contributing factors can be identified and examined and improvements can be made.
- Healthcare errors should be promptly and fully disclosed to patients and families.
- Healthcare organizations should report healthcare errors externally so that aggregate data can be analyzed by reporting agencies and used to develop improved safety systems.
- Federal protection of individuals reporting healthcare errors would strengthen the ability to compile a comprehensive database of information about these errors. Federal law, although necessary to ensure protection associated with national reporting systems, should not preempt state evidentiary laws that provide greater protections.
- Oncology nurses should advocate for patient safety legislation and participate in legislative efforts at the local, state, and national levels.
- Federal, state, local, and institutional funding should be provided to support research and education that enhances safe nursing practice.
- Oncology nurses should be actively involved in research to improve patient safety and integrate evidenced-based safety recommendations into their clinical practice.

References

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