

# focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

## Healthcare Consumers: Essential Partners in Safe Medication Use

BY MICHAEL R. COHEN, RPH, MS, ScD, FASHP, PRESIDENT, INSTITUTE FOR SAFE MEDICATION PRACTICES, HORSHAM, PA

### IN THIS ISSUE

Healthcare Consumers:  
Essential Partners in  
Safe Medication Use

Root Cause Analysis:  
Are We Looking for Keys  
Under the Lamp Post?

Improving Outreach  
Strategies to Support  
Those Affected by  
Medical Failures

NPSF News: Winter 2008

Register Now for the  
2009 NPSF Patient  
Safety Congress

Call for Poster  
Presentations at  
NPSF Congress

A study in the September 10, 2007 *Archives of Internal Medicine* found that a significant percentage of American consumers may not be using their medications safely. Between 1998 and 2005 alone, there was a 360% increase in deaths attributed to consumers using medications incorrectly at home (not involving alcohol or street drugs).<sup>1</sup>

That is a sobering statistic. The Institute for Safe Medication Practices (ISMP), the nation's only nonprofit organization devoted entirely to medication error prevention and safe medication use, believes that consumers can and want to play a key role in their safety when receiving and taking medications. However, people need to have the appropriate knowledge, resources, and tools to do so.

Following are a few ways in which healthcare practitioners can help their patients become more active in the safe medication use process.

### Increase communication about medications

Proactive communication between healthcare providers and patients is a major way to reduce the risk of medication errors. As patients become more empowered, they are better able to question healthcare professionals who prescribe, dispense, and administer medications to make sure potential problems are addressed.

However, there are barriers to patients communicating with providers about the drugs they are taking, including limited time for speaking with patients and lack of appropriate written materials. This is evidenced by a 2003 ISMP survey of nurses, in which few indicated that they offered written medication information to patients. In fact, 1 in 4 never provided it. Half of the nurses surveyed told ISMP they had no written information to provide to patients about preventing medication errors.<sup>2</sup>

Pharmacists, physicians, and nurses should explore ways to make suitable written materials on medications readily available. If patient care areas have a computer terminal

and printer, electronic databases may provide one solution. If database use is not feasible in all patient care units, the pharmacy should provide paper leaflets, updated yearly, for the most commonly used medications. Be sure to seek feedback from patients (eg, through focus groups and targeted satisfaction survey questions) and from all providers to ensure that written materials effectively communicate the most important information.

### Drug safety: Something to talk about

The more information consumers have, the more likely they are to use their medications in beneficial and safe ways to help prevent errors. When speaking with patients about their medications, be sure to mention:

- When and how they should take their medications
- What to do if they miss a dose
- Any potential side-effects
- How their medications might interact with other drugs they are taking
- How to safely dispose of unused medications
- Any known potential errors involving their medications, such as drug name mix-ups

Management support for widespread education is essential to ensure effective use of electronic resources as well as dedicated time to talk with patients.

### Take low literacy into account

Physicians, nurses, pharmacists, and other healthcare professionals might assume that their patients can read, understand, and act on instructions on medication labels and in medication information pamphlets. But although 90 million Americans read below the 5th grade level, 98% of the medication information sheets accompanying dispensed prescriptions are written at a 9th to 12th grade level or higher.<sup>3,4</sup>

A study published in the *American Journal of Health-System Pharmacy* showed there is a high level of

Michael R. Cohen, RPh, MS, ScD, FASHP, is president of Institute for Safe Medication Practices in Horsham, Pa. Contact him at [mcohen@ismp.org](mailto:mcohen@ismp.org).

## References

- 1 Moore TJ, Cohen MR, Furberg CD. *Serious adverse drug events reported to the Food and Drug Administration, 1998-2005*. Arch Intern Med. 2007;167:1752-1759.
- 2 *Helping to remove the barriers to patient education*. ISMP Medication Safety Alert! October 2, 2003;10:1.
- 3 Kirsch IS, Jugebut A, Jenkins L, Kolstad A. *Adult Literacy in America: a First Look at the Results of the National Adult Literacy Survey*. Washington, DC: Department of Education; 1993.
- 4 Roper ASW. *Health Literacy & The Prescription Drug Experience: The Front Line Perspective From Patients, Physicians and Pharmacists*. New York: Roper ASW LLC; September 2002.
- 5 Wolf MS, Davis TC, Shrank WH, Neuberger M, Parker RM. *Misunderstanding of prescription drug warning labels among patients with low literacy*. Am J Health-Syst Pharm. 2006;63:1048-1055.
- 6 Weiss BD. *20 Common Problems in Primary Care*. New York: McGraw Hill; 1999.
- 7 Eisenberg D, Davis R, Ettner SL, et al. *Trends in alternative medicine use in the US, 1990-1997*. JAMA. 1998;280:1569-1575.
- 8 Lam A, Bradley G. *Use of self prescribed nonprescription medications and dietary supplements among assisted living facility residents*. J Am Pharm Assoc. 2006;46:574-581.
- 9 Aspden P, Wolcott J, Bootman JL, Cronenwett LR, eds. *Preventing Medication Errors: Quality Chasm Series*. Washington, DC: The National Academies Press; 2007.

misunderstanding of prescription drug warning labels among adults with low literacy. Most patients misinterpreted all of the labels tested, with the exception of the simplest warning, "Take with food."<sup>5</sup>

Poor health literacy can lead to consumers misusing and making mistakes with their medications. Adults with low health literacy:

- Are less likely to adhere to prescribed treatment and self-care regimens<sup>6</sup>
- Make more medication or treatment errors<sup>7</sup>
- Are at a higher risk for hospitalization<sup>8</sup>
- Stay hospitalized an average of 2 days longer than those with adequate health literacy<sup>3</sup>

### What can providers do to address low health literacy?

One potential solution is software that offers patient leaflets at different reading levels as well as in several languages. To ensure that these systems meet your patients' needs, find out the average reading level in your community and the predominant languages spoken. This information may be available from your local government.

### Be sure to educate parents

Children are particularly vulnerable to medication misuse. One study has demonstrated that parents give their children an incorrect dose of over-the-counter fever medicine 47% of the time.<sup>9</sup> Other recent studies have shown that educating parents on how to measure and administer the correct dose of medication for their children can prevent serious errors.

Parents are often confused by the measurements used to administer liquid medications as well as the measuring devices themselves. They frequently do not understand the difference between a teaspoon and a tablespoon, or the proper use of metric measurements such as milliliters (mL).

When prescribing or administering pediatric medication, involve the child's parents and demonstrate correct measurement and administration techniques when possible.

### Tips for educating parents about children's medications

- Warn about serious consequences of overdoses and how they can occur. Stress that more is not better—even with over-the-counter medications.
- Raise awareness of the different formulations and strengths of children's medications.
- Remind parents to avoid using infant formulations as their child gets older.
- Teach reading of labels to avoid dosing errors and accidental administration of multiple products containing acetaminophen.
- Emphasize the importance of using an appropriate measuring device (the original product dropper or dosing cup, or proper type of syringe), not a household spoon.

### Mention free online resources

The Internet has opened a whole new avenue for consumers to obtain information on how to use their medications. Americans spend a large portion of time online searching for advice about health and safety. According to the 2007

CONTINUED ON PAGE 3

## Hospitals and patients can rely on [www.ConsumerMedSafety.org](http://www.ConsumerMedSafety.org)

To address the lack of reliable consumer-focused medication safety information online, ISMP has launched [www.ConsumerMedSafety.org](http://www.ConsumerMedSafety.org). This new web site is designed to improve health outcomes related to medication use and adherence, health literacy, and collaboration and communication among patients and their healthcare providers. The site offers:

- **Personal stories** as well as innovative advice and recommendations based on ISMP's decades of experience and analysis of thousands of actual error reports
- **An alert service** that e-mails customized breaking news about the medications consumers or their family

members are currently taking or in which they have indicated an interest

- **An article library** with important information about safe medication use and adverse drug reactions.
- **Confidential reporting** for medication errors, near-misses, and dangerous situations
- **A safety toolbox** including medication administration guidelines that outline how to avoid common mistakes
- **Drug information** including Food and Drug Administration (FDA) MedGuides, safety ratings, and potential drug interactions

# Root Cause Analysis: Are We Looking for Keys Under the Lamp Post?

BY ALBERT W. WU, MD, MPH, JULIUS CUONG PHAM, MD, PhD, AND PETER PRONOVOST, MD, PhD

*A man walks out of a bar and sees a drunken man searching the ground under a lamp post for his house keys. The first man decides to help him, and both search around for a while. Finally, the first man asks, "Are you sure this is where you lost your keys?" The drunken man answers, "No, I dropped them in the alley, but it's too dark there to see, and the light is better under the lamp post."*

When things go wrong and patients are harmed during medical care, patients and their families consistently have several expectations. It seems natural that they want an apology and an explanation of what happened. What is surprising is their desire for assurance that this kind of thing will not happen again.

Several explanations have been proposed for this seemingly selfless sentiment. One of the most plausible is that it is deeply disturbing for patients to learn that things can go wrong in their care, and they want reassurance that the problem will be fixed. Unfortunately, healthcare professionals can't honestly tell them this, because they do not know.

Healthcare workers and hospitals also have expectations that if there is a sentinel event, or even a serious incident that harms a patient, there will be a root cause analysis, or RCA.

## How helpful are RCAs?

An RCA is based on procedures developed to identify the causal and contributing factors that underlie failures in performance.<sup>1,2</sup> These procedures have good face validity and their application generally leads to insights about how and why things go wrong. People who do RCAs typically feel they learn something from them. Conducting an RCA promotes systems understanding of medical care failures. It seems as though RCAs ought to be helpful.

What is generally *not* acknowledged is that it is not known whether RCAs work.<sup>3</sup> RCAs typically try to answer 4 questions:

1. What happened?
2. Why did it happen?
3. What should we do about it?
4. How will we know that risk was reduced?

CONTINUED ON PAGE 4

*Albert W. Wu, MD, MPH, is a professor in the Department of Health Policy and Management at the Bloomberg School of Public Health at Johns Hopkins University. Contact him at [awu@jhsph.edu](mailto:awu@jhsph.edu).*

*Julius Cuong Pham, MD, PhD, is an assistant professor in the Department of Emergency Medicine at Johns Hopkins University School of Medicine.*

*Peter Pronovost, MD, PhD, is a professor in the Department of Anesthesiology and Critical Care Medicine at Johns Hopkins University School of Medicine.*

## Safe Medication Use

CONTINUED FROM PAGE 2

Institute of Medicine report *Preventing Medication Errors*, the percentage of adults who have sought health information online grew from 27% (54 million) in 1998 to 53% (117 million) in 2005.<sup>9</sup>

But the report found that while there is an abundance of Internet-based health information, the quality of that information is quite variable. When healthcare practitioners are questioned by their patients about information they have obtained online, providers should emphasize the importance of relying only on reputable information sources.

ISMP maintains links to leading patient safety entities and information on its web site, [www.ismp.org](http://www.ismp.org), and publishes *Safe Medicine*, a newsletter for consumers. The Institute also has launched a consumer-focused web site that pro-

vides even more specific medication safety information. Visit the new site at [www.ConsumerMedSafety.org](http://www.ConsumerMedSafety.org) (See box on page 2).

Several other organizations have publications on consumers' role in preventing medication errors. The Agency for Healthcare Research and Quality (AHRQ), at [www.ahrq.gov](http://www.ahrq.gov), offers *Your Medicine: Play it Safe*, produced with the National Council on Patient Information and Education, and *20 Tips to Help Prevent Medical Errors in Children*, produced with the American Academy of Pediatrics.

Informed consumers can have a major impact on reducing the risk of medication errors for themselves and their families. When patients become better educated about medication safety, everyone benefits. **NPSF**

CONTINUED ON PAGE 4

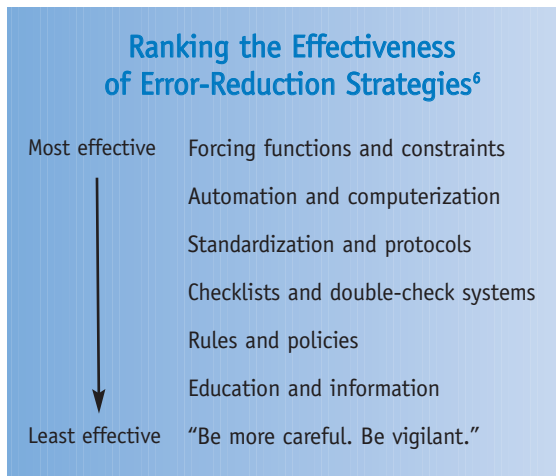
# Root Cause Analysis: Are We Looking for Keys Under the Lamp Post?

CONTINUED FROM PAGE 3

## References

- 1 *The Joint Commission sentinel event glossary of terms.* Available at: [www.jointcommission.org/SentinelEvents/se\\_glossary.htm](http://www.jointcommission.org/SentinelEvents/se_glossary.htm). Accessed October 24, 2008.
- 2 Bagian JP, Gosbee J, Lee CZ, Williams L, McKnight SD, Mannos DM. *The Veterans Affairs root cause analysis system in action.* *Jt Comm J Qual Improv.* 2002;28:531-545.
- 3 Wu AW, Lipschutz AK, Pronovost PJ. *Effectiveness and efficiency of root cause analysis in medicine.* *JAMA.* 2008;299:685-687.
- 4 *Groundhog Day.* Dir. Harold Ramis. Columbia Pictures; 1993.
- 5 Mills PD, Neily J, Luan D, Stalhandske E, Weeks WB. *Using aggregate root cause analysis to reduce falls.* *Jt Comm J Qual Patient Saf.* 2005;31:21-31.
- 6 Gosbee JW, Gosbee LL, eds. *Using Human Factors Engineering to Improve Patient Safety.* Oakbrook, Ill: Joint Commission Resources; 2005.
- 7 Pronovost PJ, Martinez EA, Rodriguez-Paz JM. *Removing "orange wires": surfacing and hopefully learning from mistakes.* *Intensive Care Med.* 2006;32:1467-1469.

RCA teams have put most of their effort into—and have succeeded at—describing what happened and the causes and contributing factors of the event. But they are not very good at designing interventions likely to reduce risk, and rarely evaluate whether risk was actually reduced.



Many people in organizations charged with carrying out RCAs are ambivalent about them. Even if these individuals cannot articulate all of their concerns, they intuitively believe that RCAs may not be cost-effective, or even effective. They also have concerns about the time and effort expended, typically ranging from 20-90 person-hours per RCA.

Both investigations and interventions require resources. Unfortunately, people who have completed an RCA cannot say with any confidence that "this sort of thing will never happen again." It is disconcerting that institutions too often seem to experience repeat occurrences of incidents shortly after an RCA is completed.<sup>3</sup>

### RCAs as currently practiced have problems in 3 areas

1. **RCAs may not be done properly.** Clinicians generally are not trained to think in a systems perspective, and those who conduct RCAs may vary in their degree of training and experience in doing them. Input from patients is rarely sought, reducing RCAs' inclusion of patient-related contributing factors and interventions.
2. **The focus tends to be too narrow.** Each RCA is performed in isolation, except in rare instances when it occurs simultaneously with similar cases. Thus, in a "Groundhog Day"-like fashion,<sup>4</sup> the collective Bill Murrays of the RCA

world tend to retread the same ground, reinventing the wheel with each new RCA. In most cases, events are not aggregated to identify common themes and recurrent incidents.

One exception is in the US Dept. of Veterans Affairs (VA), where all RCAs are reported to the National Center for Patient Safety and subjected to aggregated analyses.<sup>5</sup> Much of this work, unfortunately, is not published or well-publicized. In many cases, there is no formal tracking of what happens to the recommendations or their related patient outcomes, which are even harder to document.

### 3. The solutions are often not aimed at the best target.

RCAs include recommendations for action to prevent recurrence of incidents. However, error-reduction strategies vary in their likely effectiveness in decreasing the probability of future error, as shown in the chart at the left. The weakest strategies focus on education and information aimed at changing individual behavior—eg, "Be more careful. Be more vigilant." Stronger strategies include making rules and policies, which may never filter down to the level of front-line clinicians. The strongest strategy is to build forcing functions into tools and procedures that make it difficult to do the wrong thing.

In current practice, like the keys and the lamp post, the recommended solutions tend to be mis-aimed at individuals rather than at higher levels of the system. This strategy often relies on the fallible memory of individuals to protect patients. However, when higher-level solutions are suggested, individual organizations may not have sufficient leverage to achieve the necessary redesign of an instrument or tool. What is needed are changes at the national or international level of manufacturers or professional organizations.

### How might RCAs be improved?

A number of potential solutions should be explored:

- Adding longitudinality and history into the RCA process
- Centralizing analysis and negotiation for solutions
- Conducting research on the RCA process itself
- Adding patient input

### How can organizations enhance their RCA process?

- Organizations should build mechanisms into their RCA process that allow all RCA teams to share their learning.

CONTINUED ON PAGE 5

# Improving Outreach Strategies to Support Those Affected by Medical Failures

BY BETH CONLIN, VOLUNTEER AND PATIENT REPRESENTATIVE, MEDICALLY INDUCED TRAUMA SUPPORT SERVICES, CHESTNUT HILL, MASS.

Healthcare leaders are increasingly turning to the Internet's social media for patient safety outreach. One example: Paul Levy, president and CEO of Boston's Beth Israel Deaconess Medical Center, writes a blog, <http://runningahospital.blogspot.com>, that has been read more than 720,000 times and has stimulated communication across the world.<sup>1</sup>

Social networking can also provide online support for healthcare professionals, patients, and their families who have experienced emotional trauma and isolation following a sentinel event. Organizations can connect cost-effectively with stakeholders worldwide—and promote effective social networking to further their mission—through focused online communication.<sup>2</sup>

Medically Induced Trauma Support Services (MITSS), based in Chestnut Hill, Mass, is a non-profit organization that helps patients, families, and clinicians affected by an adverse medical event. Recently, when MITSS's outreach committee increased the organization's online and community efforts, they learned lessons that could prove helpful to patient safety entities, especially those seeking to reach individuals on a national or local level.

MITSS actively advocates for creating support systems for patients, families, and medical professionals in the wake of

an adverse medical event. The organization's efforts are focused on Boston-area institutions but extend nationally.

## Providing help on an individual basis

MITSS focuses on direct support services for individuals through a national counseling and referral hotline. The organization also sponsors a 10-week therapeutic group in the Boston area to educate affected individuals on the effects of medical trauma and provide a forum for clients to share their experiences and heal.

## Extending support through online communication

MITSS offers support resources on its web site, including 2 blogs—one for clinicians and one for patients and families—that provide resources and a place for people to voice their perspectives.

The outreach committee strives to increase the number of people accessing MITSS as a personal resource. Prior to this effort, MITSS's primary outreach efforts included its web site, referrals from institutional partners, distribution of literature through institutions and events, and local and national media coverage. MITSS realized it had the capacity to reach more individuals affected by medical error and sought a new outreach strategy.

CONTINUED ON PAGE 6

*Beth Conlin is a volunteer and patient representative for Medically Induced Trauma Support Services (MITSS) in Chestnut Hill, Mass. Contact her at [bconlin@gmail.com](mailto:bconlin@gmail.com).*

*For more information about MITSS, visit [www.mitss.org](http://www.mitss.org).*

*Visit MITSS's patients and families blog at: [www.mitsspatientsandfamilies.blogspot.com/](http://www.mitsspatientsandfamilies.blogspot.com/).*

*Visit MITSS's clinicians blog at: [www.mitssclinicians.blogspot.com/](http://www.mitssclinicians.blogspot.com/).*

## References

- 1 Blogging about running a hospital. Jt Comm Perspect Patient Saf. December 2008;8:8 (sidebar).*
- 2 Sarasohn-Kahn J. The Wisdom of Patients: Health Care Meets Online Social Media. Oakland, Calif: California HealthCare Foundation; 2008.*

## Root Cause Analysis CONTINUED FROM PAGE 4

- RCA teams should make sure to track their outcomes.
- All RCAs should be entered into a database and followed up to ensure that recommendations are implemented.
- If it is possible to follow outcomes—admittedly difficult due to the general inability to measure rates of most adverse outcomes—this should also be monitored.

Increased awareness of the strength and likely effectiveness of interventions may help organizations present stronger recommendations. One or more centralized analysis centers, analogous to that at the VA, should conduct aggregated analyses, and serve as a repository of analyses and solutions. (This could be a role of the official Patient Safety

Organizations.) Such an organization would also have the power to negotiate higher-level and more-effective fixes with manufacturers and other organizations.<sup>7</sup> Research is needed to explore the most appropriate level of intervention for common problems. The question is: which solutions are likely to be effective at a national or worldwide level compared to a local level?

## Involving patients in the RCA process

It is worth exploring the added value of including patient input in the RCA process. This may be helpful at identifying patient-level factors that contribute to medical failures. Patient input may also be valuable in proposing solutions, so patients can help make their own healthcare safer. **NPSF**

# Improving Outreach Strategies to Support Those Affected by Medical Failures

CONTINUED FROM PAGE 5

## Want to increase outreach?

BY SUSAN RAEF, EDITOR

### Boost web site visibility

Like MITSS and ISMP (see page 2), many organizations are increasing their outreach through the Internet. Here are several ways to boost a web site's non-paid or *organic* search engine rankings.

- Know—and frequently use—the most popular keywords people are using to find the site. (Check the site's web stats to find the most-often-used keywords.)
- Consider issuing monthly online news releases to drive traffic to the site and boost search engine rankings.
- Contact related organizations and ask them to link to the site.
- Update the site often.

### Stay in touch with key audiences

- Invite site visitors to sign up for a free e-newsletter. With a permission-based database, an organization can reach its core audience at the click of a mouse.
- Publish a monthly e-newsletter with personal stories, best practices, and information on events and services, as well as links to specific pages on the web site with more details.

The challenge: to reach individuals who didn't receive or might not act on MITSS literature or referrals from a medical institution, or those in underserved communities not reached by the media coverage and events where MITSS information could be found. MITSS staff also sought an outside perspective from volunteers on how to reach a greater variety of people.

---

## "The first MITSS HOPE Award was presented ... to Mt. Auburn Hospital in Cambridge, Mass, [which] has a disclosure response team ..."

---

Several volunteers have become active on the outreach committee, adding to the group's diverse skills. Committee members include representatives from healthcare-related non-profits and hospitals, as well as professionals from clinical services, public relations, and healthcare access. Patients on the committee add valuable perspective.

The committee began with several pilot projects, including search-engine-optimizing the web site, jump-starting the MITSS blog content, producing a poster to use in the community, and developing the HOPE (Honoring Outstanding People Everywhere) Award program to gain a higher profile for support activities in the medical community. The committee also sought a strategic vision to support future outreach efforts.

### HOPE Award honors those who serve the mission

The HOPE Award recognizes people from inside and outside the medical profession who exemplify the mission of MITSS: supporting healing and restoring hope to patients, families, and clinicians affected by adverse medical events.

The first MITSS HOPE Award was presented in November 2008 to Mt. Auburn Hospital in Cambridge, Mass. That institution has a disclosure response team that respects and supports the needs of patients and providers before, during, and after disclosure.

### Committee members get involved in blogging

Committee members have led the way in generating new content for the organization's clinician and patient and family blogs, supplementing resources and commentary provided by MITSS staff. All committee volunteers write for the blogs regularly to keep them active and current.

For the patient and family blog, each committee member has shared his or her personal perspective and experience to help encourage reader comments and promote active blog participation. This process has succeeded in generating significant postings and substantial user comments.

### Increasing the web site's online visibility

The committee is also working on boosting the web site's search engine rankings through the help of professional volunteers. (See sidebar at the left for recommendations on increasing online visibility.)

### Designing a compelling poster

Developing a new poster has challenged the committee to capture the MITSS mission and attract a diverse audience in just a few words and pictures. A key element has been input from focus groups, both at MITSS and with patient representatives from Health Care for All, a Massachusetts organization dedicated to making adequate and affordable health care accessible to everyone, regardless of income or socioeconomic status.

The poster campaign will be the first MITSS communication materials to go through such rigorous marketing testing; it will be followed up by careful analysis to gauge the results.

*Some non-profit organizations that needed graphic design help have been assisted by local colleges' graphic design programs, where students are invited to work on a specific project for a charitable cause. If an organization has a graphic design project and a reasonable timeline, it should contact the local college or university's graphic design or multimedia department and ask for their assistance.*

### Setting a strategic vision

The MITSS outreach committee also focused on setting clear commitments and goals for the volunteers. In addition to general participation and blogging duties, each committee volunteer works on one of 3 specific projects. Two projects focus on web outreach and one on targeted outreach for the HOPE award.

# NPSF News: Winter 2008

## AmerisourceBergen, SurgiCount Medical Join NPSF Corporate Council

NPSF recently welcomed 2 new members to its Corporate Council.

- **AmerisourceBergen**, based in Valley Forge, Pa, is one of the world's largest pharmaceutical service companies, providing the US, Canada, and selected global markets with a wide range of services from pharmacy automation and pharmaceutical packaging to reimbursement and pharmaceutical consulting services.
- **SurgiCount Medical, Inc.**, headquartered in Temecula, Calif, manufactures the SurgiCount Safety-Sponge™ System, a patented surgical sponge tracking system used in hospitals nationwide to prevent retention of surgical sponges.

The NPSF Corporate Council brings together leading healthcare solution providers in partnership with the Foundation in support of the unified goal of a safer healthcare system. For more information or to discuss membership options for your organization, e-mail [corporategouncil@npsf.org](mailto:corporategouncil@npsf.org).

## Lucian Leape Institute Defines Strategies for Patient Safety

A recent meeting of the Lucian Leape Institute addressed the topic of reforming medical education—a key component of the cultural change needed to realize the goal of the patient safety movement, and one of 5 key strategies identified by the Institute's panel as essential to the advancement of patient safety efforts. The 5 transforming concepts, which provide the theme for a series of Institute roundtable sessions, are:

1. Medical education reform
2. Enhanced consumer and patient involvement in patient care
3. The expectation of full transparency in patient care

4. Care integration in and across healthcare organizations
5. Restoration of pride, meaning, and joy in professional work.

The Institute plans to issue a set of white papers documenting recommendations and calls to action that emerge from the roundtables. A series of application-oriented articles will appear in *Focus* in 2009.

## NPSF Announces Theme for Patient Safety Awareness Week: March 8–14, 2009

NPSF recently announced the theme for Patient Safety Awareness Week 2009: "A Prescription for Patient Safety: One Partnership, One Team." This annual event is a national awareness-building campaign focused on improving patient safety at the local level by educating consumers about their role in their own care and promoting partnership between hospitals and patient communities.

NPSF provides each Stand Up for Patient Safety member facility with a complimentary Patient Safety Awareness Week toolkit filled with resources and materials designed to help them celebrate the week. Additional materials may be ordered through the NPSF web site. Please see [www.npsf.org/hp/psaw/](http://www.npsf.org/hp/psaw/) for more information.

## Stand Up Spotlight: New E-mail Publication for Stand Up for Patient Safety Members

NPSF is introducing a new resource exclusively for Stand Up for Patient Safety members. The *Stand Up Spotlight* is a monthly e-mail publication designed to keep members connected to program benefits and upcoming initiatives. This new resource gives members the opportunity to interview prominent healthcare industry experts, features the best practices of Stand Up member hospitals, and highlights the most relevant publications, resources, and events to bring members the latest in patient safety. [NPSF](#)

# Improving Outreach Strategies CONTINUED FROM PAGE 6

The third project is to develop a strategic vision for reaching out to select underserved communities. Over the next year, the MITSS community outreach committee will concentrate on developing points of presence with groups in the community and the health professions. Managing the complexities of transparency after a medical error and the individual after-effects needs the involvement of a diverse

range of individuals. For a long time, people from across the country have asked how they could help others find out about MITSS and benefit from MITSS's services. Now, through technology and energy, there is a place for them to get involved in supporting healing and restoring hope. The lessons MITSS has learned can be useful for many patient safety volunteer organizations. [NPSF](#)

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, 132 MASS MoCA Way,  
North Adams, MA 01247. Materials,  
inquiries, and subscription requests  
for the publication will be accepted  
electronically at [info@npsf.org](mailto:info@npsf.org) or  
via fax at (413) 663-8905.

#### Editorial Board

Paul A. Gluck, MD

Immediate Past Chair

NPSF Board of Directors

Associate Clinical Professor

University of Miami

School of Medicine

Diane C. Pinakiewicz, MBA

NPSF President

Allison Fissel Perry, MA

NPSF Senior Director,

Programs and Strategic Development

Managing Editor:

Lorri Zipperer

Zipperer Project Management

Evanston, Ill

Editor:

Susan Raef

WordPower Communications, Inc.

Chicago

Editorial Assistant:

Anita Spielman

Program Manager, NPSF

© 2008 National Patient Safety

Foundation. Permission to reprint

portions of this publication for edu-

cational and not-for-profit purposes

is granted subject to accompani-

ment by appropriate credit to the

NPSF and Focus on Patient Safety.

Commercial reproduction requires

pre-approval. Some fees may apply.

# Register Now for the 2009 NPSF Patient Safety Congress

**Patient Safety In Challenging Times**  
*Now More Than Ever, a Critical Need*

**2009 NPSF ANNUAL PATIENT SAFETY CONGRESS**

Gaylord National • Washington DC Area  
Pre-Congress May 20 • Congress May 21-22

Keeping patients safe in challenging times requires real-world strategies and tools, new thinking, and vigilance across health care. The 2009 NPSF Patient Safety Congress is designed to address these critical needs.

#### Plan now to attend the Congress May 21-22, 2009

You are invited to join patient safety leaders from around the world May 21-22, 2009 for the NPSF Annual Patient Safety Congress. This renowned event, recognized for its authoritative and wide-ranging content, brings together patient safety leaders, experts, and innovators for a program of engaging presentations and incomparable networking opportunities.

#### May 20 Pre-Congress Program offers in-depth sessions

The Pre-Congress Program on May 20 will feature three highly targeted day-long discussions:

- Leadership Day
- Patient Safety 101
- Community Engagement from the Patient and Family Perspective

#### Find out more and register today

For more information and to download a Congress registration form, visit [www.npsf.org](http://www.npsf.org). **NPSF**

## Call for Poster Presentations at NPSF Congress

NPSF is issuing a call for posters to be presented at the Annual Patient Safety Congress, May 20-22, 2009 in Washington, DC.

#### Research and Solutions posters wanted

Abstracts are solicited for both Research and Solutions poster presentations. Initiatives that cross or link stakeholder groups are encouraged. Research and Solutions posters are an integral component of the NPSF Annual Congress and will be showcased before an anticipated audience of more than 1,400 attendees.

#### See the NPSF web site for details

For information and submission instructions, go to [www.npsf.org/npsfac/pp/](http://www.npsf.org/npsfac/pp/).

#### Apply by January 23, 2009

The poster application deadline is Friday, January 23, 2009 at 5:00 pm EST.

#### Questions?

If you have any questions, please e-mail the NPSF Conference Department at [conferences@npsf.org](mailto:conferences@npsf.org). **NPSF**