Reaction paper

Patient Safety It is surprising to read about how quick the media organizations and public action groups were to jump in and start blaming and attempting to hold individuals accountable without also looking into the front of the problem, the need for better front-end reporting and tracking of patients through the system, particularly since the name of the report is “ To Err is Human”. This title suggests that there is no cure for the problem of human beings making errors in the treatment of patients. When there is no cure for a particular problem, the next stage of treatment is commonly to negate or contain the most troubling symptoms. As there is no means of eliminating the human ability to make errors, it is necessary to first do what can be done to negate or contain the symptoms of the problem by placing safeguards and checks in place that will protect both the patient and the caregiver in ensuring that errors made are caught in time to fix the problem. According to the author of the article, this is exactly what the IOM report was attempting to suggest, but this idea was completely overlooked by those who read it.

By putting the medical community on the defensive instead of working with it to try to address problems that arose, the emphasis on blame created a scenario in which medical professionals became fearful of reporting issues and attempted to deal with things on their own. This is comparable to a doctor yelling at a chronic patient for not getting better. It is human nature in that case for the patient to refrain from reporting new symptoms in order to avoid being yelled at, but the problem can only get worse. While it is clearly necessary to report those individuals who are deliberately or negligently endangering patients, as it would be necessary to report a new symptom that restricted breathing, it is pointless to simply assign blame without first

addressing the original problem. In introducing the nature of the problem, the report does an excellent job of bringing these issues to the front as a means of redirecting the reader's attention to the true importance of the report, which are the IOM's recommendations for safe practices.

The article gives a very informative and understandable summary of the IOM report, emphasizing the importance of preventing error through system-wide effort. The causes for error are laid out systematically as are the nine recommendations for reducing the effects of this error. This step-by-step progression of ideas is very logical and the examples provided through each step help the ideas to stay in place. As in its description of the various ways in which errors occur, the report addresses each level – from the unavoidable weaknesses of the human state to the avoidable human mistakes all the way up through team involvement and involving patients in their care. Beyond this point, the recommendations suggested by the IOM must occur on the upper levels beyond the frontline involvement.

Reading through this manual provides a strong understanding of the background behind many of the safeguards in place today. While these safeguards may sometimes seem to be excessive or bothersome, this manual provides a greater understanding of the various reasons why these types of safeguards are important. The examples provided for each of the nine recommendations point out how even the most well-meaning nurse can and sometimes will make serious mistakes in treatment without the implementation of processes and equipment designed to help reduce error on each level. Although the manual doesn't specifically cover later processes following care, such as patient follow-up and hospital discharge, it mentions the importance of these processes and the need for further safety

recommendations. After reading this, I am persuaded that more should be discovered regarding patient care following initial treatment and feel much more dedicated to safety standards.