What's New in the Patient Safety World

August 2013

AHRQ Patient Safety Primer Updates

We noted AHRQ's Patient Safety Primers in our What's New in the Patient Safety World columns for August 2008 "AHRQ's New Patient Safety Primers" and February 2009 "Some More New AHRQ Patient Safety Primers". AHRQ has recently updated some of these primers and added several more:

- Diagnostic Errors
- Adverse Events after Hospital Discharge
- Error Disclosure
- Wrong-Site, Wrong-Procedure, and Wrong-Patient Surgery
- Systems Approach
- Checklists
- Root Cause Analysis
- Handoffs and Signouts

As we noted previously they are, in fact, primers – meaning they are very introductory works on several important areas related to patient safety. However, each has extensive links to both classic and contemporary bibliographic references and tools. The new ones are no different and are equally useful resources.

The primer on Diagnostic Errors lists several of the more common types of cognitive bias with clinical examples of each. It does stress the relative paucity of interventions proven to reduce diagnostic errors. Once again, a real strength of the primer is its very useful bibliography.

The primer on Adverse Events after Hospital Discharge is an update to an earlier version. It stresses that 20% of patients discharged from the hospital will suffer an adverse event, most of which were preventable. They focus on various failed communication opportunities and discontinuities in care. They stress the importance of discharge planning, medication reconciliation, patient and family education, followup on pending tests, and attention to health literacy issues. The update notes programs like Project RED and the Transitions trial. Good discussion of our favorite tools, checklists and structured communication tools, as cornerstones. And the links and bibliography are what you've come to expect of these fine AHRQ primers.

The primer on Error Disclosure focuses on the trend toward full disclosure and apology after adverse patient events. Again, good bibliography. But it's still a primer. You'll find much more on disclosure and apology in our prior columns on the topic:

- July 24, 2007 "Serious Incident Response Checklist"
- June 16, 2009 "Disclosing Errors That Affect Multiple Patients"
- June 22, 2010 "Disclosure and Apology: How to Do It"
- September 2010 "Followup to Our Disclosure and Apology Tip of the Week"
- November 2010 "IHI: Respectful Management of Serious Clinical Adverse Events"
- April 2012 "Error Disclosure by Surgeons"
- June 2012"Oregon Adverse Event Disclosure Guide"

And several other very valuable resources on disclosure and apology:

- IHI's "Respectful Management of Serious Clinical Adverse Events" (Conway 2010)
- The Canadian Disclosure Guidelines (Canadian Patient Safety Institute 2008)
- The Harvard Disclosure Guidelines (Massachusetts Coalition for the Prevention of Medical Errors 2006)
- The ACPE Toolkit (American College of Physician Executives)
- Oregon Patient Safety Commission Oregon Adverse Event Disclosure Guide.

The primers on Wrong-Site, Wrong-Procedure, and Wrong-Patient Surgery and Checklists have good up-to-date bibliographies. Those on Systems Approach and Root Cause Analysis are introductions to human factors and the systems approach to error. The primer on Handoffs and Signouts looks at handoffs involving nurses, housestaff, hospital transitions, and lessons from other industries. It has many new references from 2013.

The entire collection of patient safety primers can be found at the AHRQ Patient Safety Primers home page and is an extremely useful resource not only for those new to the patient safety movement but even for experienced patient safety and quality improvement personnel.

References:

AHRQ Patient Safety Primers (home page)
http://psnet.ahrq.gov/primerHome.aspx

AHRQ Patient Safety Primer "Diagnostic Errors"
http://psnet.ahrq.gov/primer.aspx?primerID=12

AHRQ Patient Safety Primer "Adverse Events after Hospital Discharge"
http://psnet.ahrq.gov/primer.aspx?primerID=11

AHRQ Patient Safety Primer”Error Disclosure”
http://psnet.ahrq.gov/primer.aspx?primerID=2

AHRQ Patient Safety Primer “Wrong-Site, Wrong-Procedure, and Wrong-Patient Surgery”
http://psnet.ahrq.gov/primer.aspx?primerID=18

AHRQ Patient Safety Primer “Systems Approach”
http://psnet.ahrq.gov/primer.aspx?primerID=21

AHRQ Patient Safety Primer “Checklists”
http://psnet.ahrq.gov/primer.aspx?primerID=14

AHRQ Patient Safety Primer “Root Cause Analysis”
http://psnet.ahrq.gov/primer.aspx?primerID=10

AHRQ Patient Safety Primer “Handoffs and Signouts”
http://psnet.ahrq.gov/primer.aspx?primerID=9