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Patient safety in its current state is biased and unreliable, lets fix it

Patient safety progress has slowed. After much activity following the clarion call of "To Err is Human" in 1999, safety science lacks innovation and needs re-calibration. There is evidence of rates of harm that have not improved over time. Also, there is emerging information in the US about specific harm types known as Hospital Acquired Conditions (HAC). Incremental progress was lost during the COVID pandemic with these HACs. Now, patient groups are calling for action, and rightly so. With all the attention to patient safety in the past few decades, why do we have this stasis? We have a reliability expert wondering why patient safety is "Still Not Safe." How did we get here, and are all our efforts for naught?

We will discuss the background of this situation with an exploration of current patient safety language, including inconsistencies in safety research using this language and its impact on patient safety operations. There are discrepancies in adult and paediatric medicine from multiple countries worldwide. We will also discuss emerging biases in event identification and inequities among those who experience safety events, showing that the disadvantaged experience at least two more injustices, more experienced and fewer identified events.

We will also explore the state of safety event identification. Except in some countries, current safety event capture mechanisms have inherent flaws which make measurement impossible and improvements challenging to assess. Some additional areas impacting safety inconsistencies are the perceived level of rigor with which our organizations address safety events. For example, high harm, preventable events likely receive prompt and full-scale attention from an organization, while lesser harm events receive less attention. Finally, we will discuss the impact of incentives placed on organizations and potential solutions for each of these areas of concern.

Recent Publications

1. Landrigan CP, Schuster MA, Klugman D, Bisarya H, Classen DC, Dizon, ZB Matt Hall M, Wood M, Sharek PJ. Using a Pediatric Trigger Tool to Estimate the Proportion of Total Harm Burden Hospital Acquired Conditions Represent. Pediatr Qual Saf. 2018;3(3).
2. Landrigan CP, Toomey ST, Loren SS, Jang J, Quinn JA, Ashrafzadeh S, Wang MJ, Wu M, Sharek PJ, Classen DC, Srivastava R, Parry G, Schuster MA, for the GAPPS Study Group. Adverse Events in Hospitalized Pediatric Patients. Pediatrics. 2018. e20173360.
3. Thomas T, Fieldston ES, Hall M, Czaja AS, Stalets EL, Biehler J, Sheehan M, Foglia D, Byrd S, McClead RE. Using Length of Stay to Understand Patient Flow for Acute and Critically Ill Pediatric Hospitalized Patients. Pediatr Qual Saf. 2017;3(1).

Biography

David C Stockwell is the Chief Medical Officer of the Johns Hopkins Children's Center and an Associate Professor of Anesthesiology and Critical Care Medicine at Johns Hopkins University, School of Medicine, USA. He has over 80 publications that have been cited over 1,100 times, and his publication H-index is 22 and has been serving as an Associate Editor of Pediatric Quality and Safety since its inception. With over 15 years of patient safety research, specifically with patient adverse event identification, he is developed the American Standard Assessment method for inpatient pediatrics safety events, endorsed by the National Quality Forum. Utilizing this standard process in the paper or electronic medical record, users may detect, describe and classify adverse events in order to adequately describe the epidemiology of pediatric inpatient harm from medical care. He is also an accomplished physician administrator, previously in quality and safety and now, a wider scope.

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