

The New Patient Safety Officer: A Lifeline for Patients, A Life Jacket for CEOs

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Abstract: Virtually every health care organization in the United States faces the daunting task of transformation. The high seas of transparency and hazards of evolving systems failures lurking under the waterline pose serious risk to survival of hospitals and the careers of their leaders. New performance measures, standards, and practices will drive entirely new behaviors by hospitals, requiring important cultural and operational changes, or they will have an impact on payment and reputation through the actions of purchasing, quality, and certifying organizations. The personal success of CEOs and trustees, and the sustainability of health care organizations, will become tightly coupled to the success of safety leaders and patient safety officers. As such, it is vital that a careful and systematic approach be undertaken to both the design of this new role and the selection of such leaders. Their knowledge, skills, talents, and, most importantly, their values must be measured against a new and evolving set of safety challenges facing health care institutions. They will be a lifeline to patients and a life jacket for CEOs.

Key Words: Patient Safety Officer, PSO, patient safety leader, safe practices

NEW DEMANDS—A NEW ROLE

Whether their job title is “Patient Safety Officer (PSO)” or not, the new breed of patient safety leader must be an educator, a diplomat, an analyst, a student, a negotiator, a communicator, and a person who understands broad strategies and granular tactics. To be an agent of change, they must not only have a high intelligence quotient (IQ) but also, perhaps more importantly, a high emotional quotient (EQ)—that is to say that they must have solid people skills.^{1,2}

Most of all, they must be leaders who earn the respect of those who can influence the behaviors of everyone up and down their organizations because their impact will be made through others.³

The banner of an organization’s history is like a moving map, invisibly woven on a real time basis through the collective behavior of its people. To make safety an intrinsic property of a culture, the threads of respect, ethics, patient centeredness, and reliability, science must be fed by our safety leaders into the loom of the C-suite and governance. For in the end, all the safety science in the world will not create change. Only those who are at the helm can change the course. Governance and CEOs control the resources and the focus of the organization. They need strong and consistent support from their patient safety leaders to transform the fabric of their organizations.

There are new drivers that demand that we rethink the roles of PSOs and the attributes we should seek in them. The harmonized National Quality Forum (NQF)-endorsed Safe Practices for Better Healthcare,⁴ new and evolving Safety Goals of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO),^{5,6} the recently announced 5 Million Lives Campaign led by the Institute for Healthcare Improvement (IHI) that builds on the 100,000 Lives Campaign launched in 2004,⁷ the 2007 Leapfrog Survey released in the first quarter of 2007,⁸ and the ever-increasing demand for transparency are but just a few.

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HARMONIZED NQF-ENDORSED™ SAFE PRACTICES

In January of 2006, a set of 30 safe practices was published that were fully harmonized across JCAHO, the Centers for Medicare and Medicaid Services (CMS), the Leapfrog Group, the Agency for Healthcare Research and Quality, and the IHI 100,000 Lives Campaign. This provided a common road map for health care organizations and a substantive input source for the action plan blueprints for patient safety leaders and PSOs.⁹ This effort had been preceded by the NQF report “Safe Practices for Better Healthcare,” released in 2003, composed of 30 safe practices intended to have specificity, benefit, evidence for effectiveness, generalizability, and readiness.¹⁰ In short, the objective was to provide practices that would have life-saving impact across many care settings. The Leapfrog Group had already been surveying hospitals regarding the adoption of three of the practices, including computerized physician order entry, evidence-based referral, and intensive care unit coverage.

After the publication of the NQF 2003 report,¹⁰ the Texas Medical Institute of Technology (TMIT) committed to fund research and development in the domains of the safe practices. TMIT then developed, for the Leapfrog Group, a survey, weighing system, and scoring approach with a world class team of safety experts that allowed hospitals to report on adoption of the balance of the 27 practices. The program has been updated each year. In 2005, a total of 1267 hospitals responded to the survey from multiple rollout regions.

The learning from the Leapfrog effort and soon-to-be published detailed findings of the TMIT safe practice research were inputs to the development of an entirely updated set of the original NQF practices in 2006. Three practices were incorporated into existing ones, and 3 new safe practices were developed, which included disclosure, direct caregiver workforce, and medication reconciliation.

A major focus of the committee was to develop and refine a practice entitled “Creating and Sustaining a Culture of Patient Safety.” This practice is core to the new responsibilities of the patient safety leaders and recognizes the continued need for emphasis on leadership. It is composed of 4 elements:

- leadership structures and systems;
- culture measurement, feedback, and interventions;
- teamwork and team-based interventions; and
- identification and mitigation of risks and hazards.

The research included an analysis of a number of research topics from surveys, focus groups, input from multiple national task forces of subject matter experts, and direct interviews of hospital PSOs and CEOs. They confirmed presumptions and revealed certain surprises.

Leader champions and physician engagement were critical to improvement, as were assignments of direct accountability for performance areas. More than 90% of the hospitals have assigned formal accountability to a leader or leaders who monitor progress and drive improvement on an

ongoing basis. More than 97% identified performance gaps that they have targeted for improvement that became obvious through the process; 100% of those took actions to improve in a formal process.

The clear message was that transparency drives leader engagement; leader engagement drives budgets, and budgets drive safety. As we craft the roles for patient safety leaders and officers, it will be important that they are supported by governance and administrative leaders, have resources, and have a systematic approach to implementation.⁹

JCAHO PATIENT SAFETY GOALS

In addition to the contribution that JCAHO made to the harmonized NQF Endorsed Safe Practices, it continues to focus on the reduction of preventable harm.

As of the time of this writing, the JCAHO proposed changes or additions for 2008 to existing National Patient Safety Goals (NPSGs) that include the following:

- Organization investigation and planning for use of technology to assist with patient identification as part of existing NPSG goal 1.
- New requirements within the existing NPSG goal 3 for the selection, procurement, storage, ordering, dispensing, administration, and monitoring processes related to anti-coagulation therapy.
- New proposed goal 16 to improve recognition and response to changes in a patient’s condition.
- New proposed goal 17 to reduce the risk of postoperative complications for patients with obstructive sleep apnea.
- New proposed goal 18 to prevent patient harm associated with health-care worker fatigue.
- New proposed goal 19 to prevent catheter and tubing misconnections.⁶

The nature of these new proposed standards further expands the role of PSOs and safety and quality leaders. They require even more interaction between executive administrative teams, including those in charge of operations and multiple systems.⁶

IHI’S 5 MILLION LIVES CAMPAIGN

The IHI President and CEO, Donald Berwick, MD, MPP, speaking before thousands of health care professionals, recently announced a national campaign to dramatically reduce incidents of medical harm in U.S. hospitals (Satellite Communication, December 9, 2006). The “5 Million Lives Campaign” challenges hospitals to rapidly improve the care they provide to protect patients from 5 million incidents of medical harm over a 24-month period, ending December 9, 2008. This represents a continuation of the largest improvement effort undertaken in recent history by the health care industry.

The 5 Million Lives Campaign aims to enlist 4000 hospitals, challenging all to adopt up to 12 of the following interventions—of which, 6 were included in the 100,000 Lives Campaign, and the other 6 were new.

IHI defines *medical harm* as unintended physical injury resulting from or contributed to by medical care (including

the absence of indicated medical treatment) that requires additional monitoring, treatment, or hospitalization or results in death. New interventions targeted at harm are the following:

- Prevent methicillin-resistant *Staphylococcus aureus* infection...by reliably implementing scientifically proven infection control practices throughout the hospital.
- Reduce harm from high-alert medications...starting with a focus on anticoagulants, sedatives, narcotics, and insulin.
- Reduce surgical complications...by reliably implementing the changes in care recommended by the Surgical Care Improvement Project.
- Prevent pressure ulcers...by reliably using science-based guidelines for the prevention of this serious and common complication.
- Deliver reliable evidence-based care for congestive heart failure...to reduce readmissions.
- Get Boards on board...by defining and spreading new and leveraged processes for hospital Boards of Directors, so that they can become far more effective in accelerating the improvement of care.

The 6 interventions from the 100,000 Lives Campaign are the following:

- Deploy Rapid Response Teams...at the first sign of patient decline and before a catastrophic cardiac or respiratory event.
- Deliver reliable evidence-based care for acute myocardial infarction...to prevent deaths from myocardial infarction.
- Prevent adverse drug events...by reconciling patient medications at every transition point in care.
- Prevent central-line infections...by implementing a series of interdependent scientifically grounded steps.
- Prevent surgical-site infections...by following a series of steps, including reliable timely administration of correct perioperative antibiotics.
- Prevent ventilator-associated pneumonia...by implementing a series of interdependent scientifically grounded steps. There is no cost for hospitals to join the 5 Million Lives Campaign, although there is an obligation to adopt at least 1 intervention and an expectation of regularly reporting hospital profile and mortality data throughout the campaign.¹¹

INTERVIEWS WITH PATIENT SAFETY LEADERS

Interview: Allan Frankel, MD, Director for Patient Safety at Partners Healthcare in Boston, Mass., and a Faculty Member of the IHI (Oral Communication, January 2, 2007)

Does the title “Patient Safety Officer” reflect the scope and scale of the responsibilities of the position?

Dr. Frankel: Patient safety is a very broad set of domains. Calling someone the patient safety officer is an insufficient title. If we wanted to be more clear and less succinct, we might call them “Safety, Ethics, and Reliability Officers.” They need to have in-depth knowledge of multiple

domains and, most importantly, the ability to drive implementation of that knowledge into action.

If knowledge or what we might call truth is the currency of the mind, how important is the command of patient safety knowledge by the PSO?

Dr. Frankel: The patient safety leaders have to take a complex set of constructs and be able to explain such concepts in simple and elegant ways that provide face validity and logic. This must couple such to actions that drive outcomes of safe and reliable care. Concepts include the science of reliability, the evidence that supports safety, with components of ethics, transparency, and disclosure. The threads of the fabric of safety are quality, reliability, and ethics. By ethics, I mean, as a start, nonnegotiable mutual respect for every interaction, every person, every day, leading to an environment of trust and truth that promotes safe and reliable design.

How important is their ability to build trust in the organization?

Dr. Frankel: Vital. Safety leaders must be unimpeachable in order to help create an environment where respect and trust are intrinsic to the culture. They must be able to walk it, teach it, and implement it. They must be able to inspire and help others be inspiring to their teams.

How does the harmonized set of NQF Safe Practices for Better Healthcare help us shape the role of the patient safety officer?

Dr. Frankel: It absolutely defines the PSO role. You can look at the practices in strategy and detailed tactics to define the knowledge, skill set, and the what, when, and where they will be serving. The practices even provide insights as to the proportion of time safety leaders should allocate to such activities.

Interview: Ann Rhoades, the Former Leader of People Systems at Southwest Airlines, Cofounder of JetBlue Airline, and a TMIT Subject Matter Expert Contributor to the NQF Endorsed Safe Practices for Better Healthcare 2006 (Oral Communication, December 9, 2006)

As someone who helped shape the National Quality Forum Safe Practices, what issues are most important to the selection and design of the patient safety officer’s duties?

Ann Rhoades: The values of the safety officer are absolutely critical to their success. If their values do not match the values of the organization, they are destined to fail. If the organization has not confirmed that everyone, starting from the top, is living the values, then it is near impossible to define the desired values and behaviors you seek in a safety leader. We define an “A Player” as someone who not only has the knowledge and skills required for the position but lives and breathes the values with such great passion everyday that even difficult issues are handled by them with unexplainable ease.

What personal values should candidates possess?

Ann Rhoades: A passion for excellence, compassion for patients and for the caregivers that may be involved in

system failures or human errors that cause preventable harm, a deep and humble integrity, and courageous commitment to patient-centered care. To be a change agent for transformation, they will have to help an organization overcome preoccupation with financial performance that may currently trump patient safety. This will require someone with unimpeachable personal values and the confidence in the common good.

How can an effective PSO have impact on the performance of the workforce?

Ann Rhoades: The new NQF Safe Practices addressing nursing and direct caregivers emphasize leadership, education, and allocation of resources by professional administrators and governance leaders. The patient safety leaders will have to communicate the practical value of adoption of these practices right down to the meaning of the specifications. They will have to understand the concepts of behavioral-based interviewing and values-grounded hiring methodologies so that they can communicate them to leaders and those in charge of people systems. These methods are commonplace in other industries; however, they hold great promise for health care in that their implementation is in its infancy in many health care organizations. The safety leaders must be able to communicate how the results of safety initiatives will generate bottom line results and impact the other strategic initiatives of the organization.

Interview: David Moorhead, MD, A Former Hospital CEO, and Recently Appointed Chief Medical Officer for Florida Hospital in Orlando, Fla. (Oral Communication, December 29, 2006)

You are in the process of appointing Patient Safety Officers for 7 campuses of the largest hospital in America under 1 Medicare code. What are the challenges you face?

Dr. Moorhead: The biggest challenge I see is not only to stick with the verbiage of their job description but to determine how this person will be an effective transformational change agent. How will they interface with the CEO, CFO, CIO? How they interface with these persons will be vital. They have to come to the table with gravitas. They have to be seen by hospital leaders in a manner not unlike how a general in the field would see their chief intelligence officer.

Is “fit” critical to a successful selection of a safety officer?

Dr. Moorhead: The PSO definitely has to be a good fit for the organization. They also have to be well respected and competent: a person who can deliver early and achieve real practical impact. The CEOs have to see a solid return on their investment of funds and time in this person. We have to build a new structure around and through this person while we continue to operate the organization.

What are the major risks to the selection and placement of Safety Officers and leaders?

Dr. Moorhead: If they don't deliver real clinical, operational, and financial impact, they will be seen as a

Trojan horse that has been forced into their organization by external forces.

Is it a real challenge to help migrate an entire organization to target and adopt a new set of performance measures, practices, and standards?

Dr. Moorhead: We have a real case of transformation on our hands. Good people who have delivered solid performance in the past are going to have to stretch and adapt to this new paradigm. However, in the end, we must honor the sacred trust of our patients to deliver safe, reliable, and patient-centered care for every patient every single day.

Interview: Terri Simmons, RN, IHI's Director for Critical Care and Patient Safety, An Architect of the IHI PSO Training Curriculum, and One of the PSO Training's 7 Faculty Members (Oral Communication, January 3, 2007)

How will we know when an organization is on the right trajectory to safety? Take the new practice of disclosure for example.

Terri Simmonds: When patients and families are *truly* part of the care team, disclosure will be just a routine component of communication (with them) every single day. The word disclosure will go away as we know it today.

Is it fair to say that one responsibility of the PSO is to help build patient and family input into our operations?

Terri Simmonds: Absolutely. Here in the U.S., Cincinnati Children's Hospital and Dana-Farber Cancer Institute formally include patients and families in their operations, in counsels, and operational committees. Internationally, the U.K. and other European countries often include the voice of the patient, and families are in their operational dialog.

As one of our country's leading educators of patient safety and quality leaders, what have you learned along the way?

Terri Simmonds: The most important thing to recognize is that their power is through other people. Typically, they do not have a large staff reporting to them. To have impact, they must influence others that work for them.

So what must they be especially good at to have such impact?

Terri Simmonds: I like Steven Covey's habit "Seek first to understand, then to be understood."¹⁴ Seek first to understand the person you want to influence and the issues that they are dealing with, including the pressures they face. You must understand how to help them influence those they work with to have impact. An effective PSO must be a good listener.

Do you have a message for trustees and board members?

Terri Simmonds: Your safety officer is someone you personally want to get to know and someone you look forward to having at your board meetings.

What message do you have for CEOs regarding their PSO?

Terri Simmonds: A direct and personal relationship with the PSO will pay huge dividends in strategic planning and avoidance of preventable risk. In high-performance organizations, the PSO can become a vital element of their sensory apparatus that is necessary to lead.

Interview: Michael Leonard, MD, Physician Leader for Patient Safety at Kaiser Permanente, IHI Faculty Member and National Thought Leader in Team-Based Training (Oral Communication, January 4, 2007)

As a leading expert in team training and patient safety, what specific areas of knowledge and what skills related to teamwork will the next generation of patient safety officers have to possess to have the greatest impact on their organizations?

Dr. Leonard: Teamwork is the glue that holds high-performance care processes together. There are 3 important pieces. First, the PSO needs to be able to effectively engage administrative leaders, clinical leaders, and frontline caregivers in the process of transformation. Second, they must be skilled with regard to teaching and implementing basic tools and behaviors for effective teamwork and communications. Finally, they must be able to embed such tools and behaviors within critical care domains and through team-based interventions.

What tools and behaviors should a typical PSO be able to teach and implement?

Dr. Leonard: The primary tools are:

- Structured language—the use of methodologies such as the SBAR (Situation, Background, Assessment, and Recommendation)—briefing model, a very powerful tool;
- Use of critical language—addressing a critical issue such as “stop the line—I am worried about the safety of this patient” is a very important tool that can save lives. Caregivers are often fearful to speak up when they know something may be wrong. This has been used with great utility in aviation, nuclear, and military environments;
- *Psychological safety* is a term we use when we address creating an environment of respect that makes any team member comfortable to speak up or use critical language without fear.

In terms of patient safety, what is an “effective leader”?

Dr. Leonard: Effective leaders quickly set a positive tone for their teams, clearly share the plan, and continuously invite their teammates into the conversation. Such leaders continuously seek input from their teams, both for their technical expertise and to create the opportunity for them to voice concerns at any time.

How will we know when a PSO has been successful?

Dr. Leonard: Successful patient safety leaders will have been able to integrate core concepts and tools into the process of care in a way that allows organizations to sustain their gains and automatically build them into new processes and procedures.

Interview: Denise Murphy, MPH, BSN, RN, CIC, Vice President for Safety and Quality, Barnes-Jewish Hospital, St Louis, Mo. and President of the Association for Professionals in Infection Control (Oral Communication, December 10, 2006)

As we look at identifying and preventing hospital-associated infections, what are the most important areas of knowledge that a patient safety officer must possess?

Denise Murphy: A basic understanding of the principles of epidemiology is critical. PSOs are truly responsible for protecting the health of populations, especially those at great risk for an adverse event. Whether the event is acquisition of an infection or experiencing a fall or medication error, the same principles apply. Epidemiology helps you think in terms of assessing population risk, adjusting or stratifying based on risk, developing hypotheses, and applying interventions accordingly.

That said, patient safety happens at the bedside or in the clinic or home; therefore, integrating principles of performance improvement with epidemiological tools and methods is most effective. A good patient safety officer knows when and how to select the approach to problem solving and change that can best impact a given situation positively and improve outcomes for those in our care. Specific to hospital-acquired infections (HAIs), there are evidence-based interventions to reduce HAIs, largely found in Centers for Disease Control and Prevention Guidelines, that every professional charged with infection prevention commits to memory. The major interventions are also part of NQF’s Safe Practices, so all PSOs must know these guidelines, as well as the people in their organization who link those practices to the frontline staff and patients—the infection prevention experts.

What new skills must a safety leader develop to help bring awareness to senior leaders of the importance of health care-associated infections?

Denise Murphy: Expert knowledge, in this case, about preventing HAIs, is powerful, but only if it can be translated to executives concisely in the language they most value. PSOs must learn to create effective executive summaries, using reliable data presented as simply as possible. The summary should include:

- the scope of the problem;
- the impact on our patients, staff, and organization;
- the solution you are recommending, why, and what evidence supports the recommendation;
- the cost of implementing the solution; and
- what will happen if action isn’t taken.

Denise Murphy: What I have learned that has boosted my effectiveness the most is the ability to influence others to take action, to negotiate by always presenting options (three, if possible), and thinking in bullet-points. You have little time to communicate with executives, so be prepared to get the biggest bang for your three minutes.

What message would you like to communicate to trustees and CEOs regarding HAIs and support of their patient safety leaders?

Denise Murphy: If leadership (management and governance) is serious about improving patient safety, starting with not harming patients through exposure to hospital-acquired infections, they need to put prevention “on their calendars and in their checkbooks.” To me, *on the calendar* means they are active members of committees and visible champions in their organizations and communities. At my organization, members of the Patient Care Quality Committee (PCQC) of the Board take time to understand the reports we provide, then drill us on what we are doing to prevent HAIs and the ever-present problem of methicillin-resistant *S. aureus*. Hospital epidemiologists and the infection prevention specialists are actually invited to present performance improvement team progress at the quarterly PCQC meetings where Board and Management can provide feedback and recommendations. *In their checkbook* means that the executive team provides dedicated resources to manage prevention and improvement programs effectively.

Our specialists, both in infection prevention and patient safety, are qualified (certified), experienced, and given the tools they need to perform their jobs effectively. Projects and teams have both an executive sponsor and physician leader, which really demonstrates support and commitment to patient safety.

Interview: Jim Conway, MS, Senior Fellow at the IHI, Senior Consultant at the Dana-Farber Cancer Institute, Boston, Mass.; Served as Executive Vice President and Chief Operating Officer of Dana-Farber Cancer Institute From 1995 to 2005 (Oral Communication, January 4, 2007)

How will the 5 Million Lives Campaign impact or shape the role of the patient safety officer?

Jim Conway: The governance plank of the campaign provides an enormous opportunity for partnering with the board on harm, tragedy, and waste. Through teaching, engagement, and personal relationships, the PSO has the opportunity to tap a new source of power. Recent conversations with frontline trustees revealed that one of the things that resonate with them is discussing how their expertise could be applied to our world. Many come from nuclear power, manufacturing, and customer service industries. They don't understand our world; however, they have great expertise that can help make us safer. An effective

PSO who is given access to the board will be able to help harness that power.

What special skills will the Patient Safety Officer have to develop?

Jim Conway: The PSO has to focus on harm and become an expert in looking for trouble with tools that they have not used before. For instance, in the 5 Million Lives Campaign, the Global Trigger Tool is used to help reveal harm. Most patient safety leaders will have to continuously go back to school on their methods.

Will the Patient Safety Officer have to be good at partnering and collaborative work?

Jim Conway: A collaborative approach must be undertaken in their work. Most clinicians don't see the harm. When safety leaders can reveal harm in a clear and evidence-based way, the learning of community can definitely be accelerated. Further, the safety officer must be the guardian of patient and family input to our process. They must make sure to reinject the needs of patients at every appropriate juncture. Real lift can occur if the PSO and the leadership of the organization can inspire listening and learning from one another and between organizations.

Interview: Peter Angood, MD, FCCM, President and Chief PSO of the JCAHO, a Past President of the Society of Critical Care Medicine, Des Plaines, Ill. (Oral Communication, January 5, 2007)

From the JCAHO and Patient Safety Goals' perspective, what is most important?

Dr. Angood: A Joint Commission view would be all about changing the culture, so that there is a belief that everyone is involved in systems and organizational improvement. That means that it must come from the CEO and Board; however, the PSO must be able to translate this at the bedside. Patients must be able to perceive it.

Is there a major barrier to adoption that comes to mind?

Dr. Angood: The integrity and belief in the value of patient safety activities of the organization by the volunteer medical staff is critical. We all struggle with the physician engagement issue, and the PSO is critical to that engagement and can help drive this impact.

What can we expect in the future regarding the role of the patient safety officer?

Dr. Angood: We will want to foster and focus on areas of development of solutions in patient safety that will extend the impact of the patient safety goals. The PSO will have to keep up to date on the standards as well. They are undergoing a rewrite that will take the better part of 2 years. The patient safety officer is pivotal to being the interpreter and an agent to translate them into action at the organization.

Interview: David Bates, MD, MSc, Chief, Division of General Medicine, Brigham and Women's Hospital, and Medical Director of Clinical and Quality Analysis for Partners HealthCare System, Boston, Mass. (Oral Communication, January 6, 2007)

Are there critical success factors to the performance of patient safety officers?

Dr. Bates: PSOs must have adequate support from leadership, resources, and a clear and well-defined plan. These are definitely critical success factors to achieving patient safety.

Do you have a message for governance leaders and trustees?

Dr. Bates: Although the PSO has to have the right qualifications, leadership skills, and adequate training, the institution needs to resource the safety efforts adequately. Typically, the institutions do not have adequate resources. It is important to PSOs to take a broad enterprise-wide system approach. Too often, safety leaders are focused within silos and addressing tactical details.

Do you have a message for the formal and informal medical staff leaders?

Dr. Bates: When the PSO talks, the medical staff should listen. The pressures and risks in patient safety areas are only going to grow. The PSO helps promote the concept that every organization must invest dollars, capacity, and their best talent in patient safety.

Do you have a message to patients?

Dr. Bates: Our hospitals can be made much safer, and organizations that invest in safety are those that will deliver better care. Patients should be interested in whether their hospitals are prioritizing safety and investing in such initiatives.

What are the new breakthroughs that you are excited about in the next 5 years?

Dr. Bates: In the future, bar coding for medication, labs, and imaging will have real impact. Smart monitoring will definitely become increasingly important, and clinical data exchange will have a big impact on patient safety.

Interview: Lillee S. Gelinias, RN, BSN, MSN, FAAN, Vice President, Chief Nursing Officer of the National Group Purchasing Organization, VHA Inc., Irving, Texas (Oral Communication, December 12, 2006)

The role of Patient Safety Officer is rapidly evolving. How close are we to having standardized or common responsibilities across organizations?

Lillee Gelinias: We are not even close. In many of our organizations, the Chief Quality Officer or someone else takes on this responsibility. There is no standardization of approach. Although there are great resources, such as the IHI Patient Safety Officer Executive Development course at the IHI, we have much yet to do.

How has the newly harmonized set of NQF Safe Practices helped us along the path of developing the role for safety leaders and the PSO?

Lillee Gelinias: Harmonization of practices has provided foundational work, including vocabulary, specific activities, and insight on potential measures. However, we now have the cookbook without the cook. CMS and the Leapfrog Group are heating up the oven, and the consumers are demanding a better meal. We must focus on crafting a clear role for the patient safety officers, and they must be supported by their governance and administrative leaders.

As a leader who focuses our attention on the impact of nursing on quality and safety, how can the patient safety leaders and officers leverage the impact of nursing on safety?

Lillee Gelinias: The PSO will need to be armed with actionable information that can be used to close the knowledge gap regarding the nursing impact on safety. If they do not have command of both knowledge and the tools that can be used to improve nursing through the workforce practices and implementation of the direct care-related practices, they will fail. We have failed to provide our administrative leaders with the evidence that demands action regarding nursing and workforce issues. There is an impending crisis in this area.

Interview: Lucian Leape, MD, Adjunct Professor of Health Policy, Department of Health Policy and Management, Harvard School of Public Health, Boston, Mass. (Oral Communication, January 13, 2007)

Are there responsibilities that patient safety officers will have to undertake that are beyond the typical tactical activities?

Dr. Leape: The PSOs need to play a role in shaping how we respond when we fail. There are 2 aspects to this. They must be a resource to make sure that the investigations such as root cause analysis are done properly while, at the same time, make sure that there is proper communication with the patient and the caregiver who may be the second victim. Disclosure is critical.

Have we given our safety leaders and patient safety officers enough responsibility to have maximal impact?

Dr. Leape: It is important to address authority and accountability. A safety officer in any other industry has both authority to "stop the line" and accountability. They have the authority to act and make changes. I don't know anywhere in health care where we have created such a role. Another important point is that safety is everybody's job. We are awfully far from such a culture, and we need to think of assigning specific responsibilities and authorities as a start along this migration path.

Do we have any good models yet?

Dr. Leape: I don't know whether we have any good models yet as examples.

Can you explain the relationship of the PSO to being a facilitator of change and an enforcer?

Dr. Leape: The patient safety officer is a facilitator of change and redesign, while at the same time, they are enforcers to ensure that the safety practices are appropriately adopted. A real leader has knowledge with the power to make things happen. We have a major problem with enforcement, and nobody currently has that job.

Can you explain the impact of adoption on the hospital plan set of NQF Safe Practices.

Dr. Leape: This should be a welcomed opportunity for the PSO to have a more clear plan of action.

ORGANIZATION-SPECIFIC CRITICAL SUCCESS FACTORS

Organization-specific critical success factors for PSOs may be considered in 3 areas: leadership, resources, and systems. Dr. David Hunt, a medical officer with the CMS, uses the story of adoption of modern-day sterile technique to illustrate these 3 areas. The principles of sterile technique were developed by Lister in the U.K., yet he faced challenges driving adoption. Bill Roth is noted for successfully adopting the principles. He had the advantage of leadership engagement, resources, and a system or systematic approach to implementation (oral communication, December 9, 2006). The organizational factors important to the success of a PSO are the same.

- **Leadership.** Leadership, and its impact on culture, is single most important factor to successful performance improvement. That said, it is very important that we are very clear about the role of leaders in fostering the success of today's patient safety leaders.
- **Values.** If the values of the organization are not deeply rooted in quality and patient safety, then we are defeated before defining the role and selecting the patient safety leaders. As Ann Rhoades has shared with us: "Leaders drive values, values drive behavior, and behavior drives the performance of an organization (oral communication, December 9, 2006)." If the leaders do not embrace and live the values, today's hospitals and health care organizations are dead in the water.
- **Governance.** We are just starting to recognize the dynamic between professional administrators and their governing boards. We must refrain from blaming CEOs and their management teams alone for system failures because it is the governance boards of trustees and directors that have huge authority and somewhat surprisingly...even to them...enormous accountability. The NQF Safe Practices provide structures and systems to define specific activities that will help boards serve, and the PSO will be a key actor to coordinate the flow of information to them.
- **Professional Administrators.** A direct and supportive relationship between the CEO and the patient safety leaders is critical for both of their successes. Transparency and actions of the quality, purchasing, and certifying organizations will have a major impact on the image and accountability of the CEO.

- **Mid-level Managers.** Our director level and mid-level managers are having a difficult time understanding and focusing on clear performance targets despite the fact that their senior administrative leaders believe that they have provided clear direction. It is critical that all along the command chain have clear direction and understanding regarding the responsibilities of the PSO and how they should relate to those serving in this new and expanding role.
- **Frontline.** High-performing organizations have engendered a spirit of servant leadership and have rewarded those who innovate close to where the work is done, delivering care. When senior leaders communicate the importance of the PSO and their support of those individuals in the frontline, it can ease the tension that occurs when practices have to change by those caregivers.
- **Formal and Informal Medical Leaders.** Clearly, the vote of confidence and support by formal medical leaders are critical to the success of the PSO. They can create a clearing for key initiatives and are vital in validating the evidence for change when safety leaders are not physicians. A greatly undervalued champion of safety is the informal medical leader, such as the physician who may not hold a formal leadership role with the organization. However, this informal leader may command the respect of medical staff because of their superior skills and high-volume practice. Their support can have an extraordinary impact on safety when we develop relationships with them. Development of such champions must always be considered.
- **Patient Advocates.** We must now include patients and families in our quality and patient safety systems to be compliant to standards such as the NQF Safe Practices; however, progressive organizations such as the Dana-Farber Cancer Institute have done so for years. Their leadership and participation in multidisciplinary patient safety committees and initiatives breathe life into a safety leader's role. Their interests and stories of adverse events can recalibrate our focus from production-centered care to patient-centered care.

Resources. The line "No Bucks—No Buck Rogers" from "*The Right Stuff*," a motion picture that documented the development of the U.S. space program, was used to underscore the fact that funding made the rockets fly. In the same way, direct investment of funds into hospital safety programs is a major success factor for patient safety.

- **Cash-Dark Green Dollars.** In more than 300 direct interviews of hospital CEOs and patient safety leaders, we found that transparency through the Leapfrog Group survey public reporting drove direct financial investment in patient safety. It is very clear that patient safety leaders must be well funded either through work that they direct or through the funding of major and new patient safety initiatives undertaken by the organizations. New system failures are being discovered faster than our innovations are being developed to treat them. A 3-year-old budget will constantly be out of date—this is why new standards require more frequent evaluation of safety budgets by leaders.
- **Capacity—Light Green Dollars.** Although staff resources are in short supply, it is absolutely critical that compensated

staff time be set aside to support safety initiatives. It is easy to add more accountabilities to already-stretched staff; however, the performance impact is entirely predictable. The CEOs, COOs, and leaders that are really serious about safety will have to create mechanisms that assure that staff are directed to act on safety issues and that they have the capacity to do so.

- **Systems.**

- **A Systematic Approach to Transformation.** An organized, systematic, deliberate, and well-thought out approach to adopting new safe practices is vital to success. This will take careful planning and execution by the entire organization. The leadership and resources defined above will have to be applied to and through this approach. This was the essence of successful adoption of sterile techniques described previously.

- **Critical Hospital or Health Care Organization Systems.** It is vital that quality and safety leaders focus on critical support and service systems of health care organizations. These include management systems such as those addressing medications, information, imaging, laboratory, and leadership structures and systems addressed in the updated NQF Safe Practices.⁴ Self-limited tactical interventions that do not take into account enterprise-wide impact on integrated clinical, operational, and financial performance can burn up resources and can fail to deliver broad return on investment that ensures sustainability.

- **Knowledge Management Systems.** It is of the utmost importance that organizations learn and develop institutional memory of concepts, tools, and resources that can serve them over time. Too often, champions for safety move on, and with them, the knowledge that has been leveraged and used to improve performance moves with them. Large organizations have a hard time standardizing their approach to quality and safety improvement when they rely purely on word-of-mouth briefings or flat text content. It is time that we leverage the Internet and multimedia technologies in order to accelerate our adoption of life-saving innovations. Patient safety officers will need the support of their organization to leverage such techniques.

DESIGNING THE POSITION

We should be as careful designing the PSO position as we are in selecting the individuals that will serve. It is critical that the position be custom designed to the culture, structure, and systems of the organization. There is no best job description. The best approach is to start with the key elements that every PSO role should have and then design the role to fit the vision and mission of the organization.

The key elements of design include values, knowledge and skills, education and experience, and the principles and responsibilities of the job.

- **Values.** If the organization is dedicated to the values of patient safety and quality, these values should be expressed in the verbiage of the job description and, more importantly, sought in the character and references and

through the interview process. The values of the organization should be articulated clearly in print and communications with candidates. Most importantly, the behaviors that are expected of the candidate need to be defined and communicated clearly to all involved.

- **Education and Experience.** Although not absolutely critical, a clinical background is a great asset for this position. That said, there are systems engineers and those from other industries such as nuclear power who bring a great deal to the position. Formal education and experience in patient safety is very important. Clearly, physicians, nurses, pharmacists, radiology technologists, and the other various clinically trained applicants will have the respect of the peers that they have to influence to drive change.

- **Knowledge Domains.** The IHI Patient Safety Executive Development course curriculum provides an excellent list of the knowledge domains below.¹²

- **Reliability Science.** Using proven principles that pick up where vigilance leaves off.

- **Human Factors.** Creating systems that compensate for the limits of human ability.

- **Building a Just Culture.** Moving away from blame and shame, building a “just culture.”

- **Interpersonal Communication and Teamwork.** Developing a framework for working together and supporting each other in care delivery across the health care continuum.

- **Influencing Others.** Understanding and shaping stakeholder perspectives on safety improvement: using tested safety improvement techniques.

- **Safety Measures.** Knowing what to measure and how to measure it.

- **Critical Analysis.** Using investigative tools such as root cause analysis and proven observational techniques.

- **A Framework for Safety.** A set of concepts and tools for moving health care toward safety and reliability.

- **Spread.** Understanding and engaging key stakeholders in the process of spreading successful improvements across your organization.

- **Technology.** Understanding the promises, pitfalls, and realities of technology.

- **Leadership.** Taking it from the top—connecting the CEO with the safety agenda.

- **Positioning Patient Safety Within the Organization.** Integrating patient safety into the organizational structure and daily life.

- **Strategy and Implementation.** Creating a comprehensive safety program and implementation plan.

- **Knowledge and Skills—Examples**

The list of skills below taken from the Florida Hospital PSO job description reflect recognition of areas described earlier and addressed in the interviews.

1. Leadership skills, including a demonstrated willingness to pursue leadership roles with increasing levels of accountability; comfort with decision-making responsibilities; coaching, teaching, and counseling skills; and the ability to influence and motivate.

2. Self-motivation and willingness to study new fields for application in areas of responsibility. Self-starter and self-manager.
3. Communication skills and interpersonal skills for interfacing with all levels of the team and external stakeholders of the organization. This involves the ability to persuade and negotiate in situations that are controversial/sensitive and result in authoritative decisions.
4. Analytical ability to apply theories, principles, and practices of several disciplines for problem resolution.
5. Ability to develop and maintain knowledge of regulations and guidelines for areas of responsibility.
6. Ability to define and accomplish project goals in a resourceful and timely manner.
7. Expertise in patient safety principles, including high reliability, patient-centered care, and error/harm prevention theory and practice.
8. Expertise in performance improvement methodologies.

The following harmonization crosswalk of the NQF Safe Practices provides clear direction as to the specific duties our new PSOs must address. Although the abstracted sections of one of the safe practices is provided below, the entire set of NQF Safe Practices provides an ideal input to the blueprinting process for the design of the role of a PSO that covers medication management, health care–associated infections, and a number of condition-specific issues mentioned earlier, in addition to culture focus on consent, disclosure, information management, and continuity of care issues.

Clearly, the commitment to the IHI 100,000 Lives Campaign and now the 5 Million Lives Campaign as well as JCAHO Safety Goals focus will help shape the design of the role of safety leaders.

PSO JOB DESCRIPTION—CROSSWALK TO 2006 NQF-ENDORSED™ SAFE PRACTICE: CREATE AND SUSTAIN A HEALTHCARE CULTURE OF HEALTH

- **Practice Element 1: Structures and Systems Additional Specifications: (Direct Organization-wide Leadership Accountability)**—“...The Patient Safety Officer should have direct and regular communication with governance leaders and senior administrative management.”
- **Practice Element 1: Structures and Systems Additional Specifications: (Patient Safety Officer)**—“...Governance boards and senior administrative leaders should support leaders in patient safety to ensure that there is compliance to the specifications of all four elements of this Safe Practice.”
- **Practice Element 1: Structures and Systems Additional Specifications: (Patient Safety Officer)**—“...The organization should appoint or employ a patient safety office who is primary point of contact for questions about patient safety, and coordinated patient safety for education and deployment of system changes.”
- **Practice Element 4:** ...“Healthcare organizations must systematically identify and mitigate patient safety risks and hazards with an integrated approach to continuously drive down preventable patient harm.”
- **Practice Element 4 Additional Specifications: (Risk and Hazard Identification Activities)**—“...“Risks and hazards should be identified on an ongoing basis from multiple sources including independent retrospective, near real-time and real-time, and prospective views. The risk and hazard analysis should integrate information from multiple sources to provide enterprise wide context.”
- **Practice Element 4 Additional Specifications: (Integrated Organization-wide Risk Assessment)**—“...“Continuous systematic integration of information regarding risks and hazards across the organization should be undertaken to optimally prevent systems failures. Information regarding risks and hazards from multiple sources should be evaluated in an integrated way in order to identify patterns, systems failures, and contributing factors involving discrete service lines and units....integrate the information...Risk Management (claims management) Services participation...Complaints and Customer Services Participation...Disclosure Support System...Culture Survey Measurement, Feedback, and Interventions...Retrospective, Near-real-time, and Prospective Information Integration...”
- **Practice Element 4 Additional Specifications: (Integrated Organization-wide Risk Assessment)**—“...“Continuous systematic integration of information regarding risks and hazards across the organization should be undertaken to optimally prevent systems failures. Information regarding risks and hazards from multiple sources should be evaluated in an integrated way in order to identify patterns, systems failures, and contributing factors involving discrete service lines and units....integrate the information...Risk Management (claims management) Services participation...Complaints and Customer Services Participation...Disclosure Support System...Culture Survey Measurement, Feedback, and Interventions...Retrospective, Near-real-time, and Prospective Information Integration...”
- **Practice Element 4 Additional Specifications (Performance Improvement Programs: Senior Leadership and Governance Engagement)**—“...“Direct participation of governance board and senior, midlevel, and line managers in monitoring the progress of all patient safety programs should be documented. Tools such as summary reports, dashboards, or scorecards should be used to ensure that the most important messages are made as clear as possible and that information overload is minimized. Senior administrative leaders and governance should be involved in selection of such monitoring tools for the organization.”
- **Practice Element 4 Additional Specifications (Retrospective Identification—Patient Safety Indicators)**—“...“Patient safety indicators should be used to generate hypotheses and guide deeper investigation.”
- **Practice Element 3:** ...“Healthcare organizations must establish a proactive systematic organization-wide approach to developing team-based care through teamwork training, skill building, and team-led performance improvement interventions that reduce preventable harm to patients.”

- **Practice Element 1 (Accountability Structures and Systems—Patient Safety Programs)**—...“Leaders should create an environment where safety and quality issues are openly discussed. A just culture should be fostered in which frontline personnel feel comfortable disclosing errors...”
- **Practice Element 1 (Accountability Structures and Systems—Interdisciplinary Patient Safety Committee)**...“Leaders should establish and support an interdisciplinary patient safety improvement committee(s) or equivalent structure(s) that is(are) responsible for creating, implementing, and administering mechanisms to: oversee root cause analyses of every appropriate incident and provide feedback to frontline workers about lessons learned, disclose the organization’s.”

TIPS FOR SUCCESS

The following tips for success are suggested by IHI to those developing the role of their PSOs.¹³

- Make the position one of high rank in the organization, so the PSO will have the authority to act and remove barriers to change.
- Have regular meetings between the PSO and the chief executive officer.
- Provide educational opportunities to the PSO, so he or she can continually seek best practices.
- Ensure that the PSO has the resources and organizational support necessary to implement plans.
- Require the PSO to make regular presentations to the organization’s governing body.
- Choose a clinician who is held in high regard by peers regardless of “rank”—someone who “walks the walk” and not just “talks the talk.” Although traditional choices might be a physician or nurse, other health care providers such as pharmacists should be considered.
- Patient safety officers are important and key not only to the success of the Patient Safety program at any organization but also to the success of the organization as a whole. Patient safety officers do not need to be clinicians. The knowledge and skill sets go beyond clinical specialization. Patient safety is about culture, error analysis, and teaching.

In the words of Dr. Lee Adler of Adventist Health System (oral communication, December 9, 2006), “The Patient Safety Officer’s single most important responsibility is to take actionable steps to achieve integrated performance improvement through conducting situational assessment, developing objectives, selecting appropriate strategies and recommending required resources.”

CAREFUL SELECTION PROCESS

The fastest way to fail is to hire any warm body from within an organization or, even worse, to save money and assign PSO duties to someone who is either unqualified or not interested in the position. Both have been common practices and may fit financial constraints; however, organizations that do this will pay a far greater price as time goes on.

To transform itself and become a truly high performer, not only must the health care organization match candidates

to the design requirements of the PSO position, but they must also assure that the candidates have the personal values necessary to be a change agent in transformation.

If we are to achieve extraordinary performance, we must take the lessons from other industries such as airlines and hospitality who have successfully used values-grounded behavioral-based hiring methods that have assured that people recruited for key positions have the “right stuff.”

We must make sure that our professional leaders who work with the PSO are involved in interviews and hiring, that candidates have the people skills that are critical to the role, and that both seek to identify the best fit for the future.

A careful and systematic selection process with engagement of the leadership of an organization is a mission critical to success.

A LIFELINE TO PATIENTS AND A LIFE JACKET TO CEOS

Patient safety is a serious business. It is personal. It represents life-and-death consequences to patients and great risk to the careers of administrators and is vital to the sustainability of health care organizations. Survival will require transformation in the cultural DNA of most organizations—their values. Best practices may be enabled by products, services, and technologies; however, it is the soul of the people leading adoption of those practices that will drive success. We need to carefully and systematically design a role for our safety leaders that set them up for success. Hospital CEOs must be serious about the task of selecting who we ask to serve there and must constantly champion their mission. The sacred trust of our patients depends on it.

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