Tri-Council for Nursing

September 2000

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Response to the Institute of Medicine's Report To Err is Human: Building a Safer Health System

In November 1999, the Institute of Medicine (IOM) issued a comprehensive report on medical errors, *To Err is Human: Building a Safer Health System*. Speaking to the seriousness of the problem and issuing a call for immediate action on the part of nurses and others, the report notes that ". . . it is simply not acceptable for patients to be harmed by the health care system that is supposed to offer healing and comfort." To begin to substantively address safety improvement, the report calls on health care systems to reorient their efforts to reduce error. Rarely are errors the fault of an individual, rather, they are the culmination of characteristics of systems of care. Rather than attach blame to individuals for errors committed, organizations must design non-punitive approaches to error and look well beyond individual providers to understand and redesign system-level processes for error prevention.

This report has captured the attention of every health care stakeholder in the country, from health care professionals to the White House to the U.S. Congress. Organizational members of the Tri-Council have long considered the impact and outcomes of nursing interventions in health care delivery, health status and organizational function. Because of this focus, the following consensus statement represents the thinking of the members of Tri-Council and articulates the role of nursing in addressing and preventing medical error.

- Nurses are committed to improving patient safety. Multi-disciplinary teams of individuals, including nurses, work together to provide patients with the best care possible. This is a dynamic relationship that must be considered when investigating errors and patient outcomes.

- In order to prevent medical error, we must first better understand all the factors contributing to it. Research indicates that error is largely the result of a complex interaction of multiple factors within the health care environment (such as the care delivery system, medication administration systems, etc). Systems must be designed to overcome the multiple factors that create the potential for errors to occur.

- Because nurses work directly with patients and can provide insightful information and perspective on medical error, nurses can play a key role in engineering safer systems. As direct care providers, nurses must be involved in the evaluation, development, and implementation of efforts to overcome medical errors.

- It is critical that gathering and analyzing information related to medical error take place with a view to continuous quality improvement. A more concerted effort is needed to build systems that support the nurse who incorporates quality improvement and prevention of error into his or her practice and even more important, to create environments within health systems that focus primarily on education and prevention, not only discipline. It is essential that investigations occur in a non-punitive environment that focuses on strategies to prevent future error and balances this goal with the need to protect public safety. For any reporting system, there must be adequate legal protection for those reporting.

- The Tri-Council agrees that there is a need for a nationwide system for data collection that

focuses on safety and outcomes. Such a system of reporting and tracking adverse events must maintain data on when errors are occurring as well as information on what organizational variables may have contributed to the adverse events.

- It is the work of the nursing profession to determine the appropriate mechanisms for ensuring the ongoing competence of practitioners. In addition, through nursing education programs and ongoing professional participation, we must work to foster a culture that encourages the identification and prevention of errors.

- The Tri-Council supports a research agenda that identifies and examines the root causes and drivers of errors, approaches for error prevention, and what adverse patient outcomes are due to errors versus other causes. The research agenda also should determine the relationship between workforce and medical errors, inclusive of the entire health care team, that focuses on the level and type of staffing, educational preparation of staff, and number of continuous hours that staff work.

Tri-Council: A Forum to Shape the Direction of the Nursing Profession

The Tri-Council is an alliance of four nursing organizations focused on leadership for education, practice and research. This alliance captures the collectivity of nursing's social, political, professional and moral authority nationally and internationally to influence and provide stewardship within the profession of nursing. Although each organization within Tri-Council is autonomous with its own constituent membership, common values about nursing unite organizations for dialogue and consensus building. Tri-Council members recognize the value of involving a broader constituency as issues emerge, and therefore invite and encourage other nursing groups and stakeholders to participate in the dialogue about nursing and national health care issues.

Core Issues for Tri-Council

- Short- and long-term legislative agenda that will advance the profession of nursing.

- Methods and initiative to assess the impact and outcomes of nursing interventions on health care delivery, health status and organizational function.

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