Introduction

In 2006, the Centers for Medicare and Medicaid Services (CMS) developed a list of “never events”, significant errors that should never occur in a high quality healthcare setting. For example, wrong-site surgeries or mismatched blood transfusions should never happen. However, five years later in 2011, approximately 400,000 patients experienced “never events” at a cost of $3.7 billion dollars and, more importantly, increased patient inconvenience, suffering, and even death.

Numerous studies reveal that medical errors within the United States healthcare system are a serious problem. Longer illnesses, extended hospital stays, additional medical complications, and a high number of deaths are the result of medical mistakes each year. In fact, most reports show that medical errors are the cause of death for about 100,000 people each year in the United States. In addition, several billion dollars is spent unnecessarily each year within our medical system as a result of clinical mistakes. At an individual level, on average, hospitalized patients experience at least one medication error per day.

People in any system will make mistakes, and healthcare will never achieve perfection in terms of patient care, but these numbers are unacceptable. The purpose of this course is to help you get a better understanding of the causes of medical errors, to recognize situations that tend to foster mistakes, and to learn about ways to improve patient care by minimizing errors.

Factors Contributing to Medical Errors

The medical error problem is widespread and multifaceted within healthcare settings; the specific nature of the errors (type, scope, frequency) varies greatly and can be difficult to narrow down. However, there are several factors that we can identify as the most likely causes of the sharp increase in patient care mistakes.

- **Technological and scientific advances within the medical field.** Over the past 75 years, the medical world has taken incredible leaps forward with medications, diagnostic equipment, surgical capability, and just about every other area of patient care. The advances just within the past 50 years overwhelm the progress made in the previous 500 years. With so many options available and so much information to digest, it is understandable that the staggering advances within the industry would lead to a rise in errors.
Increasing complexity of medical care. Your grandparents may have had one family doctor that tended to all of their medical needs, but those days are mostly gone. Diagnosis and treatment have become highly specialized, and a patient may work with several physicians at once to resolve a health issue. The list of available medications has grown exponentially, fostering better health outcomes but also creating more opportunities for mistakes (drugs that interact poorly, etc.)

Complicated (flawed) healthcare delivery system. Related to the issue above is the increased difficulty of navigating the entire healthcare bureaucracy. The simplicity of fee-for-service medicine is making a small comeback, but for the most part patients are still wrestling with complicated paperwork, managing information from numerous medical visits to different providers, and struggling with medical decisions that are affected by insurance coverage. Healthcare providers work within the same difficult system, and the complications of recordkeeping, insurance claims, and the sheer volume of patient information from numerous sources contribute to a higher rate of medical errors.

Specifically within the nursing professions, there are a number of additional factors that contribute to medical errors.

- Cost pressures that have forced staff reductions
- Overworked nursing staff
- Higher patient/nurse ratios
- Expanded (nontraditional) responsibilities for licensed nursing staff
- Fewer experienced nurses in patient care roles
- High turnover

With so many complex factors and pressures coming into play in such a short period of time, it is not surprising that problems would arise in the medical world. Combine those issues with a steadily increasing demand for health care services, plus longer life expectancies for an aging population, and patient care errors are bound to occur. Let’s explore the situations that are most likely to result in errors, and then we will take a look at practical measures to reduce mistakes and improve patient outcomes.

**Recognizing Error-Prone Situations**

We’ve already listed some factors that contribute to errors, but let’s dig a little deeper to see exactly what situations are most likely to result in mistakes.
Multiple healthcare providers for one patient: As noted before, the days of a single family practitioner with one loyal nurse to care for all your needs are long gone. For example, during a typical minor outpatient surgical procedure, a patient will have 8-10 different caregivers plus administrative staff. Within service industries, your interactions usually only involve you and one other person (haircut-barber, dinner – waiter). Even a procedure at a dentist only involves 2 or 3 people at most. With so many people involved, the potential for errors grows rapidly.

High patient volume (patient/nurse ratios): There is a clear, direct correlation between higher patient volume and higher medical errors, and the linear path is indisputable – too many patients means less time per patient which creates a hurried caregiver more prone to mistakes. In one recent study (BMJ Quality and Safety in Healthcare May 2013) at a children’s hospital, it was noted that for every one extra pediatric patient per nurse (above normal load), readmissions after 30 days were 11% higher for medical patients, and an alarming 50% higher for surgical patients. Everyone sees the solution, but cost pressures and staffing difficulties often create barriers to putting the solution into practice. The work environment will not always be ideal, but nursing professionals need to recognize and verbalize when workloads are too burdensome and patients are at risk.

Overworked staff: In the same vein as high patient volume, this issue has become more of a problem in recent years as nurses are being asked to sustain heavier workloads and longer hours. Employees in any profession have overload points at which their work becomes less effective with a higher potential for errors. That may be a minor problem for staff at the public library or the local car wash, but a much more serious concern when patient care is involved. Nurses need to recognize when work hours are becoming too long to maintain high quality performance.

Inexperienced staff: To cover growing demand for nurses, healthcare facilities across the country are relying on less experienced staff, while many of the more seasoned caregivers are moving away from patient care into teaching or administrative roles. Those jobs are vital, and we need sound administrators and teachers in positions to make needed changes within the nursing profession, but if too many veteran nurses leave patient care, the likelihood for medical errors increases. Too many rookies on the field will usually lead to more mistakes.

Workplace culture/environment: A few key questions may reveal useful information about a healthcare facility. Is quality patient care clearly emphasized (with words and actions) from the top? Are physicians supportive of administrative patient care goals, and does their work verify that support? Is the environment generally good for patient safety, or are there frequent occasions when speed (or some other factor) takes priority over good care?

Every situation has the potential for errors, and we certainly can’t control everything no matter how many rules and regulations are in place. The goal is to have the fewest errors possible – or, put another way, to give the patient the best and safest care possible. Try to recognize high risk
situations and make extra effort to reduce mistakes. Be sure to document any situation that makes you uneasy, and speak up when obvious errors are taking place. Make your best attempts to improve these situations, but recognize that you may need to make a change if your efforts are unsuccessful. Don’t stay in a position that puts patients (and you) at high risk.

Improving Patient Outcomes

One obvious and foundational goal of the medical profession is to have as many satisfactory patient outcomes as possible. Successes and failures in the healthcare world would seem easy to measure (healed vs. not healed) but are often difficult to assess in terms of best possible outcomes, least amount of difficulty for patient, etc. For example, let’s say that a man, aged 67, checks in to the hospital for cardiac bypass surgery, which appears to go well. Two days after the surgery, he develops a low grade fever, and it is soon discovered that he has developed an infection. His hospital stay is extended by 10 extra days while the medical staff works to get rid of the infection. They ultimately succeed, and he goes home with no other complications from the surgery. Was it a success? Yes and no; the cardiac surgery achieved the desired goal, but no one would label the infection a success.

Medical errors are not always the cause of less-than-ideal outcomes; quite often the patient’s health is the sole problem – a patient may be extremely prone to infection. But by eliminating medical errors as much as possible, we can at least end the day knowing we handled properly the elements of patient care that are within our control. So how do we do that? Let’s explore.

In 2001, the Institute of Medicine (IOM) released a report titled Crossing the Quality Chasm: A new Health System for the 21st Century, in which the authors set out to create a roadmap for improving the quality of medical care across the country. While it was recognized that the United States had an excellent health care system, the authors concluded that:

“The U.S. health care delivery system does not provide consistent, high quality medical care to all people. Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge – yet this is frequently not the case. Health care harms too frequently and routinely fails to deliver its potential benefits. Indeed between the health care that we now have and the health care we could have lies not just a gap, but a chasm.”

Those may be hard words to hear; we like to think of our medical care as some of the finest in the world, and that is true. But we must honestly assess our weaknesses and work to improve them. That same report introduced six elementary concepts to be used as a guide for making improvements across the entire healthcare industry. They called it STEEEP:
- Safe: Preventing injuries to patients from the care that is intended to help them

- Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.

- Effective: Providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit

- Efficient: Preventing waste, including waste of equipment, supplies, ideas, and energy

- Equitable: Providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socio-economic status

- Patient centered: Providing care that is respectful of and responsive to individual patient preferences, needs, values and ensuring that patient values guide all clinical decisions

These broad concepts were then further parsed into a set of simple informal “rules" that could be used to guide specific improvement initiatives at any healthcare facility. Among those rules were several that relate to patient safety and medical errors:

- The patient is the source of control. Patients should be given the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them.

- Knowledge is shared, and information flows freely. Patients should have unfettered access to their own medical information and to clinical knowledge.

- Safety is a system priority. Patients should be safe; reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

- Transparency is necessary. The system should make available to patients and families information that allows them to make informed decisions, including information describing the system’s performance on safety, evidence-based practice, and patient satisfaction.

- Cooperation among clinicians is a priority. Actively engage in collaboration and communication to ensure an appropriate exchange of information and coordination of care.
Healthcare facilities and national health organizations began to implement specific strategies to reflect these concepts and rules. One of the steps was to introduce Quality Management (QM). Hospitals had long used Quality Assurance (QA) to gauge how well they were handling patient care (among other things), but there was a problem. QA was always looking backwards at previous events, reacting to and trying to correct earlier problems. It was usually the responsibility of a few people or a small department, and it usually had a narrow focus that only dealt with significant problems after the fact. Corrections would be mandated, and the whole process felt top-down rather than inclusive. It wasn’t all bad, but it needed improving.

The QM approach has a few key differences. Its focus is planning and prevention, a forward look rather than a rearview assessment of the past. Instead of addressing individual problems, it seeks to correct systemic issues and common errors that are routinely occurring across the facility. Rather than a top-down approach, the QM style is more collaborative, with all levels of healthcare workers involved in the proactive planning and development of better approaches to the work. Solutions and ideas are also more cross-functional and widespread, not just isolated in one department.

Furthering the cause of quality management is accreditation. The Joint Commission (TJC, shortened from its former name – The Joint Commission on Accreditation of Healthcare Organizations) was formed in 1951 as an independent agency focused on quality improvement in hospitals. TJC assesses areas such as patient safety and treatment, patient rights, and infection control; the agency also focuses on evidence of continued improvement, not just previous performance. Almost 20,000 medical facilities voluntarily seek TJC accreditation each year, aiming to achieve the “gold seal of approval” that lets the healthcare community see that they are high quality organizations. A TJC accredited institution can be relied upon to make concerted efforts to minimize medical errors and emphasize patient safety.

To get a bit more specific in terms of steps taken to improve quality, here are a few successful measures that have been introduced in recent years:

1. Process Improvement/Flowcharts

This measure involves taking a close look at the key work processes within a healthcare organization and determining how they can be improved. For example, a key process in an ICU would be administering the correct IV solution at the proper rate as ordered by the physician. It’s fairly easy to see when errors occur in this process simply by looking at patient records, but it’s more useful to dig deeper into why the errors occurred.

Taking the example above (the process of giving the correct IV solution to a patient), we can ask a few important questions:

- How does the process work from beginning to end?
- Who are the players involved in the process, and in what order? (nurses, unit secretary, pharmacy, patient, etc.)
Where are errors most likely to occur? (in pharmacy, at bedside)
How can the process be changed to reduce those errors? (increased staffing, extra verifications of dosing)

Flowcharts are very useful for an assessment of the process. Imagine an assessment of each key work process within a hospital. It creates a picture of the work flow all over the facility, which allows each area to see where mistakes are taking place, understand why they may be occurring, and take steps to improve each process so that errors are minimized. After implementation takes place and more time has passed, the processes can be re-examined to see if the changes were effective. Have we reduced the number of IV medication errors?

2. Standardized Care Processes

A number of healthcare studies have revealed that most healthcare workers don’t receive as much formal training about how to do their specific job as we might expect. In fact, most of them learn what to do by observing one of the veteran employees. As differences in style become widespread, we may find that 10 employees use 10 different ways to accomplish the same task. All 10 approaches may be acceptable, but there is much greater likelihood for errors with inconsistent procedures. A better system would be to choose one way and teach it consistently.

In light of this, another useful step is to standardize the processes in the clinical setting. In other words, make similar work processes operate the same way across the healthcare facility. In our earlier IV example, the hospital would determine the most efficient and safest way to ensure proper administration of IV medication from beginning to end, train current staff on the process, and ensure that all new employees learned it the same way. Eventually, this “best practice” becomes second nature to the employees of the facility.

3. National Patient Safety Goals

In 2002, The Joint Commission developed a set of goals to address areas of concern in patient safety. The goals are specific and comprehensive, and TJC looks for compliance with the goals when performing assessments of healthcare facilities. Here’s the most recent set of goals, for 2015.
2015 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

**Identify patients correctly**
NPSG.01.01.01 Use at least two ways to identify patients. For example, use the patient’s name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment. Make sure that the correct patient gets the correct blood when they get a blood transfusion.

NPSG.01.03.01

**Improve staff communication**
NPSG.02.03.01 Get important test results to the right staff person on time.

**Use medicines safely**
NPSG.03.04.01 Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01 Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01 Record and pass along correct information about a patient’s medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

**Use alarms safely**
NPSG.06.01.01 Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

**Prevent infection**
NPSG.07.01.01 Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

NPSG.07.03.01 Use proven guidelines to prevent infections that are difficult to treat.

NPSG.07.04.01 Use proven guidelines to prevent infection of the blood from central lines.

NPSG.07.05.01 Use proven guidelines to prevent infection after surgery.

NPSG.07.06.01 Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

**Identify patient safety risks**
NPSG.15.01.01 Find out which patients are most likely to try to commit suicide.

**Prevent mistakes in surgery**
UP.01.01.01 Make sure that the correct surgery is done on the correct patient and at the correct place on the patient’s body.

UP.01.02.01 Mark the correct place on the patient’s body where the surgery is to be done.

UP.01.03.01 Pause before the surgery to make sure that a mistake is not being made.

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This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

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View more information about National Patient Safety Goals [The Joint Commission (TJC)](https://www.jointcommission.org)
4. Never Events

In the same vein, the CMS (Center for Medicare and Medicaid services) in 2006 developed a list of “never events”, as referenced earlier in this course. The idea is to identify illnesses, injuries and complications that occur during a patient’s hospital stay that should be easily preventable. CMS will not make additional payments for treatment of the conditions on the list if they occurred while the patient was hospitalized. Clearly the goal is to strongly encourage healthcare facilities to make every effort to avoid costly and reasonably preventable errors. Here’s the most recently published list of never events from 2013:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and traumas (fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock)
- Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity)
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Surgical site infection:
  - Mediastinitis following coronary artery bypass graft
  - Any surgical site infection following bariatric surgery for obesity
    (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)
  - Any surgical site infection following spine, neck, shoulder, or elbow orthopedic procedures
- Deep vein thrombosis/pulmonary embolism following total hip/knee replacement

(Source: Hospital-Acquired Conditions [http://www.cms.gov/HospitalAcqCond/])

One final thought about all of these steps taken to reduce medical errors: they all ultimately rely on the integrity and professionalism of the healthcare providers on the scene. As nursing professionals, we are called to provide the best patient care possible (Nightingale pledge – “…devoted towards the welfare of those committed to my care”); each one of us should accept the responsibility for making sure that errors are eliminated from healthcare in the areas where we
work. Even if it creates an uncomfortable situation in your workplace, the top priority should be high quality patient care, and that means speaking up and taking action when you see something wrong.

5. Sentinel Events

A sentinel event is defined by TJC as a Patient Safety Event that results in one of the following: death, permanent harm, or severe and temporary harm and intervention required to sustain life.

In response to these types of medical errors in the healthcare setting a formal Sentinel Event Policy was developed by TJC in 1996. The goal of this policy is to help hospitals learn from these events while improving patient safety.

TJC requires use of root cause analysis (RCA) to investigate the processes and systems that contribute to a sentinel event. RCA is a tool that helps identify and clarify the bottom line factors that precipitate an error or near miss. RCA focuses on systems and processes, not on individual performance.

A team of healthcare providers is brought together to use the RCA process to repeatedly dig deeper into a sentinel event by asking "Why" questions until no additional logical answers can be identified.

Reporting Errors

Recent years have seen various groups introduce options for speaking up and taking action.

- Institute for Safe Medication Practices (www.ismp.org)

This nonprofit organization provides a way through its Medication Errors Reporting Program (MERP) for health care professionals nationwide to voluntarily and confidentially report medication errors and troubling conditions that may lead to errors. These volunteer reports are assessed by a panel of experts, and they share the information, along with suggested strategies for improvement, with the U.S. Food and Drug Administration. Healthcare facilities across the country can then access the data to find solutions to similar problems, best practices, and process changes that have worked in other places.

- American Nurses Association (www.nursingworld.org)

Around the turn of the millennium, the ANA set up the National Database of Nursing Quality Indicators. The goal is to gather information about common situations or indicators within hospital settings that have a significant effect on patient results. These hospital indicators include such things as:
Using information shared among more than 1700 U.S. hospitals, the database helps administrators compare performance and get fresh ideas for quality improvements; the information also helps healthcare facilities see a clearer picture of the connection between nurse staffing and patient outcomes. (ANA 2012)

The challenge of reporting errors usually begins with the nursing staff, the group with the most frequent patient interaction. Nursing professionals must commit to: 1) watching for early indicators of adverse events, complications and errors; and 2) following up quickly with appropriate responses and interventions in those situations. Again, speaking up and taking action promptly is the key.

Finally, please note that the U.S. Congress has passed legislation requiring all states to develop a reporting program for medical errors. At this time, many states have already enacted or adopted some requirement that hospitals report serious medical errors or similar adverse events to a state agency(ies). Others are still implementing legislation or regulations that define that requirement. States that have developed programs may also define reportable events differently.

**Special Populations**

Plenty of evidence is available to demonstrate that certain segments of our population are at greater risk for medical errors for a number of reasons. Nursing professionals need to be aware of these discrepancies to help improve outcomes. Let’s take a look at these groups and discuss why that may be occurring and what to do about it.

**Pediatric Patients**

Children present a couple of unique problems in terms of patient care. First, there is an extra layer of error potential because you are working with the child plus the parents. Depending on the age of the child, all or most communication will be between caregivers and parents rather than directly with the person as would be the case with adult patients. In addition, children are more likely to need acute, shorter-term care, and they usually have very little medical history. With no established patterns or previous records, treatment can be a bit more challenging for pediatric patients.

For example, there are typically 2-3 medical errors per 100 pediatric hospitalizations, and the death rate for children from medical errors is higher than for adults.
Elderly

As our national birth rate slows and average life spans increase, the elderly (over 65) represent a growing percentage of the total population, a trend that is expected to continue for the next few decades. In 2009, the rate of medical errors was nearly twice as high for elderly patients than for the general population of hospitalized patients. In addition, there are approximately 500,000 falls in U.S. hospitals each year, and the overwhelming majority is elderly. Meanwhile, medication errors among the elderly cause an extra 15,000 hospitalizations annually in the U.S.

Clearly this is a high risk population, but why so? Here are a few reasons:

- The elderly are more likely to have chronic health issues and more likely to have numerous health issues
- They are frequently on multiple medications that require careful coordination
- They often receive less attention than younger patients
- Quicker discharge policies at hospitals tend to compromise care to a greater degree among older patients
- The elderly are more prone to confusion, anxiety, and mobility issues – they may need an above-average level of assistance
- The rise of home health care has been a blessing for many patients, but consistency of care can create problems and errors,

Focused care is a must when dealing with elderly patients. Nursing professionals are called to be especially attentive to a group that is so vulnerable to medical errors.

Limited English Skills/Poor Health Literacy

Ten percent of the U.S. population speaks a language other than English as their primary language; studies show that medical error rates are nearly 50 percent higher for this group. On top of that, only about half of the U.S. population could be described as having strong health literacy – a good understanding of medical terminology and processes.

Communication between caregivers and non-English speaking patients must be handled through an interpreter, which increases risk for mistakes. Many times the interpreters are family members or nonclinical staff members that are not medically trained. Medical interpretations must be very precise. Quite often there is less information and less support given to non-English patients. English-speaking healthcare providers may sometimes be less comfortable with non-English speakers.

The complexity of our health system does not make things any easier. Numerical literacy, communication skills regarding health issues, the ability to work with complex forms, and the difficulty of processing treatment options versus probable outcomes; these are all factors that may expose a patient to greater risk.

AHRQ.gov provides a helpful tool called REALM that nurses can use to get a quick assessment of a patient’s literacy level. The REALM-R is a brief screening instrument used to assess an adult
patient’s ability to read common medical words. It is designed to assist medical professionals in identifying patients at risk for poor literacy skills. The REALM-R is a word recognition test – not a reading comprehension instrument. Adults are asked to de-code or pronounce words. The test takes less than 2 minutes to administer and score.

Minorities

Racial and ethnic differences in medical outcomes are well documented. Disparities related to medical errors are more difficult to pin down, but some evidence is telling. For example, African Americans have shown a higher risk of post-operative complications arising from nursing-related errors.

It may be the case that systemic disparity exists within some healthcare facilities in the way certain groups are treated, but the more likely prevalent cause is lack of access to high quality, steady healthcare; correcting the latter issue is one of the primary goals of the Affordable Care Act.

Studies will continue in this area over the next several years, and more changes are on the horizon to help resolve these issues. Still, nursing professionals must be attentive to potential problems that arise from race, ethnicity, and sexual orientation of patients. Although treatments and patient outcomes may ultimately turn out to be different based on other factors, the level of care should be unchanged no matter the patient.

Public Education

Health care institutions clearly invest quite a bit of effort and resources into their internal initiatives to reduce medical errors and improve quality of care. Another critical element to success is public education – providing more information to health care consumers and making them aware of steps they can take to improve medical accuracy. There are several organizations that contribute to this effort.

- The Partnership for Patient Safety

This organization was established in 2002 to give patients a stronger voice in the healthcare setting. The site is focused on hearing about healthcare concerns from the patient’s perspective, providing tools to help patients manage their care and navigate the healthcare system, and forming partnerships between caregivers and patients to ensure that patient safety is always a top priority.

- National Patient Safety Foundation

NPSF is designed for patients and their families. It helps them learn about current safety issues in healthcare, and it is a valuable resource to assist them as they prepare for a medical visit or a
hospital stay. They learn about topics such as wrong site surgeries, diagnostic errors, infections, and medication mistakes. NPSF has also developed a Universal Patient Compact that binds together healthcare providers and patients in a commitment to quality care:

Commitment to these principles may be the very best solution we have for eliminating medical errors.

- [Agency for Healthcare Research and Quality](https://www.ahrq.gov)
Our federal government also plays a key role in healthcare quality, and AHRQ is one of the primary agencies with that function. This organization provides valuable information for patients, providers and policymakers on a wide variety of healthcare topics, including reports measuring the success we are having in reducing medical errors. For example, here’s the heading from a report published in December 2014:

**Efforts To Improve Patient Safety Result in 1.3 Million Fewer Patient Harms**

*Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013*

The report goes on to show how much we have improved over the past 3 years, which tells us that all of this effort is worthwhile. In the details of the study, we find that hospital-acquired conditions were reduced by 1.3 million over the 3 year period, associated deaths were reduced by 50,000, and related health care costs were trimmed by $12 billion.

**Conclusion**

We began this course with a brief discussion about the serious nature of medical errors, and the statistics cited throughout show that it is still a critical issue. However, we must recognize that efforts to improve are still relatively new – most initiatives are only a few years old – and we should be encouraged by the early success that is already emerging, as evidenced by the report cited above regarding hospital acquired conditions.

Committed and conscientious healthcare professionals working with patients that are informed and fully invested in their care - that is the prescription for best results.
References


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