

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

Transitions in Care: Studying Safety in Emergency Department Signovers

BY SHAWNA PERRY, MD, FACEP, ASSISTANT CHAIR, UNIVERSITY OF FLORIDA HEALTH SCIENCE CENTER, JACKSONVILLE, FLA

IN THIS ISSUE

Transitions in Care: Studying Safety in Emergency Department Signovers

NPSF Patient Safety Congress Draws 1,300 to Boston

Why Every Hospital Should Have a Code of Conduct

My Time in the Tube: Seeing Health Care from the Patient's Perspective

ALARIS Medical Systems, Inc to Fund Nursing Fellowships in Memory of Irene Hatcher, RN, MSN

It's a fact of life: The demand for 24-hour medical care and the limitations of human fatigue require caregivers to work in shifts. The "signover" or "handoff" is a mechanism for transferring information, primary responsibility, and authority from one or a set of caregivers to oncoming staff. Signovers are commonly performed activities in health care, yet they are viewed as sources of failure and their value, power, and problems are poorly understood.

The study "Transitions in Care: Emergency Department Signovers," funded by the National Patient Safety Foundation and The Commonwealth Fund, was conducted by the AHRQ-sponsored Center for Safety in Emergency Care (CSEC) to describe the nature and content of signovers in the emergency department (ED). Information about this vital ED activity is an important first step toward improving signovers and could prevent the inadvertent loss of their positive aspects while attempting to improve transitions in care.

Why are signovers so important?

The signover is a necessary bridge to provide understanding to workers as they take over for one another; as part of the transition in care, a signover transfers not only knowledge, but responsibility and authority. Ideally, it should be a moment of shared cognition between the off-going and oncoming staff. Surprisingly, signovers among physicians have hardly been studied; most research in health care involves nursing shift changes.

Studies of nursing signovers in critical care units and inpatient wards have shown that much of the information exchanged could easily have been obtained from the medical record and for unclear reasons, was often taken for granted. It has been suggested that the greater purpose of these signovers is the ritualistic exchange that passes responsibility and authority for patient care to the oncoming shift.¹⁻³

In a study of medication errors on internal medicine wards, Petersen showed these failures were often attributable to poor signovers between cross-covering teams of house

officers. Her subsequent work demonstrated a reduction in these errors with computerized sign-out reports.^{4,5} This finding, however, may not apply in other settings because cross-coverage signovers primarily involve "just in case you need it" information, where there is a relatively high probability that the receiving physician will not need to interact with the patient.

"The purpose of ED signovers is to be a bridge for the crucial coordination needed in complex systems vulnerable to catastrophic disasters. ED signovers are generally viewed as a rich source for adverse events."

Nurse and physician signovers in settings like the ED differ in that it is certain that the receiver will be required to interact directly with the patient. Research of signovers from other domains has shown these transitions to be more conversations than transactions and suggests that failures may result from an inability to construct a shared picture of what is going on with the patient at the time of the transition, as well as expectations and plans.^{6,7}

The purpose of signovers is to be a bridge for the crucial coordination needed in complex systems vulnerable to catastrophic disasters.⁸ ED signovers are generally viewed as a rich source for adverse events.⁹ Previous work in the ED suggests that signovers can also be an opportunity for rescue and recovery because situations were reviewed by the "fresh eyes" of the oncoming shift.¹⁰

CONTINUED ON PAGE 2

Shawna Perry, MD, FACEP, is assistant chair, assistant professor, and director of clinical operations at the University of Florida Health Science Center in Jacksonville, Fla. Contact her at sperry@ufl.edu.

Dr Perry presented her findings at the NPSF Patient Safety Congress on May 4 in a session entitled "Transitions in Care: Emergency Department Signovers." To order an audiotape of the presentation, visit www.npsf.org/congress/download/audiotapes.pdf.

Research studies signovers at 5 US and Canadian EDs

In this one-year multi-center study, ethnographic observations, semi-structured interviews and selected case analyses were performed on physician and nurse signovers in 5 emergency departments in the US and Canada. The participating locations from the developing Center for Safety in Emergency Care (CSEC) include: University of Florida Health Science Center, Jacksonville, Fla; Brown University/ Rhode Island Hospital, Providence, RI; Dalhousie University/ Dartmouth General Hospital, Halifax, Nova Scotia; and Northwestern Memorial Hospital, Chicago.

The sites are a combination of urban academic institutions and non-academic community-based facilities with a combined ED volume of 325,000 visits annually. Observations were supplemented by audiotape of transitions of signovers at 4 of the EDs. IRB approval was obtained at all locations.

The study included 134 work hours of observation and almost 3 hours of audiotape of transition interactions. All field notes of observations and transcriptions of audiotapes were de-identified. Preliminary analysis of this data set finds a number of interesting similarities and differences among the EDs studied:

- Physicians and nurses consistently performed their signovers separately; both groups agreed this was the best procedure, but for unproven reasons such as "it allows someone to be free to watch the patients while each group does its rounds."
- No formal tools were used to support the transition, although oncoming staff were observed writing notes for themselves during the transition. The medical record was seldom used. However, when it was, nurses were more likely to use the medical record.
- There were 4 phases to the transitions:⁷
 1. Pre-turnover (preparing for the transition);
 2. Arrival;
 3. Meeting (exchange occurs); and
 4. Post-turnover.
- The signover mechanism varied greatly, with some occurring "one-on-one" (a dyad) or in groups. Some locations conducted signovers in large groups, but formed dyads afterward for further discussion and clarification.
- Each site had a standard order in which patients were signed over. This was usually based on geography, as EDs tend to group patients of similar acuity together.
- The exchange was more interactional (a "give and take," information-question-answer) than transactional (one-way communication, "Here you are") between caregivers.

- The location of the signovers varied, with exchanges occurring at or near the bedside, or at an intermediate location in the treatment area such as the white board.
- Interruptions were very frequent during signover activities, regardless of the location of the exchange.
- The nature of specific signovers was highly variable. A number of variables affect this, including at what point the ED signover occurs during each patient's workup. For instance, there will be less to tell about the patient who arrives just as signover begins than about a patient who has been in the ED for 8 hours.

"Case analysis of relevant incidents provided evidence that signovers were not all bad. There were a number of examples of reassessment of a patient being triggered by a question from the oncoming caregiver."

Case analysis of relevant incidents provided evidence that signovers were not all bad. There were a number of examples of reassessment of a patient being triggered by a question from the oncoming caregiver.

Case in point: A pregnant asthmatic patient being treated in the ED was ready to be discharged about the time of shift change. At the shift change signover, the oncoming caregiver asked about the patient's blood pressure. It was then realized that the blood pressure was higher than expected; reassessment found clinical evidence of pre-eclampsia that led to hospital admission. The patient deteriorated following admission and progressed to HELLP syndrome (hemolysis, elevated liver enzymes and low platelet count—a complication occurring in 2-12% of pre-eclampsia patients) and a prolonged ICU stay.

The interactive component of the signover, requiring a summary of the case and a review by a "fresh pair of eyes," identified a previously unrecognized problem. If it were not for the fortuitous shift change, the patient would have been discharged and deteriorated at home.

This incident supports the idea that signovers are a double-edged sword, capable of contributing rescue and recovery as well as failure. This positive aspect, previously unrecognized, reveals a “latent process” embedded in the signover. Because it is a mechanism for off-going and oncoming caregivers to reach mutual understanding and shared reasoning, this “co-orientation” provides a second opinion and an opportunity to recover from incipient failure.

What are the implications for patient safety?

Transitions in care and signovers are very complex processes that exhibit a high degree of variability. In the ED, this appears to be the result of variables ranging from the ED’s geography to when the transition occurs during the patient’s care. The dynamic and fluid nature of the signover, along with evidence that there are positive aspects to this activity, strongly suggest that formalizing or controlling signovers may not be the best approach to reducing their risk.

The CSEC study suggests that focusing on the enhancement of signovers is likely a better approach to improving safety and that a complete overhaul of the process could do more harm than good. Recent research work by Patterson¹¹ comparing strategies across industries highlighted 21 methods for coordination and communication during transactions. In the CSEC study, only 9 of these were used consistently in the ED. Careful investigation of the remaining 12 strategies, as well as those that may exist in other domains, might be most fruitful for improving the safety of signovers. NPSF

References

- 1 Kelly R. Goings-on in a CCU: an ethnomethodological account of things that go on in a routine hand-over. *Nurs Crit Care*. 1999;4(2):85-91.
- 2 Lamond D. The information content of the nurse change of shift report: a comparative study. *J Adv Nurs*. 2000;31:794-804.
- 3 Ekman I, Segesten K. Deputed power of medical control: the hidden message in the ritual of oral shift reports. *J Adv Nurs*. 1995;22:1006-1011.
- 4 Petersen LA, Brennan TA, O’Neil AC, Cook EF, Lee TH. Does housestaff discontinuity of care increase the risk for preventable adverse events? *Ann Intern Med*. 1994;121:866-872.
- 5 Petersen LA, Orav EJ, Teich JM, O’Neil AC, Brennan TA. Using a computerized sign-out program to improve continuity of inpatient care and prevent adverse events. *Jt Comm J Qual Improv*. 1998;24(2):77-87.
- 6 Brandwijk M, Nemeth C, O’Connor M, Kahana, M, Cook RI. Distributing cognition: *ICU handoffs conform to Grice’s maxims*. [poster] University of Chicago; ND. <http://www.ctlab.org/properties/pdf%20files/SCCM%20Poster%201.27.03.pdf>, accessed May 26, 2004.
- 7 Matthews AL, Harvey CM, Schuster RJ, Durso FT. Emergency physician to admitting physician handovers: an exploratory study. In: *Proceedings of the Human Factors and Ergonomics Society 46th Annual Meeting*. Baltimore, MD: Human Factors and Ergonomics Society; 2002:1511-1515.
- 8 Eisenhardt K. High-reliability organizations meet high-velocity environments: Common dilemmas in nuclear power plants, aircraft carriers and microcomputer firms. In: Roberts KH, ed. *New Challenges to Understanding Organizations*. New York: MacMillan; 1993:117-135.
- 9 Delays in treatment. *Sentinel Events Alert*. 2002 June 17;26:1-3.
- 10 Wears RL, Perry SJ, Shapiro M, et al. Shift changes among emergency physicians: best of times, worst of times. In: *Proceedings of the Human Factors and Ergonomics Society 47th Annual Meeting*. Denver, CO: Human Factors and Ergonomics Society; 2003:1420-1423.
- 11 Patterson ES, Roth EM, Woods DD, Chow R. Handoff strategies in settings with high consequences for failure: lessons for health care operations. *Int J Qual Health Care*. 2004;16:125-132.

NPSF Patient Safety Congress Draws 1,300 to Boston

More than 1,300 patient safety leaders from around the world gathered in Boston May 3-7 to attend NPSF’s Sixth Annual Patient Safety Congress. The conference brought leaders together to reinforce their commitment to move patient safety research into practice. Plenary sessions and workshops featured effective policies and programs that have resulted in culture change.

Congress Co-chair David Lawrence, MD, retired chairman and CEO of the Kaiser Foundation Health Plan and Kaiser Foundation Hospitals, opened the meeting with a rallying

call for patient leaders to work together to change a healthcare culture that is in denial. “Stand Up for Patient Safety” hospitals and healthcare systems showcased their initiatives to change healthcare culture on the front lines.

Conference highlights also included sessions on pay for performance, the use of simulation to improve patient safety, and the NPSF distinguished advisors town hall meeting.

To order audiotapes of the Congress sessions, visit www.npsf.org/congress/download/audiotapes.pdf. NPSF

Why Every Hospital Should Have a Code of Conduct

BY DELLA M LIN, MD, EXECUTIVE DIRECTOR, CME, THE QUEENS MEDICAL CENTER, HONOLULU, HAWAII

Everyone in health care has seen or heard it before—a practitioner who has a “temper tantrum” resulting in staff being intimidated to speak up. Healthcare professionals are known to resist confronting the situation, especially when the disruption is created by a practitioner who is a “great clinician.”

“Effective clinical team work depends on hospital leadership creating a sound policy and consistent implementation strategy for eliminating disruptive behavior.”

As healthcare teams are trained to be part of a high-reliability organization, it's important to focus on trust, transparency, and open communication among team members. Work conducted at the University of Texas clearly shows that the perception of “level of teamwork” has wide disconnects between physicians and nurses.¹

Clearly, developing good team situational awareness requires flattening the traditional hierarchy. Yet healthcare organizations seem to tolerate disruptive behaviors. A recent VHA study² affirmed that 3 of the primary barriers and resistance to reporting such behaviors are:

- Fear of retaliation/lack of confidentiality;
- Lack of follow-through and feedback; and
- Lack of administrative support.

Healthcare professionals who shrug their shoulders, roll their eyes and step gingerly around dealing with these behaviors will only obstruct patient safety efforts.

What can a hospital and its medical staff do?

Effective clinical teamwork depends on hospital leadership creating a sound policy and consistent implementation strategy for eliminating disruptive behavior. What is disruptive behavior? Definitions may include:

- Swearing or foul and abusive language;
- Inappropriate physical contact that is threatening or intimidating;

- Derogatory comments about the hospital, physicians, or staff in a patient's medical record;
- Idiosyncratic requirements imposed on nurses and other staff; and/or
- Non-constructive criticism meant to intimidate, belittle, or imply stupidity.

Not all disruptive behavior is outwardly aggressive as in the prototypical act of throwing operating room instruments at the wall or at staff. Manipulative, passive-controlling behavior can sometimes be a more dangerous vehicle in undermining effective teamwork.

Although the hospital can be a stressful, complex, and demanding place to work, there is no excuse for behavior that would not be tolerated in another public place such as a hotel, country club, or restaurant. Excuses offered (“Hey, *they're* the ones who are incompetent!” “Why punish *me* for my high standards?” “Compared to others, I'm not that bad!”) should not derail efforts to manage the problem.

Legally, the hospital has a duty to ensure it does not create “... an intimidating, hostile or offensive work environment.”³ The hospital also is legally responsible for providing quality care and for making sure the individuals providing that care exhibit clinical competence and professional behavior.

In numerous cases,³⁻⁶ courts have upheld the process and ultimate decisions by hospitals to summarily suspend or terminate physicians from the medical staff due to disruptive conduct. One court stated, “It is not difficult to imagine situations in which a physician's disruptive conduct could pose a threat to patient care.”⁷

Hospitals have received immunity from antitrust and other legal challenges when they adhere to standards set forth by the Health Care Quality Improvement Act of 1986.⁸ Ultimately, the goal should be to keep the hospital environment safe and to actively address practitioners who make the environment unsafe.

Every hospital should have a code of conduct and a disruptive-practitioner policy. The code of conduct credo may be as straightforward as: “All individuals in this organization are entitled to be treated with respect, courtesy, and dignity.”

5 steps to developing a code of conduct

- Ensure that everyone is on the same page. Involve hospital legal counsel early in the process, and make sure that administration, medical staff leadership, and the board of directors are all in agreement. This might include setting up “What if?” scenarios for discussion, eg, What if the disruptive behavior is coming from a high-volume physician, or from the only obstetrician on the medical staff?
- Be clear; set the intention of the policy with the medical staff and hospital employees. The policy needs to be part of orientation and reorientation if zero tolerance is the goal. Too often, a disruptive practitioner’s response to being confronted with a policy is “Nobody told me about this.”
- Articulate a clear process. Many hospitals have a 3-stage intervention process—the first stage being collegial and the third being a specific written and signed agreement between the practitioner and the hospital. This agreement should: outline the hospital’s expectations regarding behavior in the hospital; define the specific unacceptable behavior(s); and state the consequences if the individual does not modify his or her behavior. Both parties need to hold to the agreement. If the hospital intends to monitor behavior, a monitoring process should be in place.

Don’t fall into the trap of giving the individual a time interval for monitoring his or her behavior, eg, a 3-month “leash.” Undoubtedly, after the 3 months, there will be a slow or not-so-slow return to “business as usual.”

- Delineate how anyone in the medical center can bring disruptive behavior to the attention of the leadership for follow up, and how the reporter will obtain feedback. Full details do not need to be revealed to the person reporting a complaint, but feedback is essential so that individuals do not feel their report has fallen into a black hole.
- Always consider patient care and patient safety first. Poor behavior is really no different than incompetence, as they both affect the ability of others to get their jobs done.

Tips for successfully implementing a code of conduct

- Address problems immediately. Although people tend to avoid confrontation, it’s important not to put off this type of discussion. Avoiding conflict can result in a demoralized team that creates founded or unfounded rationalization for the behavior. Creating “work-arounds” for the behavior is a dangerous set-up for a potential error.

“Always consider patient care and patient safety first. Poor behavior is really no different than incompetence, as they both affect the ability of others to get their jobs done.”

- Document, document, document! Too often, informal discussions between the practitioner and the supervisor or department chair occur without written documentation. Every discussion should be followed by a written summary; it can be as simple as a memo. Medical staff leadership often changes on an annual or biennial basis, so this becomes particularly important in the case of a disruptive physician. Lack of documentation allows the physician to constantly “draw a new line in the sand” and wait for new leadership.
- Explicitly define the offending behavior. Do not use broad statements, eg, “Sally, you are just not a team player. You must not be intimidating and demeaning to the staff.” These words mean entirely different things to different people. Instead, be specific, citing examples the individual has used, eg, “Sally, we value your clinical contribution to our hospital and you should know that we have a policy for treating everyone here with respect. This means not using words and phrases such as ‘stupid,’ ‘jackass,’ and ‘shallow end of the gene pool.’” Devalue the behavior without devaluing the practitioner.
- Consider training a core of individuals in the hospital specifically in how to deal with the disruptive practitioner. Using simulation and role playing can encourage open discussion about the potential demands in interacting with the difficult practitioner. Mediation training is available in most communities and can be helpful in handling these complex situations.

Allowing disruptive behavior in a healthcare setting is another example of a latent error condition—the potential for a situation that results in patient harm should not be underestimated. Establishing a code of conduct and implementing a disruptive-practitioner policy will go a long way toward furthering the patient safety movement in the hospital. NPSF

Della M Lin, MD, is executive director of CME at The Queens Medical Center in Honolulu, Hawaii. She is also an inaugural fellow in the NPSF-AHA Patient Safety Leadership Fellow group.

Dr Lin was a presenter at the NPSF Patient Safety Congress; she led a session entitled “Acute Care Ensuring Clinician Accountability: The Role of Licensing Boards, Educators and Organizations.” To order an audiotape of the presentation, visit www.npsf.org/congress/download/audiotapes.pdf.

References

- 1 Thomas EJ, Sexton JB, Helmreich RL. Discrepant attitudes about teamwork among critical care nurses and physicians. *Crit Care Med.* 2003;31:956-959.
- 2 Rosenstein AH. Original research: nurse-physician relationships: impact on nurse satisfaction and retention. *Am J Nurs.* 2002;102(6):26-34.
- 3 Burlington Industries, Inc v Ellerth 118 S Ct 2257 (Ill, 1998)
- 4 Faragher v City of Boca Raton 118 S Ct 2275 (Fla, 1998)
- 5 Gordon v Lewistown Hospital, 714 A2d 539 (Pa Commw Ct 1998).
- 6 Meyers v Logan Memorial Hospital, 82 F Supp2d 707 (wD Ky 2000).
- 7 Eidelson v Archer, 645 P2d 171 (Alaska 1982).
- 8 Health Care Quality Improvement Act Title 42 USC 117 §11101 et al. (1986)

My Time in the Tube: Seeing Health Care from the Patient's Perspective

BY GERI AMORI, PHD, ARM, CPHRM, FASHRM, INDEPENDENT HEALTHCARE RISK MANAGEMENT CONSULTANT, SHELBURNE, VT

By any external measure, it was an ordinary Saturday morning. The waiting room was reasonably quiet; it had been easier to find a parking space than usual. Today, however, my usual comfort in the facility was faltering. Today was my turn in the tube.

In a dish on my bureau were the carefully placed rings and earrings that might cause a problem. "I am up for this. Piece of cake," I cajoled myself. And even though MRIs were a familiar part of my healthcare world, the stories of friends and colleagues kept fleeting like errant dust bunnies through my mind.

"It's not for claustrophobics!"
"Your nose is about 2 inches from the top."
"It's very scary because you feel trapped."
"It's loud and you think you'll never get out."

And how could I ever have an MRI without thinking about those few—but horrendous—famous incidents where death was the result?

Like any risk manager—always on duty—I checked out the waiting room carefully. There were solid, stable chairs. It was a nice environment. Glancing up, I saw the pleasant but stern admonishment in large letters: "It is important that you remove ALL jewelry and make-up."

Make-up. Hmm. Is it because some eye shadows have metal? What about my deodorant? Doesn't deodorant contain some form of aluminum? I see a flash of mental images ... armpits exploding in the machinery. The next mental flash was my recognition of a missed opportunity. With slightly more education about the reason metals are a problem, almost any patient could begin the personal body scan that might make the difference between safety and a medical incident. I was struck by the assumption of patient knowledge and willing compliance inherent in the signage. I had never noticed it before.

A pleasant woman, even if clearly unhappy to be working on such a beautiful ski day, broke my reverie. "Geri?" There was nobody else there, yet who could resist the temptation to look around before reacting, "Yes."

As we passed through magical heavy doors into the inner sanctum, my heart began pounding in my chest. Signs of

admonishment adorned the dressing room walls:
"Yes, you MUST remove your body-piercing jewelry!"
"Please ensure you have removed your make-up."

Sitting in the johnny with much-too-long tie-on pants, I flashed upon Alice in Wonderland viewing the world from the shrunken state, fearing she'd never return. The power of the meta-messages swept over me like a wave. No explanations, just "Be good."

"I now understood the perspective of the patients whom I had to convince over the years about a number of policies and procedures we supposedly instituted for their safety."

I knew the reasons for the warnings and yet they still sounded ominous and like a power play to my now-powerless ears. Even with the kindness of staff and the nice environment, the lack of explanation and engagement as a mature participant in ensuring safety reinforced the notion of the patient as the recipient of care—the willing, if reluctant "victim" of what we do to them.

I now understood the perspective of the patients whom I had to convince over the years about a number of policies and procedures we supposedly instituted for their safety. The problem wasn't with the policies, which often created an environment that enhanced the probability of safer care. The problem was that we enforced our rules for *our* convenience and because they were rules, rather than taking the time to engage patients in creating a safer healthcare environment.

An eternity later, Lisa returned to guide me into the MRI room. Somehow the machine never seemed so confining as at that moment. As she positioned me on the sled, it became apparent that my 4'11", 110-pound frame was

completely filling the space. I wondered if I had been any larger if I would have felt the slides dig into my cheeks throughout the process. It became clearer that we were entering a confined-space zone when she raised the sled closer to the top of the tube. My goodness, would they have to grease the sides if I were a normal-sized person?

Realizing I was about to enter the zone, Lisa handed me a soft bulb—the panic bulb. She soothingly reassured me that if I freaked out, a squeeze of the bulb would result in my rescue. She was quickly becoming my heroine! Then she just as cheerfully asked if I wanted a washcloth to cover my eyes. “Oh no!” I chirped. “I’ll be fine, just fine.” Finally, Lisa handed me ear plugs. “It’s rather like a jackhammer in there. You’ll need these.”

“Thanks,” I whispered. I closed my eyes and breathed deeply ... slowly ... not certain what was going to happen next. The sled moved slowly into the bowels of the unknown, and with it the pounding of my heart increased in volume to where the ear plugs amplified the internal vibrations of my body.

Soon the noise started. Her voice, “First test. 4 minutes.” Three sounds, then the jackhammer, then a steady stream of deep rhythmic sounds. “OK ... I can do this.”

“How are you in there?” “Just dreamy,” I replied. “Here goes another,” she said. Again “fa, la, re,” and the jackhammer started again. This time the pitch was different and there were other resonant sounds. “Booma booma booma booma cachunk cachunk cachunk.” Silence. Then the soothing voice. For over half an hour, I enjoyed a mixture of John Cage, Phillip Glass, and terror music composed by a machine and my mind.

“This is the last one,” chimed Lisa.

“Great! Right before you come in, can you tell me so I can open my eyes and look around?”

“Really?” she asked, surprised.

“Really,” I replied.

“OK.”

Looking around the tube, it wasn’t really so bad. It was good to be a tiny person. What a difference a short orientation would have made! If only I’d known before I had to lie on that foreboding slab of plastic that there would be a panic button, that the machine makes noise, and that some

people find it confining but that many do not. Telling me what to listen for and what could go wrong would have been helpful. Once patients are in the machine, it is too late for them to listen clearly. By then, they are in a state of reaction.

Lisa led me back to the dressing room where the admonishing signs reminded me of the fear of 30 minutes earlier. Although the information was appropriate and polite, it was non-reassuring and cold. Why wasn’t I told that the stories I had heard might not be true? Why did I have to ask for an explanation about the make-up and the deodorant? Why wasn’t I told before we entered the room that there would be someone nearby to help if I became scared?

“Once patients are in the machine, it is too late for them to listen clearly. By then, they are in a state of reaction.”

When was the last time you were really a patient—a patient without the knowledge, expertise, and comfort in healthcare facilities that you have today? The consumer advocates tell us that we who work in the field aren’t “normal” patients when we go through the system. We are known by hospital staff, which leads to different treatment. We understand what is going on so we tend not to be ruffled by things that might bother other patients. And we are not afraid to speak up because we are comfortable in the healthcare environment.

What can we do to remove ourselves from our role as healthcare professionals long enough to see our world from the patient’s perspective? How can we appreciate the type of communication that fosters patient participation until we can distance ourselves from our professional experience? Until we can see our world with new eyes, we can’t engage patients in a reciprocal relationship that allows us to work together to improve safety and to meet as partners in care. Perhaps we should all spend some time in the tube. **NPSF**

Gerri Amori, PHD, ARM, CPHRM, FASHRM, is an independent healthcare risk management consultant in Shelburne, VT.

Ms Amori led a session at the NPSF Patient Safety Congress entitled “Patient & Families: Case Closed: Safety in One Act” with Roxanne Goeltz, co-founder and president of Consumers Advancing Patient Safety, Lakeville, MN, and Michelle Hoppes, RN, MS, DFASHRM, AHRMQR, president, Risk Management and Patient Safety Institute, Lansing, Mich.

Ms Amori was also responsible for the technical presentation design of the May 5 Patient Safety Congress plenary session, The MITSS Story.

To order an audiotope of the presentation, visit www.npsf.org/congress/download/audiotapes.pdf.

Focus on Patient Safety (ISSN 1097-0673) is the official quarterly publication of the not-for-profit National Patient Safety Foundation (NPSF), in McLean, Va. 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, 8405 Greensboro Drive, Suite 800, McLean, VA 22102-5120. Materials, inquiries, and subscription requests for the publication will be accepted electronically at info@npsf.org or via fax at (703) 506-3266.

NPSF Interim Executive Director:
Diane C. Pinakiewicz
Managing Editor: Lorri Zipperer,
Zipperer Project Management,
Evanston, Ill
Editor: Susan Raef, WordPower
Communications, Inc., Chicago

© 2004 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 the NPSF and Focus on Patient Safety. Commercial reproduction requires pre-approval. Some fees may apply.

ALARIS Medical Systems, Inc to Fund Nursing Fellowships in Memory of Irene Hatcher, RN, MSN

NPSF and ALARIS Medical Systems, Inc, developer of products for the safe delivery of intravenous medications, have created 5 1-year fellowships to be funded by ALARIS in memory of Irene Hatcher, RN, MSN, who passed away last November after a distinguished nursing career at Vanderbilt University Medical Center.

"Irene Hatcher's passion for patient safety is proof that one person's dedication can have an impact on the lives of many," said ALARIS CEO and President David L. Schlotterbeck. "It is our desire that this scholarship be awarded to a Registered Nurse who is interested in a safety project related to high-risk medications."

NPSF and Health Forum-AHA, in partnership with the American Organization of Nurse Executives, the American Society of Healthcare Risk Management, and the Health Research & Educational Trust, are working together to offer this Patient Safety Leadership Fellowship Program. For more information, contact NPSF's Meg Hogan at (703) 506-3280.

National Patient Safety Foundation®
8405 Greensboro Drive, Suite 800
McLean, VA 22102-5120

What is the Patient Safety Leadership Fellowship?

The Patient Safety Leadership Fellowship program is a year-long intensive learning experience that will develop leadership skills and advance patient safety science in health care through a dynamic, participatory, and structured learning community. The highly collaborative fellowship includes:

- Executive leadership retreats—3 week-long gatherings.
- Optional meetings—Site visits and educational opportunities.
- Virtual learning community—To maintain communication with each other and expert faculty.

Each fellow also participates in an individual action learning project focused on advancing patient safety and health outcomes. These projects are designed to contribute to more cost-effective models of healthcare delivery in the organization and/or community where each fellow is based.

Fellows also take advantage of an educational resource network and peer consulting, and receive 6 self-study modules, each followed by a faculty-facilitated online discussion. NPSF

