

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

Red Rules: An Error-Reduction Strategy in the Culture of Safety

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There are substantial and problematic challenges in preventing, trapping, and mitigating error in any healthcare environment. Well-known error-reduction strategies, from least effective to most effective, include:

- Education and training—necessary but often insufficient
- Rules and policies
- Checklists and double-check systems
- Standardization and protocols
- Automation and computerization
- Forcing functions and constraints

Most healthcare systems include an assortment of these strategies in their day-to-day operations.

Culture drives patient safety

An organization's culture is the heart and soul of a safety program. Larry Bossidy, former CEO of Allied Signal, likens an organization to a computer with hardware and software. The hardware includes elements such as organizational structure, design of rewards, compensation, and sanctions. The social software includes values, beliefs, norms of behavior, and everything else that isn't hardware. An organization's social software brings the corporate hardware to life as a functioning system.¹

The importance of culture should not be underestimated. Although difficult to measure and not solidly supported by hard scientific evidence, the cultural values of an organization determine the extent to which it is safety oriented. Despite the lack of randomized control studies, metrics are evolving to measure a culture of safety.

In aviation, the Line Operations Safety Audit (LOSA) through the University of Texas Human Factors Research Project has measured flight crews in determining differences in a safety culture.^{2,3} The National Quality Forum (NQF) cites 30 safety objectives in which the lion's share of points are awarded "to have a healthcare culture of safety."⁴

One strategy that uses an organization's social software and hardware to decrease the probability of error is Red Rules.

What are Red Rules?

Red Rules are rules that cannot be broken.⁵ These rules, initially used in the nuclear power industry, are standards that should be undertaken every time in a particular process except in rare or urgent situations. An example of a Red Rule is the use of hard hats in construction and other high-risk industries.

“Red Rules ... initially used in the nuclear power industry, are standards that should be undertaken every time in a particular process except in rare or urgent situations.”

In health care, Red Rules are seen in the operating room with the use of masks, gowns, and gloves or with hand-washing prior to an operation. It would be unacceptable for someone to enter the surgical suite without appropriate attire. Even more intolerable would be to forego the use of gloves in an open wound.

Distinguishing Red Rules from Blue Rules

Red Rules are in contrast to Blue Rules—policies and procedures designed to help an organization run more efficiently. Blue Rules may be bent or broken when extenuating circumstances come into play.

An example of a Blue Rule occurs when a patient in an emergency department is typically registered first, then seen by the triage nurse. The Blue Rule is ignored under urgent conditions such as a woman in labor or a hypotensive trauma patient, since the patient's welfare takes priority.

Red Rules: An Error-Reduction Strategy

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A Blue Rule would allow the registration process to take place at a later time.

It is crucial to an organization's social software to recognize and understand the differences between Red Rules and Blue Rules. Red Rules typically arise as a consequence of ethical imperatives, strong scientific evidence, or regulation. The practice of medicine is heavily influenced by a number of outside forces, including federal, state, and local governments, the media, JCAHO, litigation, Leapfrog, the National Quality Forum, factors affecting financial integrity, and public demands. These influences can create policy changes which may result in Red Rules.

Despite the use of Red Rules in the nuclear power industry and in health care, there is a gap in the research base exploring their effectiveness.

Implementing Red Rules at OSF Healthcare

OSF St. Francis Medical Center in Peoria, Ill, is a 700-bed academic medical center. In October 2004, the medical executive committee and administrative leadership created the following Red Rules:

Service Area	Red Rule
Central line insertion	Use maximal sterile barriers
Neonatal circumcision	Perform procedural anesthesia
Procedural area	"Timeout" before all procedures
Invasive procedures	Clean scrubs must be worn in all areas where invasive procedures are performed.

To ensure successful implementation, stakeholders underwent education on Red Rules in the area where they worked. The instruction defined the basis and intent for the proposed Red Rules as well as expectations when violations were identified.

Individuals found to breach Red Rules were coached with positive disciplinary education; repeated offenses mandated stronger penalties. Non-compliance led to a visit with the CEO and/or members of the medical executive team. All employees were given immunity in reporting infringements and were followed for potential retaliation, especially when a difference in hierarchy was identified.

Cassy Horack, RN, director of safety and quality at OSF St. Francis Medical Center, notes that incorporating Red Rules into the safety culture was not easy. But despite numerous obstacles, she considers the Red Rule experience highly successful. Transgressions have been uncommon—there

have been a total of 7 instances of positive disciplinary education. No one in the organization has required remedial assistance.

Lessons learned from implementing Red Rules

Red Rules and Blue Rules are not static. Case in point: 20 years ago, it was common practice for patients to smoke in their rooms or at a number of locations in a hospital. Today, smoking restrictions have become a Red Rule as it has become unacceptable to smoke throughout most healthcare institutions for regulatory and ethical reasons.

Anyone in a healthcare organization, regardless of hierarchy, would be expected to stop an individual who violates this Red Rule. Over a period of a few years, societal values have dramatically changed.

The success of implementing a Red Rule depends on leadership. Leaders must understand that merely elevating a policy or procedure by declaring it a Red Rule does not ensure its successful execution. To make that assumption could potentially jeopardize the efficacy of existing Red Rules.

OSF has come to recognize that today's policies and procedures can become Red Rules if:

- There is strong evidence to support the policy.
- The policy is clear.
- The measurement is simple.
- The policy and supporting evidence are well-communicated.
- There is clear, swift accountability for those who fail to support the changes.

Caution: Use Red Rules sparingly

One pitfall leaders should avoid is the tendency to overuse Red Rules. A good chef knows that a meal can be ruined if a seasoning is used in excess. Skilled leaders recognize that Red Rules will be meaningless in achieving the desired goal if applied to situations where Blue Rules are more appropriate.

Healthcare leaders recognize that a culture of safety is arguably the best defense in creating a safe environment. A culture of safety can be created by using a variety of tools to reduce error, such as Red Rules, and engaging the social software of the organization (physicians, front-line staff, and patients). Red Rules, when used judiciously, can prevent, trap, and mitigate harmful error. **NPSF**

Bringing the Patient Safety Leadership Fellowship Home Lean Systems Thinking Guides Process Improvements

BY JOSEPH CONIGLIARO, MD, AND AUDREY YATES, MSE, UNIVERSITY OF KENTUCKY CENTER FOR ENTERPRISE QUALITY AND SAFETY

The Patient Safety Leadership Fellowship (PSLF) offered by NPSF, Health Forum, and the Health Research and Educational Trust, is an intensive year-long program for healthcare leaders from a wide range of disciplines who have a passion for making health care safer. As part of the PSLF, each Fellow designs an Action Learning Project (ALP) to test patient safety theories at his or her own site.

UK HealthCare applies lean systems thinking

The University of Kentucky HealthCare Enterprise (UK HealthCare) has experienced unprecedented growth over the past 2 years, with hospital discharges growing 26% from 19,098 to more than 24,000 annually. This growth demanded a new approach to managing patient throughput and coordinating appropriate post-hospital care in the most cost-effective and patient-centered manner while maintaining quality and patient safety.

Over the past year, Joseph Conigliaro, MD, a 2006-2007 Patient Safety Leadership Fellow, has been organizing UK HealthCare's quality and patient safety efforts under the newly formed University of Kentucky Center for Enterprise Quality and Safety (CEQS).

As part of his ALP, Dr. Conigliaro organized an interdisciplinary group of healthcare leaders in the summer of 2006 and formed the CEQS Lean Group. This group, assisted by Audrey Yates, CEQS lean systems manager, launched UK Healthcare Quality Design and laid the foundation for improving hospital systems through lean systems thinking.

Lean systems thinking borrows from manufacturing

Lean systems thinking, originally developed by the Toyota Motor Company, represents a group of management principles focused on reducing 7 wastes: overproduction, wasting time, transportation, processing, inventory, motion, and scrap. By eliminating waste, quality is improved and production time and costs are reduced.

But lean systems thinking is not strictly a manufacturing strategy. It is a management system to improve the processes or sets of actions required to provide a service or accomplish a task.¹ Because every organization, including a healthcare institution, performs work as a series of processes designed to meet its customers' needs, lean thinking can be universally applied to any industry.²

Designing UK Healthcare lean systems projects

The UK team chose the process for discharging hospital patients as their initial lean systems project. An interdisciplinary 20-member team was assembled representing all aspects of patient discharge, including staff from patient throughput, clerical services, environment services, hospital operations and administration, information systems, nursing, nutrition services, discharge planning, transport services, pharmacy, physical and occupational therapy, as well as physicians and social workers.

“[L]ean systems thinking is not strictly a manufacturing strategy. It is a management system to improve the processes or sets of actions required to provide a service or accomplish a task.”

The goal of UK Healthcare Quality Design is to continuously improve hospital processes that provide customer value. To accomplish this, UK Healthcare needed a cultural transformation for clinicians and front-line staff to feel empowered to look at processes from a systems view.

Each team member received more than 40 hours of training on team building and lean tools through lectures and learning simulations designed specifically for health care. Team members were then assigned to work on one of 4 projects, each led by a lean facilitator from the CEQS Lean Group. These projects gave team members and lean facilitators the opportunity to work in subgroups, practice team-building skills, and apply lean tools and concepts.

What did the lean groups accomplish?

- **Organizing patient education resources.** Previously, patient education materials were tailored more to the individual educator than to a patient's needs. During

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discharge, nurses often made multiple visits to the patient education area to collect documents due to incomplete information during discharge planning and the additional needs identified by the patient or family members. This subgroup used a lean technique known as 5S to improve the overall organization in the patient education room (see chart below) and increase the percentage of complete education packets from 36% to 98%.

- **Identifying the mode of transports.** The general perception of clinical staff was that transporters were often relaxed in their approach to moving patients from one area to another. Comments such as “Transporters do not move quickly enough” were often heard throughout the hospital. This lean systems subgroup was charged with observing transporters as they moved patients throughout the hospital.

Their initial perceptions changed as they realized 1 out of 5 transport jobs required some type of re-work, such as waiting for an additional transporter when a patient needed a bed instead of the originally indicated wheelchair for transfer. To help transporters do their job correctly without re-work, the team redesigned the front end of the process, starting when the ancillary site staff identifies the mode of transport and enters it into the transport system.

- **Organizing the supply room.** When this team began observing staff entering the supply room, they quickly noted that items in the same product family such as needles were not easily identified. Staff had to physically handle the item, read its label, and/or examine it to make sure they were picking up the right item. To improve visual identification of these products, the group redesigned the labeling and configuration of the individual bins that held the products on the shelves.
- **Setting up for admitted patients.** Members of this subgroup evaluated the procedures that occurred when a patient was admitted to the acute care unit. For example, nursing technicians and nurses often set up the room with an admission kit and IV pump, yet there was no standard for what was needed or how to set up rooms for different patients. This team was in charge of identifying a standard for setting up patients’ rooms before they are brought to the room.

Lessons learned

These subgroups are merely examples of teams using lean tools and taking important steps to transform UK Healthcare into a lean culture and philosophy. Team members not only learned how to apply lean tools, but also gained a personal appreciation for looking at systems in a new way.

Members of each team conducted observations and collected baseline data for each project, using observation data versus perception as the catalyst for justifying change. Team members learned how hospital systems comprise more than just people. These systems include the flow of verbal, written and electronic information, as well as equipment movement and material movement from one location to the next.

Culture change is based on learning

The goal of UK Healthcare Quality Design is to create value for patients (external customers) and staff (internal customers) by continuously improving hospital systems through lean systems thinking. Learning has been identified as one of the major components needed to adopt lean systems thinking and transform the culture at UK Healthcare. Empowering team members with the skills to work in teams, apply lean tools, and begin examining processes from a systems perspective are the initial steps in the journey. **NPSF**

5S Tools for Lean Systems

Sort	Eliminate unnecessary items from the workplace. Sorting is an excellent way to free up valuable floor space and eliminate such things as broken tools, obsolete jigs and fixtures, scrap and excess raw material.
Set in order	Focus on efficient and effective storage methods. “A place for everything and everything in its place.”
Shine	Thoroughly clean the work area.
Standardize	Standardize best practices in your work area.
Sustain	Focus on defining a new status quo and standard of workplace organization.

Teaching Health Literacy: Building a Foundation for Safer Health Care

BY WILLIAM HARPER, MD, THE UNIVERSITY OF CHICAGO PRITZKER SCHOOL OF MEDICINE

Individuals with limited healthcare literacy have more difficulty understanding pill bottle instructions,¹ use preventive services less,² and are poorly consented for procedures.³ As a result, limited healthcare literacy has been shown to lead to higher mortality in the elderly,⁴ poor diabetes control,⁵ and increased risk of hospitalization.⁶

Interventions to close this gap have been suggested. Speakers at the Institute of Medicine (IOM) Roundtable on Health Literacy in September 2006 described varied programs such as those teaching grade school children about health matters.⁷ Adult literacy programs often include units on health literacy,⁸ yet funds for such programs are limited.

“[L]imited literacy has been shown to lead to higher mortality in the elderly, poor diabetes control, and increased risk of hospitalization.”

Various programs have been suggested to teach healthcare providers the skills needed to ensure patient understanding. The IOM's initial report on health literacy in 2004 encourages all professional schools to implement health literacy curricula into their areas of competence.⁹

A similar recommendation is made by the Joint Commission in its February 2007 white paper entitled “What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety.”¹⁰ The solutions outlined in this document focus on making effective communication a priority in protecting the safety of patients.

What should a health literacy curriculum teach?

The main goal of any health literacy program should be to maximize patient understanding. Curricula aimed at providers should be presented in the framework of teaching the core communication skills to be used in all encounters. Strategies taught to be implemented only as an “add on” to select groups, such as those with low literacy, are less likely to be adopted by learners.

The Joint Commission, along with many groups, recommends employing “a ‘universal precautions’ approach to all patient encounters by using clear communications.”^{10(p8)} While the adverse impact of poor understanding is likely greater for those with limited literacy, the communication goals should be the same regardless of the patient's literacy level.

The fundamental communication skills central to any provider curriculum are well-described in the literature¹¹ and include skills necessary for effective information-gathering from patients as well as information-giving to patients. Key skills in information gathering include eye contact, body position, and open-ended questioning style.

6 tools for communicating health information

The following tools in giving information were highlighted in the AMA publication, *Health Literacy: A Manual for Clinicians*.^{12(p25)}

- 1. Slow down.** Communication can be improved by speaking slowly and by spending just a small amount of additional time with each patient. This will help foster a patient-centered approach to the clinician-patient interaction.
- 2. Use plain, non-medical language.** Explain things to patients as you would to a family member.
- 3. Show or draw pictures.** Visual images can improve the patient's recall of ideas.
- 4. Limit the amount of information provided, and repeat it.** Information is best remembered when it is given in small pieces pertinent to the tasks at hand. Repetition further enhances recall.
- 5. Use the teach-back or show-me technique.** Confirm that patients understand by asking them to repeat your instructions back to you.
- 6. Create a shame-free environment.** Make patients feel comfortable asking questions. Enlist the aid of others (a patient's family, friends) to promote understanding.

How to teach health literacy

Core concepts of adult education should be followed as curricula are developed. Foremost of these is the concept of deliberative practice. Learners need to practice skills in a controlled environment, obtain the feedback critical for self improvement, and then have the opportunity to practice skills again.

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"Ask Me 3" Helps Patients Get the Answers They Need

The Partnership for Clear Health Communication (www.askme3.org) has developed a program that teaches patients to ask their health-care professional 3 basic questions:

1. What is wrong?
2. What needs to be done about the problem?
3. Why is it important?

The content of the curriculum should be tailored to the developmental level of the learner. More-complex methods can be used with students at more advanced levels of training. Aspects of the medical school and physician CME curricula described below can be abstracted and applied to learners at all levels and in varied disciplines.

Teaching better communication skills in medical school

Like most medical schools, the University of Chicago Pritzker School of Medicine (Pritzker) has a clinical skills course that begins at the onset of medical school. Students learn fundamental patient-centered communication skills and practice them in interviews with both trained patient actors and actual patients in the hospital.

The topic of impaired health literacy is introduced in this course with a lecture describing its prevalence, the adverse impact on health, and how using core communication skills can help enhance patient understanding. In particular, the core skill of using plain language is highlighted. When students then practice interviewing patients in the course, one of the goals of feedback is to make sure they know the concept of plain language and know how to use it.

In the second year, when students are closer to being involved in direct patient care, the skills taught advance accordingly. Students learn about giving information, which requires attentiveness to the skill of patient education and counseling. This advanced training includes the teach-back method described above¹³ as well as how to limit patient education efforts to only the key concepts.

Students practice this skill in a workshop with trained patients, where they are instructed and assessed on their ability to explain mammography to a patient with limited literacy. After showing how to use teach-back, students receive formative feedback from the patient, colleagues and faculty.

Student skills are developed further during the third-year clerkships when they work directly with patients in both outpatient and inpatient settings. The core skill taught at this level is the final step in the patient assessment, closing the encounter. Effective closure involves summarizing the key points of the visit, educating the patient, and discussing next steps. All of the core communication skills are critical here, including using plain language, promoting patient questions, and teach-back. Students do this step

with real patients during their medicine clerkship with feedback from their faculty preceptor.

Through this vertical integration of health literacy content in the context of core communication skills, it is anticipated that students will appreciate how health literacy plays a critical role in the patient encounter. The curriculum should also equip students with the skills to effectively communicate with all patients.

"The Joint Commission estimates that communication failures are the underlying root cause of up to 65 percent of the identified adverse events in its sentinel event database."

The skills taught to Pritzker medical students have been adapted to a continuing education workshop at a recent regional and future national meeting of the Society of General Internal Medicine. The 90-minute workshop begins with the facts and impact of limited literacy. Participants then break into small groups where they practice teach-back.

In a role-play exercise, the "doctor", after reading a pre-written case, explains important information to the "patient". The "doctor" needs to assimilate the data, decide what is most important to discuss, and explain it in a simple way that the "patient" can understand. The "patient" and observers provide feedback. This is not easy to do, even for experienced clinicians taking this workshop.

Better health literacy improves patient safety

The Joint Commission estimates that communication failures are the underlying root cause of up to 65 percent of the identified adverse events in its sentinel event database. Many of these likely have been complicated by low health literacy.¹⁰ A dedicated approach to teaching core communication skills, with health literacy as a backdrop, can only serve to improve patient safety. **NPSF**

Stand Up Hospitals Participate in Audio-web Conferences by Healthcare Experts

BY MICHÈLE M. DELISLE, RN, NPSF PROGRAM DIRECTOR, AND ANITA SPIELMAN, NPSF PROGRAM MANAGER

NPSF's Stand Up for Patient Safety program has grown to include more than 400 healthcare organizations. Since its inception in 2002, Stand Up has provided hospitals with a variety of materials, resources, and tools, as well as a role in setting the national patient safety agenda.

Audio-web conferences are designed for Stand Up hospitals

An exclusive Stand Up member benefit is access to 10 audio-web conferences each year. Speakers represent a multitude of organizations, such as the Health Research & Educational Trust, VHA Inc, Iowa Health System, The Joint Commission, the International Center for Patient Safety, the American Organization of Nurse Executives, the Agency for Healthcare Research & Quality, and MD Anderson Cancer Center.

Presentations address many key topics in patient safety, such as health literacy, the national patient safety goals, hospital-associated infection, clinical communication, medication safety and reconciliation, obstetrical peer review, and the Institute for Healthcare Improvement's acclaimed 100,000 Lives Campaign. A conference typically includes a 30- to 45-minute PowerPoint presentation followed by a 15-minute question and answer period.

More than 300 hospitals participate in conferences

In 2006, more than 300 Stand Up healthcare organizations participated in at least one audio-web conference. The average registration per conference was 100 facilities, with one to 15 participants each. In a fall 2006 Stand Up program member survey, 75% of respondents ranked the audio-web conferences "very good" or "excellent" in terms of program resources' relevance to patient safety initiatives at their facility, adaptability of information to their own patient safety program, and ease of use.

Stand Up conference participants are also invited to complete a post-conference survey to evaluate the presentation and recommend future topics. Presentations are rated on speakers' presentation skills, knowledge of content, and applicability of information. In 2006, participants on average rated the overall presentation quality of the audio-web conferences "very good."

Suggestions for future topics have included SBAR (Situation, Background, Assessment, Recommendation), medication reconciliation, best practices, infection control, current research findings, and teamwork and communication.

2007 conferences off to a strong start

More than 100 registrants participated in the first 2007 audio-web conference on Jan. 25, "Engaging Staff to Improve Anticoagulant Safety." The conference offered an exclusive look at the Institute for Safe Medication Practices' current recommendations on low-molecular-weight heparin, unfractionated heparin, and warfarin, along with a discussion of a Failure Modes and Effects Analysis.

Here's What Stand Up Members Are Saying About NPSF Audio-web Conferences

"Excellent program ... I had 5 people in my office (pharmacist, 3 nurses, and risk manager) ... everyone felt the program was worthwhile. Thank you."

"I used this conference as an opportunity to introduce the idea of health literacy to my nursing staff."

"Loved the presentation of this material—it was totally understandable and relevant. I can't wait for the tool to become available on the NPSF web site."

"As a result of the conference, we are modifying our initiation process and will be taking smaller steps."

Other 2007 audio-web conferences have included a guide to the NPSF 2007 Patient Safety Awareness Week toolkit, an overview of the TeamSTEPPS (Strategies and Tools to Enhance Performance and Patient Safety) Program, and a review of best practices for patient disclosure.

The conference scheduled for April is titled "Interventions to Improve Hand Hygiene Compliance," presented by Pat Kulich, RN, CIC, from the Ohio State University Medical Center Epidemiology Department.

Potential topics for 2007 include a retrospective of the Patient Safety Leadership Fellowship program, the SBAR technique, root cause analysis, best practices of Stand Up members, worker fatigue, and staffing issues. Stand Up hospitals will receive an email invitation 2-3 weeks before each conference, and may access past presentations via NPSF's password-protected members' web site.

For details, visit www.npsf.org or contact Michèle M. Delisle, RN, Program Director, at (413)663-8900 or info@npsf.org. **NPSF**

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Patient Safety: A Road Taken Together

This year marks the 10-year anniversary of the National Patient Safety Foundation. Over the past decade, NPSF's efforts have been many, but its focus has been singular—to improve the safety of our healthcare system.

“Great strides have been made to improve the safety of patients. We look forward to another 10 years of making concrete steps to promote large-scale change in patient safety.”

Diane C. Pinakiewicz
NPSF President

The anniversary theme, “Patient Safety: A Road Taken Together,” recognizes the value NPSF places on an inclusive, collaborative approach to this work and the foundation's tremendous respect for all involved.

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The May 2007 Congress theme, “Learning from the Past ... Creating the Future” reflects the need to turn attention to the road ahead and the enormous challenge of reshaping the healthcare system so patient safety is an integral part of every health transaction.

NPSF is excited and gratified by the progress made and the effective partnerships that have arisen to meet this challenge. Constant, remarkable changes in medical science's ability to treat and cure continue to increase the need for vigilance. Your continued involvement and support will help NPSF navigate this road together into our next decade. **NPSF**

How can you get more involved in patient safety?

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