

From the Editor-in-Chief

From ‘To Err Is Human’ to ‘Safer Together’ – Progress in Patient Safety

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Twenty years ago, the Institute of Medicine (IOM) (2000) published *To Err Is Human: Building a Safer Health System*, calling attention to the number of preventable patient deaths and adverse events that were occurring each year in hospitals in the United States (U.S.) and launching the national patient safety movement. Many new programs and safety practices were developed and imple-

mented by individual and system health care organizations, as well as by national organizations, such as the Agency for Healthcare Research and Quality (AHRQ), Institute for Healthcare Improvement (IHI), The Joint Commission (TJC), and the National Patient Safety Foundation (NPSF).

Ten years after the publication of *To Err Is Human*, the Lucien Leape Institute gathered together the leaders and experts in the patient safety movement to assess the progress in patient safety and found it lacking (Leape et al., 2009). It was telling that they began the report of their assessment with the words, “Healthcare is unsafe” (Leape et al., 2009, p. 424). What they found was that implementing processes and tools was ineffective without a change in culture, noting that “safety does not depend just on measurement, practices, and rules, nor does it depend on any specific improvement methods; it depends on achieving a culture of trust, reporting, transparency and discipline” (Leape et al., 2009, p. 424). They called for a major transformation of the health care system to create cultures that were transparent in everything, with care delivered by multidisciplinary teams working in integrated care platforms, with patients engaged as full partners, and with health care workers finding joy and meaning in their work. In addition, they said, medical education needed to be redesigned to teach new physicians how to function in this new culture. Progress was made, and evidence demonstrated that patient safety cultures did, indeed, result in increased safety for patients and in better work environments for physicians, nurses, and health care workers; however, continued improvement was still required to achieve sustainable, nationwide progress.

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Safer Together

In 2018, the Institute for Healthcare Improvement (IHI) convened the National Steering Committee for Patient Safety (NSC), with 27 member organizations representing a wide range of stakeholders and subject matter experts in medicine, nursing, patients and families, accrediting agencies, health care executives, etc. Together, they have created a National Action Plan to “achieve safer care and reduce harm to patients and those caring for them” and to “create total systems safety” (IHI, 2020b, p. 6). The 17 recommendations to advance patient safety rest on four foundational elements: 1) culture, leadership, and governance that commit to and support safety as a core value; 2) authentic patient and family engagement; 3) workforce safety; and 4) creating a networked and continuous learning system. In addition, they created a *Self-Assessment Tool* to assess, learn, and track the progress of safety improvement efforts (IHI, 2020c) and an *Implementation Resource Guide* with aims, recommendations, tactics, case studies, and a compilation of published resources (IHI, 2020a).

Safer Together in Nephrology

For the last two decades, we have tried strategies to improve safety – from implementing processes and tools that we came to understand would not achieve safety without a creating a patient safety culture to now recognizing that we must work as a unified force to improve and sustain that safety. Advancing the safety of our nephrology patients and workforce requires the commitment and engagement of all stakeholder organizations working together. The Safer Together National Action Plan can offer a path and the resources to achieve that result.

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Editor-in-Chief

continued on page 411

From the Editor-in-Chief

continued from page 393

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