

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

Building the Foundation for a Culture of Safety

BY GEORGIA W. PEIRCE, DIRECTOR OF COMMUNICATIONS FOR PATIENT CARE SERVICE, MASSACHUSETTS GENERAL HOSPITAL

IN THIS ISSUE

Building the Foundation for a Culture of Safety

Facing the Challenge of Eliminating Dangerous Drug Abbreviations

A Look at 9 Years of the National Patient Safety Foundation Congress

Hospitals Nationwide Observe Patient Safety Awareness Week

NPSF Launches *Journal of Patient Safety*

NPSF Calls for Letters of Intent for Research in Patient Safety

Health care has never been more advanced or more complex. The past few decades have been marked by profound medical breakthroughs: the mapping of the human genome; the birth of MRI; novel treatments for stroke; and significant progress in managing chronic conditions such as high blood pressure, diabetes, even pain.

Healthcare professionals continue to be both blessed and overwhelmed by the rapid-fire development of thousands of new medications and the emergence of more precision-oriented technologies being introduced every year. Still, as treatments and technology have advanced exponentially, the practice, delivery, regulation, reimbursement, and development of other fundamental support structures within the healthcare system have not always kept pace.

Confronting the paradox of modern health care

Today's healthcare system is witnessing a profound paradox: medical professionals hold unprecedented potential both to care and to cure—but also to cause great harm.¹

Two highly publicized incidents of “patient death by medical error”—the Betsey Lehman case at Dana-Farber Cancer Institute some 10 years ago and the 2001 Josie King case at Johns Hopkins—brought this issue squarely into focus. These leading medical institutions were immediately forced to thoroughly reexamine their systems, policies, procedures, and practices as they relate to patient safety.

Both of these institutions, to their credit and everyone's benefit, instituted far-reaching changes and improvements. Other healthcare institutions took up the challenge of creating a safer healthcare environment before experiencing a sentinel event.

For example, in 1990, SSM Health Care (SSMHC), based in St. Louis, Mo, launched a long-term commitment to realize systemwide implementation of continuous quality. In 2002, SSMHC became the first healthcare institution ever to be awarded the Malcolm Baldrige National Quality Award.

In 1999, the landmark Institute of Medicine report, *To Err Is Human: Building a Safer Health System*,² served as a nationwide call to action to refocus healthcare leaders' individual and collective attention squarely on the somewhat hidden crisis of patient safety.

More than 5 years later, the individuals and institutions committed to this cause continue to grapple with numerous patient safety challenges, with varying degrees of success.³ Through all of the examination, discussion, and strategizing, one consistent theme has emerged: It's all about culture.

“Through all of the examination, discussion, and strategizing [about patient safety], one consistent theme has emerged: It's all about culture.”

Creating a culture of safety

Johns Hopkins, Dana-Farber, SSMHC, and other healthcare leaders have successfully committed their institutions to creating cultures of quality and safety. These were not overnight transformations. Their efforts involved a substantial and sustained commitment to realizing their goals.

Today a variety of initiatives help leaders tackle the immense challenge of creating cultures of safety in their own institutions. The National Patient Safety Leadership Fellowship offers one such example.⁴ The Fellowship, sponsored by NPSF, the Health Research and Educational Trust, and others, helps train leaders in various aspects of influencing institutional culture change, including complexity theory, creating just cultures, and human-factors studies. What patient safety leaders recognize today is that culture drives quality and safety.

CONTINUED ON PAGE 2

Corporate culture serves as an institutional conscience—the collective expression of shared values. It is how individuals view the world around them and respond when faced with a visible challenge—and when no one is looking. Culture drives individual and collective thinking, decision-making and, most importantly, people’s actions.

Changing or enhancing a culture is a lot like trying to turn around a battleship headed toward an iceberg. Even with a noble purpose, leaders cannot do it alone; ultimately, everyone on board needs to be engaged in the effort, preferably well before the ship starts taking on water.

Leadership bears the enormous responsibility of safely, efficiently, and effectively getting individuals where they need to be, but leaders cannot do this without the cooperation of others. To succeed, those in command must motivate and move people to action—at all levels of the institution. All hands need to be on deck.

It all starts with leadership

The foundation for success lies in creating, communicating, and modeling a powerful institutional vision and guiding principles. Essentially, leadership must clearly, consistently, and universally articulate where an organization is headed; describe who its members are as a community and how the organization functions as a whole; set an expectation for how each individual can contribute to achieving the common quest; and inspire everyone in the organization to participate, take ownership, and take action.

One widely told story illustrates the far-reaching impact a powerful vision can have in an organization. During a tour of NASA headquarters in Houston, President Lyndon Johnson encountered a man pushing a broom down a long corridor. As the president approached the worker and shook his hand, he asked, “Son, what are you doing?”

The man stood proudly, broom in hand, and answered without hesitation, “Sir, I’m helping to put a man on the moon.” Truth or urban legend aside, it is quite clear that this man knew his role in making NASA’s vision a reality.

Building a culture of safety at MGH

As part of its strategic planning initiatives, Massachusetts General Hospital (MGH) set out more than a year ago to re-examine its culture relative to patient safety. The objective was clear: to lead the nation in quality and safety. While this presented a worthy goal, it did not provide a clear vision of what such an organization would look or feel like, nor did it offer employees a picture of how their efforts

could contribute to the larger institutional goal. MGH set out to shape and hone its patient safety culture. Hospital leadership began by creating and empowering a “core culture committee” with members from various areas and role groups from throughout the institution.

This group spent months examining the organizational culture—searching for what made MGH tick, what its people valued—and how that picture differed from where MGH wanted to be.

“What patient safety leaders know today is that culture drives quality and safety.”

The core culture committee dissected the hospital’s three-fold mission: providing the highest quality of care, advancing care through biomedical research, and educating the next generation of practice leaders. They circulated and disseminated a statement from one of the hospital’s founders that expressed its philosophy of care: “When in distress, every man becomes our neighbor.” But the group still sought a fundamental vision statement that bound these vital aspects of the organization together.

As the caregivers listened carefully to the pulse of the organization, something began to resonate. Everyone at MGH was already committed to making a difference in someone else’s life, whether by offering a friendly smile, by successfully diagnosing a complex condition, or by making a discovery with the promise of a novel treatment. And the people of MGH were proud of it. The vision for MGH’s culture came through loud and clear: The MGH community is dedicated to “offering patients and one another our best in every moment.”

By clearly articulating a unifying vision for the institution, MGH is better positioned to focus its efforts, engage its work force in operationalizing its values, and make the hospital’s vision a universal reality. MGH has created a clear picture of how members of the MGH community are expected to think and act.

MGH’s expectation is grounded in the fundamental belief that when people like what they do, they are happy. When they are happy, they are fully engaged in their work. When they are fully engaged in their work, they will consistently

Facing the Challenge of Eliminating Dangerous Drug Abbreviations

BY STEVEN MEISEL, PHARM.D, DIRECTOR OF MEDICATION SAFETY, FAIRVIEW HEALTH SERVICES, MINNEAPOLIS, MINN

The dangers of abbreviating drug names and doses have been known since at least 1975 with the publication of a case where a patient received 40 units of Lente insulin when an order for 4 u was misread as 40.¹ The same article reported a near-miss involving an order for .1 mg of Synthroid, which was misread as 1 mg when the staff did not see the decimal point.

Such case reports have occurred for the past 30 years. Perhaps the most infamous was a 9-month-old infant who died after an order for .5 mg of morphine was misread as 5 mg.² Despite these case reports and repeated admonitions not to use such unsafe abbreviations and designations, little change in practice was observed and healthcare leaders paid little attention to this important problem.

The situation changed in 2003 when the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) called for the elimination of unsafe abbreviations as one of its 2003 National Patient Safety Goals.³ This standard requires hospitals to create a list of acceptable standardized abbreviations and a "Do Not Use" list to help reduce the risk of errors.

The JCAHO requirements have evolved since 2003 and are continually being refined. In 2004, the stipulation to create an acceptable abbreviation list was dropped and a specific list of unacceptable abbreviations was published. This list included: the terms *qd*, *qod*, *u*, *IU*, and *mg*; trailing zeros (1.0 mg); naked decimal points (.1 mg); and abbreviations for morphine and magnesium, such as MS,

CONTINUED ON PAGE 4

Steven Meisel, PharmD, is director of medication safety at Fairview Health Services in Minneapolis, Minn. He was a presenter at the 2005 NPSF Patient Safety Congress. Fairview Health Services is a Founding Member of the Stand Up for Patient Safety Program. Contact Meisel at 612-672-7061 or smeisel1@fairview.org.

Building the Foundation for a Culture of Safety

CONTINUED FROM PAGE 2

perform at their best. And a high-quality work environment is a safe environment.

Using the vision to develop guiding principles

Working from this vision, MGH also defined its guiding principles around the IOM report's 6 aims: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equality.⁵ MGH further expressed these principles relative to the patient, the staff, and the system, articulating "guarantees" for each in simple, straightforward language. For example:

- Safety—No needless death, injury, pain, or suffering for patients or staff.
- For patients—Harm no patient in our care.
 - For staff—Ensure the safest-possible work environment.
 - For the system—Seek and maximize any opportunity to learn and improve; support and encourage every effort aimed at ensuring safety.

These principles will become MGH's blueprint for guiding work throughout the hospital, providing a clear measuring

stick for evaluating and directing all that goes on. MGH has a long road ahead on this journey, but as more and more staff better understand where the hospital is headed and why, as well as the part they play in making the collective vision an everyday reality, the momentum will continue to build. MGH intends to bring all hands on deck in its effort to move full steam ahead. **NPSF**

References

- 1 Fisher ES, Welch HG. Avoiding the unintended consequences of growth in medical care: how might more be worse? *JAMA*. 1999;281:446-453.
- 2 Kohn L, Corrigan J, Donaldson M, eds. *To Err Is Human: Building a Safer Health System*. Washington, DC: Committee on Quality of Health Care in America, Institute of Medicine. National Academy Press; 2000.
- 3 Raef S. Five years after *To Err is Human*: A look at the patient safety landscape. *Focus on Patient Safety*. 2004;7(3):1-3.
- 4 Newman D, Knox E. Patient safety leadership fellows: Innovative leaders advancing cultures of safety. *Focus on Patient Safety*. 2005;8(1):3-4.
- 5 Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

Georgia W. Peirce is director of communications for patient care service at Massachusetts General Hospital in Boston and is a 2004-2005 Patient Safety Leadership Fellow. For the past 10 years, she served as the hospital's director of media relations and information systems. Contact Peirce at gwpeirce@partners.org or 617-724-9865.

Facing the Challenge of Eliminating Dangerous Drug Abbreviations

CONTINUED FROM PAGE 3

MSO4, and MgSO4. JCAHO also required organizations to identify at least 3 additional unsafe abbreviations that had been problematic in their local setting. Surveyors were instructed to examine the entire medical record and to issue Type 1 recommendations if the prevalence of such abbreviations was more than only occasional. The standard was narrowed to apply to all orders—medication-related or not—and medication-related documentation, but not to other portions of the medical record.

“Unlike other [JCAHO] standards ... this standard requires a change in long-term behavior for virtually every frontline caregiver.”

Implementing a challenging JCAHO standard

This JCAHO requirement has created significant problems for healthcare organizations. Unlike other standards where compliance may be assured by purchasing a piece of equipment or implementing a new policy, this standard requires a change in long-term behavior for virtually every frontline caregiver. Barriers to compliance include:

- The fact that most caregivers have been trained to use these abbreviations;
 - The use of these abbreviations has become hard to change;
 - Being a member of a profession implies the right to use a certain “jargon”;
 - The assumption that everyone in health care is intimately familiar with that jargon;
 - When these abbreviations are used, they rarely result in an error and even more rarely result in harm;
 - Most practitioners have never had a personal experience with an error resulting from one of these abbreviations;
 - These abbreviations are widely used in training programs. They appear in textbooks, journal articles, on medical equipment, and in pharmaceutical advertisements;
 - Healthcare organizations have limited means to force compliance; and
- There is a lack of hard data to prove that eliminating these abbreviations and designations will enhance safety.

How are hospitals complying with the new standard?

Due to the barriers to implementing the new JCAHO standard, most hospitals have relied on:

- Using education and reminders, such as posters, medical record inserts, newsletters, and discussion at department and committee meetings;
- Implementing “hard-stops” at the pharmacy level, where the pharmacist is asked not to accept the order if it contains one of the unacceptable abbreviations and to contact the prescriber for clarification; and
- Maintaining practitioner-specific defect rates and incorporating these rates into the recertification processes.

Such low-leverage changes which rely on good intent, vigilance, and hard work have not eliminated the use of unsafe drug abbreviations. The impact of education fades over time. Pharmacists become tired of calling physicians to clarify orders that were perfectly clear to them in the first place and grow weary of the inevitable conflict it creates with prescribers. Incorporating proper drug abbreviations into the recertification process seems excessively punitive for an issue that is perceived to so rarely result in a problem.

JCAHO holds medical abbreviations summit

Recognizing the controversy and the challenge of compliance, in November 2004 JCAHO convened a summit on medical abbreviations. This summit brought together representatives from a diverse group of stakeholders, including the American Hospital Association and professional organizations representing medicine, nursing, pharmacy, and other disciplines. Representatives from safety-oriented groups, such as the Institute for Safe Medication Practices and the United States Pharmacopoeia, and front-line practitioners were also present.

The conclusions and statement from this summit are still being finalized; however, the summit reached consensus on the following points:

- Unclear drug abbreviations are a safety hazard and their use must be eliminated;
- There should be a uniform list of unacceptable abbreviations to which all organizations should comply;

CONTINUED ON PAGE 5

Looking Back and Moving Ahead

A Look at 9 Years of the National Patient Safety Foundation Congress

BY MARY PITTMAN, DRPH, PRESIDENT, HEALTH RESEARCH AND EDUCATIONAL TRUST

Hospitals and health systems across the country are seeking new ways to make their organizations safer and more effective in delivering high-quality care. Throughout its 9-year history, the National Patient Safety Foundation Congress has presented the best, most-recent findings about high reliability, helping shape an ongoing agenda in research and education.

From the wake-up call sounded by the 1999 Institute of Medicine report, *To Err Is Human: Building a Safer Health System*,¹ to the more recent research of Beth McGlynn and colleagues at RAND—which documented that the healthcare system delivers the right care to patients only half of the time²—there is clearly still a long way to go in making care as safe as it should be. The NPSF meeting is designed to put the right tools for improvement in the hands of healthcare leaders.

Tracing the 9-year history of the Congress

The NPSF Congress, now in its seventh iteration, began in 1996 as the Annenberg Conference on Patient Safety—a combined effort of the American Association for the Advancement of Science, the American Medical Association, the Annenberg Center for Health Sciences, and the Joint Commission on Accreditation of Healthcare Organizations. The 1996 conference also marked the beginning of the National Patient Safety Foundation, which was formally introduced at that meeting.

The Annenberg Conference galvanized early efforts in reducing medical error with the goal of widely disseminating the best available knowledge on safety improvement. By 1996, safety pioneers such as NPSF Distinguished Advisor Lucian Leape, MD, NPSF Board Member Richard Cook, MD, and Institute for Safe Medication Practices Founder Michael Cohen, RPh, MS, DSc, had not only found ways to reduce errors in medication administration and anesthesiology, but had recognized the need for clinicians to embrace a culture of safety.

The 1996 conference was groundbreaking in gathering a cross-disciplinary audience of more than 350 practitioners in health care, aviation, and industrial engineering. That year's conference emphasized the need to borrow from aviation and other high-risk industries and to take a systems approach to learning about error.

Much was already known about safe systems, but that knowledge was concentrated in a few centers of innovation and had yet to be communicated widely. The conference planners saw the need to draft a patient safety research, education, and dissemination agenda.

The second Annenberg Conference in 1998 focused on accelerating the transfer of research findings into practice.

CONTINUED ON PAGE 7

Mary Pittman, DrPH, is president of the Chicago-based Health Research and Educational Trust. She served on the planning committee for the 2005 NPSF Patient Safety Congress and her organization is a sponsor of the Patient Safety Leadership Fellowship. Contact her at mpittman@aha.org or 312-422-2632.

Dangerous Drug Abbreviations

CONTINUED FROM PAGE 4

- Exceptions to this standard include printed laboratory results where trailing zeros are needed to convey significant digits and computer systems where use of the unacceptable abbreviation is beyond the hospital's control; and
- It is reasonable to expect that forms and pre-typed orders are configured correctly from the start. Therefore, the summit agreed there should be a zero-tolerance policy for such documents.

Because pharmacists and nurses were being put in the position of policing physicians' behavior, in 2005 the JCAHO instructed surveyors to count a defect if the dangerous abbreviation appeared as an order, even if modified through a verbal or telephone order. This means that callbacks to physicians for clarifications do not count as an acceptable means to comply with the standard.

Although there will never be a controlled clinical trial to prove the point, it is clear that the use of certain abbreviations and dose designations represents a significant hazard to patients. Eliminating these dangerous abbreviations will require changes in clinical training, as well as for journal and textbook editors and device manufacturers.

This change will ultimately require a commitment by hospital leaders to establish a culture that makes using these dangerous drug abbreviations unacceptable. JCAHO has provided the framework to make this happen; it is now up to healthcare leaders to show results. **NPSF**

References

- 1 Cohen MR. Medication error reports. *Hosp Pharm* 1975;10:120.
- 2 Cohen MR. Please don't sleep through this wake up call. ISMP Medication Safety Alert, May 2, 2001.
- 3 2003 National Patient Safety Goals. *Oakbrook Terrace, Ill. Joint Commission on Accreditation of Healthcare Organizations*. 2002. Available at: www.jcaho.org. Accessed May 8, 2005.

Hospitals Nationwide Observe Patient Safety Awareness Week

COMPILED BY ALLISON FISSEL, MANAGER, INFORMATION RESOURCES, NATIONAL PATIENT SAFETY FOUNDATION

Healthcare organizations across the US joined in celebrating the NPSF-sponsored Patient Safety Awareness Week, March 6-12. The 2005 theme, "Focus on Patient Safety: Ask, Listen, and Learn," emphasized the partnership between providers and patients in improving patient safety.

This year's theme encouraged providers to listen to their patients, to speak in simple terms, and to develop partnerships with their patients. Following are highlights of initiatives sponsored by some of NPSF's 276 Stand Up for Patient Safety members.

Baptist Health South Florida trains patient safety champions

Patient safety champions were inaugurated across Baptist Health's 5 hospitals and 16 outpatient sites. More than 240 frontline staff from all disciplines received 8 hours of training to prepare them to become safety resources for their departments.

The staff learned Baptist Health's guiding principles for patient safety and the rationale behind them. The patient safety champions' roles include mentoring peers on The JCAHO National Patient Safety Goals and helping identify opportunities to improve safety. Champions will receive ongoing education and support. Baptist Health also initiated CEO patient safety rounds and conducted an awareness campaign reminding employees that patient safety is their first priority.

Stony Brook University Hospital uses "Ask, Listen, Learn" theme

As Stony Brook University Hospital in New York celebrated its 25th anniversary in March, its lobby exhibit demonstrated improvements in patient safety with the theme, "Ask, Listen, Learn."

A Patient Safety Awareness Week banner was displayed over the entrance to the hospital garage. A "Safety on Wheels," cart toured the units, displaying the National Patient Safety Goals, a home medication cabinet, hand-washing gel, a UV demonstration of germs, patient safety education materials, and a display of the hospital's patient safety Web site.

Patient safety expert Linda Aiken, RN, PhD, presented at grand rounds. Stony Brook also offered a panel discussion with an anesthesiologist, pediatric oncology nurse practitioners, a cardiac discharge nurse and an emergency department nurse to discuss communication with patients regarding medications and discharge planning. Staff

members were honored for creating displays of patient safety activities in their respective units.

Virginia Mason Medical Center rolls out patient safety goal

The 2005 goal of Seattle's Virginia Mason Medical Center is to ensure the safety of patients by eliminating avoidable death and injury. During Patient Safety Awareness Week, the medical center formally rolled out this goal to staff and to the public.

Communication to staff included a mailing to their homes with a letter from the CEO and president, a one-page overview of the goal, a patient safety brochure, and a patient newsletter focused on safety. Virginia Mason also included its safety goal on its intranet and in newsletters.

To communicate with patients, Virginia Mason posted Patient Safety Awareness Week information on its Web site. Staff wore Patient Safety Awareness Week buttons and displayed posters and table tent cards in the cafeteria.

Brigham and Women's Hospital improves safety reporting

In May 2004, Boston's Brigham and Women's Hospital (BWH) implemented a new safety reporting system, complete with the improved ability to report near-misses and a variety of events beyond the typical falls and medication errors. The hospital promoted its new system during Patient Safety Awareness Week with a colorful newsletter advertising safety reporting: how, what, and why to report, as well as improvements already made at BWH based on safety reports.

Three staff members who reported safety events that week were rewarded with \$50 gift certificates.

MD Anderson Cancer Center hosts patient safety carnival

MD Anderson Cancer Center in Houston, Texas, celebrated Patient Safety Awareness Week 2005 with an institution-wide carnival including a week of interactive activities for employees, patients, and visitors.

The cancer center used its successful 2004 slogan, "Patient Safety: It's In Your Hands," to communicate its patient safety message. A few of the activities provided for staff, patients, and families included: patient safety fair presentations that traveled throughout the hospital on a festive cart

CONTINUED ON PAGE 7

A Look at 9 Years of the National Patient Safety Foundation Congress

CONTINUED FROM PAGE 5

A keynote address by NPSF Distinguished Advisor Donald Berwick, MD, emphasized the link between error reduction and quality improvement by sharing examples from NASA.³ Plenary sessions highlighted the development of cultures of safety, incident reporting and analysis, and multi-disciplinary approaches to safety.

The third Annenberg Conference—the first to occur after release of the landmark IOM report—focused on the role of communication in creating a blame-free culture of transparency. A keynote address by Paul Slovik, an expert on risk communication at the University of Oregon, highlighted the relationship between people's actions and their understanding of risk.⁴

In 2002, the NPSF officially assumed primary responsibility for the conference. The NPSF Annenberg IV Conference, "Let's Get Practical," focused on proven solutions. That year's conference centered on the research and findings of British patient safety expert Charles Vincent, MPhil, PhD, and the 7 factors of influence on clinical practice: institutions, organizational and management factors, the work environment, teams, individuals, tasks, and patients.⁵ Stephen Schoenbaum of the Commonwealth Fund presented 2002 findings that members of as many as 8.1 million American households had experienced a serious medical error.⁶

The 2003 NPSF Patient Safety Congress drew more than 1,000 leaders in health care and patient safety to learn how to apply solutions that get results. US Secretary of Health and Human Services Tommy Thompson presented the

proposed bar-coding rule, which was implemented in 2004.⁷ By 2003, the field focused not only on identifying sources of risk, but also on dissemination and implementation of tools to reduce harm.

The sixth annual Congress in 2004 refined the focus on solutions even further. Attendees were encouraged to apply 3 new lessons learned at the meeting and report back on their results through the NPSF listserv.

The 2005 meeting concentrated on high-risk domains of care, and on healthcare organizations' successes in reducing harm. This year, the 1,400 attendees not only heard from the prominent experts who have crafted safety innovations, but also from practitioners applying these tools at the front lines to improve patient safety.

Carrying the mission forward

The field has made encouraging progress in disseminating information about transparent communication and systems improvement. There is still a long way to go before healthcare systems become as reliable as other high-risk industries.

Improving and applying patient safety tools is now evolving along with clinical advances in diagnosis and treatment. As the science of patient safety advances, NPSF will continue to convene stakeholders to share best practices, discuss key issues, improve communication, and help make the healthcare system safer for everyone. **NPSF**

Patient Safety Awareness Week

CONTINUED FROM PAGE 6

for evening and night shift staff; grand rounds focused on hand washing; and recognition on the medical center's intranet of MD Anderson's patient safety champion stories provided by staff.

St. Luke's Regional Medical Center focuses on seniors

St. Luke's Regional Medical Center in Boise, Idaho, offered a 1-hour community presentation, "AskMe3," for senior citizen groups. A TV presentation during a "Senior Tip" segment emphasized the importance of individuals taking charge of their own health.

Safety display tables were set up in the hospital cafeteria and lobby with St. Luke's safety materials and NPSF information. The medical center rolled out its patient safety intranet during Patient Safety Awareness Week and offered a scavenger hunt with prizes for staff visiting the new site.

"Rounds" were made throughout the hospital, giving staff Patient Safety Awareness Week buttons and encouraging them to be spotted wearing the button. Several days later, follow-up rounds were done, and prizes and rewards were given to staff seen wearing the buttons. **NPSF**

References

- 1 Kohn L, Corrigan J, Donaldson M, eds. *To Err Is Human: Building a Safer Health System*. Washington, DC: Committee on Quality of Health Care in America, Institute of Medicine. National Academy Press; 2000.
- 2 McGlynn EA, Asch SM, Adams J, et al. *The quality of health care delivered to adults in the United States*. *New Engl J Med*. 2003;348:2635-2645.
- 3 Berwick DM. *Taking action to improve safety: how to increase the odds of success*. In: Scheffler AS, Zipperer LA, eds. *Enhancing Patient Safety and Reducing Errors in Health Care*. Chicago: National Patient Safety Foundation; 1999.
- 4 Slovik P. *Emotion, Reason and Risk: Lessons for Risk Communication from Cognitive Science*. Keynote Address. *Let's Talk: Communicating Risk and Safety in Health Care, 3rd Annenberg Conference on Patient Safety*. May 16, 2001; Minneapolis, Minn.
- 5 Vincent C, Taylor-Adams S, Stanhope N. *Framework for analyzing risk and safety in clinical medicine*. *BMJ*. 1998; 316:1154-1157.
- 6 Davis K, Schoenbaum SC, Collins KS, Tenney K, Hughes DL, Audet AJ. *Room for Improvement: Patients Report on the Quality of their Health Care*. New York: The Commonwealth Fund; 2002. Available at: www.cmf.org/programs/quality/davis_improvement_534.pdf. Accessed May 8, 2005.
- 7 Thompson T. *A View from the Top: The Role of Government in Improving Patient Safety*. Keynote Address: *Let's Get Results: Improving the Safety of Patients, 5th Annual NPSF Patient Safety Congress*; March 12, 2003; Washington, DC.

Focus on Patient Safety
(ISSN 1097-0673) is the official quarterly publication of the not-for-profit National Patient Safety Foundation (NPSF), in North Adams, Mass. 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, 1120 MASS MoCA Way, North Adams, MA 01247. Materials, inquiries, and subscription requests for the publication will be accepted electronically at info@npsf.org or via fax at (413) 663-8905.

NPSF President:
Diane C. Pinakiewicz
Managing Editor: Lorri Zipperer,
Zipperer Project Management,
Evanston, Ill
Editor: Susan Raef, WordPower
Communications, Inc., Chicago

© 2005 National Patient Safety Foundation. Permission to reprint portions of this publication for educational and not-for-profit purposes is granted subject to accompaniment by appropriate credit to the NPSF and Focus on Patient Safety. Commercial reproduction requires pre-approval. Some fees may apply.

NPSF Launches *Journal of Patient Safety*

Lippincott Williams & Wilkins, a leading international publisher of professional health information, has just launched *Journal of Patient Safety* (ISSN 1549-8417), a new publication focusing on patient safety and error reduction in health-care settings. This peer-reviewed, quarterly publication—the official journal of the NPSF—presents research advances and field applications in all areas of patient safety.

NPSF Calls for Letters of Intent for Research in Patient Safety

Deadline is July 1

NPSF invites you to submit a letter of intent (LOI) for your proposed patient safety research project. Please send an original hard copy and a CD with the full LOI document. All materials must be received by NPSF no later than July 1, 2005. Late arrivals will not be accepted. The budget request must not exceed \$100,000 for the entire project term, which may be up to 2 years. For more information, please review the full requirements for LOIs at www.npsf.org/html/research/rfp.html. **NPSF**

National Patient Safety Foundation®
1120 MASS MoCA Way
North Adams, MA 01247

Editor-in Chief Nancy W. Dickey, MD, is president and vice chancellor for health affairs at the A&M System Health Science Center in College Station, Texas. Dr. Dickey is also a former president of the American Medical Association and the founding chair of the NPSF.

“Journal of Patient Safety fills a growing need in the medical community for a central repository of safety-related research,” said Dr. Dickey. *“Patient safety is becoming a major driver in health care. By sharing information on this topic, Journal of Patient Safety will be an important resource that enhances the care of every patient.”*

Subscribe to *Journal of Patient Safety*

To subscribe, visit www.journalpatientsafety.com. Personal subscriptions to *Journal of Patient Safety* include access to the online version of the journal via the Web site above.

Institutions can access the journal online via Ovid at www.ovid.com. **NPSF**

