10 Years After To Err Is Human: Are We Listening to Patients and Families Yet?

BY BARBARA BALIK, RN, EdD, PRINCIPAL, COMMON FIRE HEALTHCARE CONSULTING, AND FRANK DOPKISS, CHAIR, EXECUTIVE PATIENT AND FAMILY ADVISORY COUNCIL, SPECTRUM HEALTH

Ten years after the Institute of Medicine (IOM) report To Err is Human, a million lives have been lost and billions of dollars wasted.1,2 Our progress deserves an overall grade of B-minus.3 Is patient care safer 10 years after that landmark report? The widely divergent responses to this question are all partially accurate, yet missing something essential.

The progress made since the IOM report is positive and necessary, but is not accelerating on pace with the growing complexity of patient care. Efforts to improve the reliability of highly complicated care across multiple transitions have enhanced the easier-to-change aspects of care. But when the easier solutions are accomplished, the more difficult work remains—that of assuring safety in complex systems. These systems, as shown by recent patient safety efforts, do not respond to single-source solutions such as regulatory requirements, education, public reporting, or pay for performance.

“Patients and families are the only source of information about complex healthcare systems across all settings and are best equipped, if carefully listened to, to identify the unknowable aspects of unsafe systems.”

But when the easier solutions are accomplished, the more difficult work remains—that of assuring safety in complex systems. These systems, as shown by recent patient safety efforts, do not respond to single-source solutions such as regulatory requirements, education, public reporting, or pay for performance.

Viewing each problem as a learning source

Steven Spear’s studies of very complex, yet highly reliable organizations offer a different and more productive approach.4 Rather than applying broad, large-scale solutions to highly complex systems, Spear recommends acknowledging that such systems are highly interdependent and unknowable.

This premise leads to treating each problem, no matter how small, as something not known about the system and an essential source of learning. Rather than striving to move from 80% to 90% performance in a process, each instance of something not working as expected is treated as a gift to be immediately learned from and corrected.

What’s often missing: Learning from patients and families

When safety reporting systems are consistently ineffective, how do organizations immediately identify instances of the system not working as expected? They turn to those who know the most about unsafe systems: patients and their families. To accelerate safety, clinicians and healthcare leaders must rely on these experts to supply the missing pieces of knowledge.

LII identifies transformational concepts

The Lucian Leape Institute at the National Patient Safety Foundation (LII) has articulated 6 concepts for healthcare transformation:

1. Transparency
2. Integrated care
3. Consumer engagement
4. Joy and meaning in work
5. Medical education reform
6. Safety of the Healthcare Workforce

Of the 6 concepts, consumer engagement, or “nothing about me, without me,” provides information about the problems in healthcare systems and helps transform healthcare. Engaging consumers in care partnerships is essential to achieving healthcare quality and safety.5

Patients and families are the only source of information about complex healthcare systems across all settings and are best equipped, if carefully listened to, to identify the unknowable aspects of unsafe systems. They provide untold sources of information about how to accelerate safety outcomes:

- The inability to understand healthcare information (healthcare illiteracy)
Lack of partnerships on the care team
Intolerable waits and delays
Minimal understanding of the system’s function from the patient’s view
Gaps in care transitions

Patients and families help transform care

Some healthcare organizations committed to patient- and family-centered care are making gains faster through an intense commitment to consumer engagement; they find it is the missing piece in their safety efforts. Spectrum Health in Michigan offers several examples of their patient- and family-centered care values in action:

- Nearly 100 patient and family advisors participate in improving the quality and safety of care, from front-line design and improvement to board committees.
- The Patient and Family Advisory Council (PFAC) created a video, “Partners in Care,” viewed by newly hospitalized patients and their families. It immediately sets the tone with real examples of how partnerships of clinicians, patients, and families can ensure safety, quality, and an exceptional experience. The video also shows patients and families what to do when gaps occur.
- Frank Dopkiss, chair of the Executive Patient and Family Advisory Council, is a full member of the Board Quality and Safety Committee.
- A patient/family advisor is a member of the medication safety team. This advisor recently spent 2 hours rounding with the medication safety officer to bring a different view than a clinician might have.
- Patients are engaged in their efforts to reduce avoidable rehospitalizations.
- The PFAC led to using a very different approach to discharge phone calls than that found in the literature. Calls are linked to the discharge instructions to ensure patients’ understanding of the instructions, address any questions or worries, and learn what could have been improved on throughout their stay.
- With the help of patients/families describing what the first 24–48 hours post-discharge are really like—not what clinicians expected—these discharge calls have become safety-enhancing rather than simply courtesy calls.
- The PFAC has addressed health literacy by helping the hospital communicate more clearly with patients. PFAC members continually challenge clinicians to “put it in English” or “quit speaking medical.” They have helped translate information into terms patients can easily understand.

Iowa Health System models Spear’s studies

Another example of involving patients and families to improve patient care comes from Iowa Health System.

- As part of their intense health literacy focus, clinicians partner with patients—especially new adult readers—to develop patient education materials useful for readers at all levels of literacy. Patients’ helpful red-pencil reviews of materials have provided more-effective content.

What drove my wife and me to become involved with the hospital was directly fueled by our experiences—some great, some not so great. The hospital environment can be extremely intimidating. Patients and families tend to believe anything said by a person wearing a white coat and stethoscope. Repeated admittances, unfortunate as they were, essentially armed us with information. The experience made us more comfortable in the hospital environment, certainly less intimidated. In many ways, this filled us with confidence—and in some cases, skepticism.

Without really realizing it, we became untrained observers of hospital procedures. What makes this important is that Spectrum Health was willing to listen and open to suggestions. Without that willingness to listen to families and patients, I don’t believe it is possible for a hospital to make great strides in improving quality, safety, and patient experience. Patients and families need to be involved in the score-keeping. It is too easy for the hospital to give itself a passing grade if it is not asking the right group to help interpret the grade.
Clinical Simulations: Engaging an Entire Organization in Improving Patient Safety

BY DONNA FRYE, RN, MN, CLINICAL DIRECTOR, WOMEN’S AND CHILDREN’S CLINICAL SERVICES, HOSPITAL CORPORATION OF AMERICA

Perinatal clinicians have come to expect simulations in the rudimentary form of mega-codes for adult cardiopulmonary life support (ACLS) and the neonatal resuscitation program (NRP). In 2004, the Hospital Corporation of America’s (HCA) Perinatal Safety Initiative (now the Women’s and Children’s Clinical Services Group or WCCSG) took a step beyond these basic simulations to improve maternal newborn outcomes.

Borrowing proven aviation safety concepts

HCA leadership, coached by an expert in the aviation industry, explored safety strategies such as crew resource management training, simulations, and pre- and in-flight checklists. These concepts followed Institute of Medicine (IOM) recommendations including promoting effective team functioning, anticipating the unexpected, and creating a learning environment. The new WCCSG initiative incorporated aviation safety principles with IOM recommendations by engaging perinatal healthcare team members across the enterprise in clinical simulations.

Applying an enterprise approach to perinatal clinical simulation

The challenge for the WCCSG leadership team and clinical work groups was to implement designated clinical simulations in the 111 diverse HCA perinatal services. HCA hospitals with perinatal units span from New Hampshire to South Florida, and from Southern California to Alaska. They include basic, intermediate, and tertiary perinatal services.

Some university medical centers have state-of-the-art simulation laboratories with professional, technical leadership and support. Other units have collaborated with sister facilities in their market to establish learning centers with simulation capabilities. Some smaller, community facilities have no access to such resources.

Moving beyond basic simulations

As noted, traditional simulations for perinatal clinicians have included ACLS and NRP. Simulation is also included in the system actually works.

10 Years After To Err Is Human

• Care improvement involves direct observation of patients’ care first, before any change is made. Involving patients and their families in this observation is key. What do they see? What does it mean to them? What can be done better right now for this patient? Valuable input from patients and families provides rich information to improve other patients’ care. Iowa Health System believes in making no assumptions about patients’ care and how the system actually works.

These examples illustrate what is missing in most patient safety initiatives, and perhaps what limits their results: the clear, compelling voice of the patient and family. The National Quality Forum’s Safe Practices for Better Healthcare—2009 Update offers important practices and implies that patient/family partnerships are an ingredient of safe care. Yet it falls short by not naming a proven strategy in transforming healthcare: a safety imperative.

Healthcare organizations committed to accelerating safety outcomes will tap into the missing link: patients and families. NPSF

Continued from Page 2

References


the Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) Fetal Heart Monitoring education required for nurses.4

HCA’s simulation efforts began with operative vaginal delivery and shoulder dystocia (the baby’s anterior shoulder getting stuck behind the mother’s pubic bone after delivery of the fetal head). Clinicians later helped develop and implement simulations for neonatal codes, infant security drills, and postpartum hemorrhage.

At the annual HCA Perinatal Conference in 2004, the medical director of the safety initiative demonstrated a team drill for shoulder dystocia. He recruited physicians and nurses from the audience and assigned them roles to perform in his shoulder dystocia scenario in a makeshift delivery setting.

**Simulation, role-playing emphasize teamwork and communication**

This shoulder dystocia presentation highlighted the importance of teamwork and communication. The medical director emphasized the importance of physician leadership and participation in conducting the drills. While pointing out the basic maneuvers of managing a shoulder dystocia, he led audience recruits to participate in role-playing a situation lacking communication and teamwork. This was followed by a demonstration of appropriate communication and teamwork in managing a shoulder dystocia.

Physician and nurse representatives from the 111 facilities were in the audience. The physicians left the conference appreciating the benefits of clinical simulation. They realized how simple a drill could be and felt confident in their ability to lead such a simulation. Physician engagement was demonstrated by physicians from many facilities participating in the drills and at times actually leading the drills over several years.

**Developing online education**

Later in 2004, WCCSG began developing an online education program with a shoulder dystocia module for all delivery providers and nurses caring for labor patients.2 The module emphasized communication and team training, as well as management of shoulder dystocia.

Following the shoulder dystocia module, clinicians developed an online education program for operative vaginal deliveries. Both programs contained protocols, checklists, and other tools.1,2,5

Two years later, one market began preparing to implement a neonatal transport program. Clinical leaders saw the need for their neonatal clinicians to develop standardized neonatal resuscitation skills. This team formalized a simulation format including:

- Instructor qualifications
- Setting and equipment
- Simulation goals and objectives
- Team rules
- Scenario
- Teaching points summary
- Debriefing
- Evaluation5,6

**Adapting simulations for each hospital’s needs**

The team created a grid adapting the roles of the scenario so the simulation could be individualized to meet the needs of a level 1, 2, or 3 perinatal service.

Nurses have used their expanding knowledge of simula-
tions to provide guidelines for perinatal leaders developing and implementing infant security simulations. In 2009,

“[Physicians] realized how simple a drill could be and felt confident in their ability to lead such a simulation.”

physicians and nurses designed a postpartum hemorrhage simulation and tool box. In addition to the simulation plan and scenarios, there are clinician resources such as emergency hemorrhage protocols and massive blood transfusion protocols.

**Learning from simulation experiences**

While much learning has occurred as a result of introducing simulation into perinatal services, 4 features have furthered the goals of promoting effective team functioning, anticipating the unexpected, and creating a learning environment:

- Physician engagement
- Accompanying online education
- Hospital malpractice premium credit
- Incorporation of a simple or complex philosophy

Physicians and nurses anecdotally reported through a variety of informal forums that while they were eager to participate in drills and simulations, they wanted to make
sure their practice was contemporary and evidence-based. To assure that physicians and nurses had accurate knowledge before participating in the simulations, clinicians collaborated with national experts to develop online education programs. These programs were offered free to physicians and nurses and were easily accessible through the Internet.

Physicians earned American College of Obstetricians and Gynecologists (ACOG) cognates and nurses received continuing education credits for completing the courses. Taking the online course before participating in a simulation assured that the clinicians had a common language and knowledge base.²

Hospitals received malpractice premium credits

The amount of clinicians’ time required varied by the type of simulation as well as by facility. To offset the cost of clinician time in performing the drills, the hospitals received premium credit on their malpractice insurance when an established percentage of physicians and nurses had participated in the assigned simulation. This hospital malpractice premium credit was instrumental in securing administrative support for conducting the simulation drills.

A wide variety of simulators and mannequins are available for perinatal simulation. Some teams evaluating an educational or competency validation program involving mannequins have found the mannequins cost-prohibitive. Other clinicians have been frustrated by the complexity of operating the mannequins.

Simulations help clinicians feel better prepared

While some perinatal services have purchased and mastered sophisticated simulators, clinicians from other units have designed and utilized their own teaching resources during drills and simulations. The WCCSG has emphasized the mannequin is not the key to enhancing communication and teamwork through simulation. To enhance communication skill improvement, some hospital teams practiced simulations with other team members playing the patient role.

Simulations Offer New Educational Opportunities at NPSF Congress

As an exciting new part of this year’s program, the NPSF Patient Safety Congress will feature interactive, engaging simulations depicting realistic healthcare scenarios in the context of patient safety. Demonstrations using a variety of simulation modalities will create unparalleled educational opportunities for attendees.

Simulations at the NPSF Learning & Simulation Center: Simulation for Use Testing of Medical Devices: Center for Medical Simulation

Reducing the Risk of Central Line Infections and Complications Using Guidelines, Checklists and Simulation: Institute for Medical Simulation and Advanced Learning at the New York City Health and Hospitals Corporation

Handoffs and Critical Communication: Department of Defense Patient Safety Program

Getting Results: Solutions That Work

12th ANNUAL
NPSF PATIENT SAFETY CONGRESS
Pre-Congress May 17 • Congress May 18–19
Orlando, Florida
Gaylord Palms Hotel & Convention Center

Patient Safety Risks Challenge: University of Miami Jackson Memorial Hospital Center for Patient Safety
Effective Management of Shoulder Dystocia Applying Cognitive, Technical and Teamwork Skills (TeamSTEPPS™): Society for Simulation in Healthcare and The Doctors Company

Plus, Pre-Congress half-day program: Simulation Fundamentals to Advance Your Patient Safety Agenda

For full Congress details, visit www.npsf.org. NPSF
Using Innovative Techniques to Teach Quality and Safety in Undergraduate Medical Education
BY THOMAS ISAAC, MD, MBA, MPH, INSTRUCTOR OF MEDICINE, BETH ISRAEL DEACONESS MEDICAL CENTER

There is growing recognition that undergraduate medical education has not trained students sufficiently in quality and safety. The IOM reports Health Professions Education: A Bridge to Quality and Improving Medical Education: Enhancing the Behavioral and Social Science Content of Medical School Curricula have identified several domains of quality, social, and behavioral science that require greater attention during medical school.1,2

When the Lucian Leape Institute (LLI) held its roundtable on medical education reform in October 2008 and June 2009, participants agreed that medical schools must do a better job of instilling students with the basic knowledge, skills, and attitudes they will need to ensure patient safety. In addition to basic patient safety concepts, students must learn about professionalism, teamwork, communication skills, error disclosure, and human factors.

Students should also have self-awareness and be mindful enough to identify situations that compromise safety. Participants in a 2006 international patient safety symposium prioritized similar areas for safety curriculum development.3

Inculcating concepts such as professionalism, mindfulness, and teamwork may be difficult using a traditional lecture format. Participants at the LLI roundtable felt that medical schools may have better success in teaching many of these concepts by using innovative education methods, particularly when teaching concepts related to social dynamics. Following are some effective methods for teaching patient safety.

Simulation prevents harm to patients during training
Medical simulation has become increasingly popular over the last decade. Simulation is useful for teaching basic concepts such as respiratory physiology and cardiovascular hemodynamics, as well as advanced clinical skills such as the management of difficult airways, tension pneumothorax, pulmonary embolism, and shock.4

Research on the effectiveness of medical simulation in medical schools is limited. A study in a New Zealand medical school used simulation to teach management of medical emergencies.5 Thirty-three students attended a workshop on medical emergency management and completed a post-course self-evaluation.

Sixty-four percent of students felt their teamwork skills had improved, 33% thought they had learned how to approach problems better, and 36% felt they had learned how to apply their theoretical knowledge in a clinical setting better. Further studies are needed to examine the benefits of simulation in undergraduate medical school, though the approach seems promising.

“[M]edical schools may have better success ... by using innovative education methods, particularly when teaching concepts related to social dynamics.”

Medical simulation has been widely used to assess clinical competencies.5 It has also been widely used in surgery, particularly for laparoscopic procedures.6 Medical simulation offers the advantage of avoiding harm to patients as doctors gain clinical proficiency in performing procedures.

The Israel Center for Medical Simulation (MSR) has been a pioneer in medical simulation. MSR is a multidisciplinary, multimodality medical simulation center dedicated to enhancing hands-on medical education, performance assessment, patient safety, and quality of care by improving clinical and communication skills.7 The center has been effective in Israel, and many of its techniques can likely be adapted to US medical schools.

REFERENCES
1 Cuff PA, Vanselow NA. Improving Medical Education: Enhancing the Behavioral and Social Science Content of Medical School Curricula. Washington, DC: Institute of Medicine; 2004.
Problem-based learning promotes better skill retention

Problem-based learning (PBL) allows students to define their own learning objectives from case-study scenarios. In addition to teaching problem-solving, PBL uses appropriate problems to increase knowledge and understanding of basic concepts. There are several advantages to this approach over conventional lectures and examinations. Student-centered PBL fosters more active learning, which, in turn, can promote better retention of learned skills. PBL also allows students to develop desirable attitudes and behaviors for future practice.

The McMaster University Medical School in Ontario, Canada, founded in 1965, provides a unique example of an education system based on active learning around clinical problems. The school’s intent is to train physicians to be problem solvers and lifelong learners able to work productively in multidisciplinary teams and communicate effectively with their patients.

McMaster does not use traditional examinations. Instead, students perform self-assessments and are evaluated by their peers. The school believes that although a basis of clinical knowledge is necessary, an overemphasis on knowledge can distort student learning. McMaster has thus attempted to prioritize professionalism in care and students’ application of knowledge.

Using objective structured clinical examinations (OSCEs)

OSCEs typically use individuals trained to respond to questions and behaviors in a specific way, and have been a standardized part of medical education and testing for many years. They have predominantly been used for assessing clinical skills and reasoning, although OSCEs can easily be tailored to teach and test students in safety and quality concepts.

An OSCE station on communication and management of prescription errors was introduced in 2003 as part of a quality improvement curriculum at Mayo Medical School. Forty-two third-year medical students took part in the study, designed to evaluate the usefulness of an OSCE station as an assessment and educational tool for managing prescription errors.

Seventy-seven percent of students believed the OSCE station enhanced their awareness of medication errors; 71% felt their comfort level with communicating prescription errors to patients increased. OSCEs are not widely used to teach or test patient safety concepts, though the approach seems to have promise.

Other medical educators develop innovative programs

The University of Illinois at Chicago College of Medicine (UIC) is adapting a cockpit management attitudes questionnaire (CMAQ) and crew resource management (CRM) training course for medical students. UIC is using these adapted aviation modules to assess medical student attitudes and social skills, and to implement an introductory course for medical students similar to the CRM.

UIC also sponsors the annual Telluride Interdisciplinary Roundtable to design a comprehensive patient safety curriculum for medical students. Invited members include stakeholders such as healthcare providers, senior healthcare administration, and students. The group has developed a list of general curricular principles, 11 essential elements of an effective patient safety curriculum, and challenges to implementing such a curriculum. Future annual roundtables will continue to develop and refine their work.

The Patient Safety Education Project (PSEP) is an international collaboration of medical educators, primarily American and Australian, aiming to promote patient-centered, systems-based care through the training of healthcare workers. The PSEP educates selected employees to become safety trainers, who, in turn, teach patient safety and foster its practice among other workers. Evaluation of PSEP’s impact and effectiveness is ongoing.

The work of the LLI Expert Roundtable on Reforming Medical Education culminated in the March 2010 publication of a white paper that presents analysis and consensus recommendations based on the roundtable deliberations.

Roundtable participants feel strongly that medical schools should examine what other pioneering schools and institutions have done, and that all medical schools should use the most effective, innovative teaching methods available.
Lucian Leape Institute Issues White Paper on “Unmet Needs” in Medical Education

Ten years after the Institute of Medicine's landmark 1999 report *To Err Is Human*, the Lucian Leape Institute at the National Patient Safety Foundation has released a white paper arguing that US medical schools do not adequately prepare future physicians with the skills and knowledge necessary for the provision of safe patient care. The report, *Unmet Needs: Teaching Physicians to Provide Safe Patient Care*, describes the shortcomings of the current medical education system and issues an urgent call for reform. The report represents the culmination of several LLI Roundtable discussions and is the first in a planned series of such reports on issues that the Lucian Leape Institute has identified as top priorities in ongoing efforts to improve patient safety.


Read what others have said about the report:

Members of the Lucian Leape Institute

Lucian L. Leape, MD  
*Chair, Lucian Leape Institute*  
Adjunct Professor of Health Policy  
Harvard School of Public Health

Donald M. Berwick, MD, MPP  
*President & CEO*  
Institute for Healthcare Improvement

Carolyn M. Clancy, MD  
*Director*  
Agency for Healthcare Research and Quality

James B. Conway, MS  
*Senior Vice President*  
Institute for Healthcare Improvement

Susan Edgman-Levitan, PA  
Executive Director  
John D. Stoeckle Center for Primary Care Innovation  
Massachusetts General Hospital

Paul A. Gluck, MD, *Ex-officio*  
Immediate Past Chair  
NPSF Board of Directors

James A. Guest  
*President*  
Consumers Union

Gary S. Kaplan, MD, FACP  
*President & CEO*  
Virginia Mason Medical Center

David M. Lawrence, MD, *Emeritus*  
Chairman & CEO (retired)  
Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals

Julianne M. Morath, RN, MS  
*Chief Quality and Safety Officer*  
Vanderbilt University Medical Center

Dennis S. O’Leary, MD  
*President Emeritus*  
The Joint Commission

Paul O’Neill  
Former Chairman & CEO  
Alcoa  
72nd Secretary of the US Treasury

Diane C. Pinakiewicz, MBA  
*President, Lucian Leape Institute*  
President, National Patient Safety Foundation

NPSF Awards $200,000 in Grant Funding for Patient Safety Research

The National Patient Safety Foundation has awarded grants totaling $200,000 to support new research in patient safety. The grants will support projects led by Elizabeth Cox, MD, PhD, of the University of Wisconsin School of Medicine and Public Health, and by Gordon Schiff, MD, of Brigham and Women's Hospital/Harvard Medical School.

Dr. Cox’s project, *Improving Hospital Safety for Children: Strategies to Engage Parents in Bedside Rounds*, will seek to improve family involvement in pediatric patient care through a study of bedside rounds at a children's hospital. Using video tapes of bedside rounds conducted at their institution, the investigators will work with patients’ family members and clinicians to identify factors that promote or inhibit family engagement and to develop potential strategies to eliminate barriers to engagement. The analytic approach will incorporate techniques from systems engineering and human factors theory to address the impact of work-system factors as facilitators of or barriers to family engagement.

Dr. Schiff’s study, *Analysis of CPOE-Related Errors Reported to USP’s MEDMARX Error Reporting System*, will investigate errors associated with computerized prescriber order entry (CPOE).
Focus on Patient Safety (ISSN 1097-0673) is the official quarterly publication of the not-for-profit National Patient Safety Foundation (NPSF), in Boston, Mass. The opinions expressed in this publication are not necessarily those of the National Patient Safety Foundation or 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, 268 Summer Street, 6th Floor, Boston, MA 02210-1108. Materials, inquiries, and subscription requests for the publication will be accepted electronically at info@npsf.org or via fax at (617) 391-9999.

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
President, NPSF
Manisha Shah, MBA, RCP
Vice President, Programs, NPSF
Allison Fissel Perry, MA
Senior Director, Programs and Strategic Development, NPSF
Managing Editor:
Lorri Zipperer
Zipperer Project Management
Albuquerque
Editor:
Susan Raef
WordPower Communications, Inc. Chicago
Editorial Assistant:
Anita Spielman
Director, Information Resources and Research, NPSF
© 2010 National Patient Safety Foundation. Permission to reprint portions of this publication for educational and not-for-profit purposes is granted subject to accompaniment by appropriate credit to NPSF and Focus on Patient Safety. Commercial reproduction requires pre-approval. Some fees may apply.

NPSF Awards $200,000 in Grant Funding

CONTINUED FROM PAGE 8

Additional NPSF News

Patient Safety Awareness Week 2010: Share Your Stories

Healthcare organizations, communities, and individuals across the country recently celebrated Patient Safety Awareness Week. In order to demonstrate the impact of the week and to recognize the influential work of individuals and organizations, NPSF is collecting stories, photos, videos, and other materials documenting Patient Safety Awareness Week activities. Selected items will be featured (with permission) in upcoming NPSF publications. Share your stories by sending an email to info@npsf.org, or join the discussion on the NPSF patient safety listserv at http://www.npsf.org/psfl.

Open Enrollment! The Patient Safety Initiative at America’s Public Hospitals

NPSF, in partnership with the National Association of Public Hospitals and Health Systems (NAPH), announces open enrollment for the second year of The Patient Safety Initiative at America’s Public Hospitals. This project, funded by the Kaiser Permanente Community Benefit Fund, is open to all NAPH members and is designed to create and foster a community of safety net hospitals committed to the advancement of patient safety activities. If you are a public hospital, and a member of NAPH, please visit www.naph.org for more details and to enroll!

Save the Date: September 16, 2010
Lucian Leape Institute Third Annual Forum & Gala

Plan now to attend the Lucian Leape Institute Third Annual Forum and Gala on September 16, 2010, in Boston. Join distinguished Institute members at this extraordinary event designed to celebrate the Institute’s progress in providing strategic vision for the patient safety field. The Forum & Gala event begins with afternoon discussions led by Institute members, followed by a special evening including a welcome reception, dinner, and entertainment.

Mark your calendar now and plan to join us. More details on the event will be available soon at www.npsf.org.

systems through an analysis of data from the US Pharma- copeia’s MEDMARX error reporting system. The authors will analyze 53,367 medication errors flagged in the MEDMARX database as CPOE-related and will use the results of this analysis to develop a new taxonomy for CPOE-related errors and process failure modes. The investigators will test the vulnerability of leading CPOE systems to actual errors reported to MEDMARX by attempting to replicate these reported errors experimentally. Finally, the investigators will draw upon lessons learned to make recommendations for safer CPOE use and design at the local and national levels.

NPSF research grant funding is made possible in part by contributions from the American Medical Association and its support of the James S. Todd Memorial Research Grant, and by NPSF Board members through their support of the NPSF Board Grant.

The National Patient Safety Foundation's (NPSF) Research Grants Program seeks to stimulate new, innovative projects directed toward enhancing patient safety in the United States. The Program's objective is to promote studies leading to the prevention of human errors, system errors, patient injuries and the consequences of such adverse events in the health care setting. Since 1998, the National Patient Safety Foundation Research Program has supported 34 research projects with nearly $3.4 million in grant funding. NPSF