

## 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 health care. 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 will increasingly lead and participate in multidisciplinary development of interventions to mitigate system and process failures. They will also need to assess the effects of recommended interventions across the continuum of care.

### KNOWLEDGE

*Hospitalists should be able to:*

- 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.
- 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 teams.
- Differentiate retrospective and prospective methods of evaluating medical errors.
- Discuss the significance of sentinel events and “near misses” and their relationship to voluntary and mandatory reporting regulations.
- Describe the components of Root Cause Analysis (RCA) and Failure Mode and Effects Analysis (FMEA).

### 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 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 utilizing timely, accurate and confidential mechanisms.
- 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.
- Function as a member and/or leader of interdisciplinary safety teams.
- Design evaluation methods and resources to define problems and recommend interventions.

### ATTITUDES

*Hospitalists should be able to:*

- Appreciate that adverse drug events must be monitored and steps taken to reduce their incidence.
- Advocate and help foster a non-punitive error-reporting environment.
- Exemplify safe medication prescribing and administration practices.
- Facilitate practices that reduce the likelihood of hospital-acquired infection.
- Internalize and promote behaviors that minimize workforce fatigue, occupational illness and burnout.
- Appreciate that redundant systems may reduce the likelihood of medical errors.
- Understand the risk management issues of patient safety efforts.
- Utilize evidence based evaluation methods and resources when defining problems and designing interventions.
- Lead, coordinate or participate in multidisciplinary teams to improve the delivery of safe patient care.
- Judge the effect of patient volume on the quality, efficiency and safety of healthcare services.
- Prioritize patient safety evaluation and improvement efforts based on the impact, improvability and general applicability of proposed evaluations and interventions.

- Employ continuous quality improvement techniques to identify, construct, implement and evaluate patient safety issues.
- Lead, coordinate 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 or participate in efforts to create a culture in which issues of patient safety and medical errors can be discussed openly, without fear of repercussion.