

Prologue

Laying the Foundation

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The volume starts with papers that look to the future and examine the past with respect to patient safety; however, its overarching theme is assessment. An underlying premise to any volume that focuses on assessment is that the time spent in trying to understand the nature of the problem is well worth the effort. A good understanding of the problem space provides the foundation upon which all subsequent efforts are based. Without adequate assessment, the likelihood that subsequent steps and initiatives will be wide of the mark increases substantially.

In our efforts to understand the nature and prevalence of departures from patient safety, it comes as no surprise that reporting systems and surveillance activities and efforts to improve them continue to generate considerable research interest. The present volume provides ample evidence of this with papers on reporting systems and surveillance efforts that focus on the intensive care unit, rural and critical access hospitals, ambulatory pediatric care, primary care, and a teaching hospital obstetrics/gynecology service. Also spanning the surveillance landscape are papers on a national medication error reporting system, proactive medication studies, a system that embeds the principles of high-reliability organizations, another that targets high-risk device-use areas, a close call-good catch system, and a care enhancement model relevant to the Patient Safety and Quality Improvement Act of 2005.

Of course, we would like to believe that everybody buys into the use of reporting systems, that under-reporting is not a problem, that doubts about discoverability and confidentiality do not exist, that reporting systems are not burdensome to use, that reported events do not disappear into data graveyards, and that useful information for system improvement is faithfully reported back to the relevant local unit, but few of us live in a fantasy world. The papers' authors do not shy away from the traditional challenges associated with reporting systems; in their breadth of interest, considerable intellectual vigor is demonstrated.

Challenges of reporting quickly give rise to challenges of encoding and organizing the adverse event data into a meaningful classification structure. To date, the lack of a standard set of patient safety terms, data elements, and taxonomic structure has hampered the transfer and sharing of information across different datasets and systems. Attempting to map from one system to another is not a task for the light-hearted. Papers that address these issues can be found in the taxonomies and measurement section of the volume, as can papers on a nursing virtual dashboard, a system for describing and classifying errors in primary care, the use of ICD-9-CM codes in hospital claims data, adaptation of AHRQ Patient Safety Indicators (PSI) for use in ICD-10 administrative data, and racial disparities in PSI rates at the Veterans Health Administration.

Strategies and efforts aimed at adverse event surveillance, creating useable taxonomies, and addressing measurement issues represent just part of the picture. While much of the focus is on

the development of reporting tools and indicator sets, other papers remind us that the perceptions and sensemaking that occur among the frontline personnel that are expected to use these systems need to be taken into account. Sharing this sentiment are papers that report on narratives from the frontlines, how a visual interface can help create a common vision of system vulnerabilities, and how a mentor program can help staff navigate a reporting system while alleviating fears. Another paper examines the perceptions of health care leaders and news media professionals related to adverse event reporting.

Yet another assessment approach in our pursuit of patient safety is to focus on risk. Risk is treated by safety scientists as the likelihood that exposure to a hazard will lead to adverse consequences. In other high-stakes industries, risk assessment generally involves identifying underlying hazards and assessing risk—that is, the probability that exposure to a hazard will lead to an adverse consequence. While one finds various uses of safety science terminology in health care, there is a growing interest in the risk assessment methods. Here the reader finds papers that deal with risk-based patient safety metrics, a "risk-binning" methodology applied across institutions, a case-control study to determine risk factors for falls in a cancer center, use of a computerized fall risk assessment process that tailors interventions in acute care, and an assessment of patient and safety hazards found in home health care.

Eventually, well conceived and executed assessment efforts lead to actionable recommendations and targeted interventions. The final set of papers describes initiatives that have as their point of departure root cause analysis (RCA). Root cause analysis driven initiatives include an extended protocol to ensure correct surgical and invasive procedures in New York State, a highly focused effort by the Department of Veterans Affairs to reduce emergency airway management difficulties, a statewide effort to encourage falls prevention programs in rural health care facilities in West Virginia, and a common cause analysis effort that organizes RCA action items into themes for consideration as part of the organization's yearly operating plan.

In our pursuit of safe patient care, we hope this volume on assessment provides a solid foundation and serves as a useful point of departure for readers to benefit from the diverse range of patient safety issues and approaches found in the other three volumes.