3.17 PATIENT SAFETY

The National Patient Safety Foundation defines safety as the avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of healthcare. Hospitalized patients are at risk for a variety of adverse events. Hospitalists anticipate complications from medical assessment and treatment and take steps to reduce their incidence or severity. Application of individual and system failure analysis can improve patient safety. Hospitalists lead and participate in multidisciplinary interventions to mitigate system and process failures and to assess the effects of recommended interventions across the continuum of care.

KNOWLEDGE
Hospitalists should be able to:
- Define and differentiate medical errors, adverse events, and preventable adverse events.
- Identify the most common safety problems and their causes in different hospitalized patient populations.
- Explain the role of human factors in device, procedure, and technology-related errors.
- Explain how redundant systems may reduce the likelihood of medical errors.
- Specify clinical practices and interventions that improve the safe use of high-alert medications.
- Summarize methods of system and process evaluation of patient safety.
- Describe the elements of well-functioning patient safety-focused teams.
- Distinguish retrospective and prospective methods of evaluating medical errors.
- Describe the components of Root Cause Analysis (RCA) and Failure Mode and Effects Analysis (FMEA).
- Describe principles of medical error disclosure.
- Discuss the significance of sentinel events and "near misses" and their relationship to voluntary and mandatory reporting regulations.
- Describe the risk management issues of patient safety efforts.
- Judge the effect of patient volume on the quality, efficiency, and safety of healthcare services.

SKILLS
Hospitalists should be able to:
- Prevent iatrogenic complications and proactively reduce risks of hospitalization.
- Formulate age- and disease-specific safety practices, which may include but are not limited to reduction of incidence and severity of falls, decubitus ulcers, delirium, hospital-acquired infections, venous thromboembolism, malnutrition, and medication adverse events.
- Develop, implement, and evaluate practice guidelines and care pathways as part of an interdisciplinary quality improvement initiative.
- Gather, record, and transfer patient information by adhering to timely, accurate, and confidential mechanisms.
- Prioritize patient safety evaluation and improvement efforts on the basis of the impact, improvability, and general applicability of the proposed evaluations and interventions.
- Develop systems that promote patient safety and reduce the likelihood of adverse events.
- Contribute to and interpret retrospective RCA and prospective healthcare FMEA multidisciplinary risk evaluations.
- Appropriately engage in standardized communication practices such as Situation-Background-Assessment-Recommendation (SBAR).
- Facilitate practices that reduce the likelihood of hospital-acquired infection.
- Use evaluation methods and resources to define problems and recommend interventions.
- Employ continuous quality improvement techniques to identify, construct, implement, and evaluate patient safety issues.
- Lead, coordinate, and/or participate in multidisciplinary teams to improve the delivery of safe patient care.
- Lead, coordinate, and/or participate in the development, use, and dissemination of local, regional, or national clinical practice guidelines and patient safety alerts pertaining to the prevention of complications in hospitalized patients.
- Lead, coordinate, and/or participate in efforts to advance the culture of patient safety in the hospital.

ATTITUDES
Hospitalists should be able to:
- Appreciate that adverse drug events must be monitored and that steps must be taken to reduce their incidence.
- Exemplify safe medication prescribing and administration practices.
- Advocate for and foster a nonpunitive error-reporting environment.
- Internalize and promote behaviors that minimize workforce fatigue, occupational illness, and burnout.
- Use evidence-based evaluation methods and resources when defining problems and designing interventions to lead efforts to reduce recurrent error.