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PATIENT SAFETY NETWORK

Making Healthcare Safer III Report

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What is the Making Healthcare Safer Report?

The Making Healthcare Safer Report represents an effort by the Agency for Healthcare Research and Quality (AHRQ) to consolidate the wealth of information available in the patient safety environment into an easily accessible and actionable report. The objective of the report is to provide information to providers, administrators, researchers, and government agencies that they can use to prioritize efforts to ensure patient safety.[1] The first report was published in 2001 and included 50 Patient Safety Practices (PSPs) in common and disease-specific adverse events. The second edition of the report, published in 2013, reviewed 41 PSPs, including new evidence-based practices and updates to evidence for PSPs included in the first report.[1]

This third edition builds upon the previous iterations to provide a curated source of information on care practices that can improve patient safety holistically and across a variety of settings. For the purposes of this report, PSPs are defined as “discrete and clearly recognizable structures or processes used for the provision of care that are intended to reduce the likelihood and/or severity of harm due to systems, processes, or environments of care.”[2] The report reviews 47 PSPs in high-impact harm areas.

What is New in this Third Edition?

The third edition of the Making Healthcare Safer report differs from the previous two editions in several key ways. The first is in the approach to identifying harm areas and associated PSPs. To guide the development of the report, the team developed a patient-centric framework that focuses on the patient experience at different phases of health and within different settings of care.[3] Additionally, the report sought to align with the strategic goals from the Department of Health and Human Services (HHS), including addressing the opioid crisis, emerging health risks, and the goal of reducing provider burden and burnout while still putting patients first.

Second, the content of the report has evolved in a number of ways. Most notably, this third edition includes a chapter on cross-cutting topics that are not related to a single harm event or clinical setting. These topics are designed to consider the patient holistically across the care continuum. The included cross-cutting

topics/practices are: improving safety culture; teamwork and team training; clinical decision support; person and family engagement; cultural competency; staff education and training; and data monitoring, audit, and feedback.[4] New harm-specific PSPs have also been added to this report, including practices within infection control, diagnostic errors, delirium, adverse drug events, and others.[5] This edition of the report also includes contextual factors and lessons learned that support successful implementation for each PSP. This embodies a recognition by the patient safety community that successful outcomes from a PSP are dependent as much on the plan for implementation as on the specifics of the PSP itself.[3]

Finally, the presentation of information has been refined to allow for more efficient review by interested users. For example, the PSP summary table included in the Executive Summary has been reformatted to include bulleted key takeaways, as opposed to a review of the strength of evidence for each PSP included in previous editions. This allows users to quickly determine if a PSP could be beneficial to their specific population and setting. Finally, this iteration provides PSP comparison tables across all three of the reports. With these tables, users can quickly see which report iterations address specific PSPs and easily access and compare the relevant evidence summaries.

Conclusion: How Should the Report be Used?

This edition of Making Healthcare Safer is intended to be a “go-to” resource for patient safety professionals across all settings, regardless of their expertise or familiarity with each patient safety topic. The cross-cutting topics provide users with an excellent foundation in generalizable and universally applicable practices that can improve patient safety, even if no specific harm or challenge has been identified. The harm-specific PSPs provide users with a defined patient safety challenge, a thoroughly researched review of the evidence surrounding potential solutions, and provides the starting point for further investigation into promising PSPs. The release of this report has been greatly anticipated by the patient safety community and is sure to be an excellent and highly usable reference for those working to decrease patient harms at all levels of the healthcare system.

In her professional role, Ann Gaffey is active in the American Society for Health Care Risk Management, serving on the Nominating Committee, as Chair of the Enterprise Risk Management Task Force, as a member of the Leadership Task Force, and as a Faculty member. She also services on the Advisory Council for the Coalition to Improve Diagnosis, a collaboration convened by the Society to Improve Diagnosis in Medicine. Dr. Spurlock serves as an Educational Faculty member for the American Association of Physician Leaders, a clinical and quality improvement contractor for the American Association of Physician Leaders, and as a quality improvement consultant for Valley Presbyterian Hospital.

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