

# focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

## Five Years After *To Err Is Human*: A Look at the Patient Safety Landscape

BY SUSAN RAEF, EDITOR

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*It has been 5 years since the Institute of Medicine (IOM) issued its groundbreaking patient safety report, To Err Is Human: Building a Safer Health System (National Academy Press, 1999). How has the landscape of patient safety changed since then? Where has the greatest progress been made? Which areas still need the most improvement?*

*Part of any anniversary's value is taking the opportunity to look back and gauge where you are today. With that aim, Focus spoke with NPSF Board Chair Timothy Flaherty, MD, NPSF Board Member and Interim Executive Director Diane Pinakiewicz, and Focus Managing Editor Lorri Zipperer—all of whom have been with NPSF since its inception in 1996—to gain their perspective.*

### Patient safety awareness has come a long way in 5 years

NPSF Interim Executive Director Diane Pinakiewicz sees a significant increase in awareness of patient safety since the 1999 IOM report was issued. "In the beginning, a lot of the effort in patient safety revolved around trying to understand the issue," she says. "I see a tremendous amount of progress having been made; people now recognize patient safety as a tangible issue across the spectrum of health care.

"I think there is also recognition that patient safety is a *systems* issue; it's not an individual error issue," says Pinakiewicz. "To have made that progress—where people are now speaking the same language and are understanding that to resolve patient safety issues, you need a systems approach—is a huge step forward. However, there is still a tremendous amount of work to do."

"Part of the progress has been defining what we mean by patient safety and trying to fit into the quality equation," says NPSF Board Chair Timothy Flaherty, MD. "Early on, research papers in patient safety were all based in quality improvement situations, which we're all in favor of, but they certainly didn't have the safety focus."

### How much has awareness really improved?

While *Focus* Managing Editor Lorri Zipperer notes that people today are more apt to realize that "patient safety means more than handrails," she believes there is still much work to be done in building awareness.

**"In the beginning, a lot of the effort in patient safety revolved around trying to understand the issue ... [P]eople now recognize patient safety as a tangible issue across the spectrum of health care."**

*Diane C. Pinakiewicz*

*NPSF Board Member and*

*Interim Executive Director*

"I recently participated in conversations with two people who, when asked about patient safety, illustrated this gap," says Zipperer. "One person—someone I thought would have known better—focused his response only on bad doctors. The other, a patient activist, saw the solution to safety as resting solely in the patient bill of rights.

"In some ways, we in the patient safety arena are somewhat spoiled in thinking that we've got everybody using the same language; but that's only in our insular circle," Zipperer contends. "The circle keeps growing little by little, but one of our challenges is to try to get the people who haven't stepped on board to get in there so we can all see patient safety from the same place and move forward collectively."

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## What is driving increased patient safety awareness?

- **Research**—Zipperer points to the positive changes brought about by patient safety research. “With AHRQ’s support of research, NPSF’s research program, and some of the fellowship and award programs, there’s more money being funneled into trying to figure out what’s actually going on in the healthcare system so we can learn from it. The funding also aids in the dissemination of those results so administrators and clinicians can benefit from the knowledge of others,” she says.

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“[T]here are a lot of people at home who are driving patient safety ... [T]here’s somebody in almost every organization who is enlightened now to some degree. Unfortunately, it’s not always the leadership.”

*Timothy Flaherty, MD*

*NPSF Board Chair*

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- **Increased availability of information**—Much more patient safety information is available today than in 1999. “There are more organizations in place, new Web sites and journals, an increase in the number of articles being published, and distinct information initiatives such as the NPSF Current Awareness Literature Alert,” says Zipperer. “This shows there is an intense drive in the patient safety community to share knowledge and move forward.”
- **Local patient safety advocates**—“When I see the poster sessions at the NPSF Patient Safety Congress as well as state and regional meetings, there are a lot of people at home who are driving patient safety,” says Flaherty. “It may be the safety officer or the quality improvement person, but there’s somebody in almost every organization who is enlightened now to some degree. Unfortunately, it’s not always the leadership.”
- **Patient participation**—Flaherty notes that patients are taking an active role in moving the safety agenda forward. “Some of our major ‘ahas!’ have come from our patient community,” he says. “Their input has been very

helpful. We’ve had a couple of first downs and field goals, but we haven’t made any touchdowns yet.”

- **Stand Up for Patient Safety**—Flaherty notes the tremendous buy-in to patient safety represented by the 170 hospitals across the country participating in NPSF’s Stand Up for Patient Safety initiative.
- **NPSF’s patient safety e-mail discussion forum**—“Certainly, NPSF’s online discussion forum, Patientsafety-L, reaches many people,” says Pinakiewicz. “The discussion forum’s international reach really impresses me,” adds Flaherty. “Patientsafety-L’s wide range of participants supports multidisciplinary dialogue,” says Zipperer, who launched the forum and served as its moderator for several years.
- **NPSF’s Corporate Councils and Roundtables Program**—This program is a partnership between leading corporations and NPSF, providing a means to share expertise and develop innovative, attainable patient safety solutions. “Through our Corporate Councils and Roundtables Program, we’re working with solutions providers to assist them in better understanding the culture into which their solutions are being placed and providing collaborative opportunities to expedite adoption of their solutions,” says Pinakiewicz.
- **HRET/NPSF’s Fellows Program**—“One of our recent graduates from the Fellows program is Matt Scanlon, MD, a pediatric intensivist from Milwaukee,” says Flaherty. “I recently heard him speak about product safety, an issue that has been under the radar. People design things that can be manufactured cheaply and reliably with good Six Sigma—but they don’t really look at the product from the user’s standpoint. Some of the things designed into these products that make users’ safety record somewhat questioned are a really big issue. People are thinking out of the box in different areas of patient safety, and the Fellowship was one of the drivers for [Scanlon],” says Flaherty.
- **The IOM Report itself**—Flaherty notes the value of the IOM report in raising awareness. “Even before *To Err Is Human*, we made some incremental advances,” says Flaherty, “but since the report was published 5 years ago, it’s been much easier to get everyone’s attention.”

## The patient safety environment is evolving

“One concrete sign of the progress in patient safety since 1999 is the number of environmental changes,” says

Flaherty. "It's interesting to look back 5 years at what was happening at the national level," he adds, citing several initiatives that didn't exist in 1999:

- JCAHO patient safety goals
- National Quality Forum
- Leapfrog Group
- AHRQ research agenda and results

Another yardstick of the increase in patient safety awareness is the steadily growing attendance at NPSF's conferences. The initial Annenberg conference in October 1996 drew approximately 200 attendees; NPSF's 2004 Patient Safety Congress attracted 1,400 patient safety stakeholders.

"What NPSF does best is to help build awareness of patient safety by acting as a convenor," says Flaherty. "The broad stakeholder base on our board and the wide representation we've had at our Patient Safety Congress is very important."

#### Where is improvement most evident?

In addition to the improvements in patient safety awareness in the last 5 years, there have been advances in other areas of patient safety. Flaherty believes that medication error is the area that has shown the greatest improvement. "Computerized physician order entry [CPOE] and attention from JCAHO have boosted awareness and reduced medication errors," he says.

The VA Medical System has also made a commitment to patient safety with the development of 6 patient safety centers across the country. NPSF Board Member James P. Bagian, MD, was chosen as the first director of the VA National Center for Patient Safety (NCPS).

NCPS is responsible for developing a significant patient safety tool: Failure Mode and Effect Analysis or FMEA, a prospective approach to rooting out latent errors before a patient is harmed.

#### Much more progress is still needed

Thought leaders in patient safety—including NPSF Distinguished Advisors Lucian Leape, MD, and Donald Berwick, MD, and NPSF Board Member Richard Cook, MD—argue that there is still much work to be done.

"Our colleagues have expressed their frustration with the lack of progress and the sense that leadership is not focused enough on this issue," says Pinakiewicz. "There is concern that there is still a significant amount of denial regarding patient safety and medical error. There are patient safety solutions available, and hospitals aren't

adopting them as quickly as they should be. Human-factors experts, who helped us understand the issue of patient safety to begin with, believe that people still don't understand the complexity of the issue; many people tend to over-simplify it and don't get the fact that there's still so much work to do."

#### To change the system, change medical education

Flaherty notes that medical education is an area where patient safety has not made any dramatic improvements. "What we've been working on is changing the tests," he notes. "Until you change the tests, you don't change the curriculum.

"When we've worked with some of the specialty groups that have tried to do something with their board [exam], that's where it makes a difference," says Flaherty. "When you start asking questions about patient safety, that's when you'll make the change."

#### No short-term fixes

"The solution to patient safety is not going to be a short-term fix," Pinakiewicz concludes. "We have to have patience, but not become complacent." **NPSF**

## Focus Invites You To Submit Articles

As NPSF's quarterly newsletter, *Focus on Patient Safety* provides an opportunity for authors from diverse stakeholder and expert groups to relate what they know to others working toward developing a safer system for patients. We invite health professionals, systems and human-factors specialists, patients and their families, and others involved in exploring the professional, consumer and systems issues related to patient safety to submit articles for publication.

Each submitted article should consist of no more than 1,000-1,200 words, and may be edited for style and length. References, if included, must be complete. Submit articles electronically to: [info@npsf.org](mailto:info@npsf.org) or fax them to (703) 506-3266. E-mail submissions are preferred. Include the author's complete contact information and e-mail address. Questions? Call Irene Stefanski at (703) 506-3280.

#### Growing to Advance Patient Safety An NPSF Timeline

**1996:** NPSF begins consensus building symposium. Annenberg 1 conference held, drawing 200 attendees.

**1997:** National Patient Safety Partnership established. *Issue of Focus on Patient Safety* published. First meeting of the National Health Care Safety Council.

**1998:** NPSF issues first request for proposals for patient safety research. E-mail discussion forum, Patientsafety-l, developed. Regional forums held in Washington, Florida, Minnesota, and Louisiana. NPSF awards its first research grants, totaling \$350,000.

**1999:** Regional forums held in Texas, California, Massachusetts and Wisconsin. NPSF co-sponsors "Developing a National Policy Agenda for Improving Patient Safety" with JCAHO and AHA.

**2000:** NPSF co-sponsors "Patient Safety Solutions 2000" conference with JCAHO. First NPSF Awards for Patient Safety presented.

**2001:** NPSF forms Patient Safety Family Advisory Council. Archives started. Regional forums held in Florida, Maine, Nebraska, Minnesota, North Dakota, and Texas. NPSF receives an \$845,000 AHRQ grant to develop a Web-based patient safety education program. Partnership launched with AHA Health Forum for a Patient Safety Fellowship.

**2002:** Stand Up for Patient Safety program approved. Databases merged to create a single, searchable Information Center catalog.

**2003:** Patient and Family Advisory Council publishes white paper, *Nothing About Me Without Me*.

**2004:** 6th Annual Patient Safety Congress in Boston draws over 1,400 participants. NPSF/AHA Scholarship created for Nursing Fellowship Leadership Program.

# Educational Fairs Offer Experiential Learning

BY SHANNON M. SAYLES, RN, MS, MA, DIRECTOR, SENTARA SAFETY INITIATIVE, SENTARA HEALTHCARE, NORFOLK, VA

What would events named “JCAHO House of Horrors” and “PI Camp” have to do with patient safety? They are both educational fairs—a creative approach for staff learning implemented at Sentara Healthcare, an integrated healthcare provider based in Norfolk, Va.

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**“Adults learn best when they can experience the new material. This is most effectively done when learners have hands-on opportunities or can quickly apply the information they have been taught.”**

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Sentara has used educational fairs for several years at all 6 of its hospitals with great success. This learning approach, which provides information to a large group of staff in a short period of time, was first implemented to prepare hospital staff for a JCAHO (Joint Commission on Accreditation of Healthcare Organizations) survey visit.

The fairs originally featured booths with posters and demonstrations of materials or equipment. While these were certainly educational, there was still something lacking in the staff's ability to incorporate the learning into their daily work. One manager identified what was missing: a sense of fun.

## **Experiential learning: The key to success**

Adults learn best when they can experience the new material. This is most effectively done when learners have hands-on opportunities or can quickly apply the information they have been taught. The information conveyed needs to apply to the learners' daily work so the connection is made between the information and the application.

To accomplish this, Sentara began incorporating experiential learning into educational fairs with engaging themes. The first fair using this approach, “JCAHO House of Horrors,” was launched during the week of Halloween. Its objectives: to

creatively engage staff in understanding key quality and safety issues in preparation for the JCAHO survey, and to assure that they had hands-on experience in using and applying tools appropriately. The fair was titled “House of Horrors” to convey all the bad things that could happen to patients and staff if they didn't comply with the JCAHO standards.

The staff conducting the fair dressed up in costumes to carry out the Halloween theme. Each booth included involvement activities, such as looking for documentation errors in a nursing flow sheet, washing their hands and then seeing under special lights how much bacteria still remained, and demonstrations of the infant security system. The team arranged for staff to receive educational credit if they completed and signed off at all the stations. Door prizes were awarded and small giveaways were available at many of the booths.

The response was amazing, with attendance nearly double that of previous fairs. Staff were talking about what they had learned at the “JCAHO House of Horrors” for weeks afterward.

Sentara has since applied this experiential learning approach to a variety of topics. One challenge the performance improvement team identified was that staff did not consistently carry out the activities that were part of the clinical improvement initiatives for acute myocardial infarction, congestive heart failure, and pneumonia patients.

The hospital's performance improvement (PI) coordinator adapted the learning fair idea and created “PI Camps.” The approach was similar to the “House of Horrors” fair—experiential, fun, and focused on a variety of key topics. The fair was conducted during the summer to catch the large number of staff who were orienting at that time. A summer camp theme was developed; the staff conducting the fair were “counselors” and the attendees were “campers.”

## **Conveying information**

Experiential learning fairs have now become Sentara's key method when a variety of information needs to be conveyed in a concise, hands-on format to as many people as possible. There are now quarterly hospital safety fairs, PI camps are held several times a year, and JCAHO fairs are timed to survey schedules. The topics vary depending on the educational focus. For example, the facility may want to showcase new equipment related to patient safety, or perhaps emphasize fall prevention.

### Planning an educational fair

Fair organizers have identified some techniques proven to increase the success of the event. Educational fairs are typically set up in a room near the cafeteria to attract staff as they go to and from meals or breaks. The fair should have a number of booths or tables set up with posters, involvement activities, handouts with reminders of key activities, ID badge reminder cards, giveaways, etc. Each table should be staffed by 2 people.

Activities have included involvement devices such as a scavenger test where learners picked out the unsafe things in a hospital room that are hazards for patients at high risk for falls. There are refreshments, lots of decorations, and an upbeat atmosphere. The fairs often feature a seasonal theme, such as the "PI Camp" or the "JCAHO House of Horrors." A checklist to assist fair organizers is shown below.

The cost of the fairs varies depending on the size of the facility and the number of giveaways. A small 50-bed hospital could spend approximately \$150-\$250 per fair including flyers, handouts, posters, refreshments, and door prizes. Typically, the greatest costs are for name badge reminder cards, door prizes (gift certificates to local stores), or imprinting pins or pens if the fair is for a special topic and the reminders are especially important.

### Tips for fair planners

Sentara offers the following advice for healthcare facilities planning an experiential learning fair:

- **Involve a variety of people.** The most successful fairs involve several departments and include multidisciplinary planning teams. This approach also assures that the work is shared.
- **Identify a theme.** Each fair should have a specific focus. Develop at least one umbrella theme to cover a variety of topics; alternate these events with fairs focusing on important issues for the facility, such as patient falls or pressure sores. Choose an engaging title to catch the staff's attention and build interest.

- **Schedule fairs frequently.** Quarterly fairs keep many people involved and provide opportunities to present a variety of topics. Assign a group to set a yearly schedule to enable adequate planning.
- **Publicize the fair widely.** Use a variety of methods, including posters, email, and newsletters.
- **Arrange for education or contact hours.** This is particularly important for organizations where staff are expected to have a certain number of education contact hours yearly.
- **Choose a high-traffic location.** Hold the fair where staff will see it as they come or go to work, or for meals or breaks.
- **Scheduling.** Staff the fair to cover all shifts. When appropriate, schedule the fair to run over weekends and for several days to increase attendance.
- **Make it fun!** Engage your most creative people in developing the fair. Have lots of activities, hands-on learning, and booth monitors who can effectively engage participants. [NPSF](#)

*Shannon M. Sayles, RN, MS, MA, is director of the safety initiative at Sentara Healthcare in Norfolk, Va.*

*Sentara Healthcare is an integrated healthcare provider in southeastern Virginia and northeastern North Carolina serving more than 2 million residents. Its 6 acute care hospitals range in size from a 569-bed tertiary referral center to a 65-bed community hospital. Sentara also operates home care services, long-term care facilities, outpatient diagnostic centers, physician practices, and a health plan.*

*Contact Shannon Sayles at 757-668-3197 or [smsayles@sentara.com](mailto:smsayles@sentara.com).*

<b>Educational Fair Checklist</b>	
<b>Topic:</b>	P.I. Camp: Quality Begins With You
<b>Date:</b>	August 7, 2004
<b>Location:</b>	SLH Classrooms 1-4
<b>Times:</b>	7:30 – 9:30 a.m. 11:00 – 1:00 p.m. 2:00 – 4:00 p.m.
<b>Target Audience:</b>	All employees at SLH
<b>Participants:</b>	
<b>Topic</b>	<b>Person Responsible</b>
Restraints	Sandi
Falls	Anita
Handwashing	Jacque
Alcohol Withdrawal	Michelle
Wavenet-Policy & Procedures	Sharon
Hyperbaric Medicine	Joe/Meg
Customer Service	Brenda
DDNR	Anita
Patient Education	Penny
Pain Management	Meg
Clinical Initiatives	Michelle
Patient Safety	Michelle
Heart Disease/Heart Healthy	Tom
Sentinel Event/Root Cause	Anne
Carereminder/Documentation	Mary Ellen
<b>Things to Do:</b>	
Prepare the menu and send catering request	<input type="checkbox"/>
Obtain door prizes and other giveaways	<input type="checkbox"/>
Send room set up request to ESD	<input type="checkbox"/>
Prepare flyer to forward to units for posting	<input type="checkbox"/>
Prepare evaluation information	<input type="checkbox"/>
Obtain approval for Education Credit	<input type="checkbox"/>
Prepare Education Certificates	<input type="checkbox"/>
Schedule Participants and Set up Help	<input type="checkbox"/>

## How a Sentinel Event Launched Our Hospital's Patient Safety Quest

BY LEOTA ROLLS, RN, MSN, VICE PRESIDENT, MARY LANNING MEMORIAL HOSPITAL, HASTINGS, NEB

It was a beautiful October day as I came to work. I was looking forward to a routine day, as if any day as vice president of a 198-bed rural Nebraska hospital can be considered routine.

For the 30 years I had worked at Mary Lanning, I had always been very proud of the "fact" that we didn't make many medication errors. All of us on staff were sure we did a great job of taking care of patients and keeping them safe. The systems were all in place. We knew we gave great care—after all, these patients were our neighbors, friends, and relatives, and we wanted the best for them. In our close-knit community, everyone thought we were good at providing care and would trust us totally.

How quickly that perception changed that fall morning. The phone was ringing as I walked into the office. When I answered it, the charge nurse on our 20-bed sub-acute skilled unit told me in a scared, shaky voice, "I think we made a bad med error. We sent the patient to ICU. He's in a coma, and I don't think he will come out of it."

### "It could never happen to me"

That was the start of the biggest nightmare of my life—one that many healthcare professionals may say could never happen to them. That's what I said, too, before that October day. If I had the past 30 years to live over, I would pay more attention to the near-misses and less to how good we thought we were.

The natural tendency is to look at what we think we are doing well and say, "Wow, I'm glad I caught that before I did it." The truth is that if we had conveyed to staff the need to take action on near-misses, we might have avoided our sentinel event.

My perception of "how good we are" changed that morning as I went into the ICU waiting room and saw the patient's two daughters, son, and wife. The family was angry because they didn't know what happened and fearful for their beloved father and husband; they were searching for some meaning to their loved one lying in our ICU in a vegetative state.

That morning as I sat with the family, I knew the insurance carrier for the hospital's malpractice coverage was not going to like what I was going to say, but I looked at the patient's family and knew it was the right thing to do.

### "We made a mistake"

I plainly told the family we had made a mistake. We didn't intend to make an error, but we made it. We hadn't meant to harm their husband and father, but we had harmed him. I told them I wasn't totally aware of all the factors that contributed to the medication error, but that we were going to find out and would let them know everything we discovered. I told the family that the nurse who made the mistake was inconsolable and was contemplating leaving the profession.

## "[I]f we had conveyed to staff the need to take action on near-misses, we might have avoided our sentinel event."

The family responded by saying they didn't feel they could talk to the nurse. They wanted me to tell her not to leave the profession, but to learn from the mistake and be a better nurse because of it. The family told me they knew the error was not intentional, and they wanted me to know they appreciated my approach. However, they did want to know how the error had happened, and what we could do to prevent it from ever recurring.

The family told me they were very angry when I came in because they didn't feel like anyone was telling them what had happened. But in our conversation, they understood the fact that we didn't know all the circumstances and were pleased that we were going to find out what happened and that we would let them know.

That was the start of my personal crusade for safety—the spark that ignited our organization. It led us to entirely rethink the way we had been doing business.

### How could the error have been prevented?

Our root cause analysis revealed that a simple change in the placement of medications in our dispensing machine might have prevented the error. The staff quickly made that correction, but it was not enough. Our hospital needed to look at all aspects of practice and find out what else could be done to make patients safer.

During the next year, the patient remained in our care in a vegetative state. We saw the family daily, and the patient received the best supportive care Mary Lanning could provide. As the year progressed, his son and daughters had to return to their daily activities, but visited frequently. The patient's wife remained at his side. Housing and food were provided for her and the children when they came to visit. The hospital staff gave the family support and any information they wanted during that year. On Thanksgiving, the staff provided dinner in the hospital for the extended family.

#### **Making Mary Lanning a safer place for patients**

The hospital staff invited the patient's family to participate in our root cause analysis. We talked often with them about what we were doing to make our organization a safer place. Staff members asked the family for their opinion on our actions and incorporated their ideas into our thinking.

Everyone on staff knew we had to make Mary Lanning a safer place for patients. Together we began to question why someone had not corrected this simple medication placement previously. In the past, someone must have made the same mistake of pulling the wrong drug.

Why did the staff not raise red flags and cause a change to be made? Had we gotten so complacent that we didn't envision it might happen to someone else? Did the hospital make it so difficult to make changes that we didn't try to make them? Were our processes so complex and unworkable that staff had designed shortcuts around them?

Our sentinel event caused us to examine the employee orientation program to see if we were focusing new people on patient safety. It made us ask ourselves, "Are we encouraging people to report, or do they think they will be fired? Do we support the people who make a mistake, or do we punish them? Do employees think we will terminate them for a mistake they make? Have we developed an environment that allows employees to be free of retaliation?"

In the case of our sentinel event, we knew the nurse came forward with what she believed she had done as soon as she recognized that it might be the cause of the patient's condition. We knew we had backed her by providing emotional support and encouragement, and we had not terminated her or placed any restrictions on her. We did not know if the rest of the staff was aware of what we had

done for the nurse. We discovered the nursing staff had reacted to the sentinel event either by internalizing the error and feeling as if they had participated in the failure by being a part of the nursing division—or by blaming the nurse and continuing to feel the error would never happen to them and that the nurse should be punished.

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**"The hospital staff invited the patient's family to participate in our root cause analysis. We talked often with them about what we were doing to make our organization a safer place."**

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As the staff dealt with this patient and his family during the next 9 months while he remained in our care, our hospital family saw the effect we had caused and all of us vowed to do better.

#### **Moving forward**

Mary Lanning has used this sentinel event as a means of spurring us into action. We now focus on patient safety. We encourage reporting near-misses. We encourage staff to question and not be satisfied with any answer that does not correct the problem. We have implemented bar coding for medications and have expanded our approach to participation in national patient quality initiatives.

This was our response, but it is still not enough. There can never be too much emphasis on patient safety; that is why our hospital has started the Quest for Patient Safety. We will always remember this wonderful gentleman and his gracious family, and every time we even think of being complacent, we will bring their story forward.

When the patient's family was told that our hospital had been named a finalist in the American Hospital Association's Quest for Quality Prize, they were pleased and told us, "We knew you would do the right thing, and we are pleased to know you are on the right track." **NPSF**

*Leota Rolls, RN, MSN, vice president of Mary Lanning Memorial Hospital in Hastings, Nebraska, 2004 finalist of the American Hospital Association's Quest for Quality Prize.*

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## Register Early for NPSF's 7th Annual Patient Safety Congress, "Let's Get On With It—Round 2"

This year's NPSF Patient Safety Congress, "Let's Get On With It! Improving the Safety of Patients," emphasized taking action, building cultures that support safety, and implementing best practices. To accelerate the rate of patient safety progress, NPSF will focus the 2005 Congress on critical improvements that will save lives and reduce harm every day.

Plan now to attend "Let's Get On With It—Round 2," May 4-7, 2005 at the Marriott World Center in Orlando. This meeting will focus on high-impact areas in the health system: ICUs; high-risk aspects of surgery, medicine, obstetrics, emergency care, and radiology; medication administration and usage; chronic disease management; and external forces that promote safety.

### We invite your recommendations of patient safety leaders

The Congress will also highlight international safety activities and current patient safety research. Our aim is to showcase organizations and teams that have created exceptional results by implementing programs and solutions

that have achieved near-zero tolerance in error or have resulted in significant and tangible improvements. You are invited to submit recommendations of these exceptional leaders to Carol Lieser at [clieser@dc.rr.com](mailto:clieser@dc.rr.com).

### It's easy to register online

Register early and save! If you sign up by March 19, 2005, the Early Bird registration fee is \$895 per person; the one-day rate is \$525. For more information and to register online, visit [www.npsf.org](http://www.npsf.org).

NPSF has secured a block of rooms for Patient Safety Congress attendees at the Orlando World Center Marriott at the discounted rate of \$173 per night (single or double), plus tax. The Congress online registration form at [www.npsf.org](http://www.npsf.org) contains a hyperlink to Marriott Reservations. Or you may call Marriott Reservations at (800) 564-3181. Be sure to use the Congress code "NPFNPFA" to receive the discounted rate. For an exhibitor and sponsor prospectus, call NPSF at (703) 506-3280 or e-mail [info@npsf.org](mailto:info@npsf.org). **NPSF**

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