



DUKE UNIVERSITY MEDICAL CENTER
DEPARTMENT OF MEDICINE
Duke Infection Control Outreach Network (DICON)

September 15, 2005

DICON Hospital

Dear CEO

Enclosed with this letter is a report summarizing the DICON Patient Safety Program during the period February 6, 2004 through August 24, 2005. We aggregated data from all hospitals participating in the Safety Program in this report in order to provide an assessment of the magnitude and scope of the safety problems we encountered. In addition, we are providing you with comparative hospital-specific data in order to give you some idea of the status of your program vis-a-vis other safety programs. In this report DICON Hospital is coded as "hospital A." Finally, we have attached several documents to this report including: 1) a log of all the incident reports of all the safety concerns identified during the past 18 months; 2) a summary of notable successes of your and other programs.

We believe that your safety program has made substantial progress. As we gain more experience and achieve further successes using information from future patient safety rounds we are confident that your program will become even better. Further, by continuing patient safety rounds, your institution will simultaneously demonstrate that safety and the promotion of a "blame-free culture" are priorities. The following next steps may further improve your safety program and we ask that you consider their implementation:

1. We propose that all unresolved safety issues be reviewed quarterly by a committee at your hospital. A list of unresolved safety issues can be generated at any point using the database we installed in your hospital. A summary of this review should then be forwarded to the CEO and/or head of Risk Management. Such involvement of senior leadership in the safety process sends an important message to doctors, nurses and all support staff.
2. Safety issues with a score of 10 or greater should be given top priority for resolution. A summary of the nature of the issue and a proposed plan for resolution for these should be shared with the CEO of the hospital and the head of Risk Management within 30 days of identification of such high-priority problems. Once again involvement of senior leadership in such matters can motivate and stimulate all involved.



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3. Each hospital should continue monthly or bimonthly rounds and provide support personnel to enter data into the DICON Safety Database. Data entry (which in the past has been postponed or deferred in some participating hospitals) should be done immediately so that worksheets for follow-up of unresolved issues can be generated and so that communication can flow in the manner described above.
4. Feedback to hospital personnel should occur when problems identified during patient safety rounds are resolved. Such feedback is highly effective in promoting a culture of safety in your institution.
5. We propose that all members of the safety teams in hospitals participating in the DICON safety program meet for a half-day session to share experiences, successes, and discuss common problems. We would like this meeting to occur at least annually and we are willing to organize and sponsor this endeavor.

We look forward to your continued participation in DICON Safety Program. Now that a safety database has been established, the potential utility of sharing data will increase progressively as will our understanding of the nature of the patient safety issues in your and other participating hospitals.

Sincerely yours,

Daniel J. Sexton, MD
Professor of Medicine
Director, DICON

Connie Clark RN
Infection Control Practitioner
DICON

CC: VP Patient Safety

Enclosures