

Introducing the New AHRQ WebM&M and AHRQ Patient Safety Network (PSNet)

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Editorial

Five years ago, the Institute of Medicine report, *To Err is Human*, placed the issue of medical errors squarely in the public eye.⁽¹⁾ The report led to many calls for action, including increased reporting of medical errors and improved education for both clinicians and administrators about patient safety.

It soon became clear that cases of medical errors, if mined correctly, could play an essential role in educating providers and developing safer systems of care. Yet clinicians and institutions are understandably reluctant to report their errors, fearing both adverse public relations and medicolegal consequences.

Our vision was that AHRQ WebM&M would help bridge the gap between reporting and education—a gap that most other reporting systems have not managed to close.⁽²⁾ By creating a confidential, easy-to-use reporting system, the Web site allowed clinicians from around the country (and the world) to safely submit reports of errors. Armed with such cases, our role as editors was simply to choose the most illustrative among them and then enlist the nation's (and often, the world's) top experts in safety to comment on them in a thoughtful, evidence-based, and engaging manner.

It worked. We recently posted the wonderful feedback we received from last year's users survey. We have been pleased by this response and gratified that our community of users has grown steadily (we now have 10,000 registered users). Yet, as AHRQ asked my colleagues and me to work with them to produce WebM&M for the next few years, it was clear that certain changes could make the site even better.

First and foremost, because we wanted to highlight some key issues in patient safety that might not specifically be raised by case submissions, we've added a section called "Perspectives on Safety." This month, we interview Dr. Chris Landrigan, lead author of the influential AHRQ-supported *New England Journal of Medicine* study on housestaff sleep deprivation and medical mistakes. In the next few months,

you'll see other interviews and essays covering topics such as how hospitals change in response to highly public errors, challenges in performing and interpreting patient safety research, and the role of nurses in improving safety. The goal of these Perspectives remains the same: to be lively, engaging, and a bit provocative. We hope you like the pieces and invite you to suggest topics and authors or even submit a Perspective of your own.

You'll also see more subtle enhancements to AHRQ WebM&M: a topic index, a printable view, enhanced archives, and more. We really hope you like it and continue to read the site, submit cases, and tell your friends and colleagues about it.

Three years ago, I was privileged to help edit an AHRQ evidence report on patient safety practices.⁽³⁾ Although we did find a number of practices well supported by high-quality research, my colleagues and I were struck by the relative immaturity of the research underpinnings of the patient safety field. Given the consequences in cost, time, and change management of many proposed patient safety interventions (eg, installing computerized provider order entry or bar coding systems, implementing teamwork or simulator training, maintaining certain nurse-to-patient ratios or resident duty-hour limits), it was remarkable how little high-quality research there was to inform decisions or a rich understanding of the outcomes and consequences of these changes.

Luckily, that has changed over the past few years. Now, in large part through AHRQ support, dozens of studies on patient safety are published every month, along with books, tools, surveys, and reports of individual experiences. There are also scores of conferences, proposed pieces of legislation, grant opportunities, and more.

In other words, the challenge has shifted from making decisions with an insufficient amount of information to managing a growing but messy treasure trove of data and tools. This process is made more difficult by the remarkable breadth of the patient safety field. The "consumers" of safety information range from CEOs to practicing nurses and from university researchers to patients. Patient safety information might be found in a standard medical journal, a lay-oriented book, a conference on aviation and human factors engineering, or a local newspaper.

In response to this challenge, we are pleased that this month also marks the launch of AHRQ Patient Safety Network (PSNet), a "one-stop" patient safety portal. On the left side of the AHRQ PSNet home page, you'll find "What's New": an annotated, carefully selected compilation of the most recent and important news, research, tools, and conferences in patient safety. The right side of the page is "The Collection": your front door to thousands of patient safety resources, all easily retrievable via either browsing or searching. If you're new to the field and want to see the most enduringly important articles and books in the patient safety, you'll find them under "Classics." And, if you have a particular area of interest, "My PSNet" allows you to customize the site based on your own interests (perhaps you're a nurse interested in research on preventing falls in nursing homes, or a physician interested in strategies to prevent wrong-site surgery). "My PSNet" will even alert you when a new resource on the site matches your selected criteria.

Your registration for AHRQ WebM&M, which allows you to submit cases and receive the email alert for each new issue, does not automatically register you for AHRQ PSNet. To do that, go to "Subscribe to Newsletter" and give us your email address. It's that simple. We'll notify you when new content has been posted. If you're interested in customized alerts, you can do that by clicking on "My PSNet" on the AHRQ PSNet home page.

Through these sites—AHRQ WebM&M and AHRQ PSNet—our aim is to provide a rich exposure to cases, commentaries, and the world's literature and tools in patient safety. We hope you enjoy the sites and find them useful in your vital work of keeping patients safe from harm.

Robert M. Wachter, MD Editor, AHRQ WebM&M and AHRQ Patient Safety Network

References

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