

# focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

## 2007 Annual NPSF Patient Safety Congress Draws 1,500 to Washington, DC

BY LARRY STEPNIK, SEVERYN GROUP, INC., AND ANITA SPIELMAN, NPSF

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More than 1,500 patient safety participants from around the world gathered at the Washington, DC Marriott Wardman Park on May 2-4 for NPSF's 2007 Patient Safety Congress. The event marked the tenth anniversary of NPSF's inception.

The 2007 annual Congress, "Learning from the Past, Creating the Future," featured 4 plenary sessions and 40 breakout sessions led by national and international patient safety experts, healthcare professionals, and patient and family representatives. The conference was preceded by 2 full-day workshops: Leadership Day and Patient Safety 101.

The World Health Organization again held its annual World Alliance for Patient Safety in conjunction with the NPSF Congress. Representatives from the Alliance presented a briefing on the organization's progress and current initiatives during the Congress.

### Leadership Day offers strategies for organizational leaders

Leadership Day examined how organizational leaders can make their organizations as safe as possible. "Spearheading patient safety can't be a part-time activity," said moderator Jack Silversin, DMD, DrPH, president of Amicus, Inc.

Silversin laid out a framework for improving safety:

- A compelling case for change that creates urgency;
- Leaders who visibly sponsor change;
- Broad and deep commitment to a shared vision; and
- A compact that facilitates achieving the vision.

### Patient Safety 101—An interactive introduction

This full-day workshop drew frontline, middle management, and senior leadership staff new to patient safety. Participants were introduced to approaches and techniques for detecting and reducing adverse events, as well as nationally recognized patient safety organizations and resources.

### Innovation is imperative

The opening plenary, "The 10 Faces of Innovation," was presented by Tom Kelley, general manager of IDEO, an innovation incubator and product design firm, and author of

*The Art of Innovation*.<sup>1</sup> Kelley theorized that while most CEOs—including those in health care—regard innovation as important, few make it a short-term priority.

"In the long run, innovation has an urgency all its own," Kelley explained. The successful organization is one that values and prioritizes innovation, and recognizes and supports leaders who contribute to it.

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**"Spearheading patient safety can't be a part-time activity."**

—Jack Silversin, DMD, DrPH  
President, Amicus, Inc.

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Based on his study of innovative organizations and individuals, Kelley identified 10 positive, pro-innovation roles that leaders can play in 3 categories:<sup>2</sup>

1. Learning roles—the anthropologist, the experimenter, and the cross-pollinator;
2. Organizing roles—the hurdler, the collaborator, and the director; and
3. Building roles—the experience architect, the set designer, the caregiver, and the storyteller.

Kelley argued that all roles should be recognized as essential contributors to an organization's success.

### NPSF Distinguished Advisors discuss successes, challenges

This year's Congress included the fourth annual town-hall meeting featuring NPSF Distinguished Advisors. Participants included: Donald M. Berwick, MD, MPH, president and CEO, Institute for Healthcare Improvement; Carolyn M. Clancy, MD, director, Agency for Healthcare Research and Quality; James B. Conway, MAM, CHE, senior fellow, Institute for

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The complete Congress program is available at [www.npsf.org/npsfac/pc/](http://www.npsf.org/npsfac/pc/). Full Congress proceedings will be published in an upcoming issue of NPSF's Journal of Patient Safety.

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Healthcare Improvement; David Lawrence, MD, retired chairman and CEO, Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals; Lucian L. Leape, MD, adjunct professor of health policy, Harvard School of Public Health; Dennis O'Leary, president, The Joint Commission; and Sir Liam Donaldson, chair, World Health Organization World Alliance for Patient Safety. The session was moderated by NPSF Board Member Susan Edgman-Levitan, PA, Congress co-chair and executive director of the John D. Stoeckle Center for Primary Care Innovation at Massachusetts General Hospital.

## "Today's leading-edge organizations are being almost heroic, but we can't rely on heroes to lead us to the next phase of patient safety."

—Carolyn Clancy, MD  
Director, Agency for  
Healthcare Research and Quality

Panelists discussed the patient safety movement's progress over the last 10 years, as well as the areas in greatest need of improvement. "Today's leading-edge organizations are being almost heroic," Dr. Clancy commented, "but we can't rely on heroes to lead us to the next phase of patient safety."

Dr. O'Leary acknowledged the barriers to patient safety. "Today, people have to provide good care by working around the system," he said, "but that's getting hard to do."

### Areas of patient safety progress

- Industry awareness of patient safety issues and the motivation to make the changes necessary to improve safety have increased.
- Clinicians have become more involved with and committed to patient safety.
- Patients and consumers have been moved to the forefront of the patient safety debate.

### Areas for improvement

More needs to be done to:

- Give frontline workers the tools to improve safety; and
- Establish environments in which people feel comfortable discussing patient safety and raising safety concerns.

### Team of Rivals: The Political Genius of Abraham Lincoln<sup>3</sup>

Doris Kearns Goodwin, Pulitzer Prize-winning author and presidential historian, shared her reflections on the lessons that modern-day leaders can learn from Abraham Lincoln's leadership. The personality traits integral to Lincoln's remarkable success as a leader, according to Goodwin, were:

- A willingness to embrace rivals and listen to the views of those who disagree;
- Extraordinary empathy; and
- An ability to share credit and take the blame for subordinates' failures.

Lincoln also possessed the ability to:

- Recognize errors and learn from mistakes;
- Acknowledge and compensate for weaknesses;
- Control his anger and apologize; and
- Communicate persuasively.

### Key stakeholders present perspectives on tort reform

Panel leader Benjamin W. Moulton, JD, MPH, executive director of the American Society of Law, Medicine and Ethics, shared his views on the need to rethink the issue of informed consent and to empower patients with more information. He argued for the adoption of a new type of informed consent, known as shared decision-making.

Panelist Susan E. Sheridan MIM, MBA, president, Consumers Advancing Patient Safety, argued that a good tort system should result in quick, just compensation provided with compassion, honor, and integrity. Sheridan, who has been a plaintiff in two separate cases involving medical errors, said the system should also include safeguards to ensure that others are not injured due to recurring systemic problems.

Paul J. Barringer, III, general counsel for Common Good, offered a new approach to handling legal proceedings related to medical error cases. He recommended specialized health courts to expedite compensation to those injured through an evidence-based review of best-available information.

Richard H. Bucilla, CPCU, senior executive, AIG Healthcare, an underwriter with 40 years' experience, called for changes in 3 areas: caps on non-economic damages, control or elimination of contingency fees, and reforming the expert witness system.

NPSF Board Member Dennis O'Leary, MD, concluded the discussion by reiterating the need for medical liability reform as an essential element of a multi-component, industry-wide effort to improve patient safety. **NPSF**

## Individual competency vs. system performance

# SAFE Tool Improves Flow—and Patient Safety

BY STEVE MAYFIELD, SENIOR VICE PRESIDENT, QUALITY AND PERFORMANCE IMPROVEMENT, AMERICAN HOSPITAL ASSOCIATION

Physicians, nurses, pharmacists, and other highly skilled care providers bring great competency, training, and compassion to their work. However, care in hospitals is delivered in complex adaptive systems—environments in which physically unconnected events interact to create emergent effects. Both the events and effects display great variability.

While hospitals strive to reduce harm and error, they have been unable to replicate the advances in safety that other industries have achieved. Other industries have been successful in demonstrating that harm is related to system design, rather than operator error, but hospitals have difficulty instituting a non-punitive culture.<sup>1</sup> For these reasons, while the performance of some industries approaches Six Sigma, health-care struggles to achieve Four Sigma in most processes.<sup>2</sup>

Unfortunately, the complexity of the system may diminish the positive contributions of healthcare professionals. Many care efforts focus on task execution, and often actions are completed independent of the larger context of the care system. Identifying the 4 main components of care, as shown in Figure 1 on page 5, determining the desired appropriate performance attributes, and then anticipating the most likely error types helps to improve patient flow, supports better outcomes, and significantly improves safety.

### SAFE tool helps identify errors, reduce blame

A tool known as the Systematic Assessment of Flow and Error (SAFE), as shown in Figure 2 on page 5, provides a framework to identify fundamental care events and to anticipate the most likely errors. Hospitals that have used SAFE report increases in total incident reporting, and improved dialogue about errors related to omission, matching, judgment, and communication.<sup>3</sup> The tool supports a reduction in blame associated with beliefs that harm is related to individual competency.

### How does SAFE work?

- SAFE uses information from other areas—human factors, industrial engineering, characteristics of flow, cognitive psychology, and manufacturing—and applies it to the healthcare setting.
- The approach embraces the very complex, interdependent processes of health care that typically operate in silos, and distills them into 4 main components that

all staff can understand: patient information, clinical decisions, care processes, and patient flow.

- SAFE creates a tool for analyzing care processes and allows care providers to communicate across boundaries, while facilitating accountability for tasks (more people own the process). It is effective in analyzing case studies and sentinel events, and facilitates Root Cause Analysis and Failure Mode and Effects Analysis (FMEA).

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**“Hospitals that have used SAFE report increases in total incident reporting, and improved dialogue about errors related to omission, matching, judgment, and communication.”**

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- The approach provides a method to lessen the tendency to assign blame, and to instead take actions to improve system performance.
- SAFE is compatible with the Joint Commission Tracer methodology, and assists organizations in preparing for that survey format.<sup>4</sup>
- The tool is transferable across settings, and is not constrained to only clinical processes. Any work process may be mapped, and potential errors identified.

### Enhancing communication among care providers

The SAFE tool:

- Helps providers see healthcare delivery as a system of care rather than independent care tasks;<sup>5</sup>
- Supports efforts to identify both the active and latent performance attributes that contribute to harm and are preventable; and
- Changes the organization’s culture in a way that addresses the automatic and pervasive tendency to assign blame rather than seek solutions.

*Steve Mayfield is senior vice president, quality and performance improvement, of the American Hospital Association. Prior to joining the AHA in 2006, he was the executive director of performance improvement and decision support at Athens Regional Medical Center in Georgia, where he developed and tested the SAFE tool concept. Contact him at smayfield@aha.org.*

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# SAFE Tool Improves Flow—and Patient Safety

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## Using the SAFE Tool

An event analysis may populate the SAFE Tool (shown in Figure 2) as follows:

- A 68-year-old female presents to a high-volume emergency department (ED). Her history includes insulin-dependent diabetes and several mini-strokes in the past year.
- During transport, emergency medical services (EMS) draws blood samples, groups them with an elastic band, and does a blood sugar check to assess blood glucose level. No treatments are administered in the ambulance.

**“After staff analyze a case with the SAFE tool, they more readily engage in identifying the latent factors that contribute to harm.”**

- Upon arrival at the ED, EMS hands over the unlabeled samples and reports that the blood sugar check indicates blood sugar levels greater than 500. There is no information available about the last insulin dosage or type.
- The unlabeled blood samples are placed on a table where “intake” for ED patients occurs. Unlabeled samples from other patients are on the same table. Later it is determined that 2 patients’ samples were mislabeled due to the routine of placing unlabeled specimens on the same table.
- Work-up is ordered, including lab tests, chest x-ray, flu screening, and EKG.
- Lab results indicate a blood glucose level of 92. The value is later found to have belonged to a different patient.
- EKG is not completed.

The process is iterative: information supports decisions that spur care processes that drive patient flow.

## Staff improve understanding of “competency vs. system”

Each of the components has important performance attributes associated with efficiency and effectiveness. The most likely types of errors that cause the most harm at each stage are identified.<sup>6,7</sup>

One common error type that is preventable, and leads to harm, is that of omission.<sup>8-10</sup> Yet the perception of most caregivers is that errors are attributable to competency. After staff analyze a case with the SAFE tool, they more readily engage in identifying the latent factors that contribute to harm, and self-reporting of error increases.<sup>3</sup> Staff understand that:

- Performance is adversely affected by over-reliance on memory or vigilance;
- Workload increases degrade accuracy;<sup>11</sup> and
- System design<sup>12</sup> has a powerful influence on quality of care.

## How does SAFE classify errors?

The SAFE tool defines 4 major error categories:

- 1. Intention errors**—Wanting to do the appropriate thing (intention) in the wrong setting, context, or application (intending to put labels on a specimen, but affixing to wrong specimen; intending to give medication, but giving to wrong patient, etc.).
- 2. Judgment errors**—Choosing a course of action based on misperceptions or misunderstandings; arriving at an erroneous conclusion. Judgment errors may be:
  - Rule-based: task-related things that occur routinely. Response is typical, automatic over time. “If X occurs, then do Y”; or
  - Knowledge-based (system-related): When new problems are encountered that require an understanding of performance attributes to decide on a new course of action.
- 3. Execution**—Errors of commission (slips) are skill-based, related to competency of performance (hitting a ball, inserting an IV, etc.), and performance improves with practice. Errors of omission occur when steps or tasks are omitted or significantly delayed.
- 4. Communication errors**—problems that result when information conveyed is incomplete, biased, or erroneous. Communication errors can occur when one provider or performer relinquishes control or direction of task performance to another (patient is transported from one area to another, report is given at shift change, etc.).

The SAFE tool and a template to evaluate process flow, as shown in Figure 2, are available from the AHA Quality Center by e-mailing [ahaqualitycenter@aha.org](mailto:ahaqualitycenter@aha.org) **NPSF**

## Most Likely Types of Errors at Each Stage of the Care Process

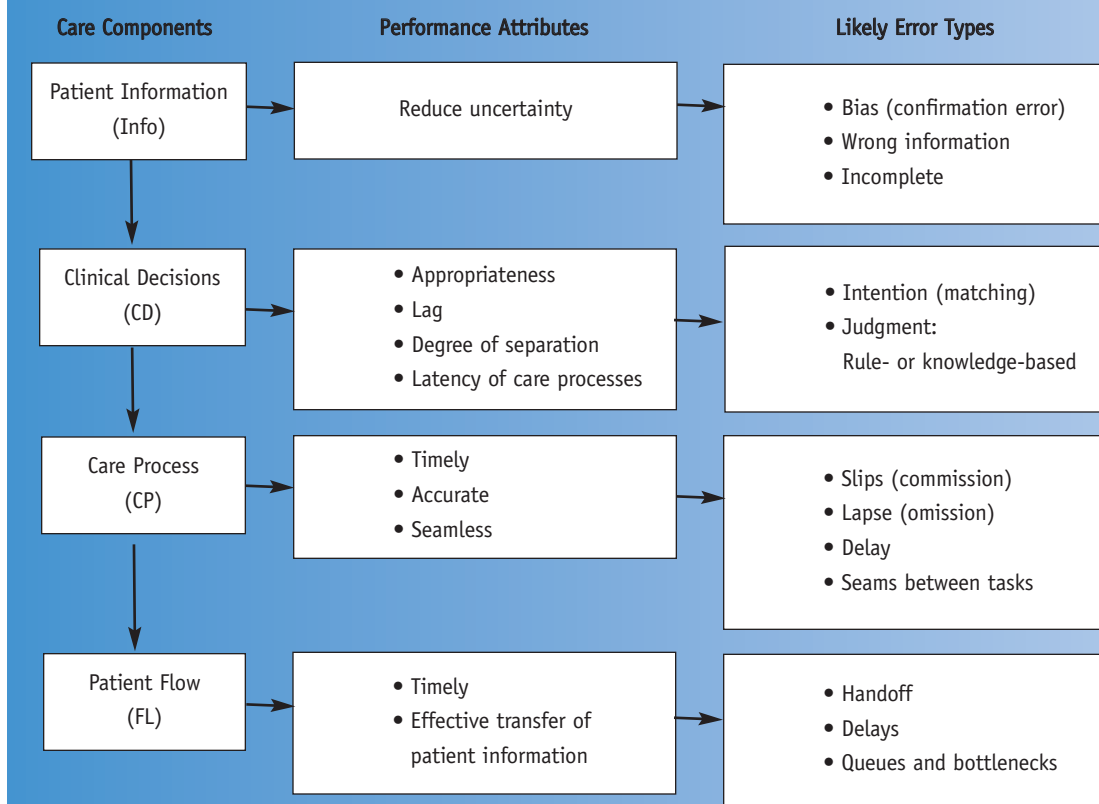


FIGURE 1

## SAFE Tool—Evaluating Process Flow

STAGES OF EVENT	CARE COMPONENT (See Figure 1)				TYPES OF ERRORS (See Figure 1)					
	Info	CD	CP	FL	Execution		Intention	Judgment		Handoff
					Slips	Omissions	Matching	Rule	Knowledge	Comm
Patient presents/ambulance				X						
Blood samples mislabeled			X				X			
No insulin information	X									X
Patient work-up ordered		X								
EKG not completed			X		X					
Blood glucose mis-reported: 92	X						X			X

Info = Information. CD = Clinical decision. CP = Care process. FL = Patient flow.

FIGURE 2

## Building Confidence in Patient Safety— A Friend's Story

BY BONNIE ADAMSON, CEO, NORTH YORK GENERAL HOSPITAL, TORONTO, ONTARIO, CANADA

As a healthcare leader, I have been passionate about patient safety for a long time, and I find our sector in the midst of encouraging changes. But the increased public attention to patient safety can be a double-edged sword. When family members are in distress, they can do things that detract from our ability to do the right thing for our patient, and their loved one.

As caregivers in transition toward higher levels of performance and safety, we need to provide confidence, navigational help, and the perception that health care is safe as we live up to those promises more and more reliably in our everyday practice.

### SARS crisis spurs a hospital's transformation

For the past four decades, I have served as a nurse, administrator, and senior administrator. My hospital in Toronto was at the epicenter of SARS; the hospital was shut down, a staff member died, and many more were traumatized. In the aftermath, we had a virulent leadership and culture implosion.

The hospital realized that the frontline staff members were our heroes, and that the positive element in this was a new platform for leadership. We knew we needed to honor the compassion and heroism of our staff, and to become more patient- and family-centered. Since then, our hospital has been on a 3-year transformational journey—from blaming to accountability, from “command and control” to thinking differently and stewardship.

In *A Tale of Two Cities*, Dickens wrote, “It was the best of times, it was the worst of times.” We hear a lot about the worst of times—broken processes, medical errors, silos. I have seen all this in my own institution and others. But I also have also seen the best of times—caring nurses, reliable teams, everyone giving their all in the final moments.

### A friend faces a critical illness

Last year a friend of mine, 56, was diagnosed with lymphoma. She received in-home care for a backache from October through December. My friend had the usual treatments, but her backache got worse, she was confused and had continuing headaches. The family brought her in to the hospital, critically ill.

### “Please come help us sort it out”

They called me late on a Friday, saying “This is the worst news we’ve heard in our lives.” It was serious; their mother, my friend, was at risk. The family was overwhelmed with stress and they pleaded, “We need another opinion.” The husband got on the phone and asked me to “Please come help us sort it out.”

When I got to the hospital, the husband told the medical team, “Bonnie has my confidence; tell her anything.” He asked me to “talk to the doctors and explain it to us.” I gathered the family with the doctor and nurse. The staff said that she had a serious infection and might die that weekend.

I explained things to the family, reassured them, and asked everyone to put themselves in my friend's shoes. Who would she want to see? What did we want to say to her? We called her brother and sisters and they came in.

Meanwhile, I sat with the physicians—it turned out she had bacterial meningitis, secondary to lymphoma, but she responded to antibiotics and began to feel better the next day. They put her on antibiotics; she died three weeks later.

My friend was very central to her family and all her relationships. She was gone in three weeks, leaving behind a large number of family members and close friends stunned and in severe shock.

But as a close friend as well as an informal member of the caregiving team, interestingly, I never felt my friend was unsafe, although I knew that the treatments for her condition were complex, with multiple high-risk procedures and toxic drugs.

### Open communication supports patient and family

The physicians and nurses answered every question. They were honest, open, frank, and factual. It was open, two-way communication. They brought in the palliative care people; they were very supportive throughout. “Is there anything else you need to know?” they asked. “How can we help?”

With the continuous exchange of information by multiple specialists, every day and often every hour, the family

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## NPSF Launches 2 New Initiatives

At the May 3-4 Patient Safety Congress in Washington, DC, the Foundation announced 2 new initiatives in which it will join forces with noted organizations and individuals committed to improving patient safety.

### Lucian Leape Institute

This NPSF initiative honors Lucian Leape, MD, a physician and adjunct professor of health policy at the Harvard School of Public Health and an internationally recognized founder and leader of the patient safety movement. Dr. Leape has been involved with NPSF since its founding and will chair the Institute, which supersedes NPSF's Distinguished Advisors panel.

The Lucian Leape Institute will operate as a think tank to provide intellectual leadership and define strategic paths for the field of patient safety. The Institute will hold 1-2 roundtables each year and will publish reports to guide work in the field and serve as calls to action on critically important patient safety issues.

### Building Confidence in Patient Safety

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was exceedingly well-informed. Collectively, very difficult decisions were made. The care was superb; I was genuinely impressed. Because there was no worry about safety or the reliability of the treatment, the family could focus on patient needs. Working with them, we could spend time on the right things; we could do what was needed for my friend and her family.

People walk into hospitals with fear; they need the perception of safety. We don't run out and talk about the statistics regarding patient safety in organizations and our "best mistakes"—if patients and the public had the patient safety data, there'd be big public pressure on organizations. Perception affects credibility, fund-raising, and confidence.

My friend went to the hospital with a backache, had aggressive chemotherapy, and died 24 days later from lymphoma. No one ever verbalized a perception of a safety issue. Is it because chemotherapy is standardized, with a clear treatment protocol? Or is it something else as well?

Do family members believe in "best practices" to the point they do not worry about safety? Do they "trust" that we have all the controls in place for high-risk treatments?

### Partnership for Clear Health Communication at NPSF

The Partnership for Clear Health Communication (PCHC) will join forces with NPSF to form the Partnership for Clear Health Communication at the NPSF. PCHC is a national, nonprofit coalition created in 2002 to increase awareness and advance solutions to improve health literacy.

PCHC's efforts have increased awareness of the prevalence of poor health literacy and its impact on health outcomes. Its widely used and respected Ask Me 3 campaign centers on 3 fundamental questions that should be asked in any patient-provider interaction. PCHC has also received recognition for Medicare Rx, an ongoing effort with the Centers for Medicare and Medicaid Services (CMS) to increase awareness and understanding of the Medicare Part D Prescription Drug Benefit.

The PCHC-NPSF collaboration aims to expand reach and awareness of both organizations' health literacy efforts. **NPSF**

Should we inform them more fully than a "consent" conversation? Should they know about the "invisible" structures and processes that affect safety? Does a positive relationship with open two-way communication create a perception of safety that supersedes other potential concerns? What is the correlation between medical competency, relationship competence, and the perception of safety?

In the case of my friend, open communication created a perception of safety, but does it also create a safer environment? There is a difference between empathy and safety. Both are needed for patient-centered, compassionate care. As patient safety evolves into the public domain in the future, how will the relationship with patients and families and care teams change?

I think we owe it to our patients and families to step inside their shoes, and their world, more often and more fully. We need to build cultures and environments where we do this for each other, so we have the capacity to do it for those we serve. And I believe we need to provide patients and families, in their darkest hours, with the feeling that we are truly with them, and the knowledge that they are safe in our hands. **NPSF**

*Bonnie Adamson is CEO of North York General Hospital in Toronto, Ontario, Canada. She can be reached at (416) 756-6122 or badamson@hygh.on.ca.*

*This article is based on remarks from a panel presentation at the Third Safety Across High-Consequences Industries (SAHI) Conference, St. Louis University, March 13-15, 2007, with assistance from Tom Bigda-Peydon, EDD, SAHI Steering Committee.*

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## NPSF Honors Patient Safety Leaders at Annual Congress

Each year, NPSF recognizes individuals and organizations that have demonstrated leadership and outstanding achievement in patient safety. NPSF was pleased to honor 3 such individuals and institutions with awards presented at its 2007 Annual Patient Safety Congress, May 2-4, in Washington, DC.

### Alison Page of Fairview Health Services wins NPSF Chairman's Medal

The NPSF Chairman's Medal was awarded to Alison H. Page, MS, MHA, chief safety officer of Fairview Health Services in Minneapolis. This award recognizes emerging leadership in patient safety and is presented to an individual or organization that has inspired and led measurable positive change and improvements in patient safety while creating a culture of respect, transparency, learning, and cooperation.

Page, a respected patient safety authority, has worked for transparency, accountability, and collaboration in numerous state and national patient safety efforts. She is a key leader in developing and implementing a statewide culture in Minnesota that supports patient safety.

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### North Carolina Children's Hospital wins Socius Award

The Socius Award, whose name derives from the Latin word for partner, recognizes work that promotes positive and effective partnering between patients/families and providers to improve patient safety. North Carolina Children's Hospital received this award for its Family Alert Initiative, which enables family members to activate the hospital's pediatric rapid response team.

### University of Texas MD Anderson Cancer Center earns NPSF's Stand Up for Patient Safety Management Award

This award is given to a Stand Up for Patient Safety member organization that has successfully implemented an outstanding patient safety initiative led by or created by mid-level management.

The University of Texas MD Anderson Cancer Center received the award for its Good Catch Program, an initiative developed by nurse managers to increase reporting of near-miss events to the facility's existing reporting system. **NPSF**

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