

## Introducing the Redesigned AHRQ Patient Safety Network

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<https://psnet.ahrq.gov/perspective/introducing-redesigned-ahrq-patient-safety-network>

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### Editorial

It's hard to believe that it has been 15 years since the Institute of Medicine report, *To Err Is Human*, launched the modern patient safety movement.<sup>(1)</sup> For those of us who were around at the time, it was a seminal moment—I tend to think of my professional life as "before-IOM" and "after-IOM."

The Agency for Healthcare Research and Quality (AHRQ), under the leadership of the late Dr. John Eisenberg, conceived the idea of a web-based morbidity and mortality (M&M) conference soon after the release of the IOM report. My colleagues and I were lucky enough to be awarded the contract to produce this website, called AHRQ WebM&M. The idea was to post anonymously submitted cases of medical errors or near misses, with those cases accompanied by commentaries written by experts that articulated their lessons in a thoughtful, evidence-based, and engaging way.

Over the nearly 15-year existence of WebM&M, we have been gratified by the response of our readers. The site has received millions of visits and nearly 70,000 hours of CME credit have been awarded. We have published 360 cases, which have been widely used in teaching and republished by several other organizations, including the Institute for Healthcare Improvement (IHI), Medscape, and the Association of periOperative Registered Nurses (AORN), resulting in hundreds of thousands of additional readers.

In the early days of the patient safety movement, a dominant challenge was the relative dearth of high-quality information to help inform clinicians and non-clinicians working in the safety field. Within a few years, we began confronting the opposite challenge—as research began to emerge on everything from the epidemiology of adverse events to the benefits of barcoding to best practices in the use of checklists. In 2005, AHRQ asked us to launch a sister site, called Patient Safety Network (PSNet), to serve as the major federal portal for information about patient safety. In an editorial I wrote at the time of PSNet's launch <sup>(2)</sup>, I reflected on the breadth of the field, which created some unique challenges for the site:

*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.*

As with AHRQ WebM&M, PSNet has become an immensely popular site. Over a decade of use, it also has been viewed millions of times and has become a go-to resource for many people in the safety field. The site now contains nearly 11,000 resources, including 7400 journal articles, 1050 newspaper/magazine articles, 630 books/reports, and more than 300 websites. Over the years, we have added features such as Patient Safety Primers and the education database.

While both WebM&M and PSNet have filled specific needs in the world of patient safety, the boundaries between them have blurred over the years. AHRQ WebM&M began as an online M&M conference, but over time we added a section called "Perspectives on Safety" featuring interviews with patient safety newsmakers and perspective essays—neither of which fit the moniker of "WebM&M." We built links from PSNet resources into our WebM&M commentaries, and, conversely, often cited WebM&M cases in our PSNet annotations. In addition, though many people subscribe to both sites' newsletters, thousands subscribed to only one or the other—and sometimes subscribers to one hadn't heard of the other.

In other words, it became clear to the editors and to AHRQ that the time had come to merge the two sites into a single one, which would carry on the name of "AHRQ Patient Safety Network." With this issue, you will see the results of this major overhaul and merger of the sites. The cases and commentaries will continue to be called "WebM&M," which will persist as a section within the larger PSNet site. The new PSNet includes numerous enhancements, taking full advantage of modern techniques of web design. Among the changes you'll notice are:

- Responsive design, which means that the site will look as good on a smartphone or a tablet as it does on a computer.
- A complete overhaul of the home page, with easier navigation to the site's various components.
- An enhanced method for searching and browsing—making it easier to drill down to different topics (this is critical since many categories—such as "journal articles" about "medication errors"—now call up more than one thousand resources).
- An easier method to customize your favorite topics via your PSNet account.
- Complete integration of WebM&M and PSNet—so that searches will not only provide relevant journal articles, websites, conferences, primers, and the like, but also highlight relevant WebM&M cases and commentaries.

You'll see many other enhancements as you explore the site—I encourage you to do just that. You don't need to re-register to receive notices of new issues. If you were registered for WebM&M or PSNet, we assume that you wish to continue to receive the new PSNet newsletter. (Opting out is easy if you choose to do so, but we hope you won't!)

I am grateful to our wonderful team of editors, both at UCSF and elsewhere, our technical expert/advisory panel, our web development team at Silverchair, and our colleagues at AHRQ for their support of these efforts for the past 15 years, and their enthusiastic input into the new AHRQ Patient Safety Network. We hope you find the site even more useful as you pursue our shared goal of keeping patients safe from harm.

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## References

- [1.](#) Kohn LT, Corrigan JM Donaldson MS, eds. To Err Is Human: Building a Safer Health System. Institute of Medicine. Committee on Quality of Health Care in America. Washington, DC: National Academy Press; 1999. [\[Available at\]](#)
- [2.](#) Wachter RM. Introducing the new AHRQ WebM&M and AHRQ Patient Safety Network (PSNet) [editorial]. AHRQ WebM&M [serial online]. April 2005. [\[Available at\]](#)