

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION

Are Industry-based Safety Initiatives Relevant to Medicine?

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Dispensing prescription drugs has been identified as one of the most serious components of risk to hospitalized patients. Many individuals as well as The Leapfrog Group, a private business-based organization (profiled in the Winter 2001 *Focus on Patient Safety*, available online at www.npsf.org), recommend using computer-based prescription and dispensing systems as a key element in helping reduce the risk of medication-based errors. For many hospitals and ambulatory facilities, computerized medication ordering and dispensing systems are effective and affordable, although the cost may be prohibitive for some facilities. Evidence suggests that computerization can reduce the risk of medication errors.

As effective as digital technology may be in decreasing the risk of medication errors, few would argue that the issue of inadequate quality performance in the American medical system extends more broadly and deeply than drug safety. However, there is much less agreement on the details behind this poor quality performance. The true scope of these problems may lie in the fundamental structure of the medical care delivery “machinery”—the lack of formal well-engineered and well-defined processes.

One approach to a solution is to apply the concepts of quality assurance and continuous improvement used by American businesses for the past 20 years. In its 1999 report, “To Err is Human,” The Institute of Medicine encouraged the medical industry to study the quality improvement successes in businesses such as aviation and the impact of governmental regulatory programs such as the Occupational Safety and Health Administration safety regulations and to apply those concepts to medical care. Applying industry-based quality initiatives can lead to improvements in medicine, both in the quality of care and in process improvements leading to better bottom-line profits.

Applying industry-based quality initiatives

Many are familiar with the tested and perfected industry-based quality initiatives such as Six Sigma, ACE (Achieving Competitive Excellence) and others. These initiatives have achieved quality and bottom-line improvements in businesses

such as Motorola, General Electric, and United Technologies. The fundamental concepts of these quality programs, although initially designed to improve manufacturing quality and efficiency, can be effectively applied to service-based activities such as medical care. In one case, implementing an industry-based quality program in the medical department of a large manufacturing concern initiated improvements and changes to the medical care process.

‘Effective quality improvement programs are powered by solutions that come from—not to—those charged with providing “hands on” services, not administrators, quality experts, or supervisors.’

Quality improvement programs generate their impetus from two primary elements:

1. Effective quality improvement requires a customer-based focus. Customers are broadly defined in quality programs. Our patients represent only one of the customers in the medical environment. Customers might also include others in our own departments and other departments in the organization in a designated “value stream.”
2. Effective quality improvement programs are powered by solutions that come from—not to—those charged with providing “hands on” services, not administrators, quality experts, or supervisors. Recognizing these concepts is not common in the framework of traditional hospital administration or operation, but can help to guide and focus

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activities to improve the efficiency and effectiveness of medical operations.

In addition to a clear customer-based focus, the key elements of the corporate medical department's pilot quality initiative are identifying and correcting flaws in process design and operation. Other components include creating a clean and organized and efficient work space, identifying root cause, applying mistake-proofing to resolve process problems and implementing standard operating procedures.

The key elements of the quality improvement process are:

1. Tidy-up
2. Machine quality maintenance
3. Job process mapping
4. Root-cause analysis
5. Mistake-proofing
6. Standard operating procedures
7. Market feedback analysis

Tidy-up

For work to be done consistently well, the work area must be tidy, well-organized, pleasant to the eye and ear, emotionally healthy, and conducive to completing tasks with little risk for error. In the industrial setting, this is often referred to as good housekeeping. The concept also includes activities such as labeling all drawers and other containers, constructing shadow boxes for storing parts to ensure that the only the required parts are used in a product, and encouraging periodic audits to ensure that standards are maintained.

In medical institutions, tidy-up refers to activities to clean up the work space, label all storage spaces such as drawers, cupboards and cabinets, and design and install shadow boxes where appropriate. Piles of charts are no longer acceptable. Offices and desks including nursing stations are kept in good order and locations of instruments, medications, and other supplies are clearly labeled. Responsibility for the cleanliness and order of conference rooms and common areas such as ward kitchens is assigned to individuals to assure these areas are presentable at all times.

Machine quality maintenance

Machines and instruments are critical to the business success of many manufacturers just as they are to the operation of many wards and ambulatory facilities in hospitals and health care institutions. In the industrial sector as in health care, the facilities component is usually responsible for maintaining machines and equipment. However, as budgets for indirect activities decrease, fewer resources are allocated to overhead costs such as equipment maintenance. This quality improvement program places part of the responsibility for

periodic equipment and machine monitoring in the hands of those who use the machines. In a medical office, the machines may be copiers, fax machines and computers. In the ward or ambulatory diagnostic setting, they may be ventilators, ECG machines or bronchoscopes. This quality program assigns priority levels to each machine and routine checks are made to assure timely maintenance and confirm that the machines and instruments are always in proper working order.

Job process mapping

Job process mapping—the heart of the quality improvement system—requires hands-on employees in each work area to identify the job processes they are engaged in and describe each process step in writing. This helps employees understand how they work and forms a basis for identifying flaws or barriers in the system on an ongoing basis.

The job process map is the basis for the quality improvement system. Every time a barrier occurs that interferes with performing a required work task or activity, the barrier is described, located at a particular step in the process, incorporated into an analytic framework, prioritized, analyzed and resolved. Job process mapping enables the individuals doing the work activities to better understand the inefficiencies in their work processes and improve them together.

Process mapping focuses on developing teams to identify problems and implement solutions at the local level. Tying the work of departments and units together is done by linking interacting and interrelated departments into a “value stream”—a grouping of units contributing to a common product or goal. In the hospital setting, this might include the laboratory, a specific ward, the radiology department and the emergency room—all of which depend on one another to produce a final result: an effectively and efficiently cared-for patient and family.

Processes in industry, as in medicine, may be widely variable and a single organization may be responsible for many of them. For example, in the administrative side of ward medicine, the activities involved in nursing shift changes might constitute an individual process. The medical care side is full of them, including operating room processes as well as the process beginning with the initial creation of the order to its final completion.

Root cause analysis

Once the process is documented and mapped, everyone involved is required to submit “quality care blocks”—descriptions of barriers or flaws encountered in the system. These documented system failures are collected, collated, and

prioritized weekly, with those occurring most frequently addressed first.

Next, the teams address their department's or area's quality care blocks by identifying the root cause through intensive questioning, then implementing solutions. These solutions are continuously monitored to ensure their effectiveness.

'[M]istake-proofing aims to remove the behavioral component of quality and other dysfunction from the process where the quality care block occurred.'

Mistake-proofing

Mistake-proofing is applied to the process of developing solutions to prevent quality care blocks; this helps assure that the fix is permanent and that the block will not recur. In most cases, mistake-proofing aims to remove the behavioral component of quality and other dysfunction from the process where the quality care block occurred. For example, a mistake-proof solution for an industrial process would be to redesign a component so it cannot be assembled improperly. In medicine, mistake-proofing might involve developing medication dispensing systems that would not allow the wrong medicine to be dispensed to a patient. Quality that depends totally on human behavior for its assurance is not effective quality.

Standard operating procedures

Standard operating procedures are an old, but necessary concept in achieving an efficient and effectively run system as well as for assuring quality. These procedures, called "standard work" in industry, should be simple, clearly documented, and adhered to at all times. Each process should have specified rules for its operation and identified goals and outcomes. Standard operating procedures are needed for processes to be replicable, efficiently run, and consistent.

Customer feedback analysis

The driving focus of any quality system is to design and develop processes and organizations that meet consumers' needs. Industry and medicine must be customer-driven and customer-focused. Identifying customers' needs and concerns depends on developing and frequently implementing

effective devices to measure their satisfaction. Two key questions are: 1) Who or what is the customer? and 2) What outcomes should we measure?

The customer should be broadly defined. Certainly our patients are important customers. Not meeting the needs of our patients may lead to poor care, poor patient outcomes, and ultimately to litigation or worse, patient death. But our patients' families are also our customers, as are other medical care providers, other health care institutions and others in our own institution. The customers of a hospital radiology department, for example, may be the separate wards, the transportation employees and/or department, the patients, the private physicians using the department's services and the hospital-based physicians. All are important and each sees the functions of the radiology department from a different perspective. The radiology department will need to develop assessment tools to measure the feedback from each of these customers to continue improving its level of service and efficiency, and its quality of patient care.

Implementing the quality system

The medical department of a large factory put this system into place as part of a factory-wide industry-based quality system. This department is a moderately-sized ambulatory facility providing walk-in and scheduled medical care services ranging from emergency care to OSHA-required medical surveillance. The facility handles approximately 40 medical visits per day.

Implementing the quality system required approximately four hours per week for the first eight weeks and two hours per week thereafter. The activity began with process mapping of the basic injury care activity. By evaluating the quality care blocks intrinsic to that system, the quality effort improved efficiency and performance.

During an eight-week introductory phase and a subsequent five-month operational phase, the medical department identified errors and barriers to quality care and improved its efficiency of patient care by 22%. The department saved almost \$30,000 annually in nursing salaries alone as a result of this improved productivity.

The concepts of local control, responsibility and accountability, fundamental focus on the customer, and the importance of removing the behavioral component from applying quality concepts ring true in medicine as well as in industry. These programs produce substantial gains in productivity and efficiency, both as a result of improved work processes and improved employee morale and team functioning. [NPSF](#)

To Improve Patient Safety, You Have to Change the Culture

BY JULIANNE MORATH

"Changing the culture of patient safety" will be the theme for next year's Annenberg IV conference, to be held in Indianapolis on April 22-24, 2002. NPSF Board Member Julianne Morath, COO and vice president of health care delivery at Children's Hospitals and Clinics in Minneapolis-St. Paul, has been instrumental in creating a more effective patient safety culture in her organization.

At Children's Hospitals and Clinics, we started focusing specifically on patient safety in the summer of 1999—several months before the release of the Institute of Medicine's landmark report, "To Err is Human." This initiative was led from the top in several key ways:

1. Working with key physician leaders, clinical staff, attitude leaders and the professional staff on the topic of patient safety and Children's experience.
2. Actively engaging the CEO and board in discussions about patient safety as a priority.
3. Integrating patient safety into the strategic plan—endorsed as serious and a priority by the board—and requiring staff to monitor and report progress on an ongoing basis.

Fulfilling promises to the community

Children's strategic plan is built around promises to the community. The first promise—the basis of our safety strategic plank—is that we will do no harm. The second promise is that we'll be there when you need us—our strategic plank around access. The third is that we provide affordable care and will not turn a child in our community away based on ability to pay—our financial strategic plank.

And lastly, we will strive to delight children and families with the experience of care; we will provide compassionate, culturally competent and sensitive care, and families and children will be involved in decision-making and participating in care to the extent they are able and willing to do so.

Developing a patient safety agenda

Next, Children's developed a patient safety agenda with three major areas of focus:

- Developing the culture;
- Building the infrastructure; and
- Implementing a zero-defect medication administration system to learn about and apply patient safety.

Because we believe language shapes culture, we developed a very specific vocabulary to talk about patient safety. (See chart below.) We used language based on the science of safety and lessons learned from other industries to begin to shape how we look *not* at accounting for errors, but understanding the stories of failures, accidents, latent conditions and recovery—moving from blame to accountability and learning.

Language Shapes Culture

Use	Do not use
Accident or failure	Error
Multicausal	Root cause
Learning	Judgment
System	Isolated event
Accountability	Blame
Examination or study	Investigation
Hierarchy	Bureaucracy

The question is

What happened? vs. Whose fault is it?

Developing a safer culture

Children's developed a patient safety steering committee to oversee safety strategy and monitor the organization's effectiveness in executing the safety agenda. This group created a learning lab where they gather and discuss articles, research and information on patient safety issues.

All Children's employees and professional staff are encouraged to attend quarterly cross-disciplinary patient safety mini-courses featuring nationally known speakers. Members of the patient safety steering committee conduct monthly dialogs with employees to involve them in conversations about safety issues. The communications staff helps carry the safety message; all publications have patient safety as a steady drumbeat.

Patient safety is a part of orientation and ongoing competencies in training and education. Children's has built patient safety criteria into job descriptions and management incentives. And senior management makes regularly scheduled patient safety rounds to ask people about what they're doing to create safety, what the barriers are, what they predict will be the next medical accident, and what we can do to prevent it. Children's family advisory council has been

very active in designing materials for parents and families of patients, letting them know what they can do to help create safety when their child is in our care—what to ask about, checking name bands, face-to-face identification, etc.

Taking the pulse of patient safety at Children's

To get things started, we decided to really understand what people think about patient safety *here*—not what we've read from other studies. Children's commissioned 19 focus groups across departments and disciplines. We asked people what patient safety meant to them, what they've seen and experienced with medical accidents and error and what they identify as the barriers to safety. One of the big debates was whether to include focus groups with families. A significant group thought we shouldn't because it would frighten the families. But we decided to go ahead and include families because they're part of the safety system. And of course, they knew everything; they're on the scene.

We analyzed the focus group results and reported back to the organization. The results painted a portrait of how we look in patient safety. No more did we debate the epidemiologic studies by nationally known patient safety experts, or what constraints or limitations might have been in the studies. We came back to ground zero and said, "This is us. Is this OK?" And it wasn't. That gave us a great launching pad to look at patient safety.

Getting rid of blame

One of the first things Children's did was to install a blameless reporting system. We built into our key performance indicators an indicator for reporting, with a reward for increased reporting. The traditional incident reporting form was recast as a patient safety learning form. We went from check-offs and coding—codifying at the front line—to telling stories about what happened, what were the conditions and what people think could prevent the incident from happening again.

Children's trained readers to interpret these narratives and extract the failures, vulnerabilities, conditions and methods of recovery, as well as patterns in the risks identified. For example, gaps are a pattern—in communication, information, transitions and hand-offs. We provide feedback to individuals who choose to identify themselves in the reports, then take informed action to remove safety barriers

and close gaps in safety. One of our mantras is, "Fix what you can. Tell others what you fix; and if you can't fix it, find someone who can."

Making safety everyone's responsibility

Children's instituted a "stop the line" policy. Anyone in our organization—including families—can stop the action to reestablish safety if they perceive that what is taking place would put a patient at risk of harm. We tell parents, "If it looks wrong, it is wrong," and we are obligated to stop. So if a parent sees a medication that is a different color, a fluid that looks different, we don't try to reassure them; we go back and confirm that the appropriate action is being taken. Families have intercepted near-misses. Children's tells patients and families, "Nothing about you without you." We strive to explain, educate and involve patients and families—and disclose when things go wrong.

Telling the truth when something goes wrong

When errors occur, Children's makes them transparent so that we see them, understand them and try to prevent recurrence. Whenever harm is done, we immediately disclose to the patient (if old enough to understand) and to the family the facts of what happened, what we're doing to keep them safe, and what the process will be to analyze what happened and take action so it won't recur. And we apologize.

Children's has a tool kit and training to help prepare clinicians for this role. In the case of medical accident, a member of the senior administrative team is also involved in the disclosure process.

Case in point: Medication accident

Recently, a medication accident at Children's caused temporary damage to a patient—but it could have been much more serious. The child's physician immediately disclosed to the family and we put an analytic team together to identify the sequence of events and analyze nature and conditions that created the circumstances for an accident to occur. Children's brought in outside experts to detect any latent conditions. We use a Web-based safety net to communicate and telegraph lessons learned, so the learning from one part can be shared throughout the organization.

People at the front line create safety all the time; it's their job. We try to understand and tame the complexity in health care so it doesn't overwhelm the people giving and receiving care. **NPSF**

Julianne Morath is COO and vice president of health care delivery at Children's Hospital and Clinics in Minneapolis. She is also a member of the NPSF Board.

Her broad health care background includes front-line experience as a nurse, 25 years in patient care administration, as well as quality and performance improvement research.

Reducing Medication Errors and Increasing Patient Safety Through Better Communication

BY DAVID M. BENJAMIN, PhD

David M. Benjamin, PhD, is a clinical pharmacologist and toxicologist in Chestnut Hill, Mass. He is on the adjunct faculty of Tufts Medical School and the Harvard Medical School Risk Management Program, where he teaches medication error reduction, legal medicine and risk management. Visit his Web site at www.channel1.com/users/medlaw

In one of his many articles on patient safety, Lucian Leape, MD, reminds us that "Modern health care presents the most complex safety challenge of any activity on earth," and recommends that health care professionals "... redesign our systems to make errors difficult to commit."

How do health care professionals redesign inpatient and outpatient integrated medication delivery systems to make them safer? Take the common act of a physician prescribing a medication. Integrated medication delivery refers to the entire process of medicating a patient, beginning with the physician's order or prescription and ending with administering the medication to the patient.

In its simplest form, the physician calls in the prescription directly to the pharmacist, who repeats it to the physician, labels it and dispenses it as ordered, and asks the patient if he or she has any questions. If a written prescription is made, additional factors are added to the process—increasing the likelihood of an error.

How many steps are involved from the time the physician writes the order in a hospital patient's chart until the nurse administers it? According to Dr. Leape, more than 20 steps are required to complete the entire process—with as many opportunities for error inherent in prescribing, dispensing and administering a dose of medication before it reaches the patient. Eliminating some of the steps would obviously decrease the potential for error while automatically promoting patient safety. Can hospitals totally eliminate errors and develop systems which are completely fail-safe? Probably not, but significant progress can be made.

Communication is key

One area where all health care professionals can improve is communication—both oral and written. When problems arise and health care professionals do not investigate the root cause, fail to alert their colleagues, and take no remedial action, the same errors are likely to be repeated.

A common scenario in hospital serial tragedies involves overmedication of patients on patient-controlled analgesia (PCA). In several hospitals, standing orders for the simultaneous administration of promethazine (Phenergan), diphenhydramine (Benadryl), and hydroxyzine to alleviate side effects of narcotic pain relievers have led to repeated

respiratory depressions and arrests—yet no alterations in protocols or procedures were made until hospital authorities were alerted to the inherent risks in such practices. When physicians, nurses and pharmacists were asked individually if they ever sat down with one another to discuss their respective problems, all stated "No."

What are the most common medication errors?

The five most common medication errors are: wrong drug, wrong dose, wrong route, wrong patient, and wrong time. Some would also add inappropriate monitoring to cover situations where a lack of follow-up failed to detect an adverse drug reaction. While medication errors can occur during any phase of the medication delivery process, 1995 *JAMA* studies by Bates and Leape indicated that most errors occur during physician ordering (39-49%), followed by nurse administration (26-38%), transcription error (11-12%) and pharmacy dispensing (11-14%). Virtually all of these errors occurred as a result of some sort of miscommunication, misunderstanding, or misinterpretation.

One obvious aid in decreasing many of these problems in integrated drug delivery is to computerize order entry. A 1998 *JAMA* study by Bates et al demonstrated that physician computerized order entry (PCOE) decreased serious medication errors 55% and decreased potential undetected adverse drug experiences 84%.

Which types of drugs are most likely to cause an adverse effect?

Drugs with a low therapeutic index—the ratio of the toxic dose to the therapeutic dose—are more likely to cause clinically significant problems. Examples include: digoxin, concentrated solutions of KCl and NaCl, heparin, coumarin anticoagulants, narcotics, insulin and chemotherapy. Unreadable medication orders and prescriptions can be an especially difficult problem when the name of the ordered drug resembles another drug name like Lamisil and Lamictal, or Elderpryl and enalapril. The manufacturers of Prilosec (a stomach acid inhibitor) had to change its original brand name from Losec when Losec got dispensed as Lasix (a potent diuretic).

What human factors contribute to medication errors?

Distractions are a frequent cause of errors. Telephone calls, pages, unnecessary banter—anything that breaks

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NPSF Research Grant Leads to Expanded Opportunities

NPSF received the following letter from George T. Blike, MD, and Joseph Cravero, MD, primary investigators for an NPSF-funded research study on pediatric sedation at the Dartmouth Hitchcock Medical Center.

Dear NPSF Research Committee, Board of Directors and Staff:

We would like to credit the National Patient Safety Foundation for its contribution to our research efforts to improve the safety of pediatric sedation care. We are receiving great interest in this NPSF-sponsored research, and our research is benefiting from an association with the NPSF in ways we did not anticipate.

NPSF offers investigator-driven financial support

While patient safety funds have become more available in recent years, much of that funding has *not* been investigator-driven. Our research involving human factors, ethnographic methods and simulation did not fit well with patient safety funds which had solicited proposals to meet the objectives of the sponsors. While obviously biased by having received NPSF funding, we believe the Foundation's funding review process was fair, objective, impartial and used a broad spectrum of expert reviewers covering clinical, medico-legal, human factors science and fiscal dimensions of patient safety. The insights provided by the scientific review panel improved our proposed research, specifically legal aspects we had overlooked. NPSF is enabling us to improve pediatric sedation in ways that will be applied by other practitioners and institutions.

We experienced a windfall following the NPSF grant

The international reputation of the NPSF's founders and its acting board and advisors is deservedly noteworthy. NPSF leads by example in espousing a cross-disciplinary approach to improving patient safety. After being awarded a competitive grant and accumulating some preliminary results, our research group has gained tremendous credibility. Locally, our institution identified opportunities to apply our insights to provide high-reliability pediatric sedation while maintaining safety. With the support of our academic institution and our research to date, we opened the PainFree Program at the Children's Hospital at Dartmouth this September with a sedation suite and mobile team using state-of-the-art approaches to maintaining the highest level of safety. Computer-based outcomes tracking will

hopefully validate our approach. Regionally, community support and philanthropy have allowed us to acquire a \$150,000 Pediatric Human Simulator to design, test and practice managing rare sedation events. Nationally, we have successfully competed for funds from the Agency for Healthcare Research and Quality to sponsor an Summit on Pediatric Sedation, convening 20 experts from multiple specialties to address key safety issues in pediatric sedation. An NPSF representative attended this conference and supports our efforts to make our findings available to a wide audience on the Internet. Our report on this summit is nearly complete and has benefited by the review of NPSF members. The NPSF will publish this report this winter with a foreword by David Woods.

Directing others to our activities

Another unexpected benefit to our research team is the manner in which the NPSF directs others with similar research challenges to our work and vice versa. At the recent Annenberg Conference, three attendees who have received funding from the NPSF were invited to a meeting with the Research Committee. We were delighted to find this committee genuinely interested in our experiences and ideas, and have agreed to continue to use the Annenberg Conference as an annual forum for sharing our progress in patient safety-related research. What better forum for a surgeon, emergency physician, anesthesiologist and human factors researcher to meet? As a result of referrals from the NPSF speakers bureau, we also have multiple invitations to present our findings regarding process re-engineering. The NPSF is a conduit, helping us connect with others through a Pediatric Sedation Newsletter which we started. Our circulation now is at 30,000, including NPSF's Patient Safety ListServ and the initial 20 experts—individuals from all specialties who share an interest in providing safe, effective sedation for children.

We are continuing to publish our findings and use NPSF funding to compete for additional resources. On behalf of our research team, we thank NPSF for supporting patient safety efforts worldwide.

Respectfully,

George T. Blike, MD
Joseph P. Cravero, MD

George T. Blike, MD, is Assistant Professor of Anesthesiology—Obstetrics and Gynecology in the Department of Anesthesiology at Dartmouth Hitchcock Medical Center (DHMC) in Lebanon, NH.

Joseph P. Cravero, MD, is Staff Pediatrician, Pediatric Intensive Care Unit, at DHMC. He is also Director of the Children's Hospital at Dartmouth PainFree Children's Hospital Initiative.

Their research team received an NPSF grant for a study titled Pediatric Sedation: A Safety and Efficacy Problem for Children Requiring Diagnostic and Therapeutic Procedures in the Hospital Setting—a Human Factors Opportunity for Improvement.

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: Jay Callahan, PhD, 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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Reducing Medication Errors and Increasing Patient Safety Through Better Communication

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our concentration—can cause an “intellectual error.”

Fatigue and stress can rise due to insufficient staffing, unrealistic workload, and long hours.

What is the answer?

Managers: Raise everyone’s awareness of patient safety by holding quality improvement meetings; make patient safety a cornerstone of your caregiving. Train your people well and provide a positive work environment. Practitioners:

Be vigilant; ask a more experienced member of the health care team for help when you are unsure. Establish a medication error reduction task force and recruit representatives from medicine, nursing, pharmacy, risk management and legal to evaluate medication errors and improve systems so the same error is less likely to occur.

Assume the patient’s perspective. Ask yourself, “If I were the patient, what would I want from the professional doing my job right now?”

Make safety a team effort

Each member of the health care team can be part of a safety net that helps improve quality of care and protect the patient. This requires adopting a culture of investigation and improvement rather than blame and punishment. As one investigator stated, “Safety is not the avoidance of all possible risks; safety is a path between the risks.”

Employing the same systems, but trying to find the “safe path” around the inherent risks is like using last year’s map to walk through today’s mine field. When near-misses or errors occur, investigate them and conduct a risk assessment to identify the system safeguards that failed. Then redesign those systems to prevent a recurrence. Mere awareness of problems and attempts to avoid them are not adequate—errors must be reported, dissected, and faulty systems redesigned to prevent repetition. Updating today’s systems is the road to a safer tomorrow. **NPSF**

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