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Symposium
Introduction

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Patient Safety Issues in Critical Care

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Health care institutions have developed a heightened awareness surrounding patient safety issues since the Institute of Medicine published its revolutionary report "To Err Is Human."[1] This report emphasized a now commonly held perspective that the vast majority of errors in health care settings are due to systems, processes, and environments that can make it difficult for care providers to do the right thing, resulting in instances of preventable errors and suboptimal care.[1] Nowhere should safety be more of a priority than in an intensive care unit (ICU). We would like to believe that everything we do in an ICU is focused on providing safe and optimal care. However, we also know that ICUs are becoming increasingly complex with the use of complicated technology, more unique and precise therapeutic interventions, and increased pressure to provide care in the most efficient and time-sensitive manner.

In the 13 years since the Institute of Medicine publication, we have learned many things about improving safety in patient care. Tools and methods are available to assist in evaluating, enhancing, and redesigning processes to maximize safety, such as root cause analysis procedures,[2] failure modes and effects analysis,[3] and handoff communication tools.[4] Nonetheless, it has also become clear that critical care providers and leaders need to be vigilant for new and unanticipated safety gaps. For instance, technology continues to advance in providing double checks and alerts in care and workflow processes. However, its use also can result in overreliance on the part of caregivers, creation of new unanticipated safety breaches, and provider workarounds when technology is nonfunctional or results in inefficient workflows.

This symposium highlights 3 evolving areas of patient safety in critical care. Drs Sendelbach and Funk have focused on the significant topic of alarm fatigue—an example of technology created to enhance the safe care of patients resulting in additional safety concerns. The authors identify resources available to assess the appropriate use of physiologic monitoring alarms and propose interventions to reduce alarm fatigue. Dr Frith addresses the complex workflow process of medication administration in the ICU, describing a systems engineering model that can be utilized to evaluate why medication errors occur. Finally, Dr Harder discusses the use of human factors concepts in designing systems and processes to meet the needs of patients and providers in delivering safe and efficient care.

I hope this series will provide readers with additional tools and perspectives to ensure safe critical care environments. Only with continued vigilance and a

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commitment to our patients can we look with new appreciation at "routine ICU care and processes" that are, in reality, complex, interdependent orchestrations.

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