

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

Implementing a Pediatric Rapid Response Team In a Community Hospital

BY TERI KANESKI, RN, BSN, AND DIANE BLEVINS, RN, MSN, EDWARD HOSPITAL, NAPERVILLE, ILL

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Focus Will Be Published Online Only Beginning in 2008

As early as 1990, literature appeared describing changes in clinical condition that often precede cardiopulmonary arrest.¹ This period of clinical instability responds to early identification and intervention, either by preventing cardiopulmonary arrest or by improving outcomes after it occurs. This knowledge paved the way for the concept of the medical emergency team, which brought critical care expertise to the bedside prior to an arrest.²

Rapid Response Teams can save lives

Medical emergency teams, or rapid response teams (RRTs), have the potential to reduce failure to rescue, the inability to save a patient once a complication has developed.³ Failure to rescue and failure to respond are often intertwined. Being able to access the right resources optimizes intervention during the pre-arrest phase, *before* irreversible complications develop.

The 2004 launch of the Institute for Healthcare Improvement's (IHI's) 100,000 Lives Campaign helped many healthcare organizations develop and implement an RRT.⁴ Pediatric settings quickly began to see the relevance of the RRT concept to their patients. The IHI Pediatric Node was launched in January 2005 with the endorsement of 3 pediatric organizations including Child Health Corporation of America, National Association of Children's Hospitals and Related Institutions, and National Initiative for Children's Healthcare Quality.

Identifying the need for a Pediatric Rapid Response Team

Edward Hospital in Naperville, Ill., successfully implemented an adult rapid response team in February 2006. While it is well-documented that cardiac arrest is relatively rare in children, the survival rate to discharge of children experiencing a cardiac arrest remains at only 27%.⁵⁻⁷

The opportunity to intervene to prevent a cardiac arrest most often occurs with effective management of respiratory distress or arrest.⁸ At Edward, there were informal peer consultation processes between pediatric, pediatric intensive care unit (PICU), neonatal intensive care unit (NICU) and obstetrical inpatient nurses to respond to a change of

patient condition. Other areas of the hospital—the ambulatory surgical care center, the post-anesthesia care unit, and the emergency department—have patient populations consisting of at least one-third children and were unaware of these informal resources. Inpatient children constitute only 2% of the pediatric patients at Edward.

“[R]apid Response Teams have the potential to reduce failure to rescue, the inability to save a patient once a complication has developed.”

Clinicians with the highest level of pediatric expertise care for those patients. Most children are managed in combined adult/pediatric settings. Significant education and staff support are needed for clinicians working with a high volume of children. The Pediatric Rapid Response Team (PRRT) was identified as a critical step in providing this support.

Edward had the internal resources to develop a PRRT. The hospital houses a 16-bed pediatric/PICU unit and a NICU with a combined total of 33 Level II and III beds. The obstetrical units manage over 4,000 deliveries annually. Edward identified PRRT development as an opportunity to improve internal processes, and ultimately patient outcomes, for all its pediatric patients.

Defining the PRRT planning and implementation process

Edward assembled an interdisciplinary team including pediatric physicians, nurses, and administrative staff to evaluate the PRRT concept. The team considered evidence from Children's Hospitals and Clinics of Minnesota, an early PRRT adopter. Children's reported a reduction in cardiac arrests and resulting deaths, number of ICU days post-arrest, hospital days post-arrest, and inpatient deaths.⁹

Teri Kaneski, RN, BSN, is performance improvement coordinator, and Diane Blevins, RN, MSN, is director of children's services at Edward Hospital in Naperville, Ill. Contact Kaneski at tkaneski@edward.org; contact Blevins at dblevins@edward.org.

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Key Decisions for Implementing a PRRT

Activity	Edward Hospital's Implementation Decisions
Leadership support	Meetings with key stakeholders—senior staff, nurses, physician leaders
Determine PRRT structure and function	<p>Team composition—</p> <ul style="list-style-type: none"> • NICU nurse • PICU nurse • Pediatric hospitalist • Respiratory therapist <p>Priorities—PRRT, Code Blue calls</p> <p>Availability 24/7</p> <p>Required responder skill set—</p> <ul style="list-style-type: none"> • PALS certification • Strong communication and clinical skills • Mentoring capabilities
Determine criteria and mechanism for calling PRRT	<p>Criteria—Acute change in: heart rate, systolic blood pressure, respiratory rate, oxygen saturation or requirements, neurological status.</p> <p>Mechanism—Call emergency line at 75555. Identify pediatric RRT needed and room number. Send text page simultaneously to all PRRT responders.</p>
Standardize documentation	<p>Bedside nurse documents pre-call events.</p> <p>Nurse responder completes Rapid Response Team Record.</p> <p>Reorganize into SBAR format (Situation, Background, Assessment and Recommendation).</p>
Implement education plan	<p>Management team</p> <p>PRRT nurses and physician responders attend 4-hour session.</p> <p>Staff Nurses from NICU, Peds/PICU, Mother Baby, Same-Day Surgery, PACU and ED</p> <ul style="list-style-type: none"> • One-hour session • Flyers • Newsletter <p>Physicians</p> <ul style="list-style-type: none"> • Posters • Newsletter • Presentation • E-mail notification <p>Telephone operators—30-minute education session</p>
Define outcome measures	<p>Hospital codes/1,000 discharges</p> <p>Hospital codes outside the PICU/NICU</p> <p>Utilization of PRRT</p> <p>Mortality rate</p> <p>Pediatric respiratory events</p>
Define process measures	Develop a physician and nursing satisfaction survey tool.
Report outcome measures	Report RRT outcome data to nursing quality, medical staff quality and board quality committees biannually.
Develop a system for staff recognition	Recognize callers through distribution of Lifesavers® candies with a note saying "Thanks for being a Lifesaver!"

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Nurse Knowledge Exchange: A Safer, More Reliable Hand-off Between Nurses

BY KRISTENE CRISTOBAL, MS, AND CHRIS MCCARTHY, MPH, MBA, KAISER PERMANENTE

Evidence is mounting that a new way of practicing at the bedside is critical to ensure patient safety. Communication breakdowns are cited as the primary cause of more than 70% of sentinel events.¹ Medical errors are responsible for the deaths of 44,000 to 98,000 people each year.² All told, as many as 88 out of every 1,000 patients will be harmed.³

The Institute of Medicine recommends that nurses be engaged to design the nursing work environment and care processes to reduce errors, especially during patient hand-offs.⁴ Kaiser Permanente's (KP's) Nurse Knowledge Exchange (NKE) is a reliable hand-off practice created by KP nurses. Nurses exchange information face-to-face and with the patient using structured communication and a specially designed shift report tool. Patient teachback ensures patient understanding.

NKE objectives

- Standardize the hand-off process to exchange key information about the patient.
- Provide a seamless face-to-face transition between shifts that engages the patient.
- Incorporate patient teachback to confirm understanding of the day's goal.
- Prevent loss of critical information about the patient's status and goals for the day.
- Optimize time during shift change.

The 4 components of the NKE system are the bedside round, shift preparation, the shift report template, and the care board.

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Kristene Cristobal, MS, is senior quality project manager, healthcare performance improvement, Department of Care and Service Quality, for Kaiser Permanente. Contact her at Kristene.Cristobal@kp.org or (510) 267-7644.

Chris McCarthy, MPH, MBA, is director of Kaiser Permanente's Innovation Learning Network.

Implementing a Pediatric Rapid Response Team

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Goals of the RRT Implementation Team

- Earlier identification and intervention for the patient prior to respiratory arrest
- A decrease in the number of pediatric respiratory events
- Prevention of cardiac arrest

PRRT planning began at Edward in March 2006 and implementation took place that September. The table on page 2 highlights the key decisions for successful implementation.

Measuring Edward's PRRT outcome

Before implementing the PRRT in 2006, Edward reported pediatric respiratory events of 4 per 1,000 patient days. In 2007 after implementing the PRRT, that number has decreased to 3.8 per 1,000 patient days. The rate of pediatric cardiac arrest for 2006 was 1.1 per 1,000 pediatric patient discharges, with no codes occurring outside the ICU. There was no statistical analysis of the outcome measurement data; however, early data seem to indicate benefits of the PRRT. The number of PRRT calls was low, with 3 calls in the first 12 months. At this point, the data would not provide conclusive evidence of the PRRT's benefits, but they did prove invaluable for the staff and patients involved in the initial 3 PRRT calls.

From January through August 2007, Edward's cardiac arrest rate was 0.27 per 1,000 patient discharges with zero codes outside the ICU. Although PRRT utilization was relatively low, each of the core inpatient units has substantial PICU or NICU clinical expertise available to both non-critical and critical patients. The PRRT's additional patient support was well-received in areas where pediatric patients are not the majority. Recent rounding in these areas to promote the PRRT seems to have increased utilization.

One primary area of concern was defining pediatric-specific outcome measures meaningful for the pediatric patients in a general hospital. Combining pediatric and adult data for analysis can be misleading because of the low incidence of pediatric cardiac arrests.¹⁰

Ultimately, Edward separated adult and pediatric code analysis and reported cardiac arrests and respiratory events as a measure of effectiveness for the PRRT. While difficult to measure, outcome of care is critically important. Having the PRRT in place now allows Edward to focus efforts on new care improvements. **NPSF**

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Nurse Knowledge Exchange

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Shift preparation: Setting the stage for the new shift

During shift preparation, the outgoing charge nurse makes the nurse-patient assignments for the incoming shift. This allows the arriving nurses to know immediately whom they are caring for, and to begin preparing for their day. The aim of assignment-making is to achieve a one-to-one (1:1) hand-off of patients (ie, the incoming nurse receives all his or her patients from the outgoing nurse). Though this is the goal, it is usually not possible. The norm is 1:2 and 1:3 (ie, the incoming nurse receives his or her patients from 2 or 3 nurses).

Shift report template: Sharing patient data across shifts

The shift report template contains the agreed-upon data elements that nurses need for a good foundation to start their shifts. The data template can be electronic or paper, depending on the system. This template standardizes the shift tool across a health system, increasing the level of safety for both patient and nurse.

Care board: Conveying information to the patient

The care board is a whiteboard with a stenciled template that the outgoing nurse uses to convey important information to the patient. This board is easily seen by patients in their beds, and includes the care team members' names and telephone numbers, date, day, goal for the shift, and notes.

The goal for the shift is the most important piece of data for the patient. This is where the outgoing nurse will write, in layperson's terms, what the patient should try to achieve during the shift. For example, if a nurse wants a patient to ambulate 3 times, he or she would write "Walk the hallway 3 times before 4 pm."

Beside round with structured report-out and teachback

The bedside round is the foundation of NKE, but it is not an ordinary bedside round. It "moves" the patient—and family, if appropriate—into the shift change itself. Patients are no longer talked *about*, but talked *with*. The outgoing and oncoming nurses enter the patient rooms and warmly introduce themselves.

This introduction is followed by a structured report-out of the patient data using the data template as a reference. Some hospitals use the iSBAR method (introductions, Situation, Background, Assessment and Recommendations)

as their structure. The report-out format should make sense to nurses and help them transmit data in a safe, methodical way.

The outgoing nurses then update the care board and use teachback to assess the patient's level of understanding. Teachback is a technique where the outgoing nurse asks the patient to describe the goal for the shift or other important pieces of information to share with family members.

NKE ensures that patient information is clearly communicated and understood among the nursing staff. To realize the potential for saving lives through improved patient safety, it is critical that NKE is implemented in KP hospitals consistently and reliably. The potential for error will always be high unless everyone is completely clear about the tasks that must be done, who should do them, and how they should be performed.³

Using reliability concepts as a guide, NKE aims to improve patient safety, increase patient satisfaction, enhance nurse communication, and increase staff satisfaction. The table below matches reliability concepts to NKE components.

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How Reliability Concepts Relate to NKE Components	
Reliability Concept ⁵	NKE Component
Decision aids and reminders built into the system	Shift report template with key safety information prompts
Desired action should be the default (based on evidence)	Bedside rounds with patient teachback as part of shift change
Redundant processes	Structured communication at bedside, whiteboard with goals, patient teachback
Use fixed current scheduling in design	Embed key information at shift change
Take advantage of habits and patterns	Shift report tool
Standardization of process based on clear specification and articulation	Simple 4-step NKE process, measuring percentage of nurses performing

Deadline is Feb. 15, 2008

Applications Being Accepted for 2008-2009 Patient Safety Leadership Fellowship

NPSF and the Health Research and Educational Trust, in partnership with Health Forum, the American Organization of Nurse Executives, the American Society for Healthcare Risk Management, the Society of Hospital Medicine, and the American Hospital Association, are now accepting applications for the 2008-2009 Patient Safety Leadership Fellowship (PSLF).

The PSLF is an educational program through which Fellows enjoy interaction with a faculty of national experts and experience a varied curriculum including independent fieldwork, self-study, and face-to-face meetings. Each individual Fellow or team completes an Action Learning Project—an initiative focused on improving quality and safety at the Fellow's organization. Fellows are encouraged to apply the new tools and techniques they have acquired to their projects.

The application deadline is Feb. 15, 2008. For details, visit www.hretfellowships.org or contact the HRET Fellowship department at 312-422-2625.

Meet the 2007-2008 Patient Safety Leadership Fellows

Janet Batchelder, RN, MDiv, Cross Country Staffing; **Jodi E. Beck, PharmD, MBA**, Memorial Healthcare System; **Maureen Buick, RN, MS**, UCSF Medical Center; **Catherine M. Capps, RN**, Long Beach VA Health Care System; **Rebecca Caschette, RN, MS**, Memorial Healthcare System; **Gretchen Cave, RN**, Memorial Hospital; **Bobbie Dietz, MHA**, Vanderbilt University Medical Center; **Stephanie Eyherabide, RN**,

Mercy Hospitals Bakersfield; **Rollin J. Fairbanks, MD, MS**, University of Rochester School of Medicine; **Betty E. Finnk, RN, CIC**, Memorial Healthcare System; **Maureen Francis, MD**, Southern Illinois University School of Medicine; **Tomas Hiciano, RP**, The Valley Hospital; **Stephanie L. Jackson, MD**, Sacred Heart Medical Center—Peace Health; **Terry S. Johnson, ARNP, RN, MN**, Lodestar Enterprises, Inc; **Paul A. Lange, MD, FCCP**, Borgess Medical Center/Borgess Health; **Dana M. Langness, RN**, Regions Hospital—Health Partners; **Karen Liptak, MPA/HCA, CPHRM**, Tenet Healthcare Corporation; **Eddy D. Maillot, MPT**, Whitman Hospital and Medical Center; **Jo McGlew, MD**, EW Sparrow Hospital; **Gary McMillan, LRRT, MM**, Sparrow Health System; **Cory Meyers, RN, MN**, Baptist Health System; **Leonora Oates de Battani**, Memorial Hospital; **Barbara Pelletreau, RN, MPH**, Catholic Healthcare West; **JoAnne Phillips, RN, MSN, CCRN, CCNS**, The Hospital of the University of Pennsylvania; **Karen S. Pierce, RN, MSN**, VA Loma Linda Healthcare System; **Deena R. Rauch, RN, MSN, CNA-BC**, Whitman Hospital and Medical Center; **Sue Sanford-Ring, MHA**, University of Wisconsin Hospital and Clinics; **Robert A. Schwab, MD**, St. Luke's Hospital; **Carol Anne Tarrant, RN, MS, JD, CPHRM**, COPIC Insurance Company; **Marty Waskul**, Huntington Hospital; **Sam R. Watson, MS**, MHA Keystone Center for Patient Safety & Quality; **Michael Weaver, MD, FACEP**, St. Luke's Healthcare System; **Robert J. Welsh, MD**, William Beaumont Hospital; **Patrice Wilson, RN, MSN, MA**, The Valley Hospital. **NPSF**

Nurse Knowledge Exchange

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NKE was spread across 20 KP hospitals during 2006. More than 9,000 nurses and 230 nursing units have implemented this information-sharing system.

Key success factors in KP's NKE implementation

- **Leadership**—Hospital leaders and staff were aligned in their understanding of the patient safety rationale for NKE (ie, the “burning platform”), the benefits to staff and patients, and the fact that NKE was “how we do business.”
- **Support for improvement capacity**—Nurses were trained in NKE and improvement methods, especially PDSA (Plan, Do, Study, Act); specific plans were set for implementation for selected units to be achieved by a designated time. Nurses held monthly sharing/networking phone meetings, face-to-face sharing/networking meetings, and

monthly coaching calls with unit managers to review implementation process metrics and develop action plans. Edward also implemented embedded unit manager observation and bedside coaching.

- **Measurement**—Monthly process metrics helped identify units or NKE components that were implemented well, also known as “green light” status. They also highlighted units or NKE components that needed attention, aka “yellow light” or “red light” status.

The Nurse Knowledge Exchange is now the preferred practice for KP nurse hand-offs. Its success relies on the comparative advantage of its simple 4-part practice, its foundation in patient safety and reliability design, and the leadership and resources supporting its implementation. **NPSF**

Patients Need to Become Educators for Patient Safety

BY ILENE CORINA, PRESIDENT AND FOUNDER, PULSE OF NY

I remember clearly the occasion, 10 years ago, when I first spoke in front of an audience. I stood high on a stage, looking down at 200 senior citizens from a local Jewish temple's senior center sipping coffee and buttering bagels. I recall thinking that this was not something I wanted to do, but something I felt I *had* to do.

“We, as consumers of health-care services, need to start asking questions, expecting answers, and insisting that we be treated like any other ‘customer’ purchasing a service.”

My work as a patient advocate began as a quest for information following the death of my son, Michael, years earlier. Michael was almost 3 years old when he died following a routine tonsillectomy. He had suffered from chronic ear infections, and doctors believed that the problem would be solved by removing his tonsils and adenoids and putting tubes in his ears.

For 8 days following his surgery, Michael grew weaker. He was bleeding from his mouth—sometimes a little, sometimes a lot. I took him to see different doctors 5 times, including 2 different emergency rooms and a follow-up with his surgeon. I implored the doctors to do something. Each time, the doctors sent me home telling me not to worry. My gut told me all along that something was seriously wrong. My once-lively toddler was so tired that he struggled to play, even to stay awake.

Tragically, I was right. Michael died from internal bleeding that had gone undetected by his doctors. Had I understood that medical mistakes can happen, I might have been more assertive in questioning the care he received following his surgery.

My anger and grief over my son's death drove me to action. I resolved to find out what had gone wrong and how this could have happened. As I sought answers, I learned about

the difficulty in accessing information about the healthcare system. I came to understand the need for education: people want to be informed about and involved in their health care, but didn't know where to begin. We, as consumers of healthcare services, need to start asking questions, expecting answers, and insisting that we be treated like any other “customer” purchasing a service. I hoped that by stirring up enough interest, people might be encouraged to become more empowered.

In 1997, I attended the second annual Annenberg conference of the National Patient Safety Foundation. I learned there that healthcare workers knew of these problems and were taking an active role in helping to reduce medical errors. I was invited to stay and be part of the process.

By the time the Institute of Medicine's landmark report, *To Err is Human*,¹ was released several years later, I was well on my way to doing community health education about safe, quality care. I was helping the community understand what I was learning from the people who worked in medicine.

Understanding the need for consumer healthcare education

National organizations dedicated to healthcare improvement and patient safety are clear on the need for patients to take an active role in their care. The Agency for Healthcare Research and Quality (AHRQ) advises patients that “the single most important way you can help to prevent errors is to be an active member of your health care team.”² The Joint Commission's Speak Up™ initiative encourages patients to become “active, involved, and informed participants on the health care team.”³

The National Patient Safety Foundation publishes a consumer fact sheet with step-by-step guidelines to help patients partner with providers for the best care possible.⁴ These and many other organizations strive to educate healthcare consumers about the actions patients can take to improve their safety during treatment. Patient- and family-oriented healthcare information is increasingly available through hospitals and doctors' offices, in print, and on the Internet.

These materials can be an effective means of education. But unfortunately, those who could benefit from it may not find this information at the most appropriate time—*before* they become patients. It is of little use for patients in the

emergency room to be counseled on the importance of keeping a medication record, or for hospitalized patients awaiting surgery to learn that they can bring an advocate with them to the doctor's office. Thus, it is important for patients and their families to be informed about patient safety before they enter the healthcare system.

Tips for patient safety educators

For the past 10 years, I have been teaching consumers about patient safety and the importance of being involved in their care. This education can take many forms: interactive discussions, presentations, sharing of stories, and even games. Here are some things I have learned.

Know your audience. Understanding your audience and tailoring your talk to their interests and needs is an important part of any presentation. Suppose you are addressing a group of senior citizens. Older adults may have multiple doctors and more-frequent doctor visits, so the presentation may need to be focused on doctor-patient communication.

Another appropriate topic for older adults would be medication safety. Encourage audience members to maintain a complete list of medications they are taking, including vitamins and supplements, to find a trusted friend or family member to know where this information is kept, and to keep copies of their medication records on hand in case of an emergency. Seniors often need frequent medical tests, so talking about the importance of following up on test results would also be appropriate.

Share stories. Telling the stories of real experiences can put a face on the problem. For instance, to illustrate the importance of asking providers to wash their hands, you could state the CDC's finding that hospital-acquired infections cause an estimated 90,000 deaths per year.⁵ Alternatively, you might show a picture of a little girl with long blond hair and a big smile who succumbed to a hospital-acquired infection. This little girl mattered. Hand-washing matters.

Ilene Corina's new book, *Teaching Patient Safety: An Educator's Guide*, offers tips on teaching patients about patient safety.

For more information, visit www.pulseofny.org.

The pathos of this image will likely have a greater impact than an impersonal statistic.

Audience members frequently want to share their own experiences. Be sure to allow time so this does not supplant other parts of the discussion. Try to extract lessons from the discussion to focus the conversation on learning, rather than blame.

“Getting out and working with people before they actually become patients ensures that they are prepared when the time comes.”

Involve family members. Focusing on the family member and not the patient can be an important part of education. The patient, often only wanting to get well, really doesn't want to ask doctors or nurses to wash their hands, or check medication—but a caring family member may be willing to instead.

Public awareness campaigns about breast cancer, AIDS and many other diseases are prevalent in the community, in schools, and in the media. As a result of these efforts, most people know that self-exams can aid in detecting early signs of breast cancer, and that safe-sex practices can prevent the spread of AIDS.

We should aim to achieve a similar level of awareness about the problem of medical errors and the steps that patients and families can take to minimize their risk. Getting out and working with people before they actually become patients ensures that they are prepared when the time comes.

Patient safety advocates and educators will continue to play an essential role in this process. People who work in health care often tell their own stories to share with one another. There is no reason, in this growing culture of transparency, why we can't take this information out of the hospital and into the community. **NPSF**

Ilene Corina is president and founder of PULSE of NY, a grassroots patient safety organization. She is a member of the NPSF Board of Governors and a founding member of the NPSF Patient and Family Advisory Council. Corina is a board member of the Joint Commission and lectures throughout the country on how healthcare facilities can include the family in patient safety. Contact her at: ICorina@aol.com.

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Safety, National Patient Safety
Foundation, 132 MASS MoCA Way,
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Beginning with the first issue of 2008, *Focus* will be published only as an electronic document. New issues will be e-mailed to subscribers, and will continue to be posted at www.npsf.org as they are released. Current and back issues will remain accessible through the site's online archive.

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