focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

EPITOME Program Educates Patients to Help Reduce Medication Errors

BY ROBERT J. WEBER, MS, FASHP, UNIVERSITY OF PITTSBURGH SCHOOL OF PHARMACY

IN THIS ISSUE

EPITOME Program Educates Patients to Help Reduce Medication Errors

Creating a Culture of Safety In An Inpatient Unit

Practice-Based Learning and Improvement Morning Report Makes Outpatients Safer

Apply Now for the 2007-2008 Patient Safety Leadership Fellowship

NPSF Welcomes 2006-2007 Leadership Fellows

Plan to Attend "Learning from the Past ... Creating the Future," May 3-4, 2007, in Washington, DC

VOL.9: ISSUE 2
2006

How can medication errors be prevented?

Analyzing medication errors has led to the development of preventive measures to improve patient safety, such as effectively informing patients about their medication. Most experts agree that making patients aware of the product name, indication, dose, frequency, and side-effects of their prescribed medication helps prevent confusion, error, and the potential for adverse drug events.

Despite this fact, studies document poor knowledge of medication information in recently discharged hospital patients.[1-4] Most hospitals are challenged to establish a sustainable system and infrastructure for providing effective medication education. To address this issue, in 2000 the University of Pittsburgh Medical Center (UPMC) conducted a pilot study of a comprehensive medication education program on 2 general medicine units. The study showed that using a systematic approach significantly improved patient knowledge and satisfaction with medication education.[5-6]

UPMC launches EPITOME program to educate patients

In September 2005, UPMC implemented a house-wide medication education program with specific roles for nurses, pharmacists, and respiratory therapists. The program, known as EPITOME (Enhanced Patient Safety Intervention To Optimize Medication Education), emphasizes patient education. EPITOME's goals are to reduce patient medication-related problems, lower the number of medications prescribed, and improve patient satisfaction with medication education.

UPMC is a 16-hospital system in Western Pennsylvania affiliated with the University of Pittsburgh School for the Health Sciences. The system has centers of excellence in transplantation, pediatrics, psychiatry, geriatrics, orthopedics, and cancer care. EPITOME was implemented at UPMC's flagship hospital, UPMC Presbyterian, a 660-bed medical center with more than 33,000 annual patient discharges.

How does EPITOME work?

The EPITOME program provides medication education to patients by pharmacists, nurses, and respiratory therapists. The chart on page 2 illustrates the program's process, as described below.

> "[M]aking patients aware of the product name, indication, dose, frequency, and side-effects of their prescribed medication helps prevent confusion, error, and the potential for adverse drug events."

Step 1. Patients are educated on all oral and selected injectable medications prescribed by physicians during their hospital stay.

Step 2. Medication information sheets are printed from the hospital's information system.

Steps 3 and 4. Nurses and respiratory therapists educate patients at each administration of oral or inhaled medication, assessing the patient's comprehension of medication information.

Steps 5 and 6. Pharmacists educate patients at risk for medication non-compliance as determined by nursing assessment and the number of medications prescribed or changed during a hospital stay. Patients are educated on the proper drug name, dose, frequency, side-effects, and significant drug interactions (both drug-drug and drug-food).

CONTINUED ON PAGE 2

EPITOME Program Educates Patients

CONTINUED FROM PAGE 1

Robert J. Weber, MS, FASHP, is an associate professor and chair of the University of Pittsburgh School of Pharmacy and executive director of pharmacy at the University of Pittsburgh Medical Center. Contact him at weberrj@upmc.edu.

References

1 *Makaryus AN, Friedman EA. Patients' understanding of their treatment plans and diagnosis at discharge.* Mayo Clin Proc. *2005;80:991-994.*

2 *King JL, Schommer JC, Wirsching RG. Patient knowledge of medication care plans after hospital discharge.* Am J Health-Syst Pharm. *1998;55:1398-1393.*

3 *Alibhai SM, Han RK, Naglie G. Medication education of acutely hospitalized older patients.* J Gen Intern Med. *1999;14:610-616.*

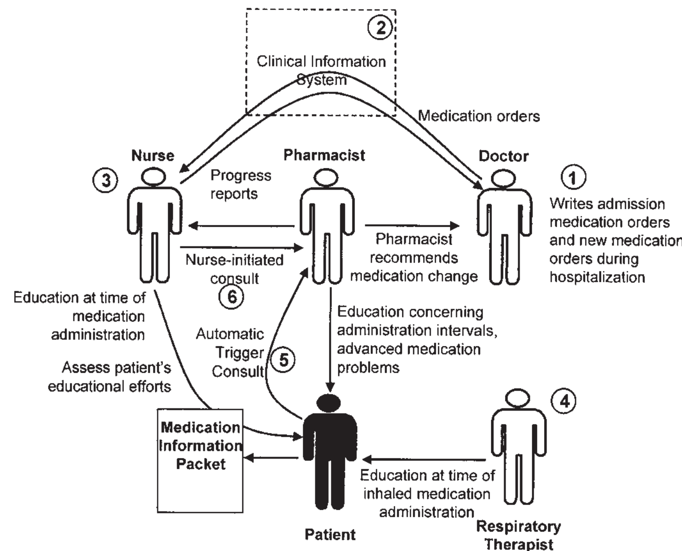
4 *Kerzman H, Baron-Epel O, Toren O. What do discharged patients know about their medication?* Pat Edu Counsel. *2005;56:276-282.*

5 *Roberts MS, Cholka K, Chang J, Calabrese A, Kapoor WN. A controlled trial of collaborative medication education and pharmaceutical care.* J Gen Intern-Med. *2001;16 (Suppl 1.):168(abstract).*

6 *Calabrese AT, Cholka K, Lenhart SE, McCarty B, Zewe G, Sunseri D, Roberts M, Kapoor W. Pharmacist involvement in a multidisciplinary inpatient medication education program.* Am J Health-Syst Pharm. *2003; 60:1012-1018.*

7 *Sirio CA, Segel KT, Keyser DJ, et al. Pittsburgh Regional Health Care Initiative: a systems approach for achieving perfect patient care.* Health Affairs. *2003;22:157-165.*

How the EPITOME Program Works



Nurses, pharmacists, and respiratory therapists educate patients in the context of a health behavior change model. Its purpose: to establish patient autonomy in medication use and assess patients' readiness to comply with their medication regimen. Caregivers providing education elicit information from patients regarding their medications, answer their questions, reinforce and assess readiness for change, create a favorable climate for patient learning, and address patient ambivalence and resistance.

EPITOME involves multiple healthcare providers

Nurses and Respiratory Therapists. EPITOME provides patient education at each medication administration. This approach offers patients many opportunities to ask questions and to clarify information regarding their medication. The nursing and respiratory staff can continually assess the patient's understanding of the medication regimen, referring the patient to a pharmacist if necessary.

Pharmacists. The pharmacist's role in EPITOME is to reinforce medication education by the nurses and respiratory therapists in patients at risk for non-compliance. In these cases, the pharmacist performs medication therapy management, simplifying dosage regimens to reduce patient confusion and error.

Medication therapy management involves monitoring regimens for medication duplicates, optimizing drug selection and dosages, reconciling the medication regimen, recommending a drug for an untreated condition, and discontinuing drugs that are not indicated. After educating the patient and reviewing the drug regimen, the pharmacist documents his or her activities in a progress note so all caregivers are aware of the intervention.

Implementation and sustainability strategies

- **Recruit physician champions.** EPITOME was championed by key medical staff physicians, making the program a priority for clinical disciplines as well as hospital administration. The physicians recognized the importance of patients' understanding their medication regimens, and provided help with resistant physicians. Without their support, EPITOME would have failed.

- **Ensure adequate resources.** The support of the hospital's chief operating officer (COO) was vital to EPITOME. The COO provided resources for pharmacy support (1.5 FTEs) and computer equipment for data collection.

- **Make patient education part of the job routine.** An important focus of EPITOME was to incorporate patient education into the daily work of pharmacists, nurses, and respiratory therapists. Nurses and respiratory therapists educate patients at the time of medication administration; pharmacists who provide care directly to nursing units perform medication regimen review and education as a regular job function.

EPITOME enhances organizational safety culture

The EPITOME program was based on the lessons learned through UPMC's participation in the Pittsburgh Regional Healthcare Initiative (PRHI). That initiative helped hospitals establish organizational patient safety cultures that promote open discussion on errors and sharing best practices.[7] EPITOME affected the organization's safety culture by increasing staff and patient awareness of medication education and by simplifying medication regimens in patients at risk for non-compliance.

EPITOME produces positive outcomes

- **Increased organizational awareness of patient medication education.** EPITOME's comprehensive approach highlighted this program as an important patient safety initiative at UPMC Presbyterian. Progress was reported on and reviewed by the hospital medical executive and executive management committees; 90% of staff surveyed reported being aware of EPITOME and its role in patient safety.

- **Increased patient awareness of medication education.** Patients are surveyed and asked "How often have you been provided education on your medications?" Patient

CONTINUED ON PAGE 3

Bringing the Patient Safety Leadership Fellowship Home

Creating a Culture of Safety In An Inpatient Unit

BY DAVID BARON, MD, CO-CHAIR, PATIENT SAFETY COMMITTEE, CAMBRIDGE HEALTH ALLIANCE

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.

Cambridge Health Alliance tests Johns Hopkins' CUSP program

An ALP conducted at Cambridge Health Alliance, a Harvard Medical School teaching affiliate, was inspired by the Comprehensive Unit Based Safety Program (CUSP). That program, described by Pronovost, et al, at Johns Hopkins Hospital, was designed to improve the culture of safety and other safety measures of an intensive care unit of a large teaching hospital.[1]

The original CUSP program consisted of 8 steps:

1. Assessment of the culture of safety
2. Education in the science of safety
3. Staff identification of safety concerns
4. Senior executives adopting a unit
5. Improvements implemented from safety concerns
6. Efforts documented and analyzed
7. Results shared
8. Culture reassessment

This process allowed staff's concerns regarding patient safety to be addressed, facilitating changes toward safer care. Measures that showed improvement during the Johns Hopkins study period included safety culture scores, medication errors at transfer, length of stay, and nursing turnover.

Cambridge Health Alliance tests CUSP in a med-surg unit

The Cambridge Health Alliance is a healthcare system of 3 community hospitals and a large primary care network providing care to a diverse population. The CUSP project test unit was a 24-bed medical-surgical unit with house staff coverage of virtually all patients.

While the Hopkins CUSP article documented a process to address safety concerns in intensive care settings, this ALP was designed to test the feasibility of setting up a CUSP-like program on a med-surg unit, with a lower intensity of care.

CONTINUED ON PAGE 4

David Baron, MD, is co-chair of the patient safety committee at Cambridge Health Alliance in Cambridge, Mass. He is an instructor in medicine at Harvard Medical School and a primary care internist in practice at Cambridge Hospital Primary Care Center. Contact him at dbaron@challiance.org.

Reference

1 *Pronovost P, Weast B, Rosenstein B. Implementing and validating a comprehensive unit-based safety program.* J Patient Saf. 2005;1:33-40.

EPITOME Program Educates Patients

CONTINUED FROM PAGE 2

responses on a Likert Scale (1-5) have improved from "Not sure" (average 2.8) to "Very often" (average 4.7) over a 9-month period.

- **An improved medication regimen in high-risk patients.** Pharmacist medication therapy management has improved the quality of patients' medication regimens. Over a recent 4-month period, pharmacists' review of the medication regimens of approximately 500 EPITOME patients resulted in more than 100 medication changes. Examples of EPITOME interventions included reconciling the medication regimen, calculating the proper dose for a patient's renal function and reducing duplicate medications.

Lessons learned through EPITOME

- A multidisciplinary, multifaceted approach to patient education reinforces safe medication practices throughout a patient's hospitalization.
- Establishing a physician champion for the program is vital to its success.
- Making education part of the work processes (eg, during medication administration or drug dispensing) promotes its sustainability.
- Hospital executives' support is critical in obtaining valued resources for programs.
- Data measurements of EPITOME's success reflect the importance of medication education as a part of the hospital's safety program. NPSF

Creating a Culture of Safety In An Inpatient Unit

CONTINUED FROM PAGE 3

Staff educational conferences address patient safety issues

The ALP was led by the unit's nursing staff leadership and the Fellow, a physician. Safety culture surveys were conducted at the project's outset and at the end of the year.

The safety education component included case reviews where key PSLF patient safety concepts were introduced during 3 1-hour educational conferences to house staff and unit nursing leadership. Concepts included recognizing and mitigating risk, flattening hierarchies, access of front-line staff to leadership, teamwork, and improving clarity of communication.

> "[A]dverse drug events dropped from 5 per thousand to 1 per thousand on the study unit, compared to a drop from 5 per thousand to 4 per thousand in the rest of the institution."

PSLF Fellows were encouraged to act as catalysts to facilitate change. With this in mind, the Fellow made regular, informal, 10-15 minute visits to the unit to ask nurses and house staff, "What are you most concerned about lately?" In this way, the Fellow "adopted" the unit, often facilitating the staff to find immediate solutions or bringing significant problems to the attention of an institutional executive. Also, executives were twice brought to the unit for executive rounds to support the work.

Project significantly reduces adverse drug events

Results were summarized and reported regularly to the institutional Patient Safety Committee, revealing a mixed picture for this pilot project. While pre- and post-safety-culture surveys on the study and control units showed no difference, adverse drug events initially dropped from 5 per thousand to 1 per thousand on the study unit, compared to a drop from 5 per thousand to 4 per thousand in the rest of the institution. These results did not appear to be sustained when the project tapered off during summer 2006. Nursing turnover remained low.

Project builds team's troubleshooting skills

The PSLF also taught Fellows to recognize useful but unexpected results. This was illustrated by the way the unit handled change during the year brought on by important, institution-wide safety projects. Medication reconciliation had proven quite a challenge to implement throughout the institution. It was hoped that combining the process with a new order form might help this critical project get traction.

The unit became one of the pilot sites and rapidly troubleshot the process, which was then successfully implemented throughout the institution by the end of the year. The unit was also instrumental in improving the reliability of several new order sets designed to ensure proven therapies ("core measures") for common admission diagnoses.

Team focuses on better communication

The team identified opportunities to improve communication, for example, implementing "nursing safety rounds" to improve communication of safety concerns at the change of nursing shifts. The unit successfully piloted a novel communication technology involving commercial hardware and software,which improved communication among nurses throughout the unit. The 2 new processes of informal Fellow and executive rounds seemed to empower the nurses to communicate critical safety concerns they identified during the year, and strengthened channels of communication to institutional leadership.

The project group didn't always closely follow the CUSP prescription for unit-based safety change, but the Fellow had learned the importance of flexibility in improvement work so teams can learn as they improve. Interestingly, the Hopkins group has also already made adaptations to CUSP, truncating the original 8 steps to 6.

CUSP offered a common-sense structure as a starting point to deal with the rapid changes necessary in transforming care to become as safe as possible. The results of this project included improved communication, better teamwork, engagement of institutional leadership, empowerment of local leadership, exposure of risk leading to risk reduction, flattening of hierarchy, and integration of processes proven to make care safer. These are some of the fundamentals emphasized by the Fellowship, and Cambridge Health Alliance now has a clearer vision of how to get there. **NPSF**

VOL.9: ISSUE 2
2006

Practice-Based Learning and Improvement Morning Report Makes Outpatients Safer

BY GAIL Y. HENDLER, MLS, HEALTH SCIENCE LIBRARY, AND MARC L. NAPP, MD, MS, LENOX HILL HOSPITAL

One challenge that healthcare leaders must overcome to improve patient safety is to educate clinicians and support staff on the ever-present risks for error and harm. Graduate medical education students now have a new source for reliable information on patient safety: the Practice-Based Learning and Improvement (PBLI) Morning Report.

Goals of the PBLI Morning Report

- Educate residents about common ambulatory medicine topics and train them to use the appropriate electronic resources to support informed clinical decision-making; and
- Teach graduate medical students how to direct patients to reliable Internet sites for patient-oriented information.

The 2006 IOM report, *Preventing Medication Errors*, specifically advises consumers to "be aware of where to find educational material in [the] local community and at reliable Internet sites," but does not identify where or how consumers will learn to use the appropriate sites.[1]

The PBLI Morning Report pairs the medical librarian with residents so clinicians can learn to use quality electronic resources for decision-making. Doctors can take this skill back to the ambulatory setting to help their patients find the reliable information they need to make informed decisions as recommended by the IOM.

Practice-based learning and improvement (PBLI) helps residents and preceptors find evidence-based solutions to their patients' medical problems and teaches them how to locate information for their patients. PBLI enables students to more rapidly formulate treatment plans for unusual situations.

As students become more adept at PBLI, a natural leap would be to adapt it to answer other questions. If a student uses PBLI to identify optimal treatments for patients in specific circumstances with a given condition, it might not be a far stretch to expand the search to include safety concerns for that situation and how the patient interacts with the healthcare system. The real return on investment from PBLI depends on teaching the right questions to ask.

What is the medical library's role in PBLI?

Better questions yield better answers. When focused clinical questions are answered with the best evidence from systematic research, the result is safer and more effective medicine. Traditionally, health sciences librarians have worked to make health care safer by connecting clinicians to quality information to improve patient care outcomes. Whether in community hospitals, large teaching hospitals or academic health centers, medical libraries play a critical role in the hospital's patient safety and quality initiatives.

Hospital librarians select, acquire, manage, and research the knowledge-based resources needed to practice 21st century medicine. They train healthcare professionals to focus clinical questions and choose and use the appropriate resources to answer questions effectively.

Hospital library information affects patient care

In 1992, the Rochester Study assessed the outcome of hospital library services by evaluating the impact of information provided by hospital librarians on clinical decision-making. Eighty percent of the 448 participating physicians stated the information they received changed care decisions and enabled them to avoid surgery, hospital admissions, patient mortality, and hospital-acquired infections.[2]

Lenox Hill Hospital trains residents in library research

At Lenox Hill Hospital in New York City, the hospital librarian collaborates with the department of medicine to train house staff to integrate clinical decision-making with the best evidence from the scientific literature. The associate chair of general internal medicine, the internal medicine program director, and the medical librarian developed PBLI Morning Report to respond to the practice-based learning and improvement and patient care competencies revised as part of the Outcomes Project by the Accreditation Council of Graduate Medical Education (ACGME) in 1999.[3]

PBLI also supports the hospital's patient safety and quality initiatives by teaching the PG Y 3 (post-graduate year 3) internal medicine residents 2 critical skills: how to put evidence into practice and how to direct patients to the best source of lay information to aid in decision-making.

As prescribed by the ACGME Outcomes Project, the practice-based learning and improvement competency teaches residents to:

- Use computer resources to support learning and patient care;
- Locate and apply scientific evidence to patient care;
- Critically appraise the scientific literature; and
- Analyze patient practice performance.

CONTINUED ON PAGE 6

Gail Y. Hendler, MLS, is director of library services for the Health Sciences Library at Manhattan's Lenox Hill Hospital. Marc L. Napp, MD, MS, is vice president, medical affairs at Lenox Hill Hospital. Contact Gail Hendler at ghendler@lenoxhill.net.

References

1 *Committee on Identifying and Preventing Medication Errors. Aspden P, Wolcott J, Bootman JL, Cronenwett LR, Eds.* Preventing Medication Errors: Quality Chasm Series. *Washington, DC: National Academies Press 2006:7. Available at: http://newton.nap.edu/catalog/11623.html#toc. Accessed August 23, 2006.*

2 *Marshall JG. The impact of the hospital library on clinical decision making: the Rochester study.* Bull Med Libr Assoc *1992;80:169-178.*

3 *Accreditation Council of Graduate Medical Education.* Outcome Project. *2006. Available at: http://www.acgme.org/outcome/instrmod/instrMod_Intro_I.asp. Accessed August 22, 2006.*

Practice-Based Learning and Improvement Morning Report Makes Outpatients Safer

CONTINUED FROM PAGE 5

Instructing residents to locate, utilize, and appraise the systematic research for medical decision-making also requires residents to learn to communicate their findings to patients in everyday language. An ACGME Patient Care competency stipulates that residents learn to use information technology to support patient care decisions and education.[3]

The medical librarian teaches the residents to find answers to related patient-oriented questions from quality-filtered information resources on the Internet. In this way, residents learn to direct their patients to authoritative sources of healthcare information, to support patient decision-making, and to facilitate communication and understanding.

Collaborating for learning

Teaching residents to improve decision-making with quality information requires a concerted effort by residents, teaching faculty, and the medical librarian. Background preparation for the Morning Report is ongoing and includes the librarian, faculty, and residents. The medical librarian teaches a series of workshops for all internal medicine residents and faculty as part of the monthly ambulatory rotation lecture schedule. Here, students learn how to focus clinical questions.

All PG Y 3 internal medical residents participate in PBLI Morning Report during the ambulatory rotation month. Each month, the 2–3 residents assigned to present at Morning Report are required to:

- Work with the medical librarian to focus an outpatient, case-based clinical question into a "usable query" and research the evidence-based answer for patient care;
- Learn from the medical librarian to locate, utilize, and direct patients to the appropriate source of patient-level information; and
- Prepare a fact sheet and pre- and post-test for the Morning Report.

During the Morning Report, the residents present the case and oversee the pre- and post-test questionnaire distributed to house staff and physician assistant students to evaluate learning. The medical librarian demonstrates information resource selection and search technique, and distributes a search handout with a step-by-step review of how to locate the information needed to answer the clinical and patient question. The faculty helps synthesize the resident/librarian presentations at Morning Report, assists the group in understanding the evidence classifications, provides a clinical context, and reinforces the major points of the case and research.

Examples of sources of reliable, web-based patient information presented in the Morning Report

Medlineplus—National Library of Medicine: http://medlineplus.gov

New York Online Access to Health (NOAH)—English and Spanish: http://www.noah-health.org

Mayo Clinic: http://www.mayoclinic.com

DailyMed—National Library of Medicine: http://dailymed.nlm.nih.gov

KidsHealth—The Nemours Foundation: http://www.kidshealth.org

Familydoctor.org—The American Academy of Family Physicians http://www.familydoctor.org

Lab Tests Online: http://www.labtestsonline.org/

Centers for Disease Control: http://www.cdc.gov/

Preliminary results measuring the effectiveness of PBLI Morning Report were positive. In-house evaluation data on 4 Morning Reports with a total of 71 learners showed a 16%-28% pre-test/post-test improvement in learning. Future evaluation may survey residents to learn whether the information accessed changed practice and prevented medical errors.

PBLI has successfully facilitated access to the medical and patient literature. The program encourages residents to develop a lifelong practice of locating and applying scientific evidence to patient care. PBLI teaches residents to question current practice patterns by training them to search for the most current guidelines to improve patient care outcomes and to locate quality, patient-oriented information.

The 2006 IOM report calls for improved provider-patient communication and an informed consumer to prevent medication errors.[1] The PBLI Morning Report is one way in which hospital libraries can contribute to patient safety by giving residents the training and skills to access the best research findings for care decisions and for physicians and their patients. NPSF

Deadline Is Jan. 30, 2007

Apply Now for the 2007-2008 Patient Safety Leadership Fellowship

Through a powerful combination of leading-edge faculty, specially designed curricula and field-based projects, the Patient Safety Leadership Fellowship offers an intensive educational opportunity for seasoned practitioners. Patient Safety Fellows explore in depth the business, cultural, and leadership implications and opportunities for embracing cultures of safety.

Fellows share perspectives, expand skill sets, and gain knowledge that prepares them for making quality improvement a reality through intense learning retreats, discussion and reflection with national experts and a community of peers. The challenges posed during the fellowship can change the way Fellows think about their leadership role and their potential to make change happen.

NPSF and the Health Research and Educational Trust, in partnership with Health Forum, the American Organization of Nurse Executives, the American Society for Healthcare Risk Management, the Society of Hospital Medicine (SHM), and the American Hospital Association, are now accepting applications for the Patient Safety Leadership Fellowship.

The application deadline is Jan. 30, 2007. For details, visit visit *www.hretfellowships.org*, or contact Dawn Haglund at 312-422-2625. **NPSF**

NPSF Welcomes 2006-2007 Leadership Fellows

Joan C. Amberik
Director, Pharmacy Services
Lakewood Hospital

Maureen A. Archambault
Vice President, Healthcare Risk Mgmt.
Marsh USA

Terri Bechtold Camp
Associate Administrator
Jefferson Healthcare

Joan Ching
Patient Safety Officer
Univ. of Washington Medical Ctr.

Joseph Conigliaro, MD
Assoc. Chief Medical Officer
Univ. of Kentucky Chandler Medical Ctr.

Marilyn L. Cox
Senior VP, Nursing and Patient Care
Clarian Health Partners
Riley Hospital for Children

Kathryn Davies
Nursing Specialist
Clarian Health Partners

Shelly DeVore
Assistant Administrator
Progress West Health Care

Kerry Anne Eaton
Vice President, Patient Outcomes
St. Vincent's Medical Center

Allison E. Fissel
Director, Programs and
Strategic Development
National Patient Safety Foundation

Donna Frye
Clinical Director
Perinatal Safety Initiative, HCA

Jennifer Fulmer Groves
Assistant Director for Medication Safety
Cleveland Clinic

Rebecca Kanjirathinkal
Risk Control Consultant
CNA HealthPro

Raed Khoury
Director, Patient Safety
John Muir Health

Sherrie Kopp
Patient Safety Officer
Genesis Medical Center

James S. Liljestrand, MD
Performance Improvement Advisor
MassPRO

Juli Maxworthy
Director, Quality/Clinical Effectiveness
John Muir Health

Gary Allan Merica
Patient Safety Officer
York Hospital—Wellspan Health

Mark Alan Monroe
Nursing Project Coordinator
The Permanente Medical Group

Kenneth L. Naylor, MD
Genesis Medical Center

Alberta Pedroja, PhD
Senior Director/Assistant Vice President
Tri-City Medical Center

Opal Reinbold
Chief Quality Officer
Palomar Pomerado Health

Christine Salaterski
Nurse Manager
The Valley Hospital

Julia Skarbinski
Nurse Coordinator, Risk Management
Univ. Hospitals of Cleveland

Janet C. Smith
Dir., Performance Improvement
Sisters of Charity Health System

Kari S. Strang
Director, Quality Management
Huntington Hospital

Diane Wehby
Clinical Service Director
Saint Mary's Health Care

Susan J. Wendell
Nursing Safety and Quality Manager
Abington Memorial Hospital

Focus on Patient Safety (ISSN 1097-0673) is the official quarterly publication of the not-for-profit National Patient Safety Foundation (NPSF), in North Adams, Mass. The opinions expressed in this publication are not necessarily those of the National Patient Safety Foundation or of its Board of Directors.

To submit articles or publications for possible review in Focus, please direct materials to: Lorri Zipperer, Managing Editor, Focus on Patient Safety, National Patient Safety Foundation, 132 MASS MoCA Way, North Adams, MA 01247. Materials, inquiries, and subscription requests for the publication will be accepted electronically at info@npsf.org or via fax at (413) 663-8905.

Editorial Board

Paul A. Gluck, MD
Chair, NPSF Board of Directors
Associate Clinical Professor
University of Miami
School of Medicine

Diane C. Pinakiewicz, MBA
NPSF President

Allison Fissel, MA
NPSF Director,
Programs and Strategic Development

Managing Editor:
Lorri Zipperer
Zipperer Project Management
Evanston, Ill

Editor:
Susan Raef
WordPower Communications, Inc.
Chicago

© 2006 National Patient Safety Foundation. Permission to reprint portions of this publication for educational and not-for-profit purposes is granted subject to accompaniment by appropriate credit to the NPSF and Focus on Patient Safety. Commercial reproduction requires pre-approval. Some fees may apply.

Plan to Attend "Learning from the Past ... Creating the Future," May 3-4, 2007, in Washington, DC

Join your colleagues from across the country and around the world in Washington, DC, on May 3-4, 2007 for the premier patient safety meeting, the Annual NPSF Patient Safety Congress.

"Learning from the Past ... Creating the Future" is the theme for the 2007 Congress, which will include sessions that build on our collective history, bringing us the leading thought in patient safety today. Experience our celebrated wide-ranging plenaries and concentrate on your specific areas of interest through the focused track breakout sessions.

Attend 2 Pre-Congress Programs

On May 2, 2007, NPSF will present 2 pre-Congress programs:

- Leadership Day is designed to focus on leadership skills and strategies.
- Patient Safety 101 is a new program designed for professionals seeking a solid foundation in patient safety basics.

For more information, visit: *www.npsf.org/congress/index.html.*

Introducing the Physician Practice Patient Safety Assessment™

The Physician Practice Patient Safety Assessment™ (PPPSA) is an online assessment tool to help your practice improve patient safety.

- Compare your practice data to aggregate national data.
- Measure your practice's progress over time.
- Minimize liability exposure.
- Enable better care and service to your patients.

For details, visit *www.PhysicianSafetyTool.org*. You can download a free PDF of the tool or access the full site, complete your assessment, and receive comparison reports and the improvement workbook for $200 per practice.

The PPPSA was developed by the Health Research and Educational Trust, the Institute for Safe Medication Practices and the Medical Group Management Association Center for Research. NPSF

National Patient Safety Foundation®
132 MASS MoCA Way
North Adams, MA 01247