

## Spotlight on Ambulatory Care Patient Safety

BY NAOMI KUZNETS, PhD, MANAGING DIRECTOR, AAAHC INSTITUTE FOR QUALITY IMPROVEMENT

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Most health care in the US today is delivered in the ambulatory setting. The National Center for Health Statistics (NCHS) has estimated that more than 77% of medical procedures are administered in the ambulatory care setting; more surgical procedures also occur in ambulatory than inpatient settings.<sup>1</sup> In 1996 alone, 31.5 million ambulatory procedures were performed.<sup>2</sup>

In 2000, NCHS estimated that 823,542,000 visits were made to physicians' offices—equating to three visits per year for every person in the United States.<sup>3</sup>

Despite the minimal discussion of ambulatory care patient safety in the groundbreaking 1999 IOM report, "To Err is Human,"<sup>4</sup> ambulatory care has not been devoid of efforts to improve patient safety. Approximately two years ago, the Accreditation Association for Ambulatory Health Care (AAAHC), Institute for Quality Improvement (IQI) polled AAAHC-accredited organizations to find out:

1. Whether they were involved in medical event-reporting programs;
2. Attributes of the programs in which they participated; and
3. What factors motivate or would motivate them to become involved in medical event-reporting programs.<sup>5</sup>

### Many ambulatory facilities have medical event reporting systems

AAAHC acknowledges that the population polled was a select group, and over-represented certain types of ambulatory health care organizations. Of the 1,250 organizations surveyed, 45% responded, generating the following results:

- A significant number of ambulatory care organizations are involved in medical event-reporting systems—many of them voluntary.
- A number of factors, such as sharing one's own experiences and having the opportunity to learn from others' mistakes, information from peers and on important issues, and multi-site and unique information, are closely associated with "actionable" feedback—which in turn appears to be linked to reporting frequently enough. However,

involuntary systems—primarily governmental or network—are doing a much poorer job of reporting frequently enough and giving actionable feedback.

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**'Many [ambulatory care] systems are not taking advantage of available information on "near misses," nor offering multi-site information.'**

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- Many systems are not taking advantage of available information on "near misses," nor offering multi-site information. Furthermore, many systems may also be redundant, ie, they do not offer unique information.
- Voluntary programs appeared to have more positive attributes than involuntary ones—especially regarding actionable feedback.
- Although there appears to be little consensus on time and cost commitments that would motivate involvement in a system, quarterly reporting seems to be quite important. Feedback for quality improvement and protection of confidentiality are apparently significant motivating factors for participation in a medical event-reporting system.

### Survey highlights issues in ambulatory care patient safety

These findings reflect some key issues in ambulatory care patient safety:

- There is a lack of infrastructure—and associated inability to accurately and without considerable burden track, categorize, and quantify ambulatory medical events—in ambulatory health care organizations that are not part of a health "system" or "network."
- There is a risk of being able to identify patients and physicians when studying a small number of solo or small-

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For more information on the Accreditation Association for Ambulatory Health Care, visit <http://www.aaahc.org>

For information on the Institute for Quality Improvement, visit <http://www.aaahciqi.org>

practice physicians and their patients in a limited geographic area.

- It is important to study aspects of ambulatory care, such as office-based surgery, that are areas of public concern.
- There is a need to identify what primary care medical events are—aside from widely recognized issues such as medication events or needle sticks—and how one may study medical “non-events,” such as failure to diagnose or to treat. It is also important to determine at what point it is appropriate or necessary to “draw the line.” For example, is failure to provide preventive counseling on smoking cessation a medical event?
- Patient safety recommendations and measures should be coordinated, as appropriate, to have the greatest socio-economic and political power.
- It is important to understand where transferring patient safety and clinical quality improvement concepts from the hospital to the ambulatory setting makes sense and where it does not, or needs some “tweaking.” For example, the shorter period of exposure may play a key role in lower nosocomial infection rates in ambulatory settings<sup>6</sup>

### What is being done to address ambulatory care patient safety?

- The AAAHC IQI's anticipates analyzing data from a proposed annual reporting system for the AAAHC, potentially offering one of the first glimpses at the epidemiology of medical events in the ambulatory setting. The IQI is also producing two studies on liposuction.
- The American Academy of Family Physicians (AAFP) is producing valuable research through its Developmental Centers for Evaluation and Research in Patient Safety (DCERPS) in Primary Care, funded by the Agency for Healthcare Research and Quality (AHRQ). (See [www.aafp.org/ptsafety.xml](http://www.aafp.org/ptsafety.xml).) The AAFP's Robert Graham Center is also studying taxonomy and primary care medical event epidemiology. For an example, please see <http://qhc.bmjournals.com/cgi/reprint/11/3/233.pdf>.
- The Centers for Disease Control and Prevention (CDC) has proposed expansion of its National Nosocomial Infections System program to ambulatory settings.
- The Centers for Medicare and Medicaid Services' Quality Improvement Organizations' (formerly Peer Review Organizations) seventh scope of work addresses improving beneficiary safety and health through clinical quality improvement in settings including the physician's office. Visit <http://cms.hhs.gov/qio/2b.pdf>.
- The Medical Group Management Association conducted an AHRQ-funded meeting, *Patient Safety in Ambulatory Care*

*Setting: Building a Research Agenda*. The conference synthesis is available at the AHRQ Web site, <http://www.ahrq.gov/about/cpcr/ptsafety/ptsafety.html>.

- NPSF has sponsored an Ambulatory Surgery in the Office Setting Initiative. Visit <http://www.npsf.org/download/ASOSFinalReport.pdf>.
- The National Quality Forum's draft (as of October 2002), “Safe Practice for Better Healthcare,” began as an acute care document and has evolved to include ambulatory care. Visit [http://www.qualityforum.org/safe\\_practices\\_report.html](http://www.qualityforum.org/safe_practices_report.html).
- The American Medical Group Association, the National Committee for Quality Assurance and the Pharmacia Corp. have awarded \$50,000 grants to eight health care providers across the country to focus on programs targeting ambulatory and outpatient safety. The grants are part of the Safety Collaborative in the Out-Patient Environment initiative.

As with other issues in health care quality, it is important to consider issues of patient safety beyond the inpatient setting. This is the challenge to researchers and policy makers; it is not easy, because ambulatory care, for the most part, does not conform to the inpatient hospital or health care system or network model.

Patients, practitioners, and administrators from the ambulatory care setting need to help researchers and policy makers better understand patient safety in this setting. Despite the new challenges the ambulatory health care setting offers, significant patient safety work is being accomplished in this setting—and more is anticipated in the future. **NPSF**

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# Using Non-clinical Evidence Practices to Face Complex Challenges

BY JEREMY FISH, MD

Health care organizations throughout the world are grappling with ways to make a real and lasting impact on patient safety. Traditionally, health care improvement has focused on clinical aspects of care, trying to improve performance at the sharp end. The patient safety movement has shifted the focus to the non-clinical, blunt end—the system. Changing something as complex as a health care organization is new to everyone, thus new ways of challenging individuals to lead healthy change must be explored.

Traditionally, success stories are shared from organizations that have made effective change. (See the “As I See It” article about Fairview Hospital on page 6.) Stories about failures seldom are shared or published. Though helpful in producing an image of what is possible, translating success stories to your own organization may be hampered by local obstacles and realities. Scenarios are an effective way to organize complex information to develop a framework for decisions in situations outside of health care<sup>3</sup>.

Following is a scenario based on a compilation of many organizations, fictionally termed “Moderate-Sized Community Hospital,” (MSCH) and an example of a patient safety director’s proposed plan to improve patient safety in the organization.

## MSCH background

The MSCH board is struggling with an avalanche of proposed safety practices. JCAHO will be coming in 18 months and the performance improvement director suggests immediately implementing root-cause analysis (RCA) for “near-misses”—terms unfamiliar to both the performance improvement director and the board. The state legislature recently mandated computerized physician order entry (CPOE) by 2005, but details and funding remain unclear.

Expected Medicaid and Medicare cuts will likely reduce revenues by several million dollars, while mandated earthquake retrofitting may run \$10-\$20 million over the next 12-18 months. During evaluation for CPOE readiness, the board learned there are four different computer systems at MSCH—pharmacy, lab, patient scheduling, and diagnostic imaging, none of which communicate with each other. The nurses union has threatened a strike if nurse wages and staffing ratios are not addressed in the upcoming negotiations. The board has called in the new patient safety director

to outline the evidence for safety practices and make recommendations for action.

## Evaluating the evidence for improving patient safety

The strongest evidence for proven benefit in multiple settings and generally low implementation costs are in the clinical evidence realm of patient safety, the EPC 11 Evidence-Based Safety Practices<sup>1</sup>. Using traditional implementation methods, it is estimated that organizations can have these practices up and running in 12-18 months.

Recommendation: Immediate review and implementation  
Resources: Low cost  
Obstacles: Low resistance from professional groups  
Complexity: Low

There is controversy about whether these EPC 11 represent true safety practices<sup>2</sup>. Perhaps the most powerful aspect of patient safety has to do with its focus on *systems* rather than individuals—organizational culture, communication, and redesigning the processes for “how people do things” rather than “what people do.” Evaluating the evidence for these important, though highly complex, non-clinical concepts is challenging. Due to its complexity, the evidence tends to be weaker than what is typically available for clinical practices. The major areas of evidence fall into the following categories (adapted from Shojania et al #1):

Leadership	Level of evidence <sup>1</sup>
Develop a culture of safety	Low (expert opinion, anecdotes)
Changing provider behavior	Medium (many small studies)
Full disclosure of unexpected outcomes to patients	Low (single VA system)
Communication	Level of evidence
Patients	
• Color-code ID bracelets to prevent falls	Medium
• Bar-coding patients	Low
System flaws	
• Root-cause analysis	Low
Computer-assisted communication	
• CPOE	Medium

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*Clinical evidence-based resources:*

- Evidence-based safety practices: [www.ahrq.gov](http://www.ahrq.gov)
- US Preventive Services Task Force: [www.ahrq.gov/clinic/uspstfix.htm](http://www.ahrq.gov/clinic/uspstfix.htm)
- Evidence-based medicine search engine: [www.tripdatabase.com](http://www.tripdatabase.com)
- Medline: [www.nlm.nih.gov](http://www.nlm.nih.gov)
- Up-to-date (subscription): [www.utdol.com](http://www.utdol.com)

*Patient safety practice resources:*

- National Quality Forum: [www.qualityforum.com](http://www.qualityforum.com)
- JCAHO: [www.jcaho.org](http://www.jcaho.org)
- National Center for Patient Safety: [www.patientsafety.gov](http://www.patientsafety.gov)
- LeapFrog Group: [www.leapfroggroup.org](http://www.leapfroggroup.org)

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## Using Non-clinical Evidence Practices to Face Complex Challenges

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### System re-design

### Level of evidence

Team building	
• MedTeams™ in emergency dept.	Low
• Geriatric multidisciplinary teams	High
• Inter-hospital transfer teams	Medium
Fatigue and staffing	
• Increase nurse staffing	Medium
• Reduce resident work hours	Low
• ICU-focused MD staffing	Medium
• Clinical pharmacist consultations	Medium

slow implementation of the other two practices. MSCH will need to rapidly address the nurse staffing practice due to its heavily penetrated nursing union environment.

### Recommendation for high-impact, medium-to-high cost, non-mandated, non-clinical practices

MedTeams™	Await further study, continue internal team-building
Nurse staffing:	Expect union and legislative pressure, be proactive in developing “nurse-friendly” environment.

**Table 1: Recommendations for Mandated Non-Clinical Practices**

Item	Recommendation
Root-cause analysis, full disclosure	Immediate education and implementation
Culture of safety:	<ul style="list-style-type: none"> <li>• Develop safety culture survey for workers and patients</li> <li>• Explore obstacles to safer system</li> </ul>
Computerized physician order entry (CPOE)	<ul style="list-style-type: none"> <li>• Integrate current computer systems in anticipation of CPOE</li> <li>• Outside funding likely required for implementation</li> </ul>
Obstacles:	<ul style="list-style-type: none"> <li>• RCA—Cost and time (\$8,000 estimated per RCA<sup>6</sup>)</li> <li>• Disclosure—Malpractice fears of staff and legal consultants</li> <li>• Culture of safety—Highly complex. How to do it?</li> <li>• CPOE—Cost and implementation; some estimates of disuse of CPOE in systems that already have it.</li> </ul>
Complexity:	High for all. Require new behaviors at all levels of organization.

In most cases, expert review of the evidence for the non-clinical safety practices in Table 1 above produced disappointing ratings<sup>1,2</sup>. However, several practices have been mandated by state law or JCAHO over the last several years, including developing a culture of safety, providing full disclosure of unexpected outcomes to patients, implementing root-cause analysis, and CPOE.

Given MSCH's limited resources and potential budget short-falls, the scenario must incorporate a limited selection of the practices in Table 2, based on impact, cost, and complexity of implementation. The non-clinical practices in “high impact” and “low or medium cost and/or complexity” are MedTeams™, nurse staffing, ICU-focused MD staffing and clinical pharmacist consultation services. MSCH already has ICU-focused MD staffing and clinical pharmacist consultation services. Depending on MSCH's financial situation, the hospital may choose to wait for adequate budgetary changes or begin

### Recommendation for low-cost, non-mandated, non-clinical safety practices

Patient ID bracelets:	Implement immediately to prevent falls
Obstacles:	Potential confusion with current bracelets

MSCH can establish clear short-, mid- and long-term priorities as shown in Table 3, based on the level of evidence, potential impact on patient safety, cost and complexity of implementation. The hospital can immediately begin building many practical patient safety clinical practices into the system with a high likelihood of success.<sup>1</sup> There are several important, somewhat costly non-clinical practices MSCH can probably implement in the mid-term—such as CPOE, team-building and improved nurse staffing ratios—that will likely have a high impact on patient safety<sup>1</sup>. MSCH must shift its culture to make patient safety the highest priority—looking deeply into how staff does things and changing leadership behavior to improve system safety. **NPSF**

**Table 2: Recommendations for Non-mandated Non-clinical Safety Practices**

Practice	Evidence Level	Impact on Safety	Costs	Complexity
Implementation of safety practices, changing provider behavior	Medium (best when local opinion leaders mentor desired change)	Must define desired behaviors first	Medium	High
Color-code patient ID bracelets to prevent falls	Medium	Medium	Low	Low
MedTeams™	Low	High	Medium	High
Geriatric multidisciplinary teams to prevent hospital complications	High	Medium	Medium	High
Inter-hospital transfer teams for ICU patient transfers	Medium	Medium	Medium	Low
Increase nurse staffing to reduce patient deaths	Medium	High	High	Low
Reduce resident work hours	Low	Unknown	High	High
ICU-focused MD staffing	Medium	High	Medium	High
Clinical pharmacist consultation service	Medium	High	High	Low

**Table 3: Short-, Mid- and Long-term Priorities**

<b>Short-term</b>	<p>Review and implement clinical evidence-based 11 “greatest strength of evidence”</p> <p>Evaluate system for healthy organizational culture change</p> <p>Implement patient safety ID bracelets for fall prevention and identification</p> <p>Begin integration of computer systems</p> <p>Establish patient safety unexpected outcome disclosure policy</p> <p>Review JCAHO’s Six Safety Practices for 2003</p> <p>Explore root-cause analysis for near misses</p> <p>Develop safety culture survey for workers, leadership, patients</p> <p>Evaluate nurse-staffing ratios and compare to best practices</p>
<b>Mid-term</b>	<p>Explore commercial CPOE; implement when resources located</p> <p>Review effect of EPC Top 11<sup>1</sup></p> <p>Evaluate changes in culture survey subgroups</p> <p>Implement high-impact, non-mandated, non-clinical practices</p> <p>Address nurse staffing first; team-building second</p>
<b>Long-term</b>	<p>Shift culture toward safety. Although the scientific evidence is lacking for culture change, safety is primarily a systems problem<sup>7</sup>. Scenario thinking is a highly regarded method of leading healthy change in many industries<sup>5</sup>.</p> <p>Educate leadership on scenario thinking to lead change</p> <ul style="list-style-type: none"> <li>• Establish effective communication, feedback</li> <li>• Evaluate effectiveness of previous system changes</li> <li>• Evaluate changes in organizational culture</li> </ul>

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## Patient Safety: Not a Project, Not a Program—It's Our Job!

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*Fairview Hospital in Great Barrington, Mass. is a 24-bed rural facility chosen as a finalist in the American Hospital Association's Quest for Quality Prize award program in 2002.*

Patient safety cannot be the latest program, or a fad that in time will be replaced by another. Safety must be lived every day and must become a core value. Fairview Hospital operates under the principle that patient safety is everyone's responsibility, so we take every opportunity to partner with staff to improve safety.

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**'On a recent survey, 90% of Fairview staff stated they felt the culture is non-punitive. Every time there is an unanticipated event, we ask ourselves, "How can we learn from this to make our hospital safer for patients and staff?"'**

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Our formal journey began in 1997 with the creation of a multidisciplinary team of staff and physicians aimed at redesigning our quality-tracking (incident-reporting) system. After the redesign, we noticed a continued increase in the number of reports and, in particular, a steady increase in "near miss" reports.

### Addressing medication errors

In 1999, Fairview created an action-oriented interdisciplinary Medication Error Team with three goals:

1. To educate themselves and other staff on reducing risk and eliminating blame;
2. To assess our organizational strategies in comparison to those recommended by the Massachusetts Coalition for the Prevention of Medical Errors; and
3. To develop and implement medication-related safety initiatives.

The result has been organization-wide education from the staff level to the governing board. We have completed our first FMECA (failure mode effect and criticality analysis) on medication administration and have implemented strategies to improve the legibility and safety of our medication ordering practices.

Over the last two years, Fairview has formulated a patient safety team, developed a disclosure policy, had leadership complete a self-assessment on patient safety, compiled a survey of staff on our culture of safety, prepared to implement a CPOE (computerized physician order entry) system and developed a medical error brochure for patients, based on the AHRQ guidelines.

### Hallmarks of a culture of safety

How do we know Fairview has achieved a culture of safety? We see signs of it every day:

- The number of quality-tracking forms has increased 150%, of which 59% now show potential for errors.
- On a recent survey, 90% of Fairview staff stated they felt the culture is non-punitive. Every time there is an unanticipated event, we ask ourselves, "How can we learn from this to make our hospital safer for patients and staff?"
- We are a team—leaders and staff are partners. Management is open to suggestions. This is evident in the feedback our staff receives and in the policy and procedure changes we have implemented. Fairview publishes a patient safety newsletter to keep all staff aware of actions taken and of safety concerns and initiatives. Staff members tell us they feel their input is valued and used, that they can make change happen. Leaders have established credibility by listening, responding and providing resources.
- Fairview offers multiple forums for raising issues and concerns; the Quality Council, the Care of Patients Committee and the Patient Safety Team. All of these groups begin their meetings with an open issues forum where anyone may raise a safety concern. Safety issues may also be brought up by either leaders or staff and, therefore, represent a variety of perspectives—actual patient care situations, perceived risks, or information discovered in the literature, regulators' bulletins and the general media.

- We encourage patients to be a part of the team. Each Fairview inpatient and outpatient is given our bright green “What Are Medical Errors?” brochure. The Fairview staff encourages patients to speak up and actively participate in their safe care.

#### Putting safety first

Why has Fairview been successful in making “safety first” a reality for patients and staff? Staff involvement and participation from the outset is critical. Being part of the ground-work and development has fostered ownership and accountability for success.

- The philosophy that everyone is responsible for a safe work environment is initiated during orientation, reinforced during our bi-annual safety fair, and reflected in performance appraisals at all levels. Grassroots participation in the process is conducive to improving the workplace.
- The interdisciplinary shared governance model and frequent walking tours by leaders, has created an environment fertile with ideas to improve our systems and equipment.
- Listening to staff—especially when they say, “But it is not safe!”—gives credence to the concerns they raise. Capitalizing on these concerns brings safety to a higher level in our organization.
- Fairview offers multiple opportunities to participate in improvement efforts. Staff nurses and pharmacy technicians, as well as the pharmacist and the shift supervisor were key participants in our FMECA on medication administration. The work flow analysis, risk designation, and brainstorming for strategies took countless hours. However, allowing the participants the valuable resource of time demonstrated leadership’s support for the project. Giving these stakeholders the opportunity to present and implement the strategies also resulted in well-deserved recognition by their peers, leaders and the JCAHO surveyors for a job well done.
- Documentation and reporting are critical steps in Fairview’s effort to maintain patient safety. It is everyone’s duty to continue to detect any problems likely to cause harm to the patient. Information from reporting is

## ‘Listening to staff—especially when they say, “But it is not safe!”—gives credence to the concerns they raise. Capitalizing on these concerns brings safety to a higher level in our organization.’

used to identify practice patterns and systems that could cause errors. We believe this is so important to our efforts that we reward departments with certificates of achievement for reporting both actual events and “near misses.”

- Our root-cause analysis process has consistently included all stakeholders in debriefing, analyzing and recommending improved strategies. This process has provided Fairview with continued opportunities to demonstrate our non-punitive culture and our efforts to eliminate blame. Staff involved in these efforts have expressed to their peers the tremendous support they received from everyone involved in the process. We share the events, the lessons learned and the changes made with all our staff. This openness has begun to remove the stigma and secrecy that usually surrounds a mistake or failure. The focus is on learning and improving.
- We view patient safety as a broad umbrella. There are many aspects of the subject that can be discussed in a variety of venues: staff meetings, formal team meetings, walking rounds, etc. This constant dialogue keeps the issue fresh and foremost in our minds.

#### A continuing commitment to safety

Patient safety at Fairview is characterized by our commitment to patients and to each other, and our partnership with patients, physicians, colleagues, leaders. At Fairview, patient safety is an expectation and a responsibility—all day, every day. [NPSF](#)

*Ruth Fitzpatrick, ARM, BS, Quality, Doreen M. Hutchinson, BSN, MBA, CNAA, Bobbi Kozlowski, CPh.T, Kathryn Palmer, RN, and Laurel Trahan, BSN, MHA, CNA are part of the multidisciplinary safety team at Fairview Hospital, Great Barrington, Mass.*

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.

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## Plan to Attend 'Integrity and Accountability in Clinical Research,' May 6-8, 2003 in Washington

Mark your calendar for May 6-8, 2003 and plan now to attend NPSF's second annual Research Conference, "Integrity and Accountability in Clinical Research," at the Renaissance Washington DC Hotel.

For registration information, please contact Carol Lieser, CMP, at 760-770-0288, or e-mail her at [clieser@npsf.org](mailto:clieser@npsf.org).

Exhibitor information is also available for companies and organizations interested in exhibit space at the conference; contact Carol Lieser for details.

If you would like information regarding sponsorship of this conference, please contact Lynda Williams at 202-437-5053, or e-mail her at [lwilliams@npsf.org](mailto:lwilliams@npsf.org).

### Register Now for 'Let's Get Results: Improving the Safety of Patients'

NPSF's fifth annual Patient Safety Congress, formerly known as the Annenberg Conference, will be held at the Renaissance Washington, DC Hotel on March 12-15, 2003. To register, visit [www.npsf.org](http://www.npsf.org) and click on the 2003 NPSF Congress link.

### Call for Research Proposals in Patient Safety for 2003

Do you have a patient safety research project in need of funding? For the fifth consecutive year, the NPSF Research Program is calling for letters of intent for research proposals

targeting the enhancement of patient safety. The 2003 submission deadline is March 28. For more information and application guidelines, visit [www.npsf.org](http://www.npsf.org).

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