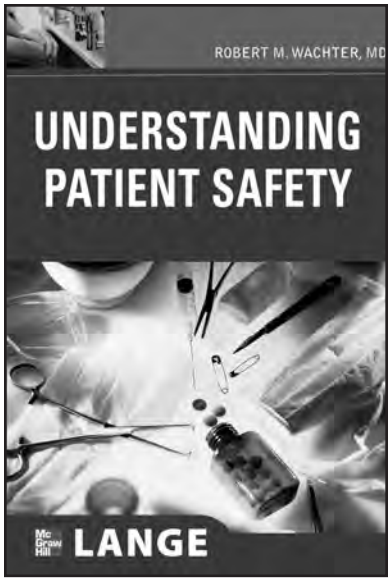

Book Review

A must read for all who strive for safer healthcare

Understanding Patient Safety
Robert M. Wachter, MD
Publisher: McGraw-Hill Companies Inc., New York
298 pages

Patient safety is a major point of interest for all who work within or are affected by the healthcare delivery system. Who doesn't want – indeed, who doesn't need – safer care? What can we do to make our organizations safer for all whom cross our thresholds? And why do we continue to be so profoundly challenged in achieving this goal? Understanding Patient Safety addresses these questions and provides the framework to instill a true understanding of the topic. This understanding creates the necessary foundation upon which we can build our efforts toward achieving safer patient care.

Dr. Robert Wachter, the author, is a practicing physician, educator, leader and researcher in a major academic medical center. In his various roles he has focused on the complexities within healthcare and their impact upon patient safety. His inspirational vision is of a healthcare system in which patients benefit from the advances of medicine as well as the reliability of organizations where tools and systems are constructively employed.

Understanding Patient Safety is written for a diverse audience and suitable for all levels of readers: from board members attempting to grasp the work being done at their organization, to the physicians or nurses trying to understand the connection between their efforts and ultimate outcomes, to the risk managers and others who are asked to direct their organizations' safety efforts.

Three main sections

The book is organized into three main sections. Section one describes the epidemiology of error, explains the differences of safety and quality and discusses key mental models to frame readers' understanding of patient safety as a categorical discipline.

Within section two we learn, through real cases, the various types of errors. We also are provided with new terminology to assist with a better understanding of errors. Additionally, we are afforded the benefit of work that has been done to help explain errors and why errors may happen as well as how they can be prevented. The last section discusses broad policy perspectives and related issues such as the medical malpractice arena, workforce issues and the role of patients. These and other topics serve to incorporate all the variables that need to be understood so that we are better equipped to approach our work in patient safety more effectively.

Each chapter and section is supported by a concluding "key points" summary and a listing of references and additional readings. The book also provides appendices that create a wealth of information from which readers can continue to develop their understanding. There are appendices with Web sites and theme issues on medical errors, a glossary of patient safety terms and actions for patients and families to improve their chances of remaining safe in the hospital.

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Throughout the book, several points are clearly made. These points are supported by an explanation illustrated by practical examples and/or evidence-based research. In discussing surgical errors, specifically wrong site/wrong patient surgery, we are provided an actual case example. We are then provided the results of a survey of such errors that note the percentage of hand surgeons who admit to having operated on the wrong site at least once in their career (20 percent). This information is supported with an explanation about how this error could occur and lastly, with the rationale and process for the Joint Commission's Universal Protocol strategy directed at prevention of such errors.

A similar framework is provided for other types of errors, as well, from nosocomial infections to information technology errors. We are also afforded the conclusions that Dr. Wachter's research has provided on such topics of reporting systems related to error management. For example, we may wonder if the existence of more error or incidents reports means we are better off or less safe. Based on research, we learn that there is simply no way to know as the existence of more reports could either mean more errors or that more people are simply willing to report based on the understanding that the report will result in meaningful action – a positive perspective.

This understanding is both empowering and motivating.

Understanding Patient Safety is available for purchase via the ASHRM Online Store (www.ashrmstore.org) and in Boston Oct. 2-5 at ASHRM's Annual Conference & Exhibition. Wachter will sign copies of the book following his Oct. 4 conference keynote address.

Strategies for managing errors

Following the discussion, we are also provided with strategies for managing medical errors such as:

- Methods to gather information about errors such as reports, trigger tools, audits;
- Use of "category managers" to review and address errors;
- Incorporating review of events at the sharp end of care;
- Using error information as part of the "script" during executive walkrounds.

Such practical strategies serve to help spring ourselves and others into action in a purposeful manner to achieve positive results. The same holds true for the guidance provided related to creating a culture of safety. In this section we are provided an organized method to achieve this goal and understand that the key aspects of strong leadership and patient safety champions, use of carefully employed non-healthcare analogies, training, and use of simulation – whether supported by technology or not – when inter-disciplinary work is focused on improving outcomes, all must be a part of the effort.

Understanding Patient Safety is a must read for all who strive to make healthcare a safer place for patients, families and staff. Through the presentation of a logical framework of where we have been in healthcare and patient safety, where we are and where we need to be, along with how to get there, the reader gains a great understanding. This understanding is both empowering and motivating and those attributes can and will benefit our patients and organizations in powerful ways.

Reviewed by ***Elaine M. Ziemba, MHA, JD,*** *director Patient Safety and Clinical Risk Services, Catholic Healthcare West (CHW), San Francisco.*