

Wisconsin Patient Safety Institute striving for positive outcomes

By Catherine Frey

Patient safety, a basic tenet of quality healthcare practice, has been a focus of Wisconsin health care organizations for many years, though there has not always been a vigorous pursuit of the means to advance safety and reduce error. That began to change in 1999, when over 100 key community and health care leaders convened at the Medical College of Wisconsin in Milwaukee for the first Wisconsin Patient Safety Summit. Soon after, the Institute of Medicine (IOM) released its landmark report, *To Err is Human, Building a Safer Health System*, and in August of this year, the Wisconsin Patient Safety Institute, Inc. was formed. A private, not-for-profit organization, the Institute is dedicated to enhancing and promoting patient safety by advocating safe practices in health care organizations throughout Wisconsin.

Much effort has gone into the creation of the Institute and the subsequent development of its mission and goals. In May 2000, the State Medical Society hosted a Wisconsin Forum on Patient Safety. More than 50 health care leaders came together to initiate this statewide effort to improve

patient safety. Discussions defining healthcare error, identifying reasons errors occur, and identifying how systems must change to improve patient safety helped fuel the energy and excitement that began the process of establishing the Institute.

A work group was formed to create the first set of patient safety recommendations. Entitled "Medical Safety Recommendations for Wisconsin Health Care Providers," the recommendations received enthusiastic support from the more than 150 health care professionals and media who attended the Wisconsin Patient Safety Forum in November 2000. The forum highlighted current patient safety projects on a national level, in neighboring states and within Wisconsin. The initial set of 10 recommendations (see sidebar) has since been shared with and adopted by numerous organizations throughout Wisconsin. It has fostered new patient safety initiatives and stimulated health care facilities statewide to improve their own patient safety efforts.

A collaborative work group has continued to meet since the November Forum, and in late spring of this year, the group began to formally establish the Institute, and develop its mission and goals. The Board of Directors, representing all of the

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sponsoring organizations (see side bar), will soon be filling the remaining seats of the 35 member board.

The Board of Directors has been instrumental in securing over \$350,000 for the Institute, including \$220,000 from the state. Additional funding will come from contributions, grants and fees for services. The Institute's Executive Committee consists of representatives of the initial sponsoring organizations, whose members have been active participants in shaping recommendations and pushing to expand the sphere of influence in patient safety.

The Institute's Goals:

- Creating and fostering implementation of specific patient safety recommendations across the full continuum of acute and long-term care
- Facilitating the creation of partnerships between health care organizations, purchasers and consumers to continue to find ways to enhance quality healthcare and improve patient safety
- Developing recommendations for long term changes in health care systems that constantly monitor and, when needed, make changes that improve healthcare services and enhance safe patient care
- Strengthening public and professional awareness of safety and best practice issues and their ethical aspects
- Serving as an advocate in healthcare to help shape public policy

To achieve these goals, the Institute will:

- Collect, develop and disseminate patient safety resources for healthcare professionals, consumers, and purchasers.
- Create recommendations to lead patient safety efforts

Medication Safety Recommendations for Wisconsin Health Care Providers

1. Hospitals, extended care facilities, nursing homes and other health care facilities need to provide 24-hour pharmacy coverage either on-site or on-call (by telephone access to a staff pharmacist or contracted through a community pharmacist).
2. Hospitals, community pharmacies, ambulatory clinics, and any other health care facilities that dispense medication should utilize available computer software to provide clinical screening to maximize patient safety in the dispensing of all prescription medications.
3. Hospitals and other appropriate health care facilities should conduct an evaluation of an integrated computerized prescriber order entry (CPOE) system with clinical decision support for medications and other ordered services by January 1, 2002 with implementation by January 1, 2004.
4. Hospitals, extended care facilities, nursing homes and other appropriate health care facilities responsible for the administration of medications to patients should implement an oral and inhalant unit dose distribution system for all non-emergency medications administered within the facility by January 1, 2002.
5. Hospitals and ambulatory health care centers should utilize a pharmacy based and pharmacist managed process for the preparation of intravenous admixture solutions.
6. Pharmacies and physicians should include the generic name on the label of prescription medications dispensed to patients.
7. Hospitals and other appropriate health care facilities should investigate and evaluate the use of bar-coding systems for the packaging and administration of medications by January 1, 2002.
8. Hospitals and other appropriate health care facilities should prepare and maintain written policies and procedures for the use of select high-risk medications within the facility.
9. Prescribers should institute actions to eliminate the use of symbols and phrases that are commonly misinterpreted by pharmacists and other health care providers.
10. Prescribers and pharmacists should include the intended use on all prescription orders and prescription drug labels and packages for consumers.

- Increase public and professional awareness and stimulate public debate
- Identify and disseminate best practices
- Encourage and stimulate research
- Sponsor continuing education and professional development
- Coordinate seminars, forums and conferences
- Facilitate partnerships between health care organizations, providers, researchers, educators, consumers and purchasers

- Provide funding for local efforts

The task before the Institute is not an easy one. However, since its inception, the Institute has fostered partnerships among health care providers, consumers, purchasers, educators, researchers and leaders in government. That kind of collaboration is crucial to the Institute's success and will no doubt be the catalyst for change in this joint effort to improve the safety of all patients in Wisconsin.



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