Top 10 Patient Safety Myths

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Many provider CIOs are reevaluating their institutions' processes for insuring patient safety. Some are seeking counsel to help break through the noise of the health information management marketplace. With that in mind, Accenture has compiled the following list of the most dominant patient safety myths, along with tips on how health care leaders can counter them.

Myth 1: Computerized physician order entry (CPOE) alone can improve patient safety.

While CPOE has been helpful minimizing errors associated with medication orders, it is only one piece of the overall patient safety solution. Health care executives should consider how their technology supports safety across the entire enterprise and realize that anytime you add new technology, change a process—or both—you can 1) enhance safety and reduce certain errors, 2) introduce new errors into the system, and 3) make some errors—either new or existing—harder to detect. Since health care organizations are now focusing on automating processes instead of departments, it is wise for them to build a quality program around any project that affects IT and/or care processes on their journey to high performance.

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Myth 2: My vendor understands patient safety.

Patient safety is still a relatively new discipline. Unfortunately there are very few individuals who understand the key issues of and approaches for patient safety, and can match that with experience to make it relevant for you and your health system. It is important to note that, to date, health information management vendors have had limited success with physician adoption of CPOE, nurse usage of clinical documentation systems and the use of bar coding. Therefore, while vendors may know their systems' capabilities, they may not have much experience with how the technology is actually used and the implications for patient outcomes. It is important to "do your homework" and learn as much as you possibly can before accepting that the vendor can truly help you enhance patient safety.

Myth 3: Return on investment (ROI) is the reason to address patient safety.

Don't build your ROI based on safety alone. Common folklore aside, it is impossible to directly measure any financial benefit from patient safety initiatives. Instead, consider investing in technology as a way to achieve high performance by improving patient safety while it enhances your bottom line in other ways, such as decreasing lengths of stay or providing less expensive formulary medication choices.

Myth 4: Implementing an advanced clinical system will mean layoffs.

Beware the vendor story that "our system will provide you enough rules and alerts that you can reduce or remove certain people from your processes." No clinical system contains enough current information to replace human decision making, nor will these systems reach that level of functionality in the span of their product lifetimes.

Myth 5: If we build it, they will come.

Trying to bring physicians on board after a clinical system has been selected and implemented is a common and, quite often, costly mistake. Do not expect anyone to "heal your pain" if you take a step that affects your medical and nursing staffs without their involvement and participation up front. At the start of the process, pull together an interdisciplinary team of clinicians to help you choose the best solution that will support their work as well as create a patient safety environment. And it is likely you may have only one chance to get this right.

Myth 6: Everyone else has a patient safety problem—except us.

When surveyed, most health care leaders believe that patient safety is a major issue in the United States—but not at their facility. If you can imagine an error occurring when reflecting on how your organization delivers care, it can, probably will or even has already happened. A good way to begin the journey is to start with a realistic expectation that your system has much work to do to improve reporting and enhance safety.

Myth 7: Benchmarking will define where we should start improving safety.

We are still early in our development of advanced reporting systems for capturing medical errors. Until we have mature reporting systems and fully institute a culture where reporting errors is less threatening, we can't really get the full picture of where medical errors may and have occurred. If you rely on existing and incomplete benchmarking data, it may hurt—and not help—your efforts.

Myth 8: Patient safety requires a new corporate department.

If you want to make lasting change in your organization, patient safety should be part of the organizational "genome." Instead of creating another large "siloed" department with new positions that focus solely on safety, let patient safety become an integral part of all processes—part of the organizational fabric in everything you do. Consider the benefits where every employee is connected with a "safety first" corporate culture.

Myth 9: It's okay to store almost all of our patient data on an outpatient system because that is how most receive care.

Since there are no standards to carry "hard coded" critical system messages between vendor systems, the usefulness of "best of breed" systems is limited. Though a patient experiences the majority of care as an outpatient, storing rich patient data on an outpatient system that cannot be extended into an inpatient or long-term care system creates a major gap through which safety issues can likely arise.

Myth 10: Most medication errors occur at the order writing stage of the process.

Not all health care organizations do the same processes the same way, and often there are many variations of the same processes within an organization. Therefore published reports from other health care organizations about where errors occur may not apply to yours. Are you positive that none of your errors are occurring when medication is dispensed? Or during its administration? Before implementing a CPOE system, which requires a financial investment and change in established processes, you must undergo a careful study of your existing system.

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