

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION

Patient Safety Remains Critical to Care Quality In IOM's New Report

BY JOANNE E. TURNBULL, PhD

On March 1, the Institute of Medicine (IOM) of the National Academy of Sciences issued the final report from its Quality of Health Care in America Project (QHCA). QHCA was initiated in June 1998 to provide leadership, strategic direction and analytic tools for significant improvement in health care quality over the next decade.

The new report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, is a follow-up to the Project's first report, *To Err Is Human: Building a Safer Health System*, which focused entirely on the urgent need to make our health care systems safer for patients. Although this final report is significantly broader in scope than the first, it continues to position safety as a critical component of care quality.

Crossing the Quality Chasm decrees that the nation's health care industry has foundered in its ability to consistently provide safe, high-quality care to all Americans, and calls for a complete redesign of the health care system as we know it. The "chasm" refers to the fact that with continued technological advancement and an ever-expanding base of scientific and medical knowledge (the "evidence base"), the industry has the potential to deliver dramatically higher quality care.

As a starting point, the report recommends that all involved in health care delivery commit to the pursuit of six essential "aims": that health care should be safe, effective, patient-centered, timely, efficient, and equitable. Demonstrating measurable gains in these six areas, IOM explains, would improve not only the patient experience but also that of clinicians and others on the delivery side.

In its discussion of the aim of safety, the report discusses several problems including variance in care standards at different times or situations, information getting lost in transitions or inadequate "handoffs," and patients not being well informed. In step with the NPSF's recently issued Statement of Principle encouraging disclosure, the report declares that when complications occur, caregivers are ethically obligated to fully inform the patient of the event and its causes, to assist recovery and take appropriate action to prevent recurrences.

'The new report decrees that the nation's health care industry has foundered in its ability to consistently provide safe, high-quality care to all Americans, and calls for a complete redesign of the health care system as we know it.'

Secondly, the report lays out 10 rules to guide the improvement and re-design care to meet the six aims. These rules were designed with three principles in mind: that care should be evidence-based, patient-centered and systems-based.

Although the link between each rule and how it might contribute to improved patient safety is plain, one rule specifically calls for "safety as a system property." This dovetails with the recommendations in the previous IOM report and with NPSF's position that safe systems be designed around human factors and that the culture of individual blame and fear of punishment give way to one of system accountability and seeking opportunities to improve when errors do occur.

As a first step to more widespread improvement, the report calls for the industry to sharpen its focus on developing evidence-based approaches to caring for the most widespread chronic conditions, a limited number of which account for the majority of illness, disability and death in the United States. The report recommends identifying 15 to 25 priority conditions—such as cancer, diabetes, hypertension and asthma—around which to focus the development of an information infrastructure that can better support synthesis and

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You can read Crossing the Quality Chasm: A New Health System for the 21st Century free online at <http://www.nap.edu/catalog/10027.html?send>. Hard copies are available from the National Academy Press by calling (202) 334-3313 or (800) 624-6242, for \$50.00 (pre-paid) plus shipping charges of \$4.50 for the first copy and \$.95 for each additional copy.

application of best practices based on a vast evidence base, and can also perform outcomes measurement.

Recognizing that even a focused effort around a small number of chronic conditions will require sizable resources, the report recommends that Congress establish a \$1 billion Quality Innovation Fund. To help initiate health care's transition to a new and better system, the fund would support projects over the next three to five years that produce measurable quality improvements in the care related to these priority conditions.

Re-design of care processes around the priority conditions emphasizes consistent application of the evidence base, rather than primary reliance on clinical training and individual professional opinion. This cannot be accomplished without a major, multi-disciplinary effort to making the evidence

base more readily accessible to clinicians and patients. Key to this effort is the role of information technology, the advancements of which, the report points out, have been woefully underutilized in health care. The report calls for government to work with health care stakeholders to build an information infrastructure that leads to the elimination of most handwritten clinical data by the end of the decade.

The report also addresses the need to re-examine and re-tool payment methods, as none today reward or encourage quality improvement, and some, in fact, punish it. And it calls on health care leaders to collaborate on strategies to prepare the health care workforce for the vast changes recommended.

The NPSF Board is studying the IOM report to understand the implications of its recommendations and to identify opportunities for leadership on new patient safety initiatives. [NPSF](#)

New Rules to Redesign and Improve Care

Reprinted from the IOM Report, *Crossing the Quality Chasm*

Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes in accordance with the following rules:

1. Care based on continuous healing relationships.

Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.

2. Customization based on patient needs and values.

The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.

3. The patient as the source of control.

Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision-making.

4. Shared knowledge and the free flow of information.

Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

5. Evidence-based decision-making.

Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.

6. Safety as a system property.

Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

7. The need for transparency.

The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

8. Need anticipation.

The health system should anticipate patient needs, rather than simply reacting to events.

9. Continuous decrease in waste.

The health system should not waste resources or patient time.

10. Clinician cooperation.

Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Facing the Challenges of Implementing a Disclosure Policy

From a patient's perspective, disclosure of a medical error can make all the difference in the world. "Disclosure starts the healing process immediately, instead of going to lawyers," says Ilene Corina, Director of PULSE New York, a survivor support group for people who have experienced errors.

The NPSF is dedicated to helping health care organizations adopt a more open stance on disclosing medical errors. In February, the Foundation sent its Statement of Principle (see box at right) to hospital CEOs and board chairs across the country. Its purpose: to improve communication with patients and their families about health care injury.

"We urge you to thoughtfully consider this principle and to adopt it within your organization as quickly as possible," say NPSF Board Chair Henri R. Manasse Jr., PhD, ScD and Executive Director Joanne E. Turnbull, PhD. "By adopting this principle, you will be leading a significant effort to help create a culture that discourages blame, advocates accountability, evolves around trust and respect, and helps foster learning and prevention."

With the letter and Statement of Principle, NPSF sent a fax-back survey to learn whether hospitals now have a disclosure policy or whether they plan to implement one. Several hospital leaders have shared their disclosure policies with us; we'll have more information on them in upcoming issues.

Survey responses are still coming in, but some of the most genuine replies identify the obstacles that health care leaders anticipate in implementing a disclosure policy.

Some of the respondents cited obstacles based on fear:

- Physicians' trepidation
- Board and administration anxiety
- Perceived increased risk in liability
- Fear of public exposure
- Admitting to wrongdoing

Other survey respondents expressed concern about gaining approval on a disclosure policy:

- Obtaining governing board approval
- Gaining consensus among administration and medical staff
- Getting medical staff buy-in

NPSF Statement of Principle

When a health care injury occurs, the patient and the family or representative are entitled to a prompt explanation of how the injury occurred and its short- and long-term effects.

When an error contributed to the injury, the patient and the family or representative should receive a truthful and compassionate explanation about the error and the remedies available to the patient. They should be informed that the factors involved in the injury will be investigated so that steps can be taken to reduce the likelihood of similar injury to other patients.

Health care professionals and institutions that accept this responsibility are acknowledging their ethical obligation to be forthcoming about health care injuries and errors.

The National Patient Safety Foundation urges all health care professionals and institutions to embrace the principle of dealing honestly with patients.

Still others saw operational barriers in implementing a disclosure policy at their hospitals:

- Training staff in a changing culture
- Inability to deal with confrontation
- Defining what a mistake is
- Determining what level of error to disclose, and the level of detail
- Managing information with a disclosure policy
- Deciding who will approach a patient's family and how
- Implementing the policy consistently
- Addressing the timeliness of disclosure
- Setting up effective processes

One respondent shared with us, "We have had a disclosure policy unofficially—but we're not sure we want to make it official." Finally, one person said the greatest barrier to implementing a disclosure policy was "just getting it done!"

We thank everyone who responded to the survey. If you haven't yet returned your survey, please fax it to NPSF headquarters at (312) 464-4154. [NPSF](#)

How to Communicate More Effectively with Journalists

BY BOB ARONSON

This article is not a defense of journalists. It is to help you understand the roles of the journalist and the spokesperson in communicating more effectively. If anything, this article is aimed at health professionals who, for whatever reason, place too much responsibility on the reporter and very little on their own communication efforts.

"I talk, therefore I communicate" is not a truism. An overwhelming number of stories become negative because the person being interviewed is not prepared to communicate the story.

There is no conspiracy. Reporters are people with a job to do, just like you. They are fiercely independent and resist management—even from their own editors. Every reporter or columnist, no matter how well known, is seeking the next great story, great job, the Pulitzer Prize or a huge book deal. Writers know they have to compete with every other journalist—and competition is intense.

So it is unreasonable to conclude, "The media are out to get me." Usually it isn't even true that one reporter is out to get you. The news media may all get involved in a good story, but to think there is some kind of James Bond "Spectre" conspiracy in all this competition severely stretches reason.

I have never met a journalist who would admit to being biased or unfair. And if you approach the issue using their logic, it is difficult to disagree—or is that unfair, unobjective and biased? One old journalistic shibboleth is, "Comfort the afflicted and afflict the comfortable." Fairness is in the eye of the beholder. When your career, business or profession has been attacked, it is difficult to believe media claims of fairness.

We all expect fairness, but by whose definition? The news media have their own definition: find all sides of the story and balance the report. They have no idea what your definition of fairness is and they don't care. Health care professionals and others assume that their own definition should be the standard. But the only definition of fairness that counts is the one employed by journalists.

You can't change the way journalists think. Don't even try. We can, however, find ways to work with their definitions and use them to our advantage.

One more "fairness" point: don't play the "off-the-record" game. It's dangerous. You may hear advice telling you when you can and can't go off the record, but unless you are a seasoned media relations professional, you could get burned very badly.

The greatest danger in working with the news media is the unrealistic expectation that they will automatically believe you are the good guy. Journalists don't automatically believe anything. They operate with suspicion and skepticism. What would have happened had they automatically believed President Nixon on Watergate or President Clinton on Monica?

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People depend too much on the media to get the story right and not enough on what they need to communicate to reporters and how they will do it. As Pogo once said, "We have met the enemy and he is us."

Are there journalists who are purposely unfair? Yes. Find a profession that doesn't have its share of unethical practitioners. Most journalists, however, take their profession very seriously. Everyone must recognize that journalists view their profession much differently than everyone else.

Let's look at the definition of news. My experience as a journalist and from 20 years of working with them is that generally, the recipe for news is that the situation must:

- Be timely
- Be unusual
- Affect a lot of people in a very significant way

Bob Aronson is founder and CEO of The Aronson Partnership, Inc., based in St. Paul, Minnesota.

News is about people. It is not about medicine, its practice, physicians or procedures. News is about how all of those things affect people. All too often, I see spokespersons for major organizations get into long, involved conversations with journalists—but nowhere is there a mention or even an allusion to people.

Print reporters are generally better informed than broadcast journalists, but broadcast has some very good people. An example is National Public Radio; their reporters and columnists are fairly knowledgeable and conduct longer and more probing interviews than do many newspapers. Many network correspondents are also highly respected journalists.

Almost on a daily basis I hear these complaints expressed about journalists:

1. "They don't do their homework."
2. "They ask stupid questions."

First, let's address the issue of homework. What we are really saying is, "If they would listen to us and see things our way, there would be no issue here." If you know reporters don't do their homework, why don't you do *your* homework?

Isn't it arrogant to expect someone on the outside with no knowledge of your profession or business to accurately communicate your story? Communicating your message to others is *your* responsibility. And you cannot successfully use internal language on external audiences. Take time to prepare for media interviews. As Winston Churchill said, "I would gladly speak for an hour but I must decline your invitation to speak for 20 minutes. I don't have enough time to prepare."

Second, let's look at the issue of stupid questions. Why are stupid questions bad? Do you want reporters to have

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done enough homework to be able to ask all the questions you want to avoid? Stupid or uninformed questions are an opportunity for you to dignify the question and make a transition to what you really want to communicate. Thank God for stupid questions. Dignify them and hope for more.

One of the biggest hurdles to overcome is attitude. Take a look at yourself. Do you hope you will survive the interview or do you view the media interview as an opportunity? If your approach is the former, then it's time to make some serious changes. Remember, you should not participate in news media interviews just to answer questions, but to accomplish a business objective.

Finally, answer the journalist's questions, however briefly. Otherwise you'll be perceived as evasive and the reporter will believe you have something to hide. An answer doesn't have to be a dissertation, only a reply that can be used as a transition to your message.

The key to success is knowing what you want to communicate and how. If you concentrate on your mission and your communication objectives, it doesn't really make any difference who is asking the questions. [NPSF](#)

Patient Safety— A Personal and Professional Perspective

BY CAROL LEY, MD

Patient safety is important to me as a health care provider, a corporate physician with responsibility to employees and our health care business units—and most importantly as a mother. To illustrate my personal commitment to patient safety, I'd like to tell you my daughter Jacquelyn's story.

Last Labor Day weekend, my seven-year-old daughter Jacquelyn was standing on a partially deflated soccer ball when she fell and shattered her elbow. My husband is an orthopaedic surgeon and I'm an occupational physician. We immediately sprang into action.

I packed an overnight bag and prepared to stay the entire time at the hospital with Jacquelyn. We brought her to what we consider the premier hospital for injuries of this type in the Midwest—driving 90 miles and bypassing five other hospitals. The surgeon on call was a spine surgeon, but my husband Jeff got the best pediatric orthopaedist in the state on his car phone. The surgeon was on the way up to his cabin, but agreed to come back and do the surgery for Jacquelyn.

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The surgery was very complicated; Jacquelyn required three pins and three hours of surgery on her elbow. Nonetheless, she came out of surgery with an excellent prognosis. For pain control, Jacquelyn was given a PCA (patient-controlled analgesia) pump; this gave her a continuous dose of morphine and allowed her to give herself additional doses as she needed.

The nurses were familiar with the PCA pump, but mentioned how difficult it was to program. The holiday weekend also caused some nursing rotations. Because of the PCA pump, Jacquelyn had many monitors with alarms—a respiratory monitor, a cardiac monitor, and an oximeter to monitor the oxygen in her blood. The alarms went off continuously. Current alarm technology does not allow a difference between a disconnected lead and a patient in distress.

We rapidly became frustrated with the alarms and did not pay much attention when they went off. The nurses echoed our frustration. My 14-year-old daughter commented that she knew how to program our telephone so it rang differently when the call was for her. Surely, she mused, better technology must be available for alarms. I vigilantly watched over Jacquelyn for two days and nights, questioning each nurse and orderly. By the third night, Jacquelyn and I were exhausted, having gotten no sleep. Thankfully her pain was under better control.

The nurses suggested turning off the PCA pump, but they left it in place in case her pain broke through the oral medications. They gave her oral codeine and some Benadryl for restlessness. The nurses then disconnected most of the monitors because Jacquelyn did not have the PCA pump activated. Because I was in the room and Jacquelyn was doing well, the nurses said they would check her vital signs in the morning and would allow us to sleep. We were really looking forward to the uninterrupted sleep time.

Jacquelyn and I both fell asleep around 2:00 a.m. At about 5:30 a.m., I awoke to deadly quiet in the room. I leaned over and Jacquelyn was barely breathing. I called her name—"Jacquelyn! Jacquelyn!" There was no response.

I jumped up and screamed for the nurses and began efforts to revive Jacquelyn. In a few minutes, she was breathing normally. The nurses discovered that instead of turning off the PCA pump, they had mistakenly programmed it to deliver several times the recommended dosage.

Jacquelyn is now a happy, healthy eight-year-old with little recollection of her hospital stay, but I still get chills every time I tell her story. I've found her experience useful in illustrating two important points.

Number one, the health care system is miraculous. Jacquelyn had access to amazing technology and incredibly dedicated nurses and doctors. Her fracture was so severe that normal arm function was in question. Thanks to all the efforts made on her behalf, her arm is growing and functioning normally. She can still punch her younger brother.

'It's easy to try to pin the problem on one thing—one cause—and seek blame. But a system failed. A system didn't deliver an expected outcome.'

But secondly, our health care system needs fundamental change. We need to focus on *system change* to improve patient safety. In a traditional health care setting, think about how this error might have been handled. The nurse might have been fired, the PCA pump might have been used only on adults, alarms might be required on all patients, and lawsuits might result.

None of these approaches can assure that what happened to Jacquelyn never happens to another child. In this case, a whole host of factors had to be in play for a medical error to occur—unfamiliar nurses, a difficult-to-program pump, alarms that sounded continuously, and a mother who is a doctor monitoring the entire hospital stay.

It's easy to try to pin the problem on one thing—one cause—and seek blame. But a *system* failed. A system didn't deliver an expected outcome.

We've reached a new milestone in patient safety. The previous hard work has been recognized and the issue has been raised to a level of national importance. Now we're at a turning point in a process where awareness of the problem has been elevated among a much broader group of stakeholders. Passion has been stirred, and action is now a requirement. In the words of Winston Churchill,

"This is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning."

Someday, each one of us will be a patient and will deserve the safest care possible. Patients are playing a much more active role in their health and well-being, and are beginning to ask questions about their care. They are looking for evidence of safe practices, and want to know what they can do to help avoid errors. Patients who have experienced medical errors are coming forward to take action—to ensure that what happened to them will never happen to anyone else. As leaders, we need to step up to meet that challenge. It's important that we continue to make patient safety a priority, and make the issue visible in our organizations by being personally involved.

As leaders, we can:

- Evolve our culture;
- Create a supportive and learning environment;
- Educate our colleagues, our patients and ourselves; and
- Perhaps most importantly, *communicate*.

Collaborative, open communication is the first step in achieving our goal: safe health care for all patients. And we can learn from the best practices of other safety-conscious industries such as aviation.

In commercial aviation, there is an industry-wide program called the Aviation Safety Reporting System (ASRS) that creates incentives for everyone to submit reports to a central database detailing "near hits" and procedures that almost went wrong. More than 30,000 reports a year are voluntarily submitted to the ASRS, because the industry has succeeded in helping everyone in the field understand their crucial role in flushing out information about emerging risks.

The ASRS analyzes the information to see if there are new patterns, new trends or just interesting "stories" that suggest a weakness in a process or a way to improve human performance in the system. The ASRS adds a new layer of *voluntary accountability* that moves beyond blame to engage its entire culture in the safety mission. It has become a powerful model for several other industries, which have adopted similar programs. [NPSF](#)

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Focus on Patient Safety (ISSN 1097-0673) is the official quarterly publication of the not-for-profit National Patient Safety Foundation (NPSF), in Chicago, IL. The NPSF represents an unprecedented initiative to improve health care safety by studying why errors in the health care system occur and implementing safeguards to prevent such failures from injuring patients. NPSF Board members represent every major segment of the health care system, as well as employers, medical ethicists, public health advocates and distinguished scientific research institutions.

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: Dawn McGinley, Managing Editor, Focus on Patient Safety, National Patient Safety Foundation, 515 N. State Street, Chicago, Illinois 60610. Materials, inquiries and subscription requests for the publication will be accepted electronically at npsf@ama-assn.org or via fax at 312-464-4154.

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Register Now for the 'Annenberg III' Conference May 16-18, 2001 in St. Paul

Enclosed is a brochure for "Let's Talk: Communicating Risk and Safety in Health Care," the third in a series of landmark conferences focused on reducing health care errors and improving patient safety. Everything you need to register for the conference is included in the brochure. Or you may visit www.mederrors.org to register online.

Exhibit Space Still Available

If you are interested in being an exhibitor at the conference, visit <http://www.mederrors.org/exhibitors.html> or call NPSF's Jay Callahan, PhD, at (312) 464-4706.

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