

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

2009 NPSF Annual Congress Addresses Patient Safety in Challenging Times

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IN THIS ISSUE

2009 NPSF Annual Congress Addresses Patient Safety in Challenging Times

What Can Aviation Teach Health Care about Consumers' Role in Safety?

Reducing Diagnostic Error in Medicine—There's a Job for Everyone

NPSF Presents 4 Annual Awards for Excellence in Patient Safety

The 2009 NPSF Annual Patient Safety Congress, "Patient Safety in Challenging Times: Now More Than Ever, A Critical Need," explored the economic difficulties facing the industry, the need to forge pathways, the frustrations endured, the successes celebrated, the anxieties being felt, and confidence that the industry can do better.

Patient safety stakeholders from around the world gathered on May 20-22 in National Harbor, Md, to focus on the need to strengthen efforts to improve patient safety and quality in the midst of the extraordinary economic challenges facing the nation. The key messages of the 1999 IOM report, *To Err is Human*—that safety problems are serious, that the system (not the worker) is the problem, and that the problem can be fixed—still resonate today.¹

The Congress featured 4 plenary sessions and 35 breakout sessions in 7 educational tracks. Other highlights included breakfast roundtables facilitated by members of NPSF's Lucian Leape Institute, poster presentations showcasing patient safety research and solutions, and presentation of 4 annual awards for patient safety achievement (see page 8).

3 simultaneous full-day workshops preceded the Congress

- **Leadership Day**, a program for C-suite and board-level executives, explored the tools necessary to build a safety framework, establish safety and quality priorities, design incentives for safety, and ensure physician engagement. The program provided a unique opportunity to interact with patient safety leaders and to learn and share via case studies, panel discussions, and open dialogue.

The presenters reflected on patient safety progress during the past 10 years, the opportunities for improvement, and what senior healthcare leaders can do to promote improvement, with a focus on the critical need to engage physicians in the process of safety and quality work.

- **Patient Safety 101** introduced patient safety concepts and practices to frontline staff, mid-level managers, and senior leadership new to the field. Presentations and interactive exercises helped participants learn about

patient safety science, principles of a safety culture, strategies and techniques for improving safety, and where to find tools and resources.

- **Community Engagement from the Patient and Family Perspective**, which debuted at last year's Congress, focused on the role of patient education and awareness at the community level as key components of patient safety. Patient safety educators, advocates, and representatives shared stories and discussed successful strategies for engaging patients and family members as partners in their care.

"The key messages of the 1999 IOM report, *To Err is Human*—that safety problems are serious, that the system (not the worker) is the problem, and that the problem can be fixed—still resonate today."

Rediscovering Play:

Bringing Fun and Passion to Your Work ... and Life

Kevin Carroll, author of *Rules of the Red Rubber Ball: Find and Sustain Your Life's Work*, spoke to Congress attendees about how to harness the spirit of play to instill meaning and fulfillment in their work.² Carroll, whose background is in health education and human performance, first learned the words "do no harm" when he began his training in sports medicine.

Carroll grew up without a father and was abandoned, along with his 2 brothers, by his substance-abusing mother when he was 6 years old. A red rubber ball on a playground in the streets of Philadelphia (where he and his brothers went to live with his grandparents) became Carroll's source of

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The complete Congress program is available at www.npsf.org. Full Congress proceedings will be published in the September 2009 issue of NPSF's Journal of Patient Safety.

References

1 Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System*. Committee on Quality of Health Care in America, Institute of Medicine. Washington, DC: National Academy Press; 2000. Available at: <http://books.nap.edu/catalog/9728.html>. Accessed April 27, 2009.

2 Carroll K. *Rules of the Red Rubber Ball: Find and Sustain Your Life's Work*. New York: ESPN Books; 2004.

3 Audet AM, Raju R, Jacobs CM, Schick JF, Aviles AD. *Transparency as a pillar of a quality and safety culture: the experience of the New York City Health and Hospitals Corporation*. Jt Comm J Qual Patient Saf. 2008;342:707-712.

inspiration. Through it he learned courage, how to deal with disappointment, how to challenge himself, and how to dream big dreams at a time when he had little hope.

Carroll's 7 lessons learned from the playground

- 1. Commit to it.** Carroll explained that individuals need to commit to something. Push back against those who want to squash creativity and ingenuity. View doing more with less as an opportunity, not an obstacle.
- 2. Seek out encouragers.** Everyone needs a team of individuals for support and to encourage brainstorming.
- 3. Work out your creative muscle.** Creativity is like a muscle: it needs to be used regularly.
- 4. Prepare to shine.** Champions must be prepared to do the "lonely" work. Those who have achieved greatness in their field—Michael Jordan, Yo-Yo Ma, Wayne Gretzky— have never been satisfied with being good; they want to be brilliant at what they do.
- 5. Speak up.** As Carroll's grandmother used to say, "A closed mouth don't get fed." Anything is possible to those who have the passion and the "want-to" to succeed.
- 6. Expect the unexpected.** Adults often ignore unexpected events, but kids never do.
- 7. Maximize the day.** Each day is a gift of 86,400 seconds that should be maximized, not wasted.

"View doing more with less as an opportunity, not an obstacle."

Lucian Leape Institute Town Hall Plenary: IOM Report Retrospective and the Decade Ahead

In the sixth annual "town-hall" plenary, experts in patient safety shared their thoughts on the challenges and opportunities facing the field. This year's session, moderated by Janet Corrigan, PhD, MBA, president and CEO, National Quality Forum and former senior board director, Institute of Medicine (IOM), reviewed progress in patient safety in the 10 years since the publication of the IOM report, *To Err is Human*.¹ The session explored the IOM report's impact, as well as challenges and opportunities for the decade ahead.

Participants included: Donald Berwick, MD, MPP, president and CEO, Institute for Healthcare Improvement (IHI); Carolyn Clancy, MD, director, AHRQ; James Conway, MAM, CHE, senior vice president, IHI; James Guest, president, Consumers

Union; David Lawrence, MD, chairman and CEO (retired), Kaiser Foundation Health Plan, Inc and Kaiser Foundation Hospitals; Lucian Leape, MD, Lucian Leape Institute chair, adjunct professor of health policy, Harvard School of Public Health; Julianne Morath, RN, MS, chief quality and safety officer, Vanderbilt University Medical School; Dennis O'Leary, MD, president emeritus, The Joint Commission; and Paul O'Neill, former chairman and CEO, Alcoa, and 72nd secretary of the US Treasury.

Health Policy Reform:

The Unfinished Business of the Baby-Boom Generation

The Honorable John Kitzhaber, MD, former governor of Oregon (1995-2003), discussed the larger context in which to view the current healthcare crisis and set forth the foundational components of reform necessary to meet the challenge of the baby-boom generation:

- **Progressive, comprehensive focus on early childhood preventive care.** Kitzhaber explained that a strategy of sustained early childhood investment must be a foundational component of any system. For example, early investments in preventing type II diabetes could eliminate the need for costly treatments and hospitalizations for the disease later in life.
- **Public financing.** The nation must explicitly answer the question of who pays for those who cannot afford care on their own. Providing access to health care, just like providing education, should be viewed as a public-sector responsibility.
- **Value-based cost sharing.** Tiered copayments should be used to drive individual behavior and accountability. Cost sharing should vary depending on the effectiveness and public health benefit of the treatment, with little or no cost sharing for services that are highly effective and highly beneficial in terms of population health, and higher cost sharing for elective and/or discretionary services.
- **New delivery model.** Care needs to be reorganized around "families" of conditions. Revenues should flow to risk-bearing entities at the regional or local level, each of which would bear economic risk and assume responsibility for the health of a defined population.
- **New payment model.** The current system of fee-for-service payments and insurance underwriting would be replaced by a new model in which the healthcare entities described above would receive monthly or annual base payments for the management of each patient. Additional bundled payments would be made for managing existing complex conditions, with bonus payments tied to improving outcomes.

“Miracle on the Hudson”—First of a 2-Part Series

What Can Aviation Teach Health Care about Consumers’ Role in Safety?

BY GRENA PORTO, RN, MS, ARM, CPHRM, PRINCIPAL, QRS HEALTHCARE CONSULTING, LLC, HOCKESSIN, DEL

On January 15, 2009 at 3:26 PM, US Airways Flight 1549 took off from New York’s LaGuardia Airport bound for Charlotte, NC. About a minute after takeoff, the aircraft struck a flock of Canada geese, causing both of its engines to lose power. When the pilot, Capt Chesley Sullenberger, was unable to glide the plane to the nearest airport in Teterboro, NJ, as suggested by air traffic control, he opted for a water landing in the Hudson River near midtown Manhattan.

At 3:31 PM, Flight 1549 splashed down in the Hudson River. All 155 on board survived. One flight attendant injured her leg, but no one else suffered serious injury. Within 4 minutes of the water landing, passenger ferries and other watercraft arrived alongside the floating plane and rescued passengers and crew, most of whom were standing in frigid water on the plane’s wings or on the floating emergency exit slides. After the passengers and crew were evacuated, emergency responders towed the still-floating plane to a dock on the southern tip of Manhattan.

This event, dubbed “the miracle on the Hudson” by New York Governor David A. Patterson, has been widely covered by the news media from minutes after it happened.¹ Much of the media attention has focused on the actions of Capt Sullenberger, who has been cast as a hero for having executed an apparently perfect, technically difficult water landing.

While there is no doubt that the pilot’s skill was an important factor in the outcome of this aviation accident, other elements also played a role. What key lessons from Flight 1549 can the healthcare industry apply in pursuing patient safety—particularly in engaging patients in ensuring their own safety?

The passenger as hero

Even as print, radio, Internet and television media were lauding the efforts of Capt Sullenberger and casting him as a hero, media interviews were identifying other heroes as well. Immediately after “the miracle on the Hudson,” journalists began interviewing passengers from the flight. Those interviews provided rare insight into how airline passengers react during an emergency, as there were so many uninjured survivors readily accessible to the media. The interviews revealed that the passengers themselves

played a critical role in Flight 1549’s successful outcome and in saving their own lives.²⁻⁵

The passengers and crew of Flight 1549 reported that passengers braced themselves for the impact of the water landing even before receiving more-explicit instructions from flight attendants about how to do it. There was no chaos or screaming in the cabin during the landing—only silence and prayers. Even after the landing, as passengers prepared to evacuate, they assisted the flight crew in opening emergency exits and helped one another.

“[T]he passengers themselves played a critical role in Flight 1549’s successful outcome and in saving their own lives.”

Passengers helped a woman carrying an infant move to the head of the line for the floating emergency exit slide. Even when help arrived, travelers still assisted one another in boarding the rescue vessels. Passengers also helped the flight crew member who was injured. It was clear that without the orderly assistance of passengers, the crew would have been challenged to safely evacuate everyone on the plane on a timely basis, particularly since one of the crew was incapacitated due to her injuries.

Some of the passengers’ efforts can be attributed to the tendency of people to draw together when confronted with adversity. In New York City, this same phenomenon was observed during the 9/11 tragedy. However, this by itself does not explain the orderly and disciplined way in which passengers prepared themselves for the landing and then followed evacuation procedures. It is doubtful that this would have occurred if the aviation industry had not had a long-standing practice of engaging consumers in safety.

Numerous safety warnings and instructions are recited to commercial airline passengers by flight attendants prior to

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References

- 1 NY jet crash called “miracle on the Hudson.” *www.msnbc.com* [online serial]. Available at: www.msnbc.msn.com/id/28678669/ Accessed March 25, 2009.
- 2 McFadden RD. Pilot is hailed after jetliner’s icy plunge. *New York Times*. January 15, 2009. Available at: http://www.nytimes.com/2009/01/16/nyregion/16crash.html?_r=1&pagewanted=2M Accessed April 8, 2009.
- 3 Radutzky M, Beecher L, Dubin J, producers. *Flight 1549: Saving 155 Souls In Minutes*. 60 Minutes. CBS News. February 8, 2009. Available at: http://www.cbsnews.com/stories/2009/02/08/60minutes/main4783586.shtml?source=related_story Accessed April 8, 2009.
- 4 Newman R. How Sullenberger really saved US Airways flight 1549. [blog entry]. *www.usnews.com*. February 03, 2009. Available at: <http://www.usnews.com/blogs/flightowchart/2009/02/03/how-sullenberger-really-saved-us-airways-flight-1549.html> Accessed April 8, 2009.
- 5 DeGregory L. Flight 1549 survivor got out of the Hudson, back into the air. *Tampa Bay Times*. March 29, 2009. Available at: <http://tampabay.com/features/humaninterest/article987899.ece> Accessed April 8, 2009.
- 6 National Patient Safety Goal #13. Joint Commission: Oakbrook Terrace, IL; 2008. Available at: http://www.joint-commission.org/NR/rdon-lyres/31666E86-E7F4-423E-9BE8-F05BD1CB0AA8/0/HAP_NPSG.pdf Accessed April 9, 2009.

CONTINUED ON PAGE 4

CONTINUED ON PAGE 5

What Can Aviation Teach Health Care about Consumers' Role in Safety?

CONTINUED FROM PAGE 3

and during every flight. These warnings and instructions are used by all commercial airlines and are repeated on every flight, regardless of whether the passengers have heard the warnings and instructions before. The oral instructions are accompanied by physical demonstrations of the procedures, either by the flight attendants or by video.

Each passenger is also provided with a written safety instruction card that describes the procedures to be followed in an emergency. All of these instructions are mandated by the Federal Aviation Administration (FAA) and are highly specific and standardized.

Whether a passenger is traveling on US Airways or any other airline in America, the safety instructions and emergency safety procedures are the same. Consumer engagement in aviation safety is also aided by FAA regulations, which make it a federal crime to violate many of the safety procedures.

Many passengers on Flight 1549 were seasoned business travelers who had heard these instructions hundreds of times before. Undoubtedly, many of them could recite them from memory. On January 15, 2009, those business travelers had the opportunity to make use of that information in a manner they had probably never anticipated.

Because of their repeated exposure to this safety information, passengers on Flight 1549 were able to respond to the emergency and participate in the evacuation in a manner that saved their own lives and those of others.

What can health care learn from aviation about safety?

Healthcare has begun to engage consumers in safety, helped by requirements from the Joint Commission.⁶ However, the healthcare industry has a long road ahead in reaching the level of engagement and compliance achieved by the aviation industry.

Fundamental differences in system design and complexity preclude a wholesale adoption of aviation practices with respect to the role of consumers. For example, although airline passengers are encouraged and required to participate in certain safety measures, they are nonetheless passive recipients of a service with little choice in the methods or outcomes. Conversely, efforts to promote consumer engagement in healthcare emphasize the rights of patients as active

participants in their care, and the need to empower patients to make treatment choices.

Patient engagement in health care—particularly in patient safety—is highly dependent on the setting and the treatment in question. For example, surgical safety standards emphasize patients' involvement in marking the surgical site, while the role of patients in MRI safety focuses not on site marking, but on reporting risk factors such as implants or past employment as a welder.

“[P]atients' responsibilities in ensuring their own safety can vary widely depending on circumstances. Conversely, the airline passenger's role in safety is highly standardized ...”

For other radiological procedures, reporting of allergy history becomes a critical patient responsibility to ensure safety. In general care, patients are encouraged to bring a list of their medications. Thus, patients' responsibilities in ensuring their own safety can vary widely depending on circumstances. Conversely, the airline passenger's role in safety is highly standardized, regardless of airline or type of plane.

Many efforts to engage patients in safety have focused on empowering and encouraging patients to ask questions about their care.^{7,8} This is in direct opposition to the aviation model of consumer engagement, in which questioning of flight crew actions and decisions is not encouraged, and failure to follow instructions can be a crime.

Learning from Flight 1549

Although there are considerable differences in models for consumer engagement between health care and aviation, Flight 1549 still provides some valuable lessons for health care, including:

- **Standardize communications.** Recent discussions on NPSF's listserv suggest that organizations routinely customize all types of safety practices involving patients,

including patient participation in surgical site marking, literature given to patients about their role in safety, and MRI pre-screening.⁹ Thus, it is not surprising that the role of patients in their own safety remains ambiguous and a source of confusion for both patients and providers. The healthcare industry needs to abandon this “craftsman” approach to patient safety practices and embrace an industry-wide standard to reduce confusion and enhance understanding and among both patients and providers.

• **Provide patients with safety information early and often.**

Many patients do not encounter information on how to help ensure their own safety until they have an acute or emergent care need, such as an emergency department visit or hospitalization. This is analogous to first informing passengers of emergency landing procedures when the plane is crashing. Also, information provided to patients is usually not repeated at regular intervals during an episode of care or hospitalization, even though patients are known to be under stress and physically ill, impairing their ability to process new information.

The healthcare industry should follow aviation’s example by focusing more effort on giving patients vital information on how to enhance their own safety. Such communication should be well-planned, easy to understand, delivered at appropriate intervals, and repeated frequently to ensure understanding and retention by patients.

• **Use multiple formats to communicate key information.**

In addition to repetition, it is critical to provide important information, such as how patients can help ensure their own safety, in multiple formats. Healthcare providers are challenged in their communication with patients by the problems of limited healthcare literacy and general literacy, as well as by language barriers. Thus, providing information only in writing, without accompanying videos, demonstrations, and discussions, does not adequately address patients’ information needs. Planned redundancy in communication methods would enhance understanding and retention even in literate and well-informed patients.

In addition to verbally informing patients about safety behaviors, healthcare providers should supply written instructions and training videos that demonstrate them.

Healthcare providers should supplement this with discussions with patients during which understanding can be assessed and enhanced.

Although many hospitals have internal television broadcasts that provide important information for patients, management mistakenly assumes that patients actually watch this programming. That is far from certain. For this reason and the ones previously discussed, information about patients’ role in ensuring their own safety should be provided in multiple formats and repeated often.

“Provide patients with safety information early and often.”

• **Do not allow for “opting out.”** Airline passengers cannot “opt out” of mandated safety practices such as wearing seatbelts, participating in emergency evacuation procedures, or following crew member instructions. This is not the case for healthcare patients, who can and do opt out of a number of practices designed to ensure appropriate care. For example, despite decades of healthcare industry effort, only a small percentage of patients have completed advance directives to help guide end-of-life care decisions. Non-participation in these practices adversely affects patients’ care.^{10,11}

As it strives to empower patients to make choices about their care, the healthcare industry also has allowed patients to opt out of safety behavior that should be mandatory, such as participating in or even allowing surgical site marking, and providing an accurate, complete medication list to providers. These behaviors should be mandatory in health care, just as wearing a seatbelt on an airplane is required.

Consumers can and do play a key role in ensuring their own safety, as the events surrounding Flight 1549 demonstrate. Healthcare providers are beginning to adopt practices to help patients become more engaged in maintaining their own safety and well-being while receiving care. However, such efforts are in their infancy, and can be improved by adopting some of aviation’s successful practices, particularly in standardization and communication. **NPSF**

References

CONTINUED FROM PAGE 3

- 7 *Speak Up. [brochure]. Joint Commission: Oakbrook Terrace, Ill. Available at: <http://www.jcrinc.com/Other-Resources/SPEAK-UP-BROCHURE-PLANNING-YOUR-FOLLOW-UP-CARE-ENGLISH/298/> Accessed April 9, 2009.*
- 8 *Ask Me 3. [brochure]. Partnership for Clear Health Communication. Available at: <http://www.npsf.org/askme3/PC-HC/download.php> Accessed April 9, 2009.*
- 9 *Patientsafety-l archive. Available at: <http://listserv.npsf.org/SCRIPTS/WA-NPSF.EXE?AO=PATIENTSAFETY-L> Accessed April 9, 2009.*
- 10 *Llovera I, Ward MF, Ryan JG, et al. Why don't emergency department patients have advance directives? Acad Emerg Med. 1999;6:1054-1060.*
- 11 *White DB, Curtis JR, Wolfe LE, et al. Life support for patients without a surrogate decision maker: Who decides? Ann Intern Med. 2007;147:34-40.*

Look for Part 2 of the “Miracle on the Hudson” series in the next issue (Volume 12, Issue 3) of Focus on Patient Safety.

Reducing Diagnostic Error in Medicine— There’s a Job for Everyone

BY MARK L GRABER, MD, CHIEF OF MEDICAL SERVICE, NORTHPORT, NY VA MEDICAL CENTER

Diagnostic error is just now emerging as a major patient safety concern, despite the enormous harm these mistakes can cause.^{1,2} One factor that has contributed to this delay is the confusing issue of ownership. Although the other stakeholders have major roles to play, we start with the proposition that reliable diagnosis is the responsibility of the physician. With the disappearance of autopsies, however, clinicians today underestimate their fallibility, believing that any errors are made by others less skilled or less careful than themselves.³ Physicians truly do not see diagnostic error as their own problem.

“With the disappearance of autopsies ... clinicians today underestimate their fallibility, believing that any errors are made by others less skilled or less careful than themselves.”

Taking ownership of diagnostic responsibility

Physicians clearly need to accept primary responsibility for diagnostic reliability. However, considering that most diagnostic errors reflect both cognitive *and* system-related elements,⁴ it makes great sense to also involve the leadership of healthcare organizations from the beginning in any consideration of possible solutions.

Through their culture, staffing, environment, and policies, healthcare organizations can play a major role in promoting reliable diagnosis. Solutions to the problem of diagnostic error might emerge more quickly by involving *all* the major stakeholders. Ideally, physicians would lead the charge, but given the magnitude of the challenge, there’s a job for everyone to make diagnosis timely and reliable.

Here is a prescription, starting with the 3 parties with the most to gain from making diagnosis reliable: physicians, patients, and the healthcare system.⁵

Physicians: Understand how errors occur

- **We as physicians need to recognize our propensity to err as well as our substantial overconfidence as the first step**

in addressing diagnostic error. The best evidence suggests that physicians are wrong 5-10% of the time, and even clinicians in the perceptual specialties commit errors at the rate of several percent.³

- **Understand the causes of diagnostic error.** We physicians are positioned to address both the system-related and cognitive origins of these errors.
- **Work with your healthcare system to fix as many system flaws as you can.** Make sure expertise is available when you need it. Try to optimize communication and coordination of care. Take advantage of as many decision-support resources as possible. Champion a culture of safety.
- **Appreciate that cognitive error typically reflects problems in the “fast and frugal” heuristics all physicians use to solve a new problem.**⁶ We physicians recognize patterns and use intuition, and these subconscious processes are error-prone. It’s better to pause, consciously reflect, and consider other possibilities.^{7,8}
- **Encourage second opinions from colleagues or specialists.** Errors are caught by fresh eyes.
- **Establish a pathway for follow-up.** Be honest with patients about the probabilistic nature of diagnosis. Tell them what to expect if the diagnosis is correct, and how to get back to you if the expected outcomes don’t happen or new signs or symptoms arise.
- **Set up a process for feedback.** We physicians need a replacement for autopsies, some way to learn of our mistakes. Tell colleagues that you want to hear about it any time your diagnosis is changed.

Patients: Take a more active role in safety

Patients can be much more than passive players in medical diagnosis. They can play a key role in helping prevent and detect diagnostic errors, both cognitive and system-related. Here are some useful tactics for patients.

- **Be a good historian.** Keep notes on which symptoms came first and how things evolved.
- **Obtain and keep copies of test results and consultations.** In an ideal world, all of this would be coordinated by your healthcare provider, but the system is not there yet. Right now, patients need to be the conduit for communication and care coordination.
- **Understand that most diagnoses are just the most likely thing, not necessarily the right thing.** Ask: “What else

as I see it

could this be?" This simple question encourages your doctor to think more broadly about your problem, reducing the likelihood of cognitive error.

- **Speak up!** Ask what to expect and how to get in touch with your doctor if new symptoms or signs develop, or if the predicted course of events doesn't happen.

What can healthcare organizations do?

Healthcare organizations (HCOs) can also positively influence diagnostic reliability, but few appreciate their pivotal role in this process. Obviously, the place to start is with easily remediated, system-related contributors to error.

- **Make sure expertise is available when needed.** Start with radiology. Radiological expertise needs to be available 24/7. Facilitating patients' access to specialists would also be helpful.
- **Optimize coordination of care.** Progress notes, discharge summaries, consultations, and test results need to be available to all providers all the time, legibly and well-organized.
- **Facilitate communication.** Faulty communication is typically cited as the number-one problem in patient safety. Regarding diagnostic error for example, good communication can help ensure that clinicians order the right tests, interpret the results correctly, and understand the thinking of other physicians involved in the patient's care. HCOs would benefit substantially by developing improved options for the medical staff to communicate with their colleagues and consultants.
- **Recognize the potential for HCOs to influence cognitive-related error.** HCOs can optimize the potential for correct and timely diagnosis by providing decision-support tools, providing pathways for feedback to replace autopsies, allowing clinicians adequate time for reflection, and by encouraging early consultation and second opinions.

What can other stakeholders do?

Beyond the core group (physicians, patients, and HCOs) are many other stakeholders who have an interest in reducing diagnostic error and are in a position to do something about it.

- **Oversight organizations** such as the Joint Commission can promote diagnostic reliability by requiring HCOs to ensure reliable and timely communication of test results. Next steps

could include requirements to develop feedback pathways, and others to ensure availability of appropriate expertise.

- **Nurses** play a key role in error detection and prevention in many areas of safety, such as in helping prevent medication error. They can play a similar role in helping reduce diagnostic error by helping patients find their voice, promoting coordinated care, and serving as a liaison between the physician and the patient.
- **Funding agencies** can substantially energize the quest to reduce diagnostic error by promoting research in this nascent area.
- **Patient safety groups** can help focus attention on the problem and available solutions through conferences and organized projects.
- **The media** can promote reliable diagnosis by ensuring that diagnostic error receives a balanced representation as a patient safety issue. Journalists can also support a culture of safety by de-sensationalizing medical error and encouraging a balanced discussion that emphasizes learning.

The healthcare community is just starting to address the problem of diagnostic error. All stakeholders need to learn more about these errors—how they arise, which factors predispose to errors, and what potential mechanisms exist to reduce the likelihood of error or harm. There is a job for everyone, and the job should start now. [NPSF](#)

References

- 1 Newman-Toker D, Pronovost PJ. Diagnostic errors—the next frontier for patient safety. *JAMA*. 2009;301:1060-1062.
- 2 Graber ML. Diagnostic error in medicine: a case of neglect. *Jt Comm J Qual Patient Saf*. 2004;31:112-119.
- 3 Berner ES, Graber ML. Overconfidence as a cause of diagnostic error in medicine. *Am J Med*. 2008;121:S2-S23.
- 4 Graber ML, Franklin N, Gordon RR. Diagnostic error in internal medicine. *Arch Int Med*. 2005;165:1493-1499.
- 5 Graber ML. Taking steps towards a safer future: Measures to promote timely and accurate diagnosis. *Am J Med*. 2008;121:S43.
- 6 Croskerry P. The importance of cognitive errors in diagnosis and strategies to minimize them. *Acad Med*. 2003;78:775-780.
- 7 Singh H, Petersen LA, Thomas EJ. Understanding diagnostic errors in medicine: a lesson from aviation. *Qual Saf Health Care*. 2006;15:159-164.
- 8 Mamede S, Schmidt HG, Rikers R. Diagnostic errors and reflective practice in medicine. *J Eval Clin Pract*. 2007;13:138-145.

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Dr Graber, with Ilene Corina of Long Island, NY, and in collaboration with NPSF, started Patient Safety Awareness Week in 2002. He has a long-standing interest in diagnostic errors, and hosted the first national conference on this subject in 2008.

This article is based on a presentation at the 2009 Annual Congress entitled Failure to Diagnose—Improvement Strategies.

The Diagnostic Errors in Medicine 2nd Annual Meeting will be held October 21-22, 2009 at the Renaissance Hollywood Hotel in Hollywood (Los Angeles), Calif. For information, visit: www.smdm.org/diagnostic_errors.shtml

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NPSF Presents 4 Annual Awards for Excellence in Patient Safety

At the 2009 Congress, NPSF presented 4 awards recognizing leadership and outstanding achievement in patient safety.

The Chairman's Medal was awarded to Heidi King, director of the Department of Defense (DoD) Healthcare Team Coordination Program and acting director of the DoD Patient Safety Program. This award recognizes emerging leadership in patient safety and is presented to an individual or organization that has inspired and led improvements in patient safety while creating a culture of respect, transparency, learning, and cooperation. King has been instrumental in developing the highly regarded TeamSTEPPS™ (Team Strategies and Tools to Enhance Performance and Patient Safety) program, an evidence-based system aimed at optimizing patient outcomes and promoting a culture of team-driven care.

The Socius Award was presented to MCGHealth of Augusta, Georgia. This award is presented to a single organization that has promoted positive and effective partnering in pursuit of improved patient safety. MCGHealth, which has earned national and international recognition for the innovative work of its Center for Patient- and Family-Centered Care, received the award for its exemplary efforts to promote patient-provider partnership throughout the planning and delivery of care.

The Stand Up for Patient Safety Management Award was presented to Mariners Hospital, an affiliate of Baptist Health South Florida. This award is given to a Stand Up for Patient Safety™ member organization that has implemented an outstanding patient safety initiative led by or created by mid-level management. Mariners Hospital received the award for a multidisciplinary initiative to improve radiologic patient safety by prospectively assessing and identifying patients at risk for contrast-induced nephropathy.

The Partnership for Clear Health Communication at NPSF presented the **Pfizer Health Literacy in Advancing Patient Safety Award to Michael Wolf, PhD**, director of the Center for Communication in Healthcare at Northwestern University's Feinberg School of Medicine, and **Rima Rudd, ScD**, senior lecturer on society, human development, and health at the Harvard School of Public Health. This award, made possible through a grant from Pfizer, Inc, recognizes the importance of health literacy to advancing patient safety and quality of care, and acknowledges leaders in this work. Dr. Wolf's efforts have helped bring health literacy and patient safety to the forefront of research and policy. Dr. Rudd's work has demonstrated that literacy is a major factor contributing to disparities in health status, access to care, and quality of care for many. The recipients shared a \$15,000 one-time award. **NPSF**

2009 NPSF Annual Congress

CONTINUED FROM PAGE 2

Patient Safety:

Reaching for Transformational Change in Challenging Times

Alan Aviles, president and CEO of New York City Health and Hospitals Corporation (HHC) and recipient of the 2008 John M. Eisenberg Patient Safety and Quality Award, discussed how HHC transformed itself from an organization with serious quality and safety problems to a model for systems across the country.³ He laid out key elements of HHC's patient safety agenda and described how each step was implemented.

These steps include: setting bold goals; engaging senior leaders and the board; creating a culture of safety; investing in training; using focused initiatives that make a difference; leveraging clinical information technology as well as simple, low-tech solutions; viewing quality through a patient safety

prism whenever possible; making transparency a core value; and recognizing and rewarding high performance.

Lessons learned from the HHC experience

1. Mistake-proof health care by hard-wiring for safety.
2. If you are a leader, lead.
3. Foster teamwork.
4. Don't waste a good crisis—embrace adaptive change.

Patient safety moves forward

The healthcare industry must be at the forefront of the debate over healthcare reform and in radically redesigning the system. The critical question is how the industry will respond to this challenge. **NPSF**