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Health Care Errors: Nursing's Perspective

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In conjunction with the American Nurses Association

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HEALTH CARE ERRORS: NURSING'S PERSPECTIVE

Executive Summary

Questionable quality of health care delivered in the United States has become a front line issue, taking a strong place alongside the more traditional concerns about health care such as increasing costs and access to care. Concerns about the safety of consumers has taken on increased visibility in health care institutions, professional associations and public policy arenas. Given that nurses comprise the largest component of the health care workforce and are involved with the provision, management, research and education related to patient care, safety and error reduction in health care are central concerns for the profession and a responsibility for every individual nurse.

Collectively, research studies point to the fact that errors are a significant cause of patient injury and death. In order to fully explore characteristics of safe nursing care, within a systems context nurse clinicians and nurse researchers need to partner with experts in human factors, and organizational and communications theory who can add valuable expertise.

This paper briefly explores key issues around health care errors including: 1) the extent of health care errors; 2) system-wide and individual recommendations to increase patient safety and reduce errors; 3) challenges and opportunities for nurses to decrease errors and improve patient safety, and 4) current status of selected federal legislative and regulatory initiatives designed to decrease health care error. In addition, an appendix provides a guide adapted from the Agency for Healthcare Quality which nurses can give to consumers to increase consumer participation in reducing the likelihood of error.

Much of the information presented in this brief is derived from content and recommendations embedded within recent public policy documents, primarily the Institute of Medicine Report To Err is Human, with specific application to nursing. Each of the IOM recommendations has implications for nursing practice, education and research and most have been endorsed by the American Nurses Association (Foley, February 9, 2000).

Introduction

Quality of care is a recurring theme within every nursing education program. From introductory to capstone courses, nurses learn and are expected to incorporate within their own practice, high quality care that does not jeopardize patient safety. Skills ranging from calculating dosages, to providing information to patients regarding self-care, to assuming responsibilities in surgery are all taught with an eye toward error-free practice. And yet, once engaged in the day-to-day health care environment, nurses find themselves in systems of care where patient safety is often compromised through error.

Over the past decade, more information regarding the nature and extent of health care error has become public, from individual anecdotes reported in the media to published research findings. As a result, knowledge of errors in patient care is no longer the sole purview of individual clinicians, risk management, and quality assurance entities. Rather, information about the extent of health care errors has prompted recent discussions in venues ranging from U. S. congressional committees to consumer advocacy organizations. Since the fall of 1999 alone, the topic has been the focus of scores of published articles, documents and features as diverse as Institute of Medicine reports, the Boston Globe, the British Medical Journal, Better Homes and Gardens magazine and national nightly news programs. Concerns about the safety of consumers receiving care has taken on increased visibility in health care institutions, professional associations and public policy arenas. Given that nurses comprise the largest component of the health care workforce and are involved with the provision, management, research and education related to patient care, safety and error reduction in health care are central concerns for the profession and a responsibility for every individual nurse.

This paper briefly explores key issues around health care errors including: 1) the extent of health care errors; 2) system-wide and individual recommendations to increase patient safety and reduce errors; 3) challenges and opportunities for nurses to decrease errors and improve patient safety, and 4) current status of selected federal legislative and regulatory initiatives designed to decrease health care error. In addition, the appendix provides a guide adapted from the Agency for Healthcare Quality which nurses can give to consumers to increase consumer participation in reducing the likelihood of error. Much of the information presented in this brief is derived from content and recommendations embedded within recent public policy documents, such as the Institute of Medicine Report To Err is Human, with specific application to nursing.

Background

Questionable quality of health care delivered in the United States has become a front line issue, taking a strong place alongside the more traditional concerns about health care such as increasing costs and access to care. While perceptions about what constitutes quality has varied, a now frequently cited definition originating from the Institute of Medicine defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health care outcomes and are consistent with current professional knowledge” (Lohr, 1990). More recently, a Commission established by President Clinton delineated the nature of

compromised quality of care by noting that there are four types of quality related problems: avoidable errors, underuse of services, overuse of services, and variation in practice (*Quality First: Better Health Care for All Americans*, 1998). With regard to avoidable error, the Commission report bluntly states “Even in the best systems...mistakes are made... (and) mistakes made by individuals, groups of individuals, or organizations can have serious, costly, or fatal consequences” (p. 156). Concerned about the disturbing extent of errors in health care delivery which has been documented through scores of studies, the Commission included the reduction of health care errors as one of six core national aims for quality improvement in American health care.

In the fall of 1999, the Institute of Medicine (IOM) released a report on errors in health care, titled *To Err is Human* (Kohn, et.al.). This report catalyzed the attention of virtually every health care stakeholder group in the country, from the nursing profession to the White House to the U.S. Congress. The IOM report defines patient safety as freedom from accidental injury, and error as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning). Speaking to the seriousness of the problem and issuing a call for immediate action on the part of nurses and others, the report notes that “...it is simply not acceptable for patients to be harmed by the same health care system that is supposed to offer healing and comfort” (p.3, 1999). And yet, “few tangible actions to improve patient safety can be found” (p. 5, 1999). In other words, the IOM committee that produced the landmark report concluded that errors are far too widespread and pose a significant threat to patient safety; that health care clinicians and others are not responding rapidly enough to address safety problems, and that many of the actions used in systems to prevent error are ineffective, or worse, drive reporting errors underground through blame and punishment and thereby fail to correct and prevent errors from reoccurring.

To begin to substantively address safety improvement, the IOM, as well as many other authors (Bogner, 1994, Cohen, 1999, Spath, 2000) call on health care systems to reorient their efforts to reduce error. Rarely are errors the fault of an individual nurse, rather, they are the culmination of characteristics of systems of care (e.g., introduction of new technology, changes in staffing mix, similarly labeled medications). Rather than attaching blame to individual nurses and others for errors committed, organizations must design non-punitive approaches to error and look well beyond individual providers to understand and redesign system-level processes for error prevention. Commitment and action at all organizational levels must be directed toward increasing awareness of errors and even near-misses, and building safety into systems of care to prevent them. Given the central role of nurses in health care delivery, including responsibility for advocating in the interests of patients, nurses are critical to changing the culture of institutions and redesigning systems so that nursing care specifically and health care more broadly is as safe as is humanly possible.

Extent of Errors in Health Care

Fundamental to ensuring the provision of safe patient care, nurses need to know the extent and circumstances under which health care errors are likely to occur. Pre-requisite to obtaining this information, is the creation of health care environments that employ policies and other approaches for reporting and investigating errors that are non-punitive and encourage candid blame-free discussions. Prevention of health care errors is only possible if information about near-misses and actual errors is willingly shared and analyzed and solutions disseminated to prevent similar occurrences. Today, obtaining such information and conducting subsequent analysis is challenging. Nevertheless, over 30 research studies analyzed in the IOM report, the most recent synthesis of relevant research, gives insight into the extent and types of some health care errors (Kohn, 1999). Collectively, these studies point to the fact that errors are a significant cause of patient injury and death.

For example, extrapolating from results of a 1984 study of more than 30,000 randomly selected discharges from New York hospitals, it is estimated that at least 98,000 deaths occur each year as a result of health care errors (Brennan, et.al.). Similarly, a 1997 study of 15,000 discharges, conducted in Utah and Colorado, would indicate that at least 44,000 preventable deaths occur each year (Thomas, et.al.). Compared to other causes, the latter study would place error as the eighth leading cause of death in the nation (Kohn, 1999).

Even given the alarming figures of the preceding two studies, the majority of research findings probably underestimate the frequency of errors and their consequences for two significant reasons. First, most studies rely primarily on data extracted from medical records, where errors are not always reported. For example, errors involving nursing care may go unnoticed and consequently, undocumented. Unreported error, whether because the error was never detected, or because nurses fear blame and punishment, or because of other causes, make understanding the etiology and ultimately error prevention much more difficult. Secondly, knowledge of the full extent of errors in health care is limited because to date, most studies have been conducted in hospitals -- in spite of the fact that significant amounts of patient care are provided in other settings. Little information currently exists about the nature of errors involving nursing and other care in non-hospital settings, including home health, ambulatory surgery centers or nursing homes. Nevertheless, among existing studies, nursing care is clearly a central component of care systems where error occurs. Likewise, nursing care is likely to be a key consideration in as yet unstudied environments.

While the provision of care involves multidisciplinary teams, there are clear examples of care design processes with which error is associated that have more nursing involvement than others. For example, medication errors, an activity directly involving nursing care, has been the subject of many of the studies on error. Within this research focus, studies have typically analyzed errors associated with the order and administration of medications. All too common and preventable are errors such as inappropriate dosage, overlooked known allergies, wrong drug or route of administration. Such errors often stem from a confluence of factors including environmental distractions, miscommunications and drug labeling problems, among others.

Designing systems of care that prevent errors in medication administration are complex in part because of the multiple stages and number of providers involved in the process as well as methods employed to communicate relevant information. Using computerized drug order entry systems and engaging pharmacists in drug order review have both significantly reduced medication errors in hospitals, as has the removal of certain highly toxic drugs such as concentrated potassium chloride from nursing units. While much has been written on medication error reduction strategies, the American Hospital Association has recently recommended a number of process redesigns that can be readily implemented which focus on medication error reduction through standardization and simplification (American Hospital Association, 1999). Suggestions include limiting the types of infusion pumps to one or two, developing written protocols for high-alert drugs and standardizing prescribing and communication practices such as the avoidance of dangerous abbreviations.

Nurse staff-to-patient ratios and staffing mix present different organizational characteristics that have the potential to increase the likelihood of error. While limited research has been conducted on the relationship between nurse staffing and adverse patient care outcomes, existing data suggest important linkages (ANA, May 2, 2000, Kovner, 1998). In the ANA study, five adverse outcome measures including hospital acquired pneumonia, postoperative infection, and decubiti, significantly decreased with higher levels of RN involvement in patient care. This area of further research is critically important and should be a high priority. In the near term however, to help ensure appropriate staffing, consideration should be given to factors reflected in documents such as ANA's Nurse Staffing Principles (Gallagher, et. al.,1999).

From these and other examples, it is clear that some research inroads are being made that expand knowledge and identify care processes that can contribute to the provision of safe nursing care. Enhancing patient safety requires a firm and shared commitment on the part of nurse clinicians, executives and researchers to fill in knowledge gaps that currently exist. Equally clear is that in order to fully explore characteristics of safe nursing care, within a systems context nurse researchers need to partner with researchers with expertise in human factors, and organizational and communications theory can add valuable expertise. In terms of research focus, nurses may first consider research problems that are likely to yield the largest gains in patient safety. For example, given that complex care, care rendered in specialty areas, care provided to the very young and very old as well as prolonged hospital stays all have higher rate of errors (Weingart, et.al., 2000), further exploration of these high risk factors and possible solutions warrant research approaches that should benefit from nurses' perspectives. Aspects of care systems including staffing mix, communication among providers, team processes, all lend themselves to further research.

Recommendations to Improve Patient Safety

The IOM report, To Err is Human (1999), offers a number of recommendations targeted at nurses and other providers, as well as health care and health related institutions and public policymakers. Each recommendation has implications for nursing practice, education and research and most have been endorsed by the American Nurses Association (Foley, February

9, 2000). The IOM recommendations are embedded within a four-part error reduction plan. First, the report advocates for the creation of a Center for Patient Safety within the federal Agency for Health Care Research and Quality (AHRQ). The Center would be responsible for a range of safety related efforts including setting national patient safety goals and a research agenda and disseminating information to health care providers and others that would improve patient safety. If established, this Center should be a key resource for error reduction information for nurses as well as a funding source for nurse researchers studying patient safety issues.

The second component of the IOM plan calls for the establishment of institutional level mandatory reporting of the most egregious health care errors as well as voluntary, protected, peer-review reporting systems. Such information, with confidentiality of patients and providers protected, would be aggregated, analyzed and disseminated to help prevent similar errors from reoccurring. Clearly, as clinicians and managers of health care operations and organizations, nurses should help initiate and actively engage in developing the structure of reporting systems as well as the determination of the type and appropriate use of collected data (Wakefield and Maddox, 2000).

The third part of the IOM plan focuses on the need to strengthen error reduction efforts of both health care organizations and health professionals by increasing expectations of purchasers, accreditors and regulators. While patient safety standards exist, they are inadequate and are fragmented across various entities. Nurses involved in public policy should review this part of the IOM plan and consider meaningful actions that could be pursued by both private purchasers and regulatory entities. For example, state nursing organizations may wish to initiate dialogue with state agencies responsible for surveying health care organizations and also consider whether licensing boards have authority for addressing health care errors beyond licensing and sanctioning individual nurses.

The fourth part of the IOM report specifically addresses opportunities for health care organizations and providers, including nurses, to improve patient safety, as described in the following section.

Challenges and Opportunities for Nurses to Improve Patient Safety

To a large extent, the organizations in which nurses practice dictate the level of attention given to reduction of health care errors. For example, some hospitals have very sophisticated error reporting, infection control and risk management programs. By comparison, ambulatory and community based care settings have generally employed less sophisticated approaches, relying on education and training, policies and procedures. There are many reasons cited for the differences between hospital and ambulatory institutions and their efforts to address patient safety. Chief contributors to these disparate approaches include significant differences in the number of staff and resources available, as well as lack of technical knowledge about effective quality improvement methods or related infrastructure and lack of recognition of errors due to short patient stay and lack of data. With the rise in outpatient and office-based patient

procedures, including surgery, attention to patient safety is increasing in all settings. (Committee on Quality Assurance in Office Based Surgery, 1999).

To improve patient safety, regardless of where care is provided, the IOM reviewed other high-risk industries and evidence of practices that improve health care safety. As a result, they identified a set of five principles, all relevant to nursing, thought to be useful to the design of safe health care systems:

- I. Providing leadership;
- II. Respect for human limits in the design process;
- V. Promoting effective team functioning;
- IV. Anticipating the unexpected; and
- V. Creating a learning environment.

Once incorporated, these principles will significantly alter the culture of health care institutions. Consequently, their application will impact nurses' practice environments and directly affect nursing care. Applying these principles in practice is complicated. To increase their relevance to a nursing audience, the discussion of the principles in the IOM report is directly applied to nursing practice here.

The IOM report calls for leadership efforts to create safer patient care systems and organizations. The commitment and responsibility for leadership is identified at all levels in the organization from governing boards to management to clinical personnel. Nurses and others are asked to treat each error and hazard as a unique event that should be viewed in the context of a larger system of care. Nurses are expected to search for improved safety mechanisms in their day-to-day practice and apply appropriate design principles. To facilitate this, visible patient safety programs with senior level nursing leadership, defined objectives and plans, adequate financial resources and data collection methods and analysis should be established. Scheduled progress reports should be shared broadly with nurses and other clinicians.

Beyond leadership, a number of specific actions are recommended by the IOM which can be made directly relevant to nurses. First, to the extent possible, nursing roles should be designed so that they offset human limitations such as fatigue and stress. Factors such as work hours, workloads, staffing ratios, and sources of distraction are key areas deserving attention. Designing jobs for safety means setting aside times, places or personnel for specific tasks such as calculating doses or mixing intravenous solutions. Designing jobs for safety also means addressing staff training needs and the use of part-time workers and 'floats' who may be unfamiliar with equipment and specialized care and procedures. Additionally, attention should be paid to the significant interaction between individual job design and work interdependency involving multiple disciplines.

In the IOM report, the use of protocols and checklists are endorsed, in order to standardize and routinize as many task functions and procedures as possible. Standardization

reduces reliance on human memory and allows novice nurses less familiar with processes or devices to use them safely. At the same time caution about using protocols is acknowledged, recognizing that not all steps of a protocol may be appropriate in every situation. Likewise, rapid changes in clinical knowledge and technology means that protocols must be regularly updated.

Other mechanisms, referred to as constraints and forcing functions, are used to guide the nurse to the next appropriate action or decision and to structure critical tasks so that errors cannot be made. These mechanisms are particularly important for designing equipment defaults and for processes such as ordering diagnostic tests and therapies. For example, if the infusion pump fails, it should default to 'off', rather than free flow. If a patient has a particular allergy, the pharmacy computer will not fill an order without intervention and follow-up.

Simplification of key processes are also identified as important to reduce the likelihood of error and minimize problem solving. Simplification typically involves reducing the number of handoffs required for a process to be completed. For example, when possible one nurse should be responsible for completing an intervention rather than relying on multiple providers.

The IOM also specifically speaks to the need for enhanced teamwork in the provision of health related services. Nurses should train in teams with other providers when their work requires team functioning. For example, in areas where care and technology intensive interventions and monitoring are highly specialized such as emergency rooms, critical care units and operating rooms, explicit efforts to recognize interdependence of team members should be recognized. The rationale for this recommendation emanates from lessons learned in the aviation industry where team training and simulation is used to plan and standardize individual responsibilities in team scenarios before they are required to perform the same functions in a real setting. Team training also helps team members learn more about the contributions and dependencies of each other while fostering trust and mutual commitment.

When possible, incorporating patients and their families as active participants in error reduction efforts is also recommended. Specific strategies that can be recommended to patients are included in an attachment to this document.

Also noted is the need for better information management and dissemination throughout health care organizations to support the implementation of systems that proactively reduce error. Individual nurses should anticipate growth in the use of technology for information management and develop associated skills in preparation for these organizational approaches that are likely to be adopted in the future.

The IOM report strongly encourages efforts to promote the recognition and reporting of errors and hazardous conditions, recognizing that current organizational cultures often and unintentionally discourage these efforts. Traditionally, nurses and other professionals have been educated and health care organizations have focused on independent action, personal responsibility and error free performance. This has led to a culture of hierarchy and authority in decision-making and a belief that mistakes made by health professionals represent personal failures (Leape et al, 1998). For this recommendation to be achieved, organizations and

professionals must work together to change current culture to accept error as a system-wide concern and accept the reporting of error as an opportunity to learn and improve safety. The need for this reorientation is apparent from studies that have demonstrated that less than 5% of errors may actually be known (Leape, 1994). In order to encourage the reporting of errors and near misses, characteristics of good reporting systems are identified in the report. They include: voluntary reporting, few restrictions on acceptable content, inclusion of descriptive content, confidentiality and accessibility for use by clinical and administrative personnel.

The IOM report also speaks to the need for developing a working culture where communication flows openly regardless of the authority gradient. Accomplishing this requires activity to begin as early as health professions education programs where students learn this orientation. In health care organizations, leadership behavior should encourage the creation of an environment where all members of a team know that their contributions and concerns are respected and valued. Examples are drawn from military pilot training, where the “two challenge” rule is used. If a pilot is challenged twice about the safety of a flight situation, without a satisfactory reply, subordinates are empowered to take over the controls. During briefings and debriefings, they are encouraged to express safety concerns.

Finally, the use by nurses of research and technical, systematic analysis should be considered part of the essential operations of the organization. Analysis contributes critical information for understanding complex problems and redesign of systems. This is particularly true for the discovery of latent errors whose adverse consequences may lie dormant within the system, requiring considerable technical and systems knowledge about a wide variety of contributing factors (human, technical and organizational).

Federal Legislative and Regulatory Initiatives

Policymakers responded swiftly following the release of the IOM report To Err is Human. President Clinton directed the Interagency Coordination Task Force (QUIC) to evaluate the IOM recommendations and to propose an action plan. The QUIC forwarded a plan to the President in February 2000, endorsing virtually all of the IOM recommendations (*Quality First: Better Health Care for all Americans*, 2000). In turn, President Clinton used his executive power to direct certain federal agencies to initiate the QUIC’s recommendations. Clinton’s actions included: allocating \$20 million in his Fiscal Year 2001 budget to fund a Center for Patient Safety; requiring all 6,000 hospitals participating in the Medicare program to establish error reduction programs; and allocating \$31 million in his Fiscal Year 2001 budget to the Food and Drug Administration to improve the safety of blood products, medical devices and medications. While unable to mandate it, President Clinton also recommended a three year phase-in of State based mandatory and voluntary error reporting systems. Meanwhile, the U.S. Congress has also pursued policy initiatives designed to enhance patient safety. Five congressional hearings have been held since early December, 1999 focusing specifically on the topic of medical errors. Additionally, in May 2000 both the Senate and House Appropriations Subcommittees with jurisdiction over the Department of Health and Human Services included

funding in their bills (\$50 million and \$20 million respectively) to support a Center on Patient Safety.

Given congressional and administration support, it is highly likely that when the Fiscal Year 2001 appropriations process is completed, significant funding will be made available to support the Center. Additionally, a number of Members of Congress have actively worked on a range of other legislative initiatives. Important to note is that many of the bills have bipartisan support and are sponsored by Members in senior positions on relevant committees of jurisdiction. For example, Senator Grassley (R-IA) has introduced the Stop all Frequent Errors Act which has a number of provisions including error reporting components and requiring different types of health care organizations, including home health agencies and skilled nursing facilities to establish medical error reduction programs. Senators Specter (R-PA) and Harkin (D-IA) have co-introduced the Medical Error Reduction Act that would authorize 15 demonstration projects to test different approaches to gathering medical error information. As of late May, staff to Congressman Bill Thomas (R-CA) are drafting a legislative proposal for possible introduction.

At the state level, many patient-safety related policies already exist or are being contemplated. According to a study published by the National Academy for State Health Policy (April, 2000), over 20 states have mandatory and/or voluntary reporting of medical errors or adverse events. The report notes that of the 15 states with mandatory reporting, 12 states require reporting by psychiatric hospitals and 13 require reporting by ambulatory care settings. Most states with reporting requirements aggregate collected data in order to determine trends. The greatest concern of states with reporting requirements revolve around inadequate resources to carry out their functions and under-reporting of health care errors. Interestingly, eight states publicly report their data. With regard to both mandatory and voluntary reporting mechanisms, there is no consistency across states in terms of what is reported, how it is reported and how it is used. Consequently, aggregating data to identify trends across states is almost impossible. The survey also found that legislation to require reporting is pending in six states.

Conclusion

The environments in which nurses work are complex systems that are prone to error. Errors in nursing care are rarely due to carelessness or incompetence. Consequently, the culture of health care organizations, created in part by nurses, needs to be blame free. A learning environment, with free flowing open communication enables nurses to identify, discuss and ultimately prevent health care errors. Patients deserve and have a right to care that minimizes the likelihood of errors and that puts their safety first. To achieve that aim, nurses and other stakeholders in health care have significant work ahead.

APPENDIX A: 20 Tips for Patients (Adapted from AHRQ)

The Agency for Healthcare Research and Quality (AHRQ), Department of Health and Human Services, recently published a fact sheet for consumers to use to help minimize the likelihood of errors in the care that they receive (February 15, 2000). Nurses may wish to use the slightly modified information that follows for use by patients to increase appropriate communication between nurses and their patients. The 20 Tips for Patients, with some modifications, are as follows:

1. The single most important way you can help to prevent errors is to be an active member of your health care team.
2. Make sure that your health care providers, including physicians, nurse practitioners, and pharmacists know about everything that you are taking. This includes prescription and over-the-counter medicines, and dietary supplements such as vitamins, minerals and herbs.
3. Make sure your health care providers, including physicians, nurses and pharmacists, know about any allergies and adverse reactions you have had to medicines.
4. When your health care provider writes you a prescription, make sure that you can read it.
5. Ask your health care providers for information about your medicines in terms you can understand—both when your medicines are prescribed and when you receive them: Questions for you to ask include: What is this medicine for? How am I supposed to take it, and for how long? What side effects are likely? What should I do if side effects occur? Is this medicine safe to take with other medicines or dietary supplements I am taking? What food, drink, or activities should I avoid while taking this medicine?
6. When you pick up your medicine from the pharmacy, ask: is this the medicine that my clinician prescribed?
7. If you have any questions about the directions on your medicine labels, ask. For example, ask if “four doses daily” means taking a dose every six hours around the clock or just during regular waking hours.
8. Ask your pharmacist for the best device to measure your liquid medicine. Also, ask questions if you’re not sure how to use it. For example, many people use household teaspoons, which often do not hold a true teaspoon of liquid. Special devices, like marked syringes can help people to measure the right dose. Asking and being told how to use the device helps even more.
9. Ask for written information about the side effects that your medicine could cause. A study found that written information about medicines can help patients recognize problem side effects. This information should be given to your clinicians—including pharmacists, nurses, physicians.

HOSPITAL STAYS

10. If you have a choice, choose a hospital at which many patients have the procedure or surgery that you need.
11. If you are in a hospital or clinic, consider asking all health care workers who have direct contact with you whether they have washed their hands. A recent study found that when patients checked whether health care workers washed their hands, the workers washed their hands more often and used more soap.
12. When you are being discharged from the hospital, ask your doctor and nurse to explain the treatment plan you will use at home. This includes learning about your medicines and finding out when you can get back to your regular activities. Research shows that at discharge time, doctors think their patients understand more than they really do about what they should or should not do when they return home.

SURGERY

13. If you are having surgery, make sure that you, your primary care provider, and your surgeon all agree and are clear on exactly what will be done.
14. Speak up if you have questions or concerns. You have a right to question anyone who is involved with your care.
15. Make sure that someone, such as your primary care provider, is in charge of your care
This is especially important if you have many health problems or are in a hospital
16. Make sure that all health professionals involved in your care have important health information about you. Do not assume that everyone knows everything they need to know.
17. Ask a family member or friend to be your advocate (someone who can help get things done and speak up for you if you can't). Even if you think you don't need help now, you might need it later.
18. Know that "more" is not always better. It is a good idea to find out why a test or treatment is needed and how it can help you. You might be better off without it.
19. If you have a test, don't assume that no news is good news. Ask about the results.
20. Learn about your condition and treatments by asking your doctor, nurse and other health care providers and by using other reliable sources. For example, treatment recommendations based on the latest scientific evidence are available from the National Guidelines Clearinghouse at www.guideline.gov/. Ask your health care providers if your treatment is based on the latest evidence.

APPENDIX B: Questions to Guide Nurses' Discussion of Patient Safety and Error-Reduction

Patient safety is the most fundamental aim of nursing practice, making current discussions around health care errors directly relevant to individual nurses and nursing associations. Nurses committed to improving patient safety may want to begin their efforts by convening their colleagues through employment based and/or professional associations to consider pertinent questions that could include the following:

- Do nurses think that errors are underreported in their facility?
- Can nurses identify recurring near-misses in their unit/ agency?
- Have near-misses or errors been associated with circumstances such that the situation could be repeated by someone else?
- What is the institutional culture toward reporting/discussing/learning from errors?
- How high a priority is patient safety in the organization?
- How are nurses currently involved in the organization to improve patient safety?
- Based on nurses' experiences, what system characteristics contribute to errors?
- What do nurses think the local district or state nurses association could/should do to focus attention on health care error reduction? Could the nurses association act in tandem with other local and state health care provider organizations?
- How should nursing education be redesigned to increase focus on a systems approach to error reduction?
- What research should be conducted within the nurses' institution?
- How can patients be engaged so that they too are alert to sources of error and near misses?
- What would be the nature of interactions with state and federal policymakers around patient safety?

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