

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

Alchemy: Medical Mediation at Its Best

BY MARTHA E. GAINES, JD, LL.M., DIRECTOR, CENTER FOR PATIENT PARTNERSHIPS, UNIVERSITY OF WISCONSIN-MADISON; AND SUE SANFORD-RING, MS, DIRECTOR OF PATIENT AND FAMILY SERVICES, UNIVERSITY OF WISCONSIN HOSPITALS AND CLINICS

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"Conflicts and differences are an inevitable part of our work and relationships in health care. How we handle those differences affects what we can and cannot accomplish as people and as professionals. To benefit from those differences, we must not only be prepared to change what we do, we must also be ready to examine and perhaps shift the very assumptions that impel why we do it."

—Leonard J. Marcus
*Renegotiating Health Care:
Resolving Conflict to Build Collaboration¹*

Anyone experienced in patient relations knows that relatively minor problems often consume the most time and resources. Many of these problems involve communication breakdowns where patients feel frightened and powerless, culminating in the dissolution of the patient/physician relationship. As in the case study below, many patients take this frustration to a lawyer's office to explore the possibility of a lawsuit. Lawyers spend considerable time listening to the patient's frustrations, but in the end, there are no violations of the law and lawyers usher these clients to the door—still unsatisfied.

While good patient/physician relationships are the best way to head off communication breakdowns, healthcare institutions would do well to consider dispute-resolution measures, such as mediation, as early as possible. Following is an actual case mediated by the authors, Martha Gaines, director of the Center for Patient Partnerships, a patient advocacy center at the University of Wisconsin-Madison, and Sue Sanford-Ring, director of patient and family services at the University of Wisconsin (UW) Hospitals and Clinics.

Case in Point: Tom Davis

Tom Davis (not his real name), a grocery store employee in his mid-50s, underwent a second surgery for a localized cancer. While completing the consent form on the day of surgery, Davis wrote, "Do not remove any bone." Just before surgery, the patient tried to discuss with Dr. Peterson (not his real name) his deep fear of disfigurement

that originated with a horrifying childhood experience when he saw a disfigured car wash attendant. Prior to Davis' second surgery, Dr. Peterson promised that no bone would be removed. He reassured the patient that he would wake him up to get his permission if he needed to remove bone.

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During the operation, Dr. Peterson saw what he thought might be the beginnings of cancer in the tissue directly over the bone, with some suspicious pock-marking on the bone surface. He decided to scrape the tissue away and sample the bone by taking a small scraping for analysis. There was no outward visible sign that a biopsy occurred. Dr. Peterson hoped that if there was cancer, he had removed it in the early stages.

After the surgery, Dr. Peterson told Davis the good news: there was no additional cancer in either the tissue or the bone sample. Much to Dr. Peterson's surprise, the patient was outraged that Dr. Peterson had, in his view, violated their agreement that no bone would be removed. This was, for Davis, the straw that broke the camel's back in a relationship that had included several heated exchanges, with both men expressing their frustration at the other's

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intransigence. Dr. Peterson was confused by Davis' angry response to what he thought was good news, and was not sorry when the patient immediately terminated their relationship.

The patient seeks help from attorneys

Davis selected another physician in the same group practice to continue his medical care, and met with several attorneys to explore possible legal action. After those meetings, Davis felt he had a "great case," but that there were insufficient damages to motivate a lawyer to file a lawsuit.

"When all the mediation participants had arrived, Dr. Peterson stepped outside the room and called his office to direct that he not be interrupted for any reason. This conversation, overheard by all, formed a powerful beginning to a very effective meeting."

Davis and his wife, Kristi, remained incredibly frustrated, seeing nowhere else to turn. One night while watching the local news, they saw a story about the Center for Patient Partnerships at the University of Wisconsin-Madison. The Center is a multi-disciplinary patient advocacy resource staffed by students pursuing health-related careers.

The Davises contacted the Center's director, Martha Gaines, who met with them and suggested they consider mediation with the physician and Sue Sanford-Ring, director of the Patient Relations Program at UW Hospital and Clinics. Davis agreed, and gave his permission for them to talk about his concerns.

Mediation gets to the heart of the problem

Gaines and Sanford-Ring met and discussed Davis' concerns. Sanford-Ring had reviewed the medical record and noted the patient's direction that no bone be removed was indeed documented as he described. There was no indication by any member of the healthcare team that there was any follow-up on the patient's directive. Gaines and Sanford-Ring agreed that there was an issue that might be effectively remedied by mediation. Davis was angry with Dr. Peterson,

which appeared to be based more on his feeling of the physician's lack of respect for him throughout their relationship than on the specific results of the surgery. On the other hand, the apparent lack of follow-up on Davis' directions on the consent form was troubling.

Sanford-Ring contacted Dr. Peterson to request his participation in the meeting, and shared the patient's concerns with him. Dr. Peterson recognized that Davis was very angry and that their interactions had not always gone well. He felt it was important to get the patient's concerns addressed and resolved to the extent possible.

Gaines met with Davis and asked him to write up what he wanted to say to Dr. Peterson at the mediation. Not surprisingly, the patient's remarks reflected his anger more than his hurt, and Gaines thought that if left unedited, the comments could cause a deeper rift. When they met again, she gave him her edited version, which Davis promised to consider.

On the day of mediation, Gaines talked with the Davises just before the meeting. The patient brought his remarks into which he had reinserted several of his original, strongly worded criticisms of Dr. Peterson's behavior. Gaines again stressed the potential unproductive effect of those remarks on his attempt to communicate his real objections to Dr. Peterson. Davis indicated he understood and would proceed as he saw fit.

When all the mediation participants had arrived, Dr. Peterson stepped outside the room and called his office to direct that he not be interrupted for any reason. This conversation, overheard by all, formed a powerful beginning to a very effective meeting.

Dr. Peterson began the meeting by saying how thankful he was that the Davises had come in, and that he knew this was a difficult thing to do. He wanted first to apologize that their poor communication had gotten in the way of the patient's care. "Although I've never had your disease, I understand that it is difficult enough to be sick, and I am supposed to make it easier on you, not harder. I am truly sorry for my part in adding to your distress," he told Davis.

Next, the patient was invited to share his feelings. Davis commented that he was going to read from his prepared remarks as he was feeling quite nervous and didn't want to say anything he might regret. While Davis read his remarks his voice trembled—he was visibly moved by the experience.

After hearing his concerns, Dr. Peterson told Davis that when he took the bone biopsy, he believed he was acting

consistently with his understanding of the patient's concerns and that he was maximizing Davis' chances of survival.

Knowing the patient's frustration with his attempts to communicate with Dr. Peterson, Kristi Davis interjected that they just hadn't felt able to get their wishes across to Dr. Peterson throughout the course of her husband's care, and she began to cry. They felt Dr. Peterson had met their attempts to raise questions with frustration. The Davises were frightened and angry and didn't know where to get help.

Davis recalled an evening phone conversation where both he and his wife felt like Dr. Peterson had yelled at them when they had tried to get additional information. Dr. Peterson immediately apologized for any time he might have seemed short and then leaned back in his chair and smiled, saying, "From the beginning, Tom, it was clear that you and I had a lot in common. We are both alpha dogs, and I think it's fair to say that our interaction has been characterized, for better and for worse, by that."

After what seemed to Gaines and Sanford-Ring like the longest second in history, Davis smiled and replied, "I guess that's true. You know, in another time under different circumstances, you and I probably would have been friends, doc."

Kristi Davis continued, "We didn't know what to do, so we went to lawyers. We had no idea that a meeting like this was even possible until we talked with Martha Gaines." Davis disclosed that in his worst moments, he had had thoughts of "getting even." Dr. Peterson replied, "I am really glad you came, I know how hard it is to do this and I really appreciate it. I'm sorry for adding to your pain."

After Dr. Peterson left the room, the Davises were visibly relieved and commented on how much it meant to them that Dr. Peterson had listened to them and apologized for his part in a relationship that had not served either man well. They understood for the first time what Dr. Peterson was thinking when he scraped the bone for a biopsy—or perhaps they just finally felt heard and honored by him. In either case, the Davises went home with their peace of mind restored. Dr. Peterson, too, was relieved to have had the meeting. He seemed pleased that a source of stress for him had been resolved and that there was real closure to the relationship for all of them.

Lessons Learned:

- **Involve 2 people in a case.** This is crucial to prepare the parties for a productive exchange, lay fair ground rules and help the parties feel there is someone in the room

who is committed to ensuring their voice will be heard.

- **The problem that comes in the door is not always the problem to be mediated.** Often, the initial complaints do not reflect the heart of the problem, but merely express symptoms of the real issue. It is thus necessary to "download" the patient's panoply of feelings first and gradually discover which are at the core. Preparing parties for mediation involves defining the real issues and, where possible, leaving posturing and defensiveness behind in favor of real communication and understanding. This happens only when a person feels heard and understood.
- **Get the real facts.** There is no substitute for a thorough understanding of what actually happened in a given situation. Feelings are important, but facts are vital to integrity in mediation.
- **Understand and set a realistic goal for the mediation.** If a relationship incurred too much damage, don't strive to repair it. Acceptance of how things are is a noble goal and a valuable outcome.
- **If the relationship can be repaired and communication restored, patients will take more responsibility in caring for their health.**
- **Good communication makes satisfied patients and physicians.** Satisfied patients don't sue their doctors.^{2,3}

The participants gain a new perspective

Dr. Peterson never considered that his actions in the operating room might have been contrary to the patient's wishes and interests. So why did this problem arise? As usual, both parties bear some responsibility for their communication failure. Dr. Peterson is an extraordinarily talented and, therefore, busy man who probably did not spend the time necessary at the outset to establish the trust so critical in relationships where patients are frightened for their lives. When Davis felt Dr. Peterson's time constraints, he was hurt and then angry that he did not get the time he felt he deserved.

There are institutional resources that could have intervened at several points along the way had either party raised the issues earlier. This is a typical patient complaint—a classic example of a problem that is often avoidable and is extraordinarily time-consuming to address. It is likely that more time was spent dealing with this issue after the fact than would have been required had it been raised in a timely fashion. **NPSF**

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New Illinois Learning Collaborative Focuses on Medication Reconciliation

BY CATHY GROSSI, JD, BSN, SENIOR DIRECTOR, HEALTH POLICY AND REGULATION, ILLINOIS HOSPITAL ASSOCIATION

Most medical errors today result from problems in the complex healthcare system, such as the proliferation of pharmaceuticals with names that sound alike, and the increased likelihood for miscommunication when many individual practitioners care for a patient in multiple care settings. In the wake of the Institute of Medicine's 1999 landmark study, *To Err is Human: Building a Safer Health Care System*,¹ Illinois hospitals, like many around the country, recognized that patient safety is a broad issue that goes beyond any individual caregiver or facility.

The Illinois Hospital Association (IHA), which represents 200 hospitals and health systems, has established the Patient Safety Steering Committee to facilitate guidance and direction for advancing a culture of patient safety in hospitals throughout the state. The committee's charge includes identifying leadership opportunities that contribute to coordinated systemwide safety improvements beyond a single organization.

**“Collaborative learning networks
...provide a mechanism for
transferring evidence-based
knowledge and information
and a dynamic means for
supporting cultural changes
and team skills-building.”**

IHA initially developed an “Organizational Framework for a Culture of Safety,”² a resource template for hospitals outlining leadership and safety strategies from accreditation authorities, government sources, literature searches, and hospitals' insights. The template serves as a checklist of key organizational components hospitals can use to gauge their efforts to evolve to a culture of safety. More than 90% of Illinois hospital CEOs signed a pledge adopting the framework, demonstrating their commitment to actively promoting patient safety as a top organizational priority.

In spring 2004, IHA compiled a Quality/Patient Safety Data Guide³ as a one-source reference document. The guide summarizes the many state and federal quality and patient safety reporting activities—both mandatory and voluntary—that

involve Illinois hospitals. This document serves as a resource tool for IHA members and shows the public and policymakers the amount of reporting activity that Illinois hospitals are engaged in with industry stakeholders to improve quality and patient safety.

New initiative: Unique learning network on patient safety

At the recommendation of the Patient Safety Steering Committee, IHA will soon launch the Patient Safety Learning Collaborative, based on the model developed by the Institute for Healthcare Improvement (IHI) for supporting organizational change and improving patient care.⁴ Collaborative learning networks involve expert faculty and peer exchanges; the networks provide a mechanism for transferring evidence-based knowledge and information and a dynamic means for supporting cultural changes and team skills-building. The forum speeds the adoption of successful strategies for implementing and disseminating best practices for patient safety by providing real-time access for interaction and collaboration.

While IHA's initiative adheres to the IHI collaborative formula, including face-to-face learning sessions, virtual connectivity and real-time access to organizational coaches, it also adds a unique “homegrown” dimension, benefiting from IHA member safety experts and local connections. IHI faculty and former participants, some serving on the IHA Patient Safety Committee, are lending their time and guidance to the IHA collaborative. The Chicago Patient Safety Forum (CPSF), a community-based coalition dedicated to facilitating system approaches for improving safety and affiliated with the Institute of Medicine in Chicago, also is providing regional expertise and fundraising support to offset program expenses.⁵

Initial focus: Medication reconciliation

IHA has selected medication safety—a key component of patient safety—as the first focused improvement initiative for its regional learning collaborative. The number of prescriptions in the United States is 3.4 billion a year.⁶ Patient injuries and deaths resulting from medication errors are among the most common types of adverse events in hospitals.

Patients who experience adverse drug events (ADEs) have longer, more expensive hospitalizations than those who do not. The Agency for Healthcare Research and Quality (AHRQ) estimates the ADE incident rate is between 2 and 7 per 100 hospital admissions, with a mean cost of \$4,685 per incident.⁷ Patient transfers into, within, and out of the hospital are

high-risk times for adverse medication events. Hospital chart reviews show that up to 60% of ADEs occur at these key transitions in patient care.⁸ One safety strategy, medication reconciliation, has been developed and promoted by researchers, IHI and the Massachusetts Coalition to Prevent Medical Errors as a systems approach to prevent ADEs. In July 2004, the Joint Commission on the Accreditation of Health Care Organizations added medication reconciliation as one of its National Patient Safety Goals for hospitals to implement by January 2006.⁹

“A recent study found that [reconciling medications] reduces the rate of medication errors by 70% and adverse medication events by 15%.”

Reconciling medications is a systematic process that develops an up-to-date, one-source medication profile for all caregivers' reference during an individual patient's admission, transfer and discharge. Any discrepancies or inconsistencies revealed by comparing the real-time profile against newly written physician orders are brought to the attention of the physician and, if warranted, changes are made to the orders.

Through this medication reconciliation process, the appropriateness of patients' medications is verified. This improvement process promotes seamless communication among the patient's caregivers and appropriate medication therapy to avoid inadvertent duplications or omissions. The intended outcome is that each patient receives the right medication, in the right doses, at the right time along the continuum of care.

What is the potential impact of reconciling medications? A recent study¹⁰ found that this process reduces the rate of medication errors by 70% and adverse medication events by 15%. Reconciling medications also greatly improves staff efficiency in managing medication orders by reducing nursing work time at admission and pharmacist work time at discharge.

By January 2005, IHA plans to recruit 20-25 hospitals that will designate interdisciplinary teams to participate in the 9-month collaborative. The first learning session is scheduled

for February 2005 with faculty including John Whittington, MD, patient safety officer, OSF Healthcare System, Peoria, Ill and a safety scholar for IHI; Clark Fenn, vice president, Holyoke Hospital; and Bruce Lambert, PhD, associate professor, University of Illinois at Chicago College of Pharmacy and member of the Chicago Patient Safety Forum steering committee.

The regional initiative is an innovative way for the Illinois hospital community to collaborate more closely and exchange ideas, strategies, and lessons learned on preventing patient harm and promoting better patient outcomes—without reinventing the wheel. Collaboration for the IHA initiative is not limited to the hospital community. The effort involves numerous stakeholders and experts, including the CPSF and other Illinois groups.

Over time, the project will demonstrate to the public the commitment of IHA and hospitals to improving patient safety and in advancing the safety culture. It is hoped that the new knowledge and lessons learned can be disseminated and will be useful as a model for the wider hospital community. **NPSF**

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NPSF's Stand Up for Patient Safety Program offers a multifaceted approach to assist hospitals in their patient safety efforts by providing resources and tools to member hospitals on an ongoing basis.

These best practices are supplemented with audio conferences and discussion forums to facilitate their learning and implementation.

Join over 170 hospitals and hospital systems to improve patient safety. Visit the Stand Up for Patient Safety Web site at <http://www.npsf.org/html/StandUp/standup.html>.

Patients and Families Can Offer Key Insights in Root Cause Analyses

BY DAVID M. MUNCH, MD, CHIEF CLINICAL AND QUALITY OFFICER, EXEMPLA LUTHERAN MEDICAL CENTER

The patient's father, an articulate, well-respected attorney, was quite frustrated with the care his daughter had received in our hospital. He requested a meeting with the senior team and opened the conversation by saying, "I am not interested in suing you. I am interested that you take steps so that what happened to my daughter won't happen to other patients in your hospital."

He then described his daughter's experience during her 6-day hospital stay:

- The family was not kept informed or involved in her care;
- There was poor communication among teams;
- Pain was not adequately controlled;
- There were unnecessary and significant delays;
- Mistakes were made in medication management; and
- The hospital was not properly staffed.

What do patients and their families expect of hospitals?

At the end of the discussion, the patient's father made 8 simple requests:

1. **Be open and honest.** So much time was wasted on hiding what was going on.
2. **Prioritize inpatient care.** It's not appropriate for the sickest to wait while elective or less-urgent patients get more timely service.
3. **Learn humility. If you don't know, say so.** Please do not treat the family in a condescending manner.
4. **Listen to the family and patient about their needs.** Involve them in the care process.
5. **Don't believe exclusively in 1 or 2 tests.** Assess the patient.
6. **Improve your pain management processes.**
7. **Find appropriate staffing.**
8. **Get the bill right.**

That meeting was very long—and very necessary. It was apparent that our hospital did not meet his daughter's needs, and there was work to do to honor his requests. We decided to perform a root cause analysis (RCA) on this case and asked the family if they would be willing to participate.

Gaining insight from patients and their families

Little has been written about involving patients and families in root cause analyses. Thus, we have considered what

has been learned about debriefing to guide our decisions in involving families. Debriefing is used to evaluate significant events to learn as much as possible about them. The objective: to better handle similar situations in the future. However, debriefing does have its limitations.

"Our decision to invite the family to participate in the root cause analysis was based on our desire to discover their insight and respond to their concerns."

"[Debriefing] is totally inappropriate in form and orientation to deal with bereavement and acute grief," write Beverley Raphael, MD, and Sally Wooding, PhD.¹ If the event resulted in a death or significant loss, having the patient or family participate in debriefing or an RCA could do even more harm by exposing them to the event again. If, on the other hand, the event does not involve a significant loss and the patient and family are willing to engage, participation in an RCA process could provide valuable information for improvements and help in the healing process.

Our decision to invite the family to participate in the RCA was based on our desire to discover their insight and respond to their concerns. After the family decided to participate, they determined that the father would be their most appropriate spokesperson.

Measuring the risk of trauma to the family from RCA

Our evaluation concluded that there was little risk of causing further trauma to the father for several reasons:

- Even with his frustration, he was never critical of people and even praised many of the caregivers for their efforts;
- He focused on our broken processes, poor communication, and our inability to involve the family in the care, even though they had significant knowledge of their daughter's chronic condition;
- His daughter fully recovered, even though her care was not ideal; and

- This gentleman had a sophisticated awareness of organizational dynamics and knew that solutions could be achieved with systems improvement, not with blame.

Meet with team members before the RCA

As we discovered, simply informing the team that a patient or family member will be participating is not sufficient. Meeting with team members who cared for the patient on an individual basis prior to the RCA allows them to express their opinions and feelings without others present. This gives us the opportunity to explore their issues more deeply and to reassure the team.

In this instance, the meeting began with a discussion of the RCA process for the entire team, a genuine thanks to the members for their commitment, acknowledgement of their dedication, and reinforcement of the expectation that this would be a safe environment for improvement and growth.

During the review, we realized we had little appreciation of the family and patient's need to be kept informed of the processes that affected her care. Throughout the patient's stay, we missed many opportunities to communicate with the family and involve them in the care process. It was only with the presence of the patient's father at the RCA that these came to light.

During discussion of the staffing issues in the emergency department, the father said, "The family is blind to your staffing issues. They have a right to know you are being slammed and that there could be care delays. What steps can you put in place to keep us more fully informed?"

Offering staff a rare opportunity to debrief

After the family member left, we gave the team a chance to debrief. They openly expressed their feelings about the case and the RCA process. "I try very hard," said one nurse. The pediatrician volunteered, "I make mistakes every day."

This was a rare opportunity to describe how better processes could address these issues and give needed support to these hard-working, dedicated clinicians. It also reinforced the value of a debriefing for staff members involved in the RCA process.

Evaluating lessons learned

In the final RCA session, we reviewed the activity of the previous meeting as well as the team's progress in addressing opportunities for improvement. The team then completed a review to finalize action plans and measures of success. At the end of the meeting, the patient's father volunteered, "You have exceeded my expectations and have done far more than I anticipated you would. Thank you for taking this seriously." This experience gave us the opportunity to reestablish trust with this family and improve care for future patients.

"Throughout the patient's stay, we missed many opportunities to communicate with the family and involve them in the care process. It was only with the presence of the patient's father at the RCA that these came to light."

What to consider before including patients or families in an RCA

Involving patients and family members in root cause analyses can enrich the outcome if done properly. The staff needs to be prepared and supported throughout the process. The RCA facilitators have to be skilled in managing the meeting to assure a safe environment and open communication.

Before committing to involve the patient or family members in this process, the healthcare team should discuss the potential effectiveness of their participation. Assess their vulnerability, their emotional condition and the risk of causing them more harm. If the risk is low, you have the opportunity to make more effective improvements and contribute to the healing process for all involved. **NPSF**

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

To submit articles or publications for possible review in Focus, please direct materials to: Lorri Zipperer, Managing Editor, Focus on Patient Safety, National Patient Safety Foundation, 8405 Greensboro Drive, Suite 800, McLean, VA 22102-5120. Materials, inquiries, and subscription requests for the publication will be accepted electronically at info@npsf.org or via fax at (703) 506-3266.

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Patient Safety Awareness Week Set for March 6-12, 2005

Hospitals, communities, and organizations across the United States will celebrate National Patient Safety Awareness Week (NPSAW), March 6-12, 2005.

Leading the way is the National Patient Safety Foundation's more than 170 Stand Up for Patient Safety Hospitals and healthcare systems, which will hold special activities for patients, families, and healthcare providers. The theme for NPSAW is "Focus on Patient Safety: Ask, Listen and Learn."

National Patient Safety Awareness Week, coordinated by NPSF, encourages hospitals, healthcare systems, and providers to partner with patients

and their families in the delivery of medical care to reduce medical errors and improve safety. Providers are encouraged to speak in terms their patients will understand when communicating information regarding their health care.

"National Patient Safety Awareness Week is a call to action that promotes patient safety and the importance of listening as one of the 'Patient Safety Tools of Choice' in improving safe outcomes," said Diane C. Pinakiewicz, NPSF Interim Executive Director and board member.

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