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Fifteen years after To Err Is Human: a success story to learn from.

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https://psnet.ahrq.gov/issue/fifteen-years-after-err-human-success-story-learn

When *To Err Is Human* was published, central line–associated bloodstream infections were considered an unavoidable patient safety problem. This commentary discusses how this mindset has changed over the past decade, citing the Keystone ICU project and other efforts that substantially decreased rates of this preventable hospital-acquired condition. The authors outline five elements that contributed to the reduction, including reliable and valid measurement processes, evidence-based care practices, and alignment around common goals and measures.