

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

Fulfilling the Promise of Health Information Technology

BY DAVID J. BRAILER, MD, PhD, NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY,
AND CAROLYN M. CLANCY, MD, DIRECTOR, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

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"And so the fundamental question is, how do we encourage information technology in a field like health care that will save lives, make patients more involved in decision-making, and save money for the American people? That's what we're here to talk about."

—President George W. Bush

Address at the Cleveland Clinic, Jan. 27, 2005

Just a year ago, "HIT" was an abbreviation that few Americans would recognize. Health Information Technology was not yet a prominent issue on the national agenda. Indeed, when asked, many Americans said they thought key elements of HIT—like electronic health records—were already in place.

US goal: Electronic health records for Americans in 10 years

Today the federal government is playing a leadership role in HIT. President Bush discussed HIT in his 2004 State of the Union address and identified it last April as one of the areas of technology most important to the nation's future. The president created the new position of National Coordinator for Health Information Technology, charged with achieving his HIT goals—including electronic health records for most Americans within 10 years.

This January, when President Bush went to the Cleveland Clinic to press the case for HIT, Americans were ready for a more complete understanding of its goals, including the crucial importance of "interoperability" of health information systems to achieve the benefits HIT promises.

Of course, HIT has a longer history. The Agency for Healthcare Research and Quality (AHRQ), along with its predecessor agencies, has a 30-year record of support for informatics research that has helped lay the groundwork for the HIT initiative. But beginning in 2002, AHRQ's renewed focus on HIT actually grew out of the agency's active role in patient safety. The emerging prominence of HIT has closely followed the public awareness of the patient safety issue. The Institute of Medicine's landmark 1999 report,

To Err Is Human, made it clear that information technology has powerful and unique potential for reducing errors and helping clinicians deliver the highest-quality health care.

"...AHRQ's renewed focus on HIT actually grew out of the agency's active role in patient safety. The emerging prominence of HIT has closely followed the public awareness of the patient safety issue."

Many information technology tools are already clearly appropriate for enhancing patient safety. This observation is well-founded in the scientific evidence that shows that checking for drug interactions and allergies, using evidence-based decision support, and issuing preventive care reminders can systematically and reproducibly improve care.

For example, a 2003 study from the Center for Information Technology Leadership at Harvard University showed that nationwide adoption of ambulatory computer physician order entry could prevent more than 2 million adverse drug events and nearly 190,000 hospitalizations each year. This would save up to \$44 billion annually through reduced medication, radiology, laboratory, and hospitalization expenditures.¹

However, to make HIT tools realize their true potential, they should be placed within their broader social potential to change the market for healthcare services. This will be accomplished by health information exchange and

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interoperability, ie, health information systems in which a patient's health information can be retrieved—with his or her authorization—from multiple sites so it can be shared with clinicians who need it.

Understanding the importance of interoperability

Interoperability is the key to achieving HIT's purpose: to bring together the information required for proper treatment, specifically for the patient being treated, at the time and place it is needed. Systems must be interoperable to exchange patient health information among disparate clinicians and other authorized entities, in real time and under stringent security, privacy, and other protections.

As the industry moves to accelerate the development and use of HIT, a commitment to interoperable systems will make the difference between building a linked healthcare system that is patient-centered and information-rich, or prolonging a de-linked system in which information remains in silos, whether in paper or electronic form. For example, seamless flow of information on an individual's medications across care settings could prevent a substantial percentage of "reconciliation" errors that are now a focus in many communities.

Lack of access to complete, timely healthcare information is a common cause of medical errors and of wasteful duplication. Healthcare information exchange and interoperability will allow clinicians, for the first time, to access full information about each patient—and consumers will be able to move easily among clinicians without fear that their information will be lost. Reduced costs promise to be significant: more than \$77 billion per year resulting from interoperability efficiencies alone, according to a recent estimate.²

Identifying the building blocks

There are 3 building blocks to achieving health information exchange and interoperability:

1. Adoption of electronic health records (EHRs);
2. Regional collaborations; and
3. Developing a national network that provides technical standards to support regional collaborations.

Difficult as the task will be, America needs to move forward on all of these goals together, with a constant eye on coordination among them. To meet the president's challenge, EHRs must be in physician offices, hospitals and other clinical setting and used routinely by clinicians.

Beyond simply developing these electronic records, however, EHRs must be connected through support systems and

technical capacity to be able to transmit and receive information from others in a secure and intelligible manner. Stand-alone EHRs, even if widely adopted, cannot enable the necessary error reductions, cost savings or marketplace changes. Therefore, clinicians need to be linked, or in the president's words, "We need a "Medical Internet."

“Access to the right information about the right person at the right time and place will present a new level of opportunity to provide the most appropriate care and avoid errors.”

Finally, widespread sharing of patient-specific clinical information will require oversight and operational management that is not in place today. Consistent procedures will be needed to support routine processes including access and protection. Because healthcare is delivered locally, this kind of oversight can best be carried out on a regional level. Healthcare organizations need to support Regional Health Information Organizations (RHIOs) and the grants used to evaluate them in order to make interoperability occur without new federal regulations.

Investing in EHR

Achieving these HIT goals will not be simple. Physicians, especially those in small practices, will need to perceive benefits that outweigh the financial and nonfinancial barriers to EHR investment, including the need for retraining and changes in work flow. The development of EHRs and the building of the national network also will need to proceed in a coordinated fashion to achieve interoperability.

With these building blocks in place, patients and clinicians will have information tools at their disposal unlike anything that exists today. Access to the right information about the right person at the right time and place will present a new level of opportunity to provide the most appropriate care and avoid errors.

An information-rich healthcare system will enhance transparency and clinicians' ability to match scientific information

Patient Safety Leadership Fellows: Innovative Leaders Advancing Cultures of Safety

BY DUFFY NEWMAN, MHA, SENIOR DIRECTOR OF LEADERSHIP DEVELOPMENT & FELLOWSHIPS, HEALTH RESEARCH & EDUCATIONAL TRUST, AND ERIC KNOX, MD, CURRICULUM ADVISOR, PATIENT SAFETY LEADERSHIP FELLOWSHIP

"I came to the Fellowship intending to learn more about the scope of patient safety and to implement a project at our medical center. I ended the Fellowship understanding that the work of safety is never-ending personal mastery, teachable moments, and catalyzing and leading change at all levels and in all directions in the system where I work. Keeping all patients safe has become a personal mission and will direct my career."

—Donald W. Moorman, MD
Associate Professor of Surgery
Harvard Medical School

How can healthcare organization leaders build and sustain a culture of safety with attributes articulated, understood, and practiced not only at the executive level, but at the

point of care? Culture and attitude are at the core of creating safer systems of care.

"Culture makes it possible for people to know just how to act to support the organization or group they are in," says Justin W. Schultz, MD. "These social actions—the way we do things around here—develop into patterns that are recognizable as they become stable."¹

All organizations have cultures; however, many cultures are defined by default rather than by design. To intentionally create healthcare delivery systems with the potential to do no harm—achieve zero defects and save lives—health leaders must think beyond what is. They must embrace the vision

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Fulfilling the Promise of HIT

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to an individual's needs and preferences. Looking farther into the future, an interoperable system can help transform health care by putting consumers at the center of their care. Clinical information will not only follow the consumer; consumers will take a more active role in their health management.

Patients maintain personal health records

Personal health records (PHRs) will be fundamental to consumer-centric health care. Where records are interoperable, they will provide consumers with portability and choice—not just choice of clinicians, but of treatment options. PHRs can be integrated with EHRs or independent, in which case they are populated and maintained by the patient.

For a striking number of Americans, the need is already self-evident: a recent survey by AHRQ with the Kaiser Family Foundation and the Harvard School of Public Health found that nearly 1 in 3 people say that they or a family member have created their own set of medical records to ensure their healthcare providers have all of their medical information. This finding reflects a growing interest among patients for playing a more active role in managing their health and health care, which can be enhanced by bringing the power of HIT to PHRs.

The Institute of Medicine's November 2003 report on patient safety stated that achieving predictably safe health care will require "... improved information systems and a culture of safety."² The knowledge that errors and near-misses are currently pervasive in health care has motivated broad support for accelerating HIT implementation.

A fully interoperable electronic healthcare system will translate the vision of patient safety champions into the new baseline for all aspects of health care—from the way care is delivered by clinicians to the way consumers choose among clinicians and even treatment options. Working together, everyone involved in the American healthcare system can achieve this vision. **NPSF**

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David J. Brailer, MD, PhD, was appointed the first National Health Information Technology Coordinator on May 6, 2004. His duties are to execute the actions ordered by President Bush in the Executive Order issued on April 27, 2004, which called for widespread deployment of health information technology within 10 years to help realize substantial improvements in safety and efficiency.

Carolyn M. Clancy, MD, is director of the Agency for Healthcare Research and Quality (AHRQ). She is a general internist and health services researcher and serves as a Distinguished Advisor to the National Patient Safety Foundation.

Patient Safety Leadership Fellows

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that a culture of safety is possible and will lead to enhanced outcomes and superior performance as an organization.

Leaders in high-reliability organizations realize:

- Culture is local;
- Change is the work of teams;
- Communication must be a focus; and
- Respect for the wisdom of front-line workers is central to advancing safety.

“[T]he Fellowship allows innovative leaders to build skills, challenges them to think differently, and helps them create and contribute to safer systems of care around the world.”

What is the role of leadership in patient safety?

Senior leadership enables—but cannot create—a culture of safety. On the other hand, poor leadership can ensure that a culture of safety will never happen. The broad skill set and will to succeed are an ongoing challenge, and the journey to broaden effective skills throughout an organization is never finished.

Leadership is not an exact science, but it should not be a mystery. Leaders can learn and apply practices that help them lead effectively. Health leaders, faced with constant change, must be able to respond to the complex systems for which they are responsible. “Hour to hour, day to day, week to week, [leaders] must play their leadership styles like a pro—using the right one at just the right time and in the right measure,” says Daniel Goleman, PhD.²

Fellowship program builds patient safety leadership skills

More than 115 Fellows have participated in the Patient Safety Leadership Fellowship program offered by the Health Research & Educational Trust and NPSF. These executives are broadening their personal and organizational leadership skills while learning and working to advance the science of safety.

Each Fellow or team of Fellows is responsible for designing and implementing a project that advances the culture of safety in their organization. Through the application of new mental models, frameworks, and evidence-based practices in care, Fellows are making significant strides and have valuable stories to share.

Caring deeply enough to risk changing the order of things, while not knowing what direction will emerge, takes tremendous courage. It also calls for deep trust in the team’s creative adaptability and embracing collective contribution. Patient safety fellowship leaders are taking a “no holds barred” path to greatness: a path toward a new way of organizing and leading.

Very few people ask to go on a journey in which the destination is not clearly known—much less when the path hugs a precarious edge between what is known and what is barely imagined and yet to be. The journey is best explored collectively and mindfully. This is a challenge in which no one leader is smart enough, but everyone together is.³ The journey of the Fellowship allows innovative leaders to build skills, challenges them to think differently, and helps them create and contribute to safer systems of care around the world.

A new feature in *Focus on Patient Safety* will highlight the work of past and present Fellows. The Patient Safety Leadership Fellowship program is offered by the Health Research & Educational Trust and the National Patient Safety Foundation in partnership with the American Hospital Association, the American Society for Healthcare Risk Management, the American Organization of Nurse Executives, Health Forum, and the Society for Hospital Medicine.

For more information about the Patient Safety Leadership Fellowship program, please visit www.hret.org. [NPSF](http://www.npsf.org)

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An Essential Patient Safety Requirement: Teamwork in the “C Suite”

BY WILLIAM F. JESSEE, MD, FACMPE, PRESIDENT AND CEO, MEDICAL GROUP MANAGEMENT ASSOCIATION, AND NPSF BOARD MEMBER

One of the most obvious lessons learned over the last few years is that patient safety in healthcare institutions doesn't just happen spontaneously—it is a product of an organizational culture that regularly and systematically reinforces the importance of safety as an overriding value. Creating, nurturing, and maintaining that organizational culture is one of the most important responsibilities of senior leaders.

Patient safety begins at the top

It all starts with the CEO. Without a passionate and committed CEO, one who sees his or her role in assuring patient safety to be at least as important as that in achieving financial success, attaining a culture of patient safety is virtually impossible. But even the most passionate safety advocate in the CEO's office can't make it happen alone.

Just as safe care requires a team effort, with outstanding communication and coordination among the patient care team, creating an organizational culture of commitment to safety requires a similar level of teamwork. The chief financial officer (CFO) must be an advocate for making financial decisions that will best enhance the safety of patients in the organization. The chief medical officer (CMO) and chief nursing officer (CNO) play key roles in setting the expectations for physician and nurse teamwork centered on identifying and reducing safety risks, while continuously improving quality and safety.

The chief information officer (CIO) must assure that caregivers have access to the information they need, when they need it, to optimize safety. And the leaders of medical practices affiliated with each hospital must similarly assure that they support and enhance coordination between inpatient and ambulatory care to maximize safety across the continuum.

All of these “chiefs” in what may be called the “C suite” are key players in creating a culture of patient safety in any healthcare organization. That's why the 6 professional associations representing senior healthcare executives and managers, working together as the Healthcare Leadership Alliance,¹ have joined with NPSF to plan the first Leadership Day in conjunction with the NPSF Patient Safety Congress in Orlando.

The Leadership Day, scheduled for May 4, is designed exclusively for senior leaders of healthcare organizations: CEOs, CFOs, CIOs, CMOs, CNOs, etc. It will make use of case studies

and draw on the experiences of “C suite” leaders from around the country who have learned what works—and what doesn't—in building the kind of organization in which safety initiatives can flourish.

“Without a passionate and committed CEO, one who sees his or her role in assuring patient safety to be at least as important as that in achieving financial success, attaining a culture of patient safety is virtually impossible.”

You are invited to join the leaders of the Healthcare Leadership Alliance, as well as senior executives from hospitals, health systems and medical groups around the nation, for this valuable learning and networking opportunity. **NPSF**

See the back cover for more details on the 2005 NPSF Patient Safety Congress.

See page 7 for a description of key sessions and speakers, and details on the May 4 Leadership Day sessions.

To register for the Congress, visit www.npsf.org/congress or contact Congress Manager Carol Lieser at clieser@dc.rr.com or (760) 323-9505.

William F. Jessee, MD, FACMPE, is president and CEO of the Medical Group Management Association, and serves as an NPSF Board member. Contact him at wfj@mgma.com or (303) 397-7861.

** The Healthcare Leadership Alliance is composed of the nation's leading professional associations for healthcare managers and executive leaders: American College of Healthcare Executives (ACHE), American College of Physician Executives (ACPE), Association of Nurse Executives (AONE), Healthcare Financial Management Association (HFMA), Health Information Management and Systems Society (HIMSS), and Medical Group Management Association (MGMA).*

Stand Up Hospital Wins National Quality Award

BY SHAWN TAYLOR ZELMAN, MPA

The Robert Wood Johnson University Hospital at Hamilton (RWJ Hamilton) in New Jersey, a Stand Up for Patient Safety member, has been awarded the highly regarded Malcolm Baldrige National Quality Award. RWJ Hamilton has demonstrated that by adapting the Malcolm Baldrige criteria for performance excellence, a healthcare provider can achieve breakthrough performance across all levels of the organization. This honor is the nation's only presidential award for quality and organizational performance excellence.

In announcing the results for the 2004 award, the judges highlighted the 204-bed hospital's 90% patient satisfaction rate in the emergency room in 2004, its patient-centered care model, its focus on employees providing quality care, and its commitment to community health.

"The National Patient Safety Foundation congratulates RWJ Hamilton on its leadership in patient safety, and the commitment the hospital has shown to its patients, staff, and community," says NPSF President and Founding Board Member, Diane Pinakiewicz. "Patient safety is an important component of quality care. The Baldrige award is a wonderful recognition of the work that RWJ Hamilton has done in this area."

RWJ Hamilton began its patient safety journey by adopting the Baldrige model's criteria in the late 1990s and by working closely with its state patient safety organization. The Baldrige model consists of 6 important elements: beginning with leadership, strategic planning, customer focus, measurement and analysis, staff focus, and process management.

These 6 elements are vital in implementing and improving a patient safety process according to 2 champions of this effort at RWJ Hamilton: Vice President of Patient Safety Care, Deb Baehser; and Assistant Vice President of Nursing, Sharon Brown. "We identified our strategic objectives for improving our care and made patient safety a key objective," says Baehser.

Another vital component of RWJ Hamilton's success was identifying an "owner" for each leadership team. Each owner was responsible for driving the process and making sure strategic planning was a key piece of the puzzle. When implementing the process management portion of the plan, each category was given a standardized approach that led

to consistent planning steps across the hospital's teams. Brown emphasizes, "You need to develop a commitment of culture change, identify champions in your organization to move ideas through the organization, and develop a strong communications plan."

"In announcing the results for the 2004 [Baldrige] award, the judges highlighted the 204-bed hospital's 90% patient satisfaction rate in the emergency room in 2004."

Both leaders realize the patient safety initiative needs to be continued to carry on the organization's success. "The Baldrige criteria have shown us that there are always opportunities for improvement," says Brown. To scan the environment for ways to improve patient safety, RWJ Hamilton continues its benchmarking efforts with healthcare institutions as well as organizations outside of health care.

To others beginning this process, Baehser suggests "getting involved with your state organizations and state quality programs." Collaborating with local, state, and national programs like Stand Up for Patient Safety can also provide ideas and resources for implementing patient safety initiatives.

NPSF provides Stand Up for Patient Safety participants with resources to help them develop a hospital-driven, patient-focused safety agenda for winning results. The Foundation launched the Stand Up for Patient Safety campaign in 2002 with 17 Founding Members to offer hospitals and health systems a meaningful way to participate in the national patient safety movement. This innovative program provides its current 229 member hospitals and health systems with educational tools and programs, conferences on safety topics, forums for sharing best practices, and materials for internal and external communication. [NPSF](http://www.npsf.org)

For more information on the Stand Up for Patient Safety Program, visit www.npsf.org/standup.

A Preview of May 4-6 Sessions You Won't Want to Miss

7th Annual NPSF Patient Safety Congress Focuses on Improvements That Save Lives

Congress Sessions Target 5 Key Areas

Here are just a few examples of the many sessions on May 5 and 6 at the 7th Annual Patient Safety Congress.

1. Medication Errors: Errors that involve wrong drug, wrong dose, wrong time, wrong patient, wrong route—regardless of location

- A Systems Approach to Reducing ADEs: The Fairview Story
- Practical Approaches to Ambulatory Patient Safety
- Special-Population Strategies: Pediatrics and Geriatrics

2. ICU/CCU ED/Errors: Errors that result from failures in equipment, communications, protocols, change of condition notification, rescue, safety engineering, etc.

- Improving the Effectiveness and Safety of ICU Care: Transformation of the Intensive Care Unit: A National Collaborative
- The Role of Technology in Reducing ADEs: Smart Pumps
- Error Persistence in Fast-Paced Diagnostic Problem Solving: The Intertwined Roles of Cognition, Conversation, and Action

3. Surgical Errors: Errors that involve wrong site, anesthesia, infection, wrong follow-up, informed consent

- Reducing Risk of Wrong-Site Surgery
- Implementation of CMS-SIPP Measures in Surgery: Strategies to Achieve Success

4. Chronic-Disease Management Errors: Errors that involve communications, coordination, patient/family education, failure to rescue, protocol design or applications.

- Getting Started with Rapid-Response Teams
- Using Information Technology to Achieve Safe and Effective Chronic Care
- The Consumer Perspective on Patient Safety
- Managing Transitions: Site-to-Site, Person-to-Person
- The Informed, Activated Patient and Family

5. Role Conflict-Induced Errors: Errors that result from role conflicts among physicians, nurses, safety leaders, patients and families.

- Shaping a Labor/Management Partnership to Advance Patient Safety.
- Lessons learned in Simulation Training
- Look, Then Look Again: The Surprising Power of What We Take for Granted in Clinical Practice
- Error-Proofing Health Care to Improve Patient Safety Using Crew Resource Management
- Partnering for Patient Empowerment through Community Awareness: A Hospital-Public Library Collaborative Program

May 4 Executive Leadership Day

This full-day session, described on page 5, is designed exclusively for senior leaders of healthcare organizations.

The Role of Senior Leaders in Creating a Culture of Passion for Patient Safety—Jeffrey Selberg, President and CEO, Exempla Healthcare, Denver, Colo.

What Can We Learn from the Columbia to Help Lead the Patient Safety Movement?

- Richard Bohmer, MD, will present a Harvard Graduate School of Business Facilitated Case Study; participants will receive the case prior to the conference.
- James Bagian MD, PE, Director, Veterans Health Administration, US National Center for Patient Safety,

Ann Arbor, Mich, will join Dr. Bohmer as a resource on the Columbia disaster and will attend throughout the day.

Patient Safety Teamwork in the C Suite—A presentation by teams that have had successes—and setbacks—in creating an organizational culture that puts patient safety at the forefront of the organization's value system.

- Brian Jacobs, MD, MS, FAAP, Director, Technology & Patient Safety, Cincinnati Children's Hospital (2003 Davies Award Winner)
- Diane Carr, Associate Executive Director, Healthcare Information Systems, Queens Health Network (2002 Davies Award Winner)

To register, visit www.npsf.org/congress or call Carol Lieser at (760) 323-9505

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Plan to Attend “Let’s Get On With It—Round 2!” May 4-6, 2005 in Orlando

“Let’s Get On With It—Round 2!” is the theme for the 2005 NPSF Patient Safety Congress to be held May 4-6 at the Orlando World Center Resort Marriott. The Congress will focus on critical improvements that save lives and reduce harm, with a concentration on high-risk/high-impact areas of medical care. (See details on page 7.)

Leaders and organizations that have made quantum leaps in patient safety by implementing solutions resulting in improvements in culture will be showcased. The NPSF Congress is designed to help patients, family members, physicians, nurses, pharmacists, risk managers, educators, researchers, legislators, manufacturers, hospital administrators, trustees, regulators and government officials, and other patient safety stakeholders share critical information and affordable solutions so progress can be made in preventing medical errors.

New! May 4 Executive Leadership Day

Join senior leaders on May 4 for an Executive Leadership Day on Patient Safety, co-sponsored by the Healthcare

National Patient Safety Foundation®
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Leadership Alliance. For more details, see pages 5 and 7. Visit the Congress Web site regularly at www.npsf.org/congress for more details or contact Congress Manager Carol Lieser at clieser@dc.rr.com or (760) 323-9505. **NPSF**

NPSF Moves Offices

On Feb. 28, the NPSF offices were relocated to:

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