Without these measures, the key ingredient in these efforts is missing: systematic, real-time data on adverse events with timely feedback to clinicians and health care organizations" Jha and Pronovost (2016).

Abstract:

It has been more than 15 years since To Err Is Human, the landmark report by the Institute of Medicine (IOM), revealed the substantial morbidity and mortality related to medical errors in the United States. Two recent developments have refocused policy makers on getting patient safety right.

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The first are data suggesting that deaths associated with medical errors may exceed 400 000 annually,1 although this number is controversial, with questions about the degree to which medical errors truly caused each of these deaths and how many deaths were attributable to a medical error when death was inevitable. Regardless, medical error is likely a major cause of death and disability in the United States. The second is the Affordable Care Act, which has, through programs like Value-Based Purchasing and Hospital-Acquired Conditions penalties, made patient safety a financial priority for hospitals. While greater focus on safety is a welcome development, there is little reason to believe that added attention alone will lead to safer care. Why? Because the health care industry lacks valid patient safety measures, which are fundamental to improvement. Without these measures, the key ingredient in these efforts is missing: systematic, real-time data on adverse events with timely feedback to clinicians and health care organizations. Without effective measurement and reporting, progress in patient safety will be arduous and slow.

Full Text

Reference:

Jha, A. and Pronovost, P. (2016) Toward a Safer Health Care System: The Critical Need to Improve Measurement. JAMA. April 14th. .

doi:10.1001/jama.2016.3448.

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