

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

Understanding the Power of Apology: How Saying “I’m Sorry” Helps Heal Patients and Caregivers

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Since the patient safety movement began, its major focus has been on redesigning systems and implementing safe practices. However, a parallel concern has gained momentum over the past few years: the way institutions and caregivers respond when preventable injuries occur.

As consumer and patient advocacy groups persistently point out, many healthcare professionals, particularly physicians, have major problems in communicating with patients. In fact, the genesis of advocacy groups is often an individual’s dissatisfaction—nay, outrage—with their care: not because of the injury, but because of the way they have been treated. Many believe that failure of communication, specifically the failure to acknowledge an adverse event and admit error, is the major cause of malpractice suits.

Understanding the effect of medical injury

Charles Vincent has written persuasively on the impact of medical injury on patients.^{1,2} He notes that when patients suffer a treatment-caused injury, they experience a complex array of emotions ranging from confusion, uncertainty, and fear to anxiety and loss of trust. If the injury is not acknowledged or their concerns are dismissed, patients feel devalued, humiliated, and disrespected. Anxiety turns to anger, and the doctor-patient, or nurse-patient, relationship is shattered.

As Vincent points out, medical injury is very different from other types of physical or emotional injuries that people may suffer. Medical injury is a by-product of treatment intended to help them. It is caused by a person to whom patients have entrusted their care, even their life. And patients will, in most cases, continue to be cared for by the same people.

What do patients expect when an error occurs?

How should clinicians respond following an injury caused by medical treatment? Results from surveys and the experience from mediation show remarkable congruence in terms of what patients expect.

- First, patients want caregivers to acknowledge the incident and tell them what happened, to the extent that it is known. In other words, they want to know what happened and why.
- Patients expect someone, usually their physician, to take responsibility for the event and, if an error has been made, to admit it and apologize.

“Many believe that failure of communication, specifically the failure to acknowledge an adverse event and admit error, is the major cause of malpractice suits.”

- Patients also expect the hospital to undertake a serious effort to find out why the incident happened and, when possible, make changes to ensure that it doesn’t happen to someone else. Being assured that it won’t happen to someone else is very important to patients, more so than many caregivers seem to appreciate. It gives meaning to patients’ suffering.

Most caregivers, I suspect, consider those reasonable requests. It is what we would want for ourselves if we were patients.

Why aren’t these expectations being met?

Unfortunately, all too often there is a big difference between the care patients expect and what they receive after a medical error occurs. For too many patients, a clear acknowledgement that a mishap has occurred is not forthcoming; no one seems to be responsible for what happened or for explaining it, and no one apologizes. There is a sort

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References

- 1 Vincent C, Young M, Phillips A. *Why do people sue doctors? A study of patients and relatives taking legal action.* Lancet. 1994;343:1609-1614.
- 2 Vincent C. *Understanding and responding to adverse events.* N Engl J Med. 2003;348:1051-1056.
- 3 Lazare A. *On Apology.* Oxford, Oxford University Press; 2004.
- 4 Kraman SS, Hamm G. *Risk management: extreme honesty may be the best policy.* Ann Intern Med. 1999;131:963-967.
- 5 Hall S. *U-M docs say sorry, avert suits.* Detroit News. May 12, 2004;Business:01C.

of charade of pretending either that nothing very important happened, or that the causes are mysterious and unknowable. Patients meet a wall of silence.

Why aren't providers more open?

Why are doctors and nurses sometimes not open and honest with patients when things go wrong? The reasons are many and complex:

- Admitting fault and apologizing is often very difficult for the caregiver. Medical injury, particularly if it is serious, is very different from other types of situations where people apologize, because it is a physical injury, albeit unintended.
- The consequences for patient and doctor can be substantial: the patient may die or suffer a lifelong disability.
- For the physician, in addition to provoking feelings of shame and guilt, the incident raises concerns about his or her reputation, and the possibility of a malpractice suit. The more profound the consequences, the more difficult it is to accept responsibility and apologize.
- The natural reluctance to "fess up" has long been legitimized by lawyers and risk managers who have advised physicians not to admit responsibility or apologize—advice that is still given in many institutions.

This natural reluctance is compounded by other factors. The physician may not realize the extent to which a serious medical error is a major threat to patient trust, and thus to the healing relationship. He or she may feel little sense of responsibility, or of the need to apologize, if the injury results from an error by someone else on the care team. Many physicians also lack the skills to communicate well in difficult situations, not having received instruction in medical school or after.

Apologizing is particularly problematic for some. While many clinicians feel comfortable expressing empathy with the patient—"I'm sorry this happened to you"—true apology entails much more. As Lazare has pointed out, the essence of apology is taking personal responsibility, showing genuine remorse, and trying to make amends.³ All 3 are important, and none can be faked. Apologizing may be the most important thing we do after a serious event, both to help the patient begin to heal and to heal ourselves.

How apology heals

Lazare describes 6 ways in which apology heals.

1. Apology begins to restore the patient's dignity and self-respect. Injury is humiliating and unfair. Lack of apology

intensifies this humiliation: "You don't respect me enough to acknowledge my hurt."

2. Apology provides assurance of shared values, reaffirming the patient's and doctor's mutual commitment to the rules and values of the relationship. "I really am the person you thought I was." Trust is re-established.
3. Apology assures patients that they are not at fault—a common and often unappreciated response to mishaps.
4. Apology assures patients that they are now safe, that the caregiver recognizes the hurt and is committed to taking every possible measure to prevent further injury.
5. Apology shows the patient that the doctor is also suffering. In this sense, it "levels the playing field," helping to restore the victim's self-respect.

"Apologizing may be the most important thing we do after a serious event, both to help the patient begin to heal and to heal ourselves."

6. By making amends, such as by providing extra attention or sometimes attending to immediate financial needs, apology demonstrates that the doctor understands the impact of the victim's suffering and loss of trust.

Caregivers need healing, too

Apology is also the first step in healing for the provider. It helps us deal with the normal shame and guilt we feel and provides expression of the normal empathic concern we have for those we have harmed. By restoring the balance—we're both hurting—it begins to restore the relationship, which is important to both parties.

Conversely, failure to apologize, or even accept responsibility, is incredibly damaging for the patient and for the relationship. Failing to acknowledge that something went wrong is incredibly disrespectful. It is also dishonest. That dishonesty is corrosive not only to the patient's trust, but to the physician's integrity.

It is not surprising that many doctors have felt "unclean" after following advice to not admit responsibility for a serious error. Honesty is not just the best policy; it is also essential to our mental health.

Gaining Synergy: How Duke University Hospital Built an Infrastructure for Safety

BY GAIL SHULBY, RN, MA, AND KAREN FRUSH, BSN, MD, DUKE UNIVERSITY HEALTH SYSTEM

Gail Shulby, RN, and Karen Frush, MD, patient safety professionals from Duke University Hospital (DUH), participated as Fellows in the 2004-2005 Patient Safety Leadership Fellowship (PSLF) offered by NPSF and the Health Research and Educational Trust. Shulby and Frush have since used their learnings from the Fellowship to enhance the culture of safety at DUH and its surrounding community.

The PSLF was established to advance the culture of safety in health care and promote breakthroughs in the science of patient safety through development of leadership competencies. Each PSLF Fellow or team is responsible for designing and implementing an *action learning project* (ALP) to advance the culture of safety in their organization. To measure progress in developing Duke's culture of safety, the Fellows used the results of the second annual survey of staff and physicians conducted during the hospital's Patient Safety and Clinical Quality Week.

Though the Fellows were pleased with the survey results, they recognized the need to educate DUH staff and

physicians in the science of patient safety to give them a better understanding of the organizational factors that contribute to errors.¹

Duke's ALP: Educate broadly on patient safety

The Fellows developed an ALP to design a comprehensive education program for a broad audience: hospital employees and staff, faculty and students, and patients and families, recognizing that everyone has a role in patient safety.

Frush and Shulby formed an Executive Steering Committee (ESC) to guide the development of the educational program. The committee included board members, DUH's CEO and chief nursing officer, 2 nursing leaders who were long-term patients at Duke, DUH's Latino Program coordinator, a lead surgeon, the associate director of the Graduate Medical Education program, and an associate professor from the university's School of Public Policy. Also participating was a PSLF colleague from Massachusetts General Hospital with expertise in communications.

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What is the risk of apology?

Won't such openness and apologizing lead more patients to sue? And won't admission of responsibility and apologizing be used against the doctor in court? For years, hospital lawyers have assured us that is so, although to the author's knowledge, there has never been a study establishing the validity of either of these assertions.

In fact, recent evidence from programs of honest disclosure and apology coupled with modest payments, established by the Lexington VA Hospital,⁴ University of Michigan,⁵ and COPIC Insurance Company a liability insurer in Colorado, suggest the opposite is true (R Quinn, oral communication, 2005). Both the number of suits and the total payouts are markedly reduced.

What if patients still sue?

But suppose the lawyers are right—that more patients will sue. What happens? Well, if you have been fully honest and

forthcoming with the patient, the suit will not be to find out what happened, not to establish fault. That will have already been admitted. The suit will be for damages—a crucial difference.

The long, painful, shameful spectacle of the plaintiff lawyer trying to prove in public that the physician is negligent, a bad person, will not take place. The court's role will be limited to establishing just compensation. What is a jury likely to do with a physician who has been honest and also apologized? Judgments will most likely be far less costly.

So apologizing is not only the right thing to do—it is the smart thing to do. The time has come to get on with it. It's time for doctors and nurses to do what they have known all along is the right thing to do: tell the patient everything that happened, including how things went wrong, and express our genuine feelings of sorrow and remorse. We owe them, and ourselves, nothing less. **NPSF**

Gaining Synergy: How Duke University Hospital Built an Infrastructure for Safety

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In tandem with their ALP work, the Fellows assessed DUH's infrastructure for patient safety and clinical quality improvement. Building on PSLF models and concepts as well as input from Duke's administrative and clinical leaders, Frush and Shulby proposed a restructuring of safety/quality teams throughout the hospital. The educational needs of these team leaders became the first target of the ALP, as the teams' success depended on leaders with strong knowledge of the science of safety.

Educating on the science of safety

The Duke Fellows determined that an educational retreat was the most effective way to deliver the needed information, and planned a one-day educational event. The retreat was attended by more than 175 nurses, physicians, pharmacists, respiratory therapists, administrators, management engineers, and others who contribute to the safety of patients. Local DUH senior leaders and board members also attended.

The retreat's objectives were to:

- Explore the human impact of a medical error from the perspective of a family member;
- Describe the basics of error theory and principles of medication safety;
- Define the components needed for a culture of safety in a hospital;
- Discuss strategies for engaging frontline staff in patient safety and clinical quality initiatives and practices;
- Review faculty members' role in patient safety and clinical quality;
- Describe the DUH Patient Safety Center and its goals for education, training, and research;
- Define the components and goals of the DUH Patient Safety and Clinical Quality Program; and
- Explore strategies for implementing the Patient Safety and Clinical Quality Program within the clinical services unit (CSU) or department.

To set the tone, the conference began with a personal story by an individual whose mother was affected by a perceived medical error at DUH. This approach was effective in gaining the audience's attention and emphasizing the need to focus on patient safety and clinical quality. The hospital's CEO, who also is the chief medical officer, then presented

his vision for patient safety and clinical quality at DUH. The chair of the Pharmacy and Therapeutics Committee explained the evolution of patient safety and medication safety. Two physician leaders from the Department of Surgery spoke of their role in the hospital's efforts, specifically about the benefit of patient safety WalkRounds® and the changes in practice that can be achieved through that effort.² The patient safety officer of the Health System spoke about the planned DUH Patient Safety Center aimed at furthering the science of safety through the academic mission. Finally, DUH's patient safety officer talked about operationalizing the DUH Patient Safety & Clinical Quality Program.

Retreat produces positive effects

Retreat attendees reported feeling more knowledgeable, as well as energized to lead the way to an enhanced culture of safety and recommitted to efforts to prevent harm to patients. Further evidence of the educational event's effect on leaders can be seen in their response to online reports of patient care events. Initially, senior CSU leaders were not included in follow-up activities in response to reports. When they recognized the important learnings that could be culled from these reports, the leaders insisted on being included.

With DUH's implementation of Six Sigma performance improvement methodology, a growing number of physicians have become leaders of safety initiatives. CSU leaders are now conducting executive WalkRounds® in units throughout the hospital in coordination with the hospital's executive team.

Educating frontline staff in patient safety

The next step in developing a comprehensive patient safety educational program was to create a course targeted at frontline staff involved in local clinical quality and patient safety teams. This course was designed to be used in conjunction with classroom training on the Six Sigma DMAIC (define, measure, analyze, improve, control) performance improvement methodology.

Course content focused on patients' and families' expectations related to patient safety and quality, error theory, and strategies to prevent errors or mitigate harm. The online presentation format allowed staff to view the material at their own pace at their convenience. Staff who have completed the training say

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Massachusetts Coalition for the Prevention of Medical Errors Creates Model Program NPSF Stand Up for Patient Safety® Hospitals Receive Medication Reconciliation Model Program

BY C. LYNN CHEVALIER, MPH, MS, CPC, PROGRAM MANAGER, NPSF

Medication reconciliation is a challenging safety process to implement, and there are often inaccuracies when obtaining a medication history from patients at the time of hospital admission.¹ Approximately 46% of inpatient medical errors may occur on admission and discharge, or when new medication orders are written for a patient.² Medication reconciliation can be associated with reducing medical errors, especially during transition points in the hospital setting.³

JCAHO sets National Patient Safety Goal

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has made medication reconciliation a 2005 National Patient Safety Goal. By January 2006, all accredited hospitals must implement a process that meets JCAHO's standards for medication reconciliation, including:

- Having a process for collecting and documenting a complete list of each patient's medications on hospital admission and those prescribed during the hospital stay. The process must include patient involvement; and

- Communicating a complete list of a patient's medications to subsequent providers on transfer of care to another setting, service, or practitioner—both inside and outside the current organization.

“Approximately 46% of inpatient medical errors may occur on admission and discharge, or when new medication orders are written for a patient.”

NPSF disseminates Massachusetts Coalition's model program

As a benefit of membership in NPSF's Stand Up for Patient Safety® (SUPS) program, each member hospital has

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they feel better prepared to address patient safety issues in their area.

Educating the public

One of the ALP's largest hurdles is reaching out to the community to educate potential patients on their role in patient safety. To address this need, Duke held a half-day retreat focusing on community education with individuals from throughout the health system. Participants included staff from the health education outreach program, communication specialists, community relations experts, the Latino coordinator, an educator, and ESC members. Discussion centered on ways to involve community members, patients, and families in improving safety.

The group recommended an initial focus on handwashing and medication management. For example, as the flu season approaches, community members can learn from public safety announcements and other forms of public education that they can help reduce the risk of flu by practicing good handwashing habits. Patients and families may then better understand that the risk of infection acquired during a

hospital stay can be reduced by proper hand hygiene of all care providers and visitors. Through informational flyers and posters in care areas, patients will be encouraged to ask providers if they washed their hands prior to entering the room. Work groups are developing further strategies, and additional efforts are under way.

Learning through peer interaction

Duke's comprehensive patient safety educational program has been enhanced by PSLF faculty and Fellows who have shared their expertise and guidance. The Fellowship curriculum's information on the science of safety was incorporated into the educational materials developed for a broad audience of healthcare providers, learners, and consumers.

Duke now has infrastructure in place to support ongoing education of frontline staff and leaders of safety/quality teams. Using experiences provided through the Fellowship to enhance leadership skills, DUH Fellows hope to facilitate the development of safety leaders at DUH, and serve as catalysts for change in all areas of the health system. **NPSF**

The Stand Up for Patient Safety Program® offers hospitals and health systems a meaningful way to participate in the national patient safety movement. For more program information, contact Louise Kodela at (413) 663-2009 or lkodela@npsf.org.

References

- 1 Cornish PL, Knowles SR, Marchesano R, et al. Unintended medication discrepancies at the time of hospital admission. *Arch Intern Med.* 2005;165:424-429.
- 2 Bates D, Spell N, Cullen D, et al. The costs of adverse drug events in hospitalized patients: results of the Harvard Medical Practice Study II. *N Engl J Med* 1997;277:307-311.

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References

- 1 Leape LL. Error in medicine. *JAMA.* 1994;272:1851-1857.
- 2 Thomas EJ, Sexton JB, Neilands TB, Frankel A, Helmreich RL. The effect of executive walk rounds on nurse safety climate attitudes: a randomized trial of clinical units. *BMC Health Serv Res.* 2005;5:28-.

A View from the Emergency Department: Patient Safety Should Never Take a Holiday

BY MATTHEW M. RICE, MD, JD, SENIOR VICE PRESIDENT, TEAM HEALTH WEST

Now that the holidays are over, it's a good time to reflect on how all the festivities can cause individuals to overlook safety principles. During the holidays, there are frequent public service announcements on safety concerns related to travel, weather, and holiday activities^{1,2}—but virtually none on patient safety. It can be difficult for healthcare workers and patients to maintain a patient safety focus throughout the holiday season. Perhaps holiday patient safety alerts are an idea worth considering.

How do the holidays affect the Emergency Department?

Looking at holiday patient safety from the vantage point of the Emergency Department (ED) offers some perspective on the complexity of health systems.³ The ED provides a tremendous array of services 24 hours a day, 7 days a week. It must function autonomously, yet integrate with almost every other area of hospital and ambulatory care. Because of its unique operations, the ED is an interesting place to study safety and systems.⁴

ED staff across the country must be prepared for increased demand, with millions of patients presenting with thousands of emergency medical conditions.⁵ Emergency care must integrate evaluation and treatment of large patient volumes into the other parts of holiday-oriented systems. During holidays, most clinics and physicians' offices are closed or operating with limited services. These health system holiday changes accommodate contracts, medical staff desires, supplier availability, and elective medical patient demands—but in doing so, safety is often overlooked or ignored.⁶

Because of limited health system support services, the ED is often left with fewer ancillary staff and resources to support the increased work load. Hospital holiday staffing patterns confront medical institutions with difficult decisions; often hospital staffing is reduced to meet institutional and staff needs rather than those of patient safety. This creates difficulty when predictable surges in patient volume bog down and delay emergency care services.⁷ When this reduced staff is overwhelmed, patient safety will be compromised.

Medical specialists are frequently less available to emergency patients⁸—and even more so during the holidays. This often requires the ED to delay certain services, provide substitute services or transfer patients more frequently. Sometimes holiday hospital staffing is relegated to less-experienced personnel, leading to embittered staff who feel they “have to work.” This attitude can negatively affect efficiencies and

professional behavior. The less-focused or less-efficient novice workers and understaffed workplaces may contribute to longer waits for diagnostic tests and ancillary support. These inefficiencies, in turn, tie up resources and create system stresses on staff and patients.

Health system components can and do fail at the time of greatest need through lack of both adequate system support and patient safety vigilance.⁹ The reality is that complex medical operations in a holiday atmosphere involve an increased risk to patient safety. Readiness and focus must be constantly maintained to avoid error and patient harm.

How can holiday stress affect patient safety?

Stress is associated with holiday activities and significantly affects human-factors-related safety issues.¹⁰⁻¹² Working when others are relaxing places an additional burden on a reduced work force. Changes in processes make routine work more difficult to complete. Increased demands for emergency services put intense pressure on emergency staff, with large numbers of patients increasingly funneled into a diminishing number of EDs.

ED staff may also have personal worries over finances, weather, travel, and family activities—stressors that can create anxiety, depression, and fatigue that affect individuals' morale and focus. These stressors contribute to changes in performance that can manifest as errors and failures in professionalism, leading to significant patient safety concerns.¹³

Patient behaviors can also negatively affect safe medical practice during the holidays. Overindulgence in alcohol or dietary indiscretions may lead to health problems. Often, patients have not planned for their holiday healthcare needs. Failure to fill prescriptions creates health problems and increases demand for services. Forgetting to comply with medications can lead to increases in illness. Having limited access to medical records when illness occurs creates safety problems, making communications with primary physicians and obtaining missing health information more difficult.

Medical systems must learn to enhance holiday patient safety, and patients need to become more aware of health systems' limitations during the holidays and plan accordingly by:

- Ensuring that they have enough medication to last through the holiday season;
- Keeping important medical information at home or along while traveling—which can be life-saving; and

- Knowing what medical resources are open and how to best access them, thus saving valuable time.

Patients should know when to use the ED

Understanding when to access the ED can be difficult for patients. Because limited facilities are much in demand, it is best not to use emergency services unless the patient feels there is a true emergency. The opposite is also true: a patient should not delay seeking emergency care when needed to avoid serious health-related complications.

Patients needing emergency services during the holidays need to be vigilant and aware of the care they receive and the limitations of the system. It's important to realize that healthcare workers truly care about patients, but are affected on a personal level by the holiday season. **NPSF**

References

- 1 Holiday season safety. National Safety Council. Available at: www.nsc.org/library/fonts/holseason. Accessed Dec. 1, 2005.
- 2 Dunn, S. Happy holidays without emergency rooms. 2002. Available at: <http://www.americaninsurancedepot.com//protectyourself/holidays.htm>. Accessed Dec. 1, 2005.
- 3 Reason, J. *Human Error*. Cambridge, Mass: Cambridge University Press; 1990.
- 4 Biros MH, Adams JG, Wears RL. Errors in emergency medicine: a call to action. *Acad Emerg Med*. 2000;7:1173-1174.

- 5 McCaig LF, Burt CW. National Hospital Ambulatory Medical Care Survey, emergency department summary. *Advance Data*. May 26, 2005;358:1-40. Available at: <http://www.cdc.gov/nchs/data/ad/ad358.pdf>. Accessed Dec. 1, 2005.
- 6 Mundell EJ. Death rates highest during holidays. 2004;ScoutNews. Available at: <http://www.healthfinder.gov/news/newsstory.asp?docid=522847>. Accessed Oct. 2, 2005.
- 7 Litvak E, Buerhaus PI, Davidoff F, Long MC, McManus ML, Berwick DM. Managing unnecessary variability in patient demand to reduce nursing stress and improve patient safety. *Jt Comm J Qual Patient Saf*. 2005;31:330-338.
- 8 On call physicians at California Emergency Departments. Available at: www.chcf.org/documents/hospitals/oncallphysicians. Accessed Dec. 1, 2005.
- 9 Weissman, J. Weekend effects and the July phenomenon in patient safety. Available at: www.mgh.harvard.edu/healthpolicy/IHP_quality.html. Accessed Dec. 1, 2005.
- 10 National Mental Health Association. Holiday depression and stress. Available at: <http://nmha.org/infoctr/factsheets/103.cfm>. Accessed Dec. 1, 2005.
- 11 Centers for Disease Control and Prevention. Safe and healthy workplaces in the holiday season. Available at: <http://www.cdc.gov/niosh/topics/holiday/>. Accessed Dec. 1, 2005.
- 12 Salvendy, G ed. *Handbook of Human Factors and Ergonomics*. New York: John Wiley & Sons; 1997.
- 13 Dawson D, Reid K. Fatigue, alcohol and performance impairment. *Nature*. 1997;338:235.

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received from NPSF a model program and toolkit on implementing a medication reconciliation process developed by the Massachusetts Coalition for the Prevention of Medical Errors (Massachusetts Coalition) and the Massachusetts Hospital Association. The materials focus primarily on medication reconciliation on admission to the hospital.

The toolkit, *Reconciling Medications: Safe-Practice Recommendations and Implementation Tools*, includes everything needed to start a program or to support an existing one.⁴ The program was endorsed by JCAHO Executive Director Richard Croteau, MD, during an October SUPS audio conference. The Massachusetts Coalition program provides safe practices, model forms and policies, implementation guides and tools, as well as tips to assist hospitals in adopting recommended practices.

The Massachusetts Coalition was established in 1998 to improve patient safety and minimize medical errors in the Commonwealth. Its goals include disseminating knowledge and information and increasing awareness of error prevention strategies through public and professional education.

NPSF has hosted one Massachusetts Coalition audioconference to support the program's implementation and is hosting a second one in early January. Hospitals that have implemented these strategies also participate in the audioconferences to share real-life implementation issues and lessons learned. **NPSF**

References (continued)

- 3 Pronovost P, Weast B, Schwarz M, et al. Medication reconciliation: A practical tool to reduce the risk of medication errors. *J Crit Care* 2003;18:201-205.
- 4 Massachusetts Coalition for the Prevention of Medical Errors and the Massachusetts Hospital Association. Reconciling medications: safe practice recommendations and implementation tools. Available at <http://www.macoalition.org/Initiatives/docs/RMbinderOrder.pdf>.

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National Patient Safety Awareness Week Set for March 5-11, 2006

Hospitals, communities, and organizations across the country will celebrate *National Patient Safety Awareness Week (PSAW)* March 5-11, 2006. Leading the way are NPSF's nearly 400 Stand Up for Patient Safety hospitals and healthcare systems, conducting special activities for patients, families, and healthcare providers. The 2006 *PSAW* theme is *Our Patients—Our Partners: One Team, One Goal*.

The theme emphasizes patient- and family-centered care and promotes building partnerships between providers and patients, families and advocates. PSAW also encourages hospitals to actively engage their community in patient safety activities and in all aspects of their health care.

For information on how to participate or to order posters and other PSAW items, visit www.npsf.org or e-mail info@npsf.org.

Save the Date for the 8th Annual NPSF Patient Safety Congress Leadership for Safety—The Time is NOW! May 10–12, 2006 San Francisco

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Disclosure and Apology—Stories from Doctors and Patients

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Our Time, Our Watch, Our Work; Nurse Leaders in Action

Timothy Porter O'Grady, PhD, RN, panel leader; Kathleen
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