MISSION: A safe environment for all patients & healthcare providers, in all processes, all the time.
Message from the Executive Director

Patient safety is a continuing focus for healthcare providers, payers, policy makers and the public. At the Center for Patient Safety, we are excited to continue being part of a solution for healthcare providers and consumers to work together and better understand how to address the multitude of issues surrounding patient safety.

Illustrating the need for ongoing efforts to improve patient safety and reduce patient harm, the Journal of Patient Safety’s September 2013 article estimates that avoidable deaths from errors in hospitals is as high as 400,000; higher than original estimate of 98,000 from the Institute of Medicine in 1999. Other studies confirm errors occurring in healthcare settings: physician offices, ambulatory settings, home care and long-term care. Many are preventable.

Last year was an exciting one for us at the Center, as we expanded on our work with health systems, hospitals, physician offices, ambulance services and long-term care. We also built on our work assessing and improving the safety culture—enhancing the learning and sharing among providers and with the public; a necessity to prevent medical errors.

Our work is leading us to learn more about common and uncommon errors, why they occur and how we can prevent them. Regardless of the medical error, the most common causes relate to the safety culture, teamwork and communication; areas that are a primary focus of our work.

At the Center we are proud of the array of focused services we provide for healthcare providers and consumers, including safety culture assessment and federally-designated Patient Safety Organization services; education and training; clinical collaboratives and our presence on the Web and social media through Twitter, LinkedIn and Facebook.

With a continued focus on collaboration across healthcare providers, including the important role of healthcare consumers, we can and must continue to work toward reducing patient harm in any healthcare setting.

Looking ahead, we continue to grow and enhance our services to be a catalyst in the reduction of patient harm. I invite you to join us in these efforts, through participation in our education, training, as a PSO participant, and engaging with us on social media.

In particular, please join us as we maintain our focus on safe care 24/7/365, the theme of our patient safety awareness week recognition in March and join us at our 8th Annual Conference, Safe Care: Our Focus 24/7/365, March 21 in St. Louis.

Becky Miller, MHA, FACHE, CPHQ, CPPS
Executive Director
From a physician’s perspective, organizations such as the Center for Patient Safety, including the role of a federally-designated Patient Safety Organization (PSO), are playing a key role in healthcare and can play an even greater role in the future.

I am proud to serve as the Center’s Medical Director supporting the Center’s work with health systems, hospitals, ambulance services, physician practices and nursing homes as well as its outreach to consumers.

As the healthcare landscape continues to change under the federal Affordable Care Act, implementation of Health Insurance Exchanges and the explosion of Accountable Care Organizations, the need for healthcare providers to work together across various settings is increasing exponentially. This work must focus on the assessment, evaluation and improvement of the quality and safety of healthcare delivery regardless of where that care is delivered. This is where organizations like the Center come into play!

Healthcare providers in any setting, stakeholder groups such as legislators, regulators, insurers and, the public should be impressed by the work being done by organizations like the Center.

Such work is imperative to move healthcare forward through collaboration that includes improving systems designed to reduce medical errors and patient harm—harm that occurs more often than it should.

I am pleased to be part of the Center and encourage others to join our efforts in remaining steadfast to our commitment of the vision: “a healthcare environment safe for all patients and healthcare providers, in all processes, all the time.”

Michael Handler, MD
Medical Director, Center for Patient Safety
psd services
Center Selects New Vendor for PSO Platform

On June 1, the Center enhanced our PSO data platform by collaborating with a new PSO platform vendor, VergeSolutions. Our data platform, the ShareSuite, will facilitate data submission, reporting and communication with all of PSO participants. The Center is pleased to work with VergeSolutions, a company sharing our vision and mission for PSO services. Together, we support our PSO participants through ShareSuite, a user-friendly, secure, online, collaborative tool.

Health Reform and PSOs

On December 2 the Centers for Medicare & Medicaid Services (CMS) published long-awaited rules pertaining to Section 1311 of the Affordable Care Act (ACA). This provision requires hospitals with more than 50 beds to participate with a PSO in order to be eligible to participate with health plans that are part of the Health Insurance Exchanges (HIEs).

The draft rules called for a two-year delay in the PSO requirement. Many PSOs, including the Center, provided comments to CMS on the rule noting the need for safety improvement efforts to be enhanced and the ability of PSOs to accommodate additional participants in order to comply with the rule.

Health Information Technology (HIT) and PSOs

The federal Office of the National Coordinator for HIT continues to be interested in the work of Patient Safety Organizations in assessing and improving the quality and safety of care using HIT, as well as identifying HIT risks to safe care. The ONC’s final Patient Safety Action & Surveillance Plan, released in July, calls for consistent, streamlined reporting of HIT events and hazards through PSOs using the AHRQ developed Common Data Formats and certification for EHR technology.

For More Information

For more information on PSO reporting and learning from the reports, see the Center’s Annual PSO Report Supplement.

If your organization desires to reduce medical error and patient harm; learn more about what errors occur, why they occur and how to prevent them; and network with others on sensitive patient safety topics, contact the Center for information at info@mocps.org about PSO participation.
PSO Day Annual Participant Meeting

Again in 2013, the Center for Patient Safety’s annual PSO Day was a success! The annual event for organizations contracted with the Center for PSO services included PSO contacts, senior leaders and attorneys representing the Center’s 140 hospital and ASC PSO participants.

The day included hands-on learning and sharing of adverse events, safety issues and the benefits and challenges associated with PSO participation.

Highlights of PSO Day included:

- Michael R Callahan, JD, Partner at Katten Muchin Rosenman, LLP, providing insight into the legal benefits and challenges associated with PSO protections as well as recent litigation upholding the PSO confidentiality protections.
- Mike Personett, MA, MPA, Executive VP of Healthcare Solutions at Verge Solutions, describing measurement methods enabling safety officers to gain perspective on event reporting, their organization’s pace of change and key measures to improve the effectiveness of their safety program.
- The Center’s PSO team provided an update on PSO data, findings of analysis and key learnings as well as introduction of an updated PSO toolkit and primary contact handbook to guide participants through gaining the most of their PSO participation.
- Safe Tables discussions on high priority safety topics of medication shortages impacting safe care, health information technology related errors and suicide prevention; each topic allowing participants to share experiences, discuss literature and best practices and learn from each other, learning they can take back to their own work place.

What PSO Day Participants said:

“I really enjoy the Safe Tables. They are a great opportunity to discover solutions to problems that we all face.”

– Keith Griffeth, Hannibal Regional Hospital

“I thought PSO Day was all excellent. I want to delve deeper into the logistics of event reporting and how to set up our PSES and PSWP.”

– Vereline Johnson, Saint Francis Medical Center

CALL TO ACTION PSO participants are invited to join the Center for a series of Webinars on key Center PSO topics and regional meetings, including Safe Tables in August 2014.

Center PSO services are available at a reasonable fee for service and provided to Missouri Hospital Association member hospitals through funding provided to the Center by MHA.
PSO: Hospital & ASC

Hospital PSO participants have reported more than 15,000 events to the Center, including incidents, near misses and unsafe conditions—all important in evaluating how to improve the safety of care.

Of these events the most common are falls, medication events and surgery-related events. Other types reported include:

- healthcare acquired infections
- venous thromboembolism
- pressure ulcers
- perinatal events
- device-related events
- blood and blood product related events.

The most commonly cited causes for these events are communication issues among healthcare providers; competence of individual providers; accuracy issues; clarity of policies and managerial supervision issues.

The good news is the majority of events indicated no harm came to patients. Still, some harm was indicated in more than 36 percent of events reported, including severe harm or death to more than 100 patients.

**CALL TO ACTION** For more information on PSO reporting and case studies from the reports, see the Center’s Annual PSO Report Supplement.

**CALL TO ACTION** Contact the Center at info@mocps.org for information about PSO participation if your organization wants to:

- reduce medical error and patient harm
- learn more about what errors occur, why they occur and how to prevent them in a protected environment
- network with others on sensitive patient safety topics.
PSO: EMS

As the first in the nation to establish common data formats for EMS and integrating safety culture into PSO services for Emergency Medical Services (EMS), 2013 was a tremendous year of growth in the Center’s EMS PSO service. The Center is now contracted with more than 100 ambulance services which are committed to improving the safety of care delivered in the pre-hospital setting.

In addition to PSO participation, Just Culture in EMS is gaining traction with the lead of the Center and the Missouri Ambulance Association. And, active reporting of events into the Center’s EMS PSO data base has continued to grow and expand.

The Center’s contracted agencies have reported more than 80 events, including issues surrounding:
- airway management
- device use
- medication use
- ambulance crashes
- the timeliness of stroke and heart attack care

In collaboration with the EMS community, the Center continues to enhance data definitions to ensure meaningful and useful reporting of events. We believe this important data will lead to learning about how to improve the safety of care delivered by air and ground ambulance services.

CALL TO ACTION Find more information about EMS PSO Services online and see the Center’s Annual PSO Supplement ➤
PSO: Long-Term Care

The Center for Patient Safety took its first steps toward becoming a national provider of resident safety services for long-term care providers in 2013. With the support of a grant from the Missouri Foundation for Health, the Center expanded its safety culture survey services and PSO services to Missouri nursing homes.

These services are designed to help nursing homes enhance their safety programs, learn about the safety culture through assessments and Just Culture training and provide a confidential way to evaluate the safety of care in their homes. In addition, our services help long-term care providers gain an advantage in complying with new federal requirements for Quality Assurance and Performance Improvement (QAPI) programs. In Missouri, the Center is collaborating with Primaris, supporting its QAPI Learning and Action Network and with the Department of Health and Senior Services to collaborate with long-term care providers.

All of these services are available at no charge to Missouri licensed long-term care providers, courtesy of a grant from the Missouri Foundation for Health.

CALL TO ACTION Contact the Center at info@mocps.org to learn how to obtain the Center’s culture assessment, training and PSO services to assist in QAPI implementation and safety improvement. Find more information about LTC safety services online ►

Center PSO services are available at a reasonable fee for service and provided to Missouri Long-term Care facilities free of charge through funding provided to the Center by the Missouri Foundation for Health.
Patient Safety Culture Survey

The importance of a culture for safe care is growing, as evidenced by the growth in the Center’s survey administration services since 2011. Because the Center focuses solely on patient safety, including Just Culture and CUSP training, the survey is a clear connection between the services provided by the Center to positively impact the safety and the quality of healthcare organizations across the country and support a culture that encourages reporting of adverse events.

Survey services include:

• hospital, medical office, long-term care, pharmacy, and home care surveys
• online resources: survey guidance, tips, standard and customizable marketing templates (emails, posters, and flyers), etc.
• online survey with optional paper survey collection
• survey guide with helpful tips and additional resources
• one-on-one support — we want you to be successful!
• extensive report: our standard report surpasses every other standard report available. Reports include dashboards, graphics, prioritized questions and dimensions as well as next steps.

Each year, we see the number of participating organizations grow. In 2013, the Center administered the survey to more than 60 hospitals and provided department level response rate reports to thousands of hospital units.

From 2012 to 2013, organizations participating with the Center that are actively involved in patient safety efforts and implemented changes by using their baseline survey results saw positive changes. These changes related to improvements in teamwork, communication and implementation of a “just” culture. Improvements are:

• Scores on 34 of 42 questions on the survey showed improvement
• Scores on 11 of 12 dimensions surveyed showed improvement
• Eighteen questions answered by Center survey respondents were, on average, higher than the national average, compared to only seven questions at baseline

The greatest improvement was noted in the survey dimension “Nonpunitive Response to Error”. The greatest improvement was noted in response to the question “Staff feel like their mistakes are held against them”

CALL TO ACTION Contact the Center at info@mocps.org to schedule your next survey and let us help you identify and prioritize safety culture improvement needs and improve patient safety. Learn more about the Center’s survey services online ▶.
2013 Patient Safety Awareness Month & Annual Conference

In March 2013, the theme of the Center’s 7th Annual Conference was “Safe Care is Our Focus: 24/7/365,” recognizing that patient safety is always a priority. Also, in an effort to spread that message to providers and their patients, the Center sponsored March as Patient Safety Awareness Month.

The Center made a Patient Safety Awareness Month Toolkit available to individuals and organizations to help promote their patient safety efforts. This resource included posters, table tents, stickers, and tips to highlight and celebrate patient safety efforts throughout the month.

“During the month we emphasized that safety is the highest priority, all the time for patients and healthcare providers, from the moment an individual seeks and receives healthcare in any setting,” said Becky Miller, CPS Executive Director.

Additionally, more than 600 people participated in a series of five live, web sessions spanning the month of March. These sessions allowed the Center to share the expertise of national faculty with a broad audience. Organizations hosted group sessions locally so front line staff and teams could benefit together. National faculty included:

- Christopher Jerry, who shared his personal story about a tragic, preventable medication error that resulted in the loss of his daughter and led to incarceration of the pharmacist involved in the mistake. The session focused on how this tragedy has led to collaboration between families and professionals impacted by medical errors to improve medication safety.
- Sue Scott, RN, MSN, and Laura Hirschinger RN, MSN, from the University of Missouri Healthcare, presented the success and impact of their Second Victim Program, focusing on the importance of leadership in supporting such programs and clinicians who are impacted by unexpected clinical events.
- Jim Conway, MS, shared his insights and experience on the important role of governance, management, and front-line staff in making safe care a priority through all aspects of healthcare organizations.
- Becky Miller, MHA, CPHQ, FACHE, CPPS, provided an update on the Center’s activities and presented the Missouri Excellence in Safe Care Award winners who provided highlights of their successful safety projects. (See Missouri Excellence in Safe Care Award)


CALL TO ACTION Download the Center’s free Patient Safety Awareness Week Toolkit to help you acknowledge your organization’s focus on patient safety every minute of every day.
education & sharing
CLINICAL COLLABORATIVE: On the CUSP/Stop CAUTI

The year 2013 led to the wrap-up of the Center’s work for the On the CUSP/Stop CAUTI national project, Cohort 4, after 18 months of work. Twenty-four Missouri hospitals and 35 units within those hospitals participated in the project to improve bedside teamwork and communication and implementation of best practices to prevent catheter-associated urinary tract infections. Results of this project led to a 30 percent reduction in CAUTI over the period of the project.

The Center acknowledges the support of the Missouri Hospital Association and funding for this project from the AHA’s Hospital Research and Education Trust.

CLINICAL COLLABORATIVE: Hospital Engagement Network

The Center also completed a project under contract with the Missouri Hospital Association for the national Hospital Engagement Network. The goal was to reduce healthcare acquired conditions by 40 percent and reduce readmissions by 20 percent.

For this project, the Center led five of the ten clinical focus areas of the project:

1. Central Line Associated Blood Stream Infections (CLABSI)
2. Catheter Associated Urinary Tract Infections (CAUTI)
3. Falls/Injuries from Falls
4. Surgical Site Infections (SSI)
5. Ventilator Associated Events (VAE)

The Center also supported the HEN project through administration of the Hospital Survey on Patient Safety Culture (HSOPSC) to 32 hospitals and providing expert faculty for training on the Comprehensive Unit-based Safety Program (CUSP).

An additional goal of the Missouri HEN activity was to increase participation in the Center’s PSO by 25 percent. We are proud the goal was exceeded. There was a 33 percent increase in hospitals actively reporting to the PSO and a 230 percent increase in events reported to the PSO. This reporting will lead to additional learning about how to reduce healthcare acquired conditions.

CUSP Training Nationwide

During 2013, the Center served as faculty for Tenet Healthcare providing a 6-month series on the Comprehensive Unit-based Safety Program (CUSP).
National Webinar Series - PSO? PSES? PSWP? You Have Questions, We Have Answers

In partnership with VergeSolutions, the Center served as faculty for three nationwide educational webinars in the fall of 2013. The Center shared its expertise in PSO operations and value, developing a patient safety evaluation system, defining patient safety work product and defining workforce as well as a legal overview of successful challenges to the PSO protections.

The final session of the series featured Dr. William Munier, Agency for Healthcare Research and Quality, who presented a national perspective on the importance of PSOs. More than two hundred professionals from California to New York and 27 states in between benefited from the Center’s experience through this Webinar series.

National Webinar Series on EMS PSO Activities

In 2013, the Center also provided expert faculty for a three-part webinar series for the American Ambulance Association. The series focused on understanding what a culture of safety and participation in a PSO means to quality and safety improvements in EMS. This included an overview of actual data being reported from EMS agencies to the CPS PSO, as well as testimonies from those who have begun implementing a culture of safety and are participating in regional quality committees which share information about safety concerns in the pre-hospital setting.

Patient Safety Boot Camp

The Center began providing expert faculty for a five-part Patient Safety Boot Camp for the Illinois Critical Access Hospital Network on the following topics:

- A National Patient Safety Perspective
- Building a Business Case for Patient Safety
- Creating a Patient Safety Culture
- TeamSTEPPS™ Overview
- Impact of Health Information Technology on Patient Safety
- Completing a Credible Root Cause Analyses
- Disclosure and Communication
- Establishing Safety Priorities and Measurements
- Human Factors, High Reliability and System Design
- Second Victim Train-the-Trainer

CALL TO ACTION Let us know how we can help you or your organization by offering our expertise. Check out the Center Speaker’s Bureau for opportunities and expertise.
Missouri Excellence in Safe Care Award

We are proud to recognize the following recipients of the 2013 Excellence in Safe Care Award, which honors successful patient safety practices. The 2013 winners join ten other organizations receiving the Award in previous years:

Ozarks Medical Center, West Plains, Missouri – Comprehensive Unit-based Safety Program (CUSP) – Stop CAUTI

The project provided evidence of involvement of frontline staff as critical to patient care with the highest awareness of patient needs, improving the culture for safety and significantly impacting elimination of catheter-associated urinary tract infections (CAUTI) on one unit.

Truman Medical Center, Kansas City, Missouri – Reduced Use of Behavioral Restraints

The project significantly reduced the use of behavioral restraints through implementing staff and patient debriefings and alternative interventions for patients, thereby reducing the potential for physical or psychological harm, loss of dignity, violation of rights, and even death. The success has proven to be sustainable.

CALL TO ACTION Want to see these project presentations and more virtual posters? Visit our Sharing the Learnings page!

EMS Patient Safety Conference

The Center hosted its 4th Annual EMS Patient Safety Conference in May, attended by more than 80 EMS personnel. Conference day highlights included:

• Ivan Pupulidy, Human Performance Specialist, discussed the hidden errors in EMS and how to make quality and safety improvement part of everyday work life.
• Paul LeSage, Outcome Engenuity, shared best practices in performing event investigations specific to EMS.
• Scott Hadley, Sedgwick County EMS, provided information about the National EMS Culture of Safety Project.
• Paul Misasi, Sedgwick County EMS, shared the success of the agency’s medication safety project.
• A panel of PSO participants shared their stories about PSO implementation and the benefits and advantages of PSO participation. The panelists highlighted newly launched collaborative efforts to discuss regional EMS quality issues among EMS and hospitals.

CALL TO ACTION EMS PSO participants are invited to join the Center on November 12, 2014 for the 5th Annual EMS Patient Safety Conference. EMS organizations interested in working with the Center and other agencies to improve the safety of pre-hospital care should contact the Center at info@mocps.org.
coming in 2014
Efforts in 2014 Include:

- Growth and enhancement of PSO Services for hospitals, ambulance services and long-term care
- Launch of culture assessment and culture training for nursing homes
- Expansion of PSO services for physician practices to participate in a PSO, including publication of a white paper on PSOs and Accountable Care Organizations to highlight the need for quality and safety evaluation within ACOs and opportunities PSOs provide to support these efforts
- Growth and enhancement of safety culture services
- Culture, communication and teamwork training (Just Culture, Comprehensive Unit-based Safety Program)
- Growth of safety culture assessment services: Enhanced AHRQ Survey on Patient Safety Culture (SOPS) administration and reporting
- Expansion of work to reduce catheter-related urinary tract infections with a focus on including Emergency Departments along with hospital units in the project
- Expansion and sustainability of the Hospital Engagement Network activities under contract with the Missouri Hospital Association, continuing work to reduce healthcare acquired infections (CLABSI, CAUTI, SSI and VAE) and new work focusing on reducing CDiff and Sepsis, as well as culture assessment and training and a patient safety bootcamp for rural hospital
- Looking forward to a successful Patient Safety Awareness Week and the 8th Annual Conference on March 21st

**CALL TO ACTION** Join the Center’s efforts in 2014 to improve the safety of healthcare delivery and reduce patient harm.
thank you to our supporters
Thank you to our Center supporters

Over the past eight years, participation in the Center’s initiatives has spread throughout the country. We thank all organizations and individuals that have and are actively involved in our important work to improve the safety of healthcare delivery.

FOUNDING MEMBERS
Missouri Hospital Association
Missouri State Medical Association
Primaris

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EMS PSO Advisory Committee
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Sisters of Mercy Healthcare System
Swarens, C.C.
University of Missouri Healthcare
VergeSolutions
Warren, Jeanette
Thank you to our Board of Directors

In 2013, the Center welcomed Stephen R. Smith, MD to the Board of Directors as a representative from the Missouri State Medical Association. Dr. Smith is a practicing anesthesiologist in the St. Louis area and a past commissioner on the Missouri Commission for Patient Safety.

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Thank you to our dedicated staff...

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Patient Safety Specialist

KATHY WIRE  
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MARILYN KEILHOLZ  
Executive Assistant

CALL TO ACTION Join the Center’s learning and sharing efforts to reduce medical error and patient harm through education, training, recognition of your safety work, safety culture assessment and training, and PSO participation.

CALL TO ACTION Interested in learning more about the Center? Visit our website regularly to stay current with activities, find resources, toolkits, and much more! 

We congratulated Center staff who became Certified as Professionals in Patient Safety: Carol Hafley, Asst Director and Becky Miller, Exec Director!
HOW YOU CAN HELP! Become a safety sponsor

The Center for Patient Safety values partnerships with organizations and individuals who want to support improvement in healthcare quality and patient safety. Because the Center is a not-for-profit organization, donations are tax-deductible.

There are three ways to join the effort to spread safety improvement throughout the healthcare community:

- individual donations
- organizational sponsorship levels
- sponsorships of events and initiatives

Opportunities include:

- Education and training activities
- Patient Safety Awareness Month activities and events
- Clinical collaboration
- Surveys, analysis, and reports
- Adverse event reporting system
- Research and analysis
- Publications and reports

The Center makes the process easy; you can donate online in minutes. And, of course, any of the Center staff can answer your questions and provide more information.

CALL TO ACTION Learn more about Center sponsors, sponsorships and donation. Visit our sponsor information page to learn how to become a Safety Sponsor or contact us directly to get involved.

Social Media Presence

The Center’s website continues to engage consumers, participating organizations and others interested in healthcare safety, welcoming an additional 5,000 new visitors in 2013.

The CPS Safety Snapshot is a summary of the latest hot topics and valuable resources, delivered directly to inboxes across the country on a biweekly basis. Our distribution increased to 3,573 in 2013.

The Center’s presence on Facebook, LinkedIn and Twitter gained ground in 2013 by welcoming an additional 21,321, and 295 followers. [51, 240 and 265 followers respectively in 2012]

CALL TO ACTION Join Us, Follow Us, Find Us today on Linkedin, Twitter, or Facebook, or subscribe to receive biweekly email updates on the latest patient safety trends and notices.
ABOUT THE CENTER FOR PATIENT SAFETY

The Center for Patient Safety was founded by the Missouri Hospital Association, Missouri State Medical Association and Primaris as a private, non-profit corporation to serve as a leader to fulfill its vision of a healthcare environment safe for all patients and healthcare providers, in all processes, all the time.