Why Patient Safety?

Medication errors harm an estimated 1.5 million Americans each year, resulting in more than $3.5 billion in additional medical costs.

About 1 in 25 US patients suffers at least one infection contracted during the course of their hospital care.

About 1 in 10 US patients experiences an adverse condition, such as a pressure ulcer or a fall, during hospitalization.

In the United States each year there are 611,100 deaths from heart disease, 574,800 cancer-related deaths, and 44,000 to 440,000 estimated deaths from preventable medical errors in hospitals.

According to the World Health Organization

1 in 1,000,000
The risk of being injured during air travel

1 in 300
The risk of being harmed while in a health care setting

Why NPSF?

The National Patient Safety Foundation’s mission is to advance patient safety and disseminate strategies to prevent harm.

Founded: 1997

States we reach: 49

Countries we reach: 9

Health professionals touched by our programs: 30,000+

Patient safety certifications awarded since 2012: 1,100+

Continuing education credits awarded 2014–2015: 1,500+

Full-time team members: 18

Sources:
Medical errors make headlines when a patient dies. Yet the truth is that we are all at risk of harm in health care settings, often resulting in the need for additional care or hospitalization, and sometimes causing lifelong consequences.

We say this not to promote fear or lay blame, but to elevate patient safety to its rightful place as a serious public health issue in which we all have a stake.

In the 19 years since the National Patient Safety Foundation was founded, we have learned a lot about what drives safety, and we’ve seen much progress. Yet we know that safety lapses resulting in preventable harm remain alarmingly common today.

Recent changes in health care have brought about a greater focus on value as consumers pay more for care and health insurers move increasingly toward offering financial incentives to providers based on their patients’ overall health and outcomes. We see this as both a challenge and an opportunity for patient safety. The challenge is in maintaining the focus on safety, so we can continue to make progress. The opportunity lies in extending our reach across all health settings to demonstrate how safer health care leads to better outcomes, happier patients, more meaningful work for health professionals, and more efficient use of health care resources.

Everyone will be a patient at some point in life. We hope you will review this report of our recent activities and achievements and reflect on how you, too, can be part of this effort.

Tejal K. Gandhi, MD, MPH, CPPS
President and Chief Executive Officer

Gregg S. Meyer, MD, MSc, CPPS
Chair, Board of Directors

February 2016
NPSF Milestones  1997–2015

1997  NPSF founded. Survey reveals 100,000 people touched by medical error

1998  First research grants announced

2001  First Patient Safety Congress organized under the NPSF name

2002  Patient Safety Awareness Week first organized

2007  Lucian Leape Institute founded

2008  Lucian Leape Institute Inaugural Forum Event

2009  Transforming Healthcare: A Safety Imperative published

2010  Unmet Needs: Teaching Physicians to Provide Safe Care published

2011  American Society of Professionals in Patient Safety founded

2012  Certification Board for Professionals in Patient Safety established, first CPPS credentials awarded

2013  Patient Safety Curriculum issued

2014  Order from Chaos: Accelerating Care Integration published

2015  Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care published

NPSF Vision

Creating a world where patients and those who care for them are free from harm.

Mission

NPSF partners with patients and families, the health care community, and key stakeholders to advance patient safety and health care workforce safety and disseminate strategies to prevent harm.

Goals

Foster collaboration among patients, families, and the health care community to identify and create strategies and disseminate tools to improve patient safety.

Engage the health care community through education, shared learning, and professional advancement to improve the safety of both patients and the health care workforce.

Partner with key stakeholders to identify and evaluate safety issues requiring best practices, solutions, or business innovation.

Guide health care leaders and policy makers to advance patient safety in the evolving market.
Leading the Way

NPSF has worked to move stakeholders toward a systems approach to patient safety, and away from project-by-project safety initiatives, which, while important, cannot move the needle in a substantial way. In 2015, NPSF convened an expert panel whose recommendations provide us with the blueprint for our continued work. Fifteen years after the Institute of Medicine first brought the issue of medical error into public focus with its report To Err Is Human, the panel, led by the NPSF team and co-chairs Donald M. Berwick, MD, MPP, and Kaveh G. Shojania, MD, have left us with the following charges:

1. Ensure that leaders establish and sustain a safety culture.
2. Create centralized and coordinated oversight of patient safety.
3. Create a common set of safety metrics that reflect meaningful outcomes.
4. Prioritize funding for research in patient safety and implementation science.
5. Address safety across the entire care continuum.
7. Partner with patients and families for the safest care.
8. Ensure that technology is safe and optimized to improve patient safety.
Patients As Experts

NPSF works in many ways to promote the importance of patients as partners with their health care teams.

Health care consumers have always been at the center of the NPSF mission, but never more so than in the past two years, when we have strongly emphasized patient and family engagement as a means to improve the safety of health care.

Patients have shared their unique stories with NPSF, both in testimonials of safety lapses and in accounts of empowerment. Some of the best stories we hear involve patients and family members who have become part of the solution.

Kim Blanton is one such patient. We invited Ms. Blanton to speak at our 2015 annual meeting, where she confessed to having once been a “bad patient.” She did what she was told, but was not fully engaged in her care.

Today, she serves as a patient advisor at her hospital. As part of this work, she contributed to the creation of a disease management program to help heart failure patients like herself learn to perform self-care activities after discharge from the hospital—and avoid readmission.

“We all have to make that personal commitment that we’re about safety, that we’re partnering to make it better,” she said.

Bringing patients like Kim Blanton together with health care professionals is one way we advocate for the patient’s voice at all levels of care.

Photo: David C. Aleman
More Than a Week

Since 2002, NPSF has led Patient Safety Awareness Week, an annual campaign to help educate the public and the health care community about patient safety. The recognition week was started by Ilene Corina, a patient advocate who has long been active on the governing boards of NPSF.

For the past two years, the week’s theme has highlighted the need for greater patient and family engagement in order to drive safety. Through our collaboration with like-minded organizations, we have offered tools for patients to use before, during, and after their medical encounters or hospital stay, as well as webcasts on topics demonstrating how patients and families are making a difference.

A big part of our work over the past two years has been to emphasize that patient engagement is needed throughout the health care system—in the exam room, in designing care processes, in the board room, and in the national research agenda.

1,400+ organizations participated in Patient Safety Awareness Week activities in 2015.

National Patient Safety Foundation’s more than 730 Stand Up for Patient Safety members participated at their own facilities and systems.

14,000 users visited our website during Patient Safety Awareness Week in 2015.

Amplifying the Patient’s Voice

- Patients play an important role on the NPSF Board of Directors and Board of Advisors, and as contributors to all of our programs and activities.

- Patients are involved in all of our grant-funded work, ensuring that their perspective is included in all reports, position statements, and educational programs.

- Our annual meeting features patients as faculty and includes content dedicated to patient and family engagement themes, such as shared decision making and communication and apology after medical error.
Promoting Shared Learning

NPSF has long partnered with health professionals and organizations to advance safety science. Our work brings education, information, and resources to health professionals on the front lines of care.

Over the past two years, a number of hospital associations designated as Hospital Engagement Networks (HENs) by the Centers for Medicare and Medicaid Services partnered with NPSF to bring patient safety education to 3,000 health professionals of diverse disciplines and experience.

“NPSF has really created a shared foundational knowledge in patient safety,” says Adam Kohlrus, MS, CPHQ, CPPS, director of performance improvement for the Illinois Hospital Association. “Our collaboration with them has allowed health professionals in Illinois to achieve a level of competency that they may not have had the opportunity to get on their own because they don’t have the funding in the hospital settings.”

The NPSF approach to engaging the health care community has two independent, yet interrelated components: education and competency. The first step is to provide those working in a health setting with a foundational understanding of what we mean when we talk about patient safety. The second step challenges health professionals to test their knowledge and experience through a rigorous, evidence-based certification exam.

One of the institutions that benefited from the NPSF-HEN collaboration was Edward Hospital in Naperville, Illinois. More than a dozen Edward staff—physicians, nurses, pharmacists, risk managers, and infection control professionals—completed a foundational online curriculum developed by NPSF and went on to achieve certification in patient safety.

Patti Ludwig-Beymer, PhD, RN, CPPS, vice president and chief nursing officer at Edward, points out that the benefit of this kind of professional development is not easily quantified, but evidence of its influence permeates the organizational culture. “One of the things that participating with NPSF did was raise our awareness throughout the organization of the need to focus on being a highly reliable organization. That has resulted in many positive things.”

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Patti Ludwig-Beymer, PhD, RN, CPPS
Vice President and Chief Nursing Officer
Edward Hospital

Photo: Edward-Elmhurst Health
In addition to participants in the NPSF-HEN collaboration, others are working toward certification on their own or through their institutions. At the close of 2015, there were more than 1,100 certified professionals in patient safety across the US and in nine other countries.

Our goal is to see at least one certified patient safety professional at every one of the nation’s 5,000 hospitals, as well as in every setting across the continuum of care and in the pharmaceutical and medical device industries that service the medical community.

**Over the past two years . . .**

- More than 7,000 health professionals have received training through the NPSF Online Patient Safety Curriculum, a 10-part educational program that provides foundational knowledge of patient safety science, human factors, and other key themes in patient safety.
- NPSF presented 44 experts and awarded nearly 600 hours of continuing education credit through the Professional Learning Series webcasts. In the 2014–2015 cycle, we addressed pressing safety topics such as opioid safety, medication reconciliation, technology hazards, and health literacy.
- Approximately 2,000 health professionals earned more than 800 hours of continuing education credit by attending the annual NPSF Patient Safety Congress. The cornerstone of the Foundation’s educational programming and now going into its 18th year, this annual international meeting brings together health professionals from many disciplines and settings to learn about the latest research and best practices.

As the only annual meeting dedicated solely to patient safety, the NPSF Congress serves as a vital point of interaction for professionals of diverse experiences and backgrounds.

In 2015, NPSF partnered with the DAISY Foundation for Extraordinary Nurses to create the NPSF DAISY Award for Extraordinary Nurses, a national award program recognizing nurses with a commitment to safe practice. The team award was given to the Emory University Hospital Serious Communicable Diseases Unit for their care of patients with Ebola virus disease.
Getting to the Root of the Problem

Getting to the root of patient safety problems requires hearing from everyone involved. We work with partners to identify and evaluate safety issues in order to develop best practices, solutions, or innovations.

Root cause analysis (RCA) is a retrospective way of examining an undesirable outcome that seeks to prevent a similar event from happening again by identifying and controlling for its root cause. At the heart of the process is a thorough, often time-consuming and costly, analysis of the systems underlying adverse medical events.

RCA was originally developed to better understand industrial accidents, but it is now employed across the health care continuum with regularity. In fact, health care accreditation agencies and many state licensing bodies require provider organizations to conduct an RCA after an unexpected event that results in death or serious injury.

The RCA challenge in health care has not been getting providers to adopt the tools and processes, but rather that they are not applied in a consistent, standardized way. NPSF took the lead in responding to the need for a standardized approach to carrying out RCAs.

In 2015, with a grant from The Doctors Company Foundation, NPSF brought together a team of experts to address this need. Over the course of an eight-month period, the team developed a process and toolset that providers are now using to ensure that their root cause analyses are undertaken in keeping with best practices and the most current thinking. >>

Finding Solutions

In 2014, NPSF received a grant from the Ullem Charitable Gift Fund to advance transparency in health care through early communication and resolution after a medical error or adverse event. NPSF worked alongside experts to develop a curriculum to help health care leaders and their teams successfully implement programs to communicate, apologize, and provide resolution to patients and families who are affected by error and harm.

Non-ventilator-associated pneumonia is a complication in hospitalized patients that may be under-reported. NPSF is overseeing a national, multi-site study funded by Sage Products that seeks to more extensively quantify the potential scope of the problem in all types of hospitals.
The comprehensive RCA\(^2\) (RCA “squared”) report received a strong set of endorsements from leading health care organizations, generated significant visibility for this essential activity, and attracted health care professionals in record numbers to the Foundation’s introductory webinar on the topic. More than 7,000 professionals were in attendance.

Ailish Wilkie, MS, CPHQ, CPHRM, is senior project manager at Atrius Healthcare, the largest primary care practice in eastern Massachusetts, serving more than 650,000 children and adults each year throughout 42 locations. Atrius Healthcare receives consistent high quality scores from the Massachusetts Health Quality Partners (MHQP). She had this to say about the NPSF report:

Many of us have been performing RCAs for a very long time and have tweaked the process in different areas based on our individual style. Reviewing the RCA\(^2\) document allowed us to re-evaluate the way we conduct RCAs, get back to basics, and ensure that we follow the correct process.

The most overlooked piece of this crucial investigation technique is the action plan. RCAs are only successful if the issues that caused the event are addressed. While we can all agree that it is important to identify why something happened, one can argue it is more important to put steps in place to prevent it from happening again.

Of the nine recommendations [in the RCA\(^2\) report], pre-RCA\(^2\) release we religiously performed half. After reading the document, we have begun to revitalize our RCA process to incorporate others. Specifically, we are beefing up the process by which we provide feedback to participants, including RCA\(^2\) action items and next steps.

The NPSF team is currently working with endorsing organizations to explore additional ways to disseminate this important work.
Providing Guidance Today for Tomorrow’s Health Care

At NPSF we recognize the importance of positioning patient safety work for future challenges and opportunities. Most recently, the NPSF Lucian Leape Institute has published three influential reports and has furthered the national conversation through op-eds, webcasts, and presentations at national meetings on the following topics:

Learning from Errors

In January 2015, the Lucian Leape Institute released *Shining a Light: Safer Health Care Through Transparency*, a report calling for greater transparency in health care and presenting broad recommendations for policy makers, leaders of health care organizations, and medical professionals. In short, our position is that only by sharing information about medical errors will we be able to learn from them and be able to prevent them from recurring. Transparency around safety and outcomes also allows all to learn from the top performers.

Advocating for Patient and Family Engagement

The patient is the only one who is present throughout his or her entire experience of care. In 2014, the NPSF Lucian Leape Institute published *Safety Is Personal: Partnering with Patients and Families for the Safest Care*, a report calling for greater consumer involvement at all levels of health care. A central argument of the report is that, “while patients and families can play a critical role in preventing medical errors and reducing harm, the responsibility for safe care lies primarily with the leaders of health care organizations and the clinicians and staff who deliver care.”

NPSF Lucian Leape Institute: Mapping Future Efforts in Patient Safety

Named for Dr. Lucian Leape, a world-renowned leader in patient safety, the NPSF Lucian Leape Institute works as a think tank to identify systemic problems within health care and to research best practices to help overcome them. Its members meet with leading thinkers on these topics to develop recommendations for policy makers, organizations, and health care professionals.

This work has led to productive collaborations with the U.S. Occupational Safety and Health Administration; the Association of American Medical Colleges; SEIU Healthcare; the Kaiser Permanente Institute for Health Policy; and other entities.
Standing Up for the Health Care Workforce

The family secret of the health care industry is that health care workers are at a greater risk of psychological and physical harm than workers in most other industries. Our position, presented in *Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care*, is that the safety of health professionals is a precondition to patient safety. In developing recommendations to improve this situation, the Institute members worked with representatives of the Service Employees Industrial Union, the U.S. Department of Labor, and health care and patient advocacy organizations.

“As part of the content development team for the U.S. Department of Health and Human Services Partnership for Patients Campaign, I recommended that we feature NPSF Lucian Leape Institute members in national events. The Institute’s reports have generated remarkable response and continue to resonate in subsequent discussions and planning activities tracked by the Campaign.”

Martin J. Hatlie, JD, CEO
Project Patient Care

“At MedStar Health, we have used numerous recommendations from the NPSF Lucian Leape Institute report on joy, meaning, and workforce safety across our 10 hospitals. Through the use of associate recognition programs and senior leadership participation in celebrations of safety ‘catches’ and top performing units, we have seen substantial improvements in workforce engagement and satisfaction scores across our system.”

David Mayer, MD, Vice President Quality & Safety
MedStar Health

“We are one among so many organizations that look to the NPSF Lucian Leape Institute for insights and leadership as we embark on the road forward in health care. They are not only premier thought leaders on patient safety, but even more importantly, they are a motivational voice for change. Their impact has been profound.”

Leah Binder, President & CEO
The Leapfrog Group
Help Us Advance the Work

You can help us advance the work necessary to achieve our goals and aggressively move toward the systems approach to patient safety that shows great promise for effectively improving safety in health care.

Ways in which you can offer your support include:

Supporting specific programs
- Patient Safety Research Grant
- Patient Safety Leadership Fellows
- Certified Professionals in Patient Safety (CPPS) Credentialing
- Leadership Chair on the NPSF Lucian Leape Institute
- NPSF Online Patient Safety Curriculum Next Edition
- Patient Safety Awareness Week
- NPSF Health Literacy Programs
- Professional Learning Series Webcasts
- NPSF Patient Safety Congress Educational Grant

Memorial donations honoring a cherished friend or relative

Scholarships for patients and patient advocates to attend the NPSF Congress

Operational support
- Funding of aggressive NPSF outreach to further impact the field
- Matching funds from your organization
- Estate planning / Planned giving

To support our work visit npsf.org/donations

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