What the Evidence Tells Us About Safety and Care

In a newly released report from the Agency for Healthcare Research and Quality (AHRQ, 2013), several patient safety practices were reviewed. What makes this report valuable is the fact that its emphasis lies in context and generalizability. Several factors were used for this report. In addition to the practice itself, for example, that sufficient detail was provided so that another group could replicate the practice, the context was reviewed. The context included such factors as the infrastructure for quality, external factors (e.g., regulations), a patient safety culture, and the “availability and implementation of management tools” (AHRQ, 2013, p. 4). The latter, of course, is of great concern to us.

What good is the evidence if we aren’t able to embed it into the practice of the people providing care? Those of us concerned with ongoing professional development know the challenges of achieving consistency across a group of practitioners. In part, our challenge resides in the changing (emerging) evidence that suggests changes in what we do and in the complex nature of working with numerous individuals with differing motivations for learning something new. And now, this report provides something we knew existed but probably haven’t seen presented so succinctly.

Through a complex methodology, 158 patient safety practice topics were narrowed to 41. These were then narrowed to 18 in-depth reviews and 23 brief reviews. The former comprised systematic reviews and the latter varied by the topic, but generally were led by an expert in the area and were focused reviews. Each practice was reported in terms of the following factors:

- Scope of the practice (does it commonly occur and how severe is it?)
- Strength of the evidence (low to high)
- Potential for harmful, unintended consequences (low to high)
- Estimate of cost (low to high)
- Implementation issues (how much we know and how easy/difficult it is to achieve)

The practices were reported by category: adverse drug events; infection control; surgery, anesthesia, and perioperative medicine; hospitalized elders; general clinical topics; and improvements of overall system/multiple targets. Although many individuals could benefit from the research across these areas (think an elder patient with an infection who has a surgical experience and experiences a medication reaction), I was surprised that only two topics related directly to hospitalized elders. In almost any setting (except those devoted to children and child birth experiences), a large portion of the population is elderly. This alone suggests we have much work to do to produce the evidence we need for safe patient care.

Out of the in-depth and brief reviews, only 10 practices were strongly encouraged and 12 were “encouraged.” (Remember these conclusions are based on the list of factors above.) Rather than reproduce the findings here, I will target those that apply in almost any setting in which nurses work. There is one: hand hygiene. Although the others are important, they may relate only to surgical suites or inpatient settings. No matter where we work, we need to be concerned with hand hygiene!

Finally, I would be remiss if I didn’t mention the encouraged practice that relates to what we do: “use of simulation exercises in patient safety efforts” (AHRQ, 2013, p. 11). We can’t just talk about patient safety, we can’t just do the “annual safety day” demonstrations, and we can’t just create incentives and punishments. We must
actually practice what we value. This report provides several ideas for what those simulations could address. The documentation that our evidence across the literature is not as strong as we would like tells us we have lots of opportunity to study safety and then to simulate experiences that embed practices into our daily lives. How long, for example, have we talked about hand hygiene? Florence Nightingale would be chagrined that we haven’t done better with her original data from more than a century ago! I cannot envision a simulation involving a patient where that skill would be missing. (Yes, even if we are just talking with a patient, it might be good for us to have clean hands in case we touch the patient.) We have much work to do if we want stronger evidence and if we care about safety.

REFERENCE

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The author has disclosed no potential conflicts of interest, financial or otherwise.
doi:10.3928/00220124-20130327-58