Although many of the organizations reporting to ECRI Institute PSO are hospitals, the list of patient safety concerns, such as drug shortages, mislabeled specimens, and care coordination, also applies to non-hospital settings, such as physician practices and long-term care settings.

This article highlights three of ECRI Institute's 2014 Top 10: care coordination, test result reporting, and drug shortages.

Where to find the full list

The complete 2014 ECRI Institute Top 10 Patient Safety Concerns list, which ECRI Institute plans to update annually, is available for free download at https://www.ecri.org/Products/PatientSafetyQualityRiskManagement/Pages/Free-Reports-Advisories.aspx. It includes strategies for mitigating each of the ten concerns and is accompanied by a poster, PowerPoint presentation, and other tools.

Care coordination

Care coordination is a "shared responsibility" of all providers involved in a patient's care, says Lorraine Possanza, DPM, JD, MBE, patient safety, risk, and quality analyst at ECRI Institute. However, events reported to ECRI Institute PSO reveal gaps in communication—between hospitals and providers, among providers, and between long-term care settings and hospitals or other providers. For example, in one event, an

"Walk This Way": Impacting the Culture of Safety through Time and Example

By Missy Padoll

On June 13, 2014, more than 200 patient safety advocates from across the country gathered to participate in a day-long symposium that was focused on how culture can progressively impact patient safety in healthcare organizations. Sponsored by CRICO, the goal was to gain a better understanding of the ways by which culture can enhance or inhibit safety improvements, and how organizations can affect their own environment by learning to "Walk This Way."

In a unique opening segment, a skit comprising a series of acts depicted the evolution of smoking behavior in the hospital setting. Many of you may recall a time in the not so distant past when it was common practice for clinicians and patients to smoke on the wards, in the break room, and at nursing stations. This practice evolved—slowly, but surely—to remote smoking rooms at the end of the hallway, outside designated smoking areas, and finally, to present-day smoke-free campuses around the country.

Looking back, it's difficult to believe we ever smoked on the ward, drove our children around without car seats, or allowed them to ride their bicycles helmet-free. However, through years of research, education, and persistence, all of these safety risks have indeed been recognized and changes introduced, and people have adapted. This premise segued to a robust program that captured an array of perspectives and impactful lessons for creating a stronger safety culture, including:

Paul McTague, Esq.: Culture as a Contributing Factor to Legal Defense

- Three "Cs" for MDs: be Competent, Confident, and Caring—in court and in practice.
- Follow policies; it's difficult to defend a claim when they're not followed.
- Document, as needed, to provide for good medical care, not what you think will protect you in court.

Asaf Bitton, MD: Envisioning Your Future Work Environment

- If we want to make drastic changes, we need to take drastic steps.
- Imagine a patient-centered medical home that was designed for maximum teamwork and connected by robust IT systems.
- Establish the goal of your culture through seven habits: co-location, huddles, warm handoffs, weekly meetings, staffing that matches the culture, work force development, and committed leadership.

Tracy Granzyk: What's Your Story? The Power of Narrative

- Storytelling can change attitudes and beliefs, because it breaks down cognitive resistance.
- Data helps us focus on "what" to fix; storytelling gives us the emotional connection to "why" it matters.
- Honor patient and caregiver stories through actions respectful of their lesson.

Jerry Hickson, MD: How to Recognize and Remove Obstacles

- Establish an infrastructure that promotes reliability and professional accountability.
- Fix your faulty systems and promote professional behavior to set the right balance.
- Respond to every incident of unprofessional behavior with a consistent constructive response.

At lunch, attendees were asked to envision evolved cultural events five to ten years from now that may be as difficult to believe as the "smoking story." The day wrapped up with a summary of the myriad submissions on the general topic: *It's hard to believe there was a time when…*

- We did not always wash our hands before seeing a patient.
- We did not do formal timeouts for every surgery.
- We were afraid to report adverse events.
- We did not have efficient systems for tracking/follow-up on abnormal test results.
- We did not consider patients part of their own care team.

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For related information, see www.rmf.harvard.edu.