Center for Patient Safety
Delivering PSO Solutions

EMSPSONEWS

A publication for Emergency Medical Services (EMS)

SUMMER 2015 EDITION

Have you noticed this icon?
Look for this icon to find additional resources in the articles. You'll find links to downloadable templates, websites and other resources.
Available in the electronic version of this newsletter.

IN THIS EDITION

CPS SHARES SUCCESSES
AT ANNUAL AHRQ PSO MEETING

ROCKVILLE, MD The Center for Patient Safety (CPS) Executive Director, Becky Miller, and staff, Alex Christgen and Lee Varner, joined other PSO representatives from around the country at the Agency for Healthcare Research and Quality (AHRQ) Headquarters in Rockville, Maryland for the7th Annual AHRQ PSO Meeting.

As one of 85 PSOs certified nationally, operating within 30 states and District of Columbia, CPS continues to be a leader in PSO activity.

CPS is:

- 1 of nine PSOs with more than 250 PSO contracts
- 1 of only 44 PSOs receiving reports
- 1 of 16 PSOs with more than 10,000 reports
- 1 of 38 PSOs providing services to all specialties
- 1 of 2 PSOs providing services to EMS services
- 1 of 13 PSOs receiving reports in all AHRQ defined safety categories

HIGHLIGHTS OF THE MEETING:

- AHRQ and CMS representatives stated the regulations for Section 1311(h) of the Affordable Care Act are in the process of being written for an **effective date of January 1, 2017**. The Section requires hospitals with more than 50 beds to participate in a PSO in order to be eligible to participate in Health Insurance Exchanges.
- AHRQ Director, Dr. Richard Kronick, noted that the AHRQ and CMS have "reached an agreement in principle" regarding coordination of PSO activity and protections and needs of CMS state surveyors to ensure regulatory compliance. Additional information should be available to surveyors, providers and PSOs in the near future.
- A mock trial highlighted recent challenges to the PSO protections, raising points from both the plaintiff and defendant perspectives. Presenters cautioned that PSO participants need to have well-defined policies and report to their PSO in order to successfully claim the federal protections of the Patient Safety and Quality Improvement Act of 2005 in court. If you need help updating your PSO policy, contact Eunice Halverson.
- CPS presented on a panel with the Michigan Keystone Center PSO and the Maryland Hospital Association PSO highlighting best practices to perform Safe Tables, the challenges and successes, and how each organization performs its Safe Tables.
- The AHRQ has provided, and will continue to develop, resources to help providers better understand PSOs and select a PSO on its Web site at www.pso.ahrq.gov.

PATIENT SAFETY INSIDER

Did you miss any of these hot resources and articles the first time around? Here's another chance to check them out...

The Center for Patient Safety provides EMS PSO services to hundreds of air and ground EMS locations in 19 states across the U.S.

PSOs in the news

We have seen significant interest in PSOs over the past year as more EMS leaders learn the benefits and opportunities for PSO participants. One EMS leader who has taken interest in PSO's is Allison J. Bloom, Esq. Ms. Bloom is well known as a recognized attorney, writer, and board member of the NEMSMA. Ms. Bloom shares broad experience in EMS as well as high degree of passion and interest in Mobile Integrated Health Care. This interest has led to several articles that have been published in *EMS Insider*. Watch for more articles as EMS patient safety and quality continues to become an important topic.

If you missed Ms. Bloom's articles you can find them on the Center's website. Watch for future articles and papers as we all take greater interest in PSO's to provide safe care and reduce patient harm. We are excited to have Attorney Bloom as one of our speakers at the Center's EMS Patient Safety Conference on October 30.

SAFETY watches&alerts

One of the benefits of participating with a PSO is the shared learning and opportunity to be proactive and improve patient safety. The Center issued several Watches and Alerts last year. Remember this information is for your benefit, as it offers insight to areas of risk as well as concern. You can read more including the most current Watch issued this spring about airway management.

GATHERING of Eagles and Dr. Jay Reich

The EMS State of the Sciences Conference, also known as "The Gathering of Eagles" is a unique conference featuring rapid fire presentations and networking with some of the most highly respected leaders in EMS. Each year the conference offers opportunities to learn the latest science and advances in EMS, including current research, data and industry innovations. Those selected to present at the conference are medical directors from the largest EMS systems in the United States. In addition, it features other leading experts from around the world who present relative information to advance the practice of EMS.

This year Dr. Jay Reich, medical director from the Kansas City Fire Department (KCFD), was selected to present on work being done at his department. Reich's presentation titled "PSOs as SOPs! Getting Patient Safety Organization Buy-In for EMS CQI" shared how participating with a Patient Safety Organization (PSO) can protect the quality and safety work in EMS, as well as support the EMS staff including the medical director. Since PSOs are fairly new to EMS, Reich outlined some of the benefits of PSO participation, such as information and key examples of how KCFD is implementing processes to improve patient safety and quality improvement. His presentation focused on the ways a PSO supports the EMS staff to become proactive in preventing adverse events and unsafe conditions instead of just being reactive.

Dr. Reich explained the Patient Safety Quality Improvement Act and the importance of shared learning through reporting adverse events, near misses and unsafe conditions. The Center for Patient Safety thanks Dr. Reich for his support of our PSO, as well as choosing to present information about PSOs. We hope to see more topics about EMS quality and patient safety at the Eagles Conference in the future. Dr. Reich's presentation can be found at the Gathering of Eagles website under 2015 presentations.

EMS data committee

Data never sleeps and neither does our committee! They are working hard to focus efforts around improving and gathering additional data. One special project led by Jason Shearer is the committee's effort to learn more about behavioral health and EMS. Part of this work includes on-scene emergency interactions as well as inter-facility transfers.

The Center was approached by EMS leaders and other stakeholders who would like to learn how this patient population impacts EMS, how resources are utilized as well as to identify safety concerns. The PSO offers a confidential space where data can be submitted, de-identified, aggregated and protected under the PSQIA. "The obvious place to do this work is with the PSO" remarked Jason White, who has been working with leaders around the state to heighten awareness. The collection of data relative to this patient population is starting as a pilot program and then will be expanded to other PSO participants. Jason went on to say "Our EMS professionals will see another way the PSO supports them". If you would like to learn more, contact Lee Varner.

SPONSORS and vendors

Now is the time to reserve your place for the EMS Patient Conference on October 30. Reserve early and you will gain more exposure on the Center's website.

PATIENT safety conference

Don't forget to mark your calendars for the EMS Patient Safety conference. This year's conference will be October 30th at the Hollywood Hotel and Casino in Saint Louis.

We are excited to announce our speakers:

- **Peter Antevy, MD**
- **Allison Bloom, Esq.**
- **Anthony Garza, MD**
- **Daniel Patterson, PhD**

In addition, Safe Tables will be offered again this year. This shared learning opportunity is only open to PSO participants. Registration will open soon.

WELCOME to our new participants

The work that many of you started years ago in Missouri is now growing coast to coast. Two national contracts were added to the Center's PSO: Paramedics Plus and Lifeteam Air Evac. The Center is now providing EMS PSO services in 19 states including, most recently, the state of New York.

Likewise we are excited to welcome Canandaigua Rescue Squad (CRS) to our EMS PSO family. CRS is a progressive EMS service that has a keen interest in patient safety and quality. Chief Ken Beers quickly saw the importance and value of PSO services. Within days of first seeing an overview from the Center, he completed his PSO contract and policy to begin receiving PSO services. Congratulations to CRS, Paramedics Plus and Lifeteam Air Evac for taking proactive steps and supporting patient safety in their communities. We look forward to announcing new participants in the near future.

The Center for Patient Safety Presents

2015 Webinar Series

EMS Quality & Patient Safety
LEARNING SERIES
for EMS Leaders and Providers

The Center for Patient Safety staff has the opportunity to meet and listen to EMS leaders and providers from around the country. Frequently we are asked "what is patient safety and how do we improve it"? We believe patient safety is composed of many areas and can't be defined by one process. Therefore, the goal of this series of free webinars is to offer you information and content that addresses these questions as well as human factors, quality, risk, culture and other new and innovative ideas.

If you have the desire to learn and would like to improve what you do as an EMS professional, please join us. Each webinar will focus on topics designed to enlighten and educate as well as encourage participants to take a proactive approach to reducing patient harm.

Register for these webinars at:
www.centerforpatientsafety.org/upcoming-events

Center for Patient Safety
Delivering EMS Solutions

SESSIONS:

Mar 11
#1 March 11 at 1200 noon (Central) - FREE
Human factors and the delivery of prehospital medicine: A primer for EMS leadership
Presented by: **Joseph R. Keebler**, PhD, Assistant Professor, Wichita State University, Department of Psychology **and Paul Misasi**, MS, NRP, CPPS, Clinical Manager, Sedgwick County EMS

Jun 30
#2 June 30 at 1200 noon (Central) - FREE
Quality Management in EMS: It's everybody's game
Presented by: **Megan Sorensen**, RN, CEN, MHA, Clinical Manager, Critical Care Transport, Children's Hospital-Omaha, Nebraska. Graduate Studies Coordinator, EMS Education, Creighton University

Sep 3
#3 September 3 at 1200 noon (Central) - FREE
Second Victim: Caring for the Caregiver
Presented by **Laura Hirschinger**, RN, MSN, Performance Improvement Professional at MU Health Care's Office of Clinical Effectiveness, University of Missouri

Dec 2
#4 December 2 at 1200 noon (Central) - FREE
Patient Rights, Risk and Refusal
Presented by **Lee Varner**, BS EMS, EMT-P, Project Manager at Center for Patient Safety **and Kathy Wire**, JD, MBA, CPHRM, Project Manager at Center for Patient Safety

Questions? Call the Center for Patient Safety at 888.935.8272 or email info@mocps.org

CULTURE CORNER
culture services grow

The Center for Patient Safety (CPS) continues to build on culture services to support adverse event reporting and the learning that results from increased reporting.

JUST CULTURE

Just Culture, the balance between human and system accountability, is a hot topic in patient safety and reduction of errors in today's healthcare industry. CPS fully supports the implementation of a Just Culture in healthcare organizations across the continuum of care. Reporting events is important as it leads to knowledge and process changes that contribute to future error prevention. Organizations with cultures that support open communication of errors in a non-punitive environment, a "just" culture, are more likely to experience higher levels of improvement in patient safety.

The Center has provided and supported education of hundreds of healthcare individuals across the country to implement Just Culture in hospitals, long-term care, EMS services, individual organizations, and state agencies.

Are you practicing Just Culture in your organization?

If not, you are missing a valuable opportunity to improve your organization by working towards a culture of safety with shared accountability. In partnership with the Missouri Ambulance Association, the Center supports, coordinates and teaches this foundational approach for EMS leaders. If you are interested in learning more, contact the Center or the Missouri Ambulance Association. Classes are being planned for the remainder of the year and 2016. The next Managers' class will be on June 22 at the Central Jackson County Fire training center.

Thanks to the certified Just Culture trainers who take time to teach this important program, often as unpaid volunteers:

- Mark Alexander
- Dr. John Russell
- Kim McKenna

SECOND VICTIMS
(READ MORE AT BOTTOM OF PAGE)

Being a health professional often requires putting emotions aside for the sake of patients. Despite the emotional resilience that allows health care providers to care for their patients under stressful, high-stakes circumstances, sometimes an unexpected clinical event or outcome creates a heavy emotional impact.

In collaboration with the University of Missouri Health System Second Victim Program, the Center for Patient Safety is pleased to host two upcoming workshops.

University of Missouri Health System
forYOU team

THE SECOND VICTIM EXPERIENCE

Train-the-Trainer Workshop

Second Victims are "healthcare providers who are involved in an unanticipated adverse patient event, medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event."

The Center for Patient Safety is pleased to offer another dynamic workshop, hosting trainers from the University of Missouri who will teach peer support skills for staff members and physicians who are impacted by adverse and/or unexpected clinical events and outcomes.

Participants will gain insights into the "second victim" experience as well as supportive interventions. Attendees will also acquire the knowledge, skills and techniques necessary to implement a "second victim" program for peers within their own organization.

Space is limited to 40 participants, available on a first come, first served basis.

Date: Thursday, September 24, 2015
Location: Mid-America Transplant Services
St. Louis, Missouri

REGISTRATION AVAILABLE
www.centerforpatientsafety.org

Center for Patient Safety

Have you noticed this icon?

Look for this icon to find additional resources in the articles. You'll find links to downloadable templates, websites and other resources.

Available in the electronic version of this newsletter.

PSO PARTICIPANTS-ONLY:
PSO Dashboards will be delivered via secure email to PSO Primary Contacts in June.

PSO.DATA.UPDATE

As the Center grows, so grows our data. Our goal is to share information to help prevent the occurrence of events at your organization. Looking at the diagram we see areas of concern, which is a good reminder that har does reach our patients. Looking at the "No Harm" area could be misleading as it might be part of a "Near Miss". That's when an event almost occurs but doesn't reach the patient. Near miss information is important to share as it might offer an opportunity to prevent a future event. Not all events are due to human errors; most are the result of a poor design, system or process. Regardless, reporting any event, near miss or unsafe condition helps all of us become more proactive.

Somebody recently said "...it's easy to think that EMS has become so safe that we have forgotten how dangerous it is".

The EMS profession is filled with dangers and the unknown; therefore, being proactive and anticipating risk is part of prevention. We can learn from other organizations that have become High Reliability Organizations as they have implemented processes and systems as well as safety behaviors. Our goal must be to improve our culture of safety where every staff member is focused on identifying risk and failure.

> "...it's easy to think that EMS has become so safe that we have forgotten how dangerous it is."

STATS

With hundreds of events from the 236 participating EMS agencies, medication- and substance-related events remain the most frequently reported event.

Six percent of reported events are near-misses and eleven percent are unsafe conditions, in which a mistake or error was about to occur, or could have occurreed, but was caught before it reached the patient.

Seventy percent of incidents submitted to the PSO resulted in no harm.

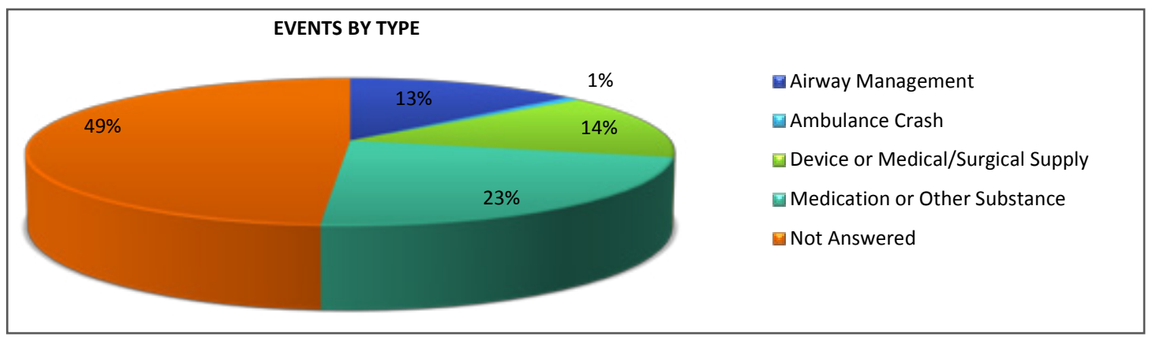
The most commonly reported factors contributing to adverse events are documented as lack of communication or miscommunication, inexperience or incompetence, and unclear policies.

PSO DASHBOARDS

PSO participant dashboards will be sent via secure email in June. If you do not receive a dashboard, or have questions about your dashboard, please contact Alex Christgen at the Center for Patient Safety.

2014 CPS ANNUAL REPORT & PSO SUPPLEMENT

CPS again released its PSO supplement report in conjunction with the release of the annual report. The PSO Supplement summarizes the full PSO database and takes a deeper look at the individual event types for hospitals, ASCs, and EMS. Event scenarios are presented with research and resources to raise awareness and prevent similar events in the future.



HIGH ALERT MEDICATIONS

PSO ALERT!

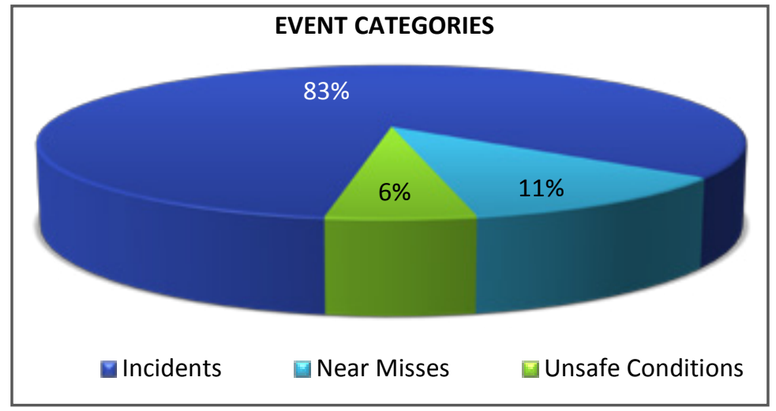
In a case submitted to the CPS PSO, a pediatric patient received a higher than standard dose of Propofol and required resuscitation. In another case, a battery failed on an insulin IV pump and went unnoticed. Approximately one in every five reported PSO medication events involved a high alert medication such as anticoagulants (warfarin, heparin, Lovenox), Propofol, insulin, hypoglycemic agents, opioids and so forth. Events related to prescribing, dispensing, administering and monitoring errors.

High-alert medications are drugs that bear a heightened risk of causing significant patient harm when used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating. Use lists provided by the Institute of Safe Medication Practices (ISMP) to determine which medications require special safeguards to reduce the risk of errors.

REPORTING TO THE PSO

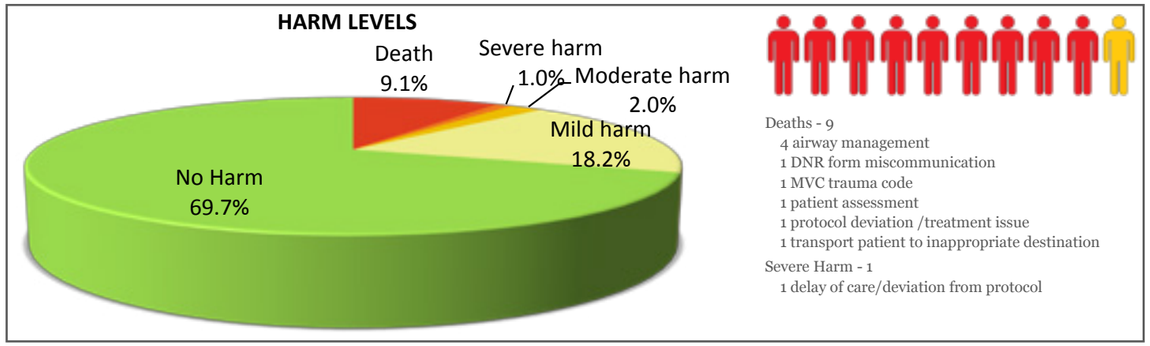
Did you know that almost anything can be reported to the PSO? This includes concerns about patient hand-offs or the transfer of care as well as concerns around hand hygiene or infection control. The value of a PSO is to safely share information so we all can learn. It's not always about adverse events. Make a commitment and set up a plan to submit your events, near misses, unsafe conditions and other documents each week or month. If you need training or assistance, contact us for hands-on support.

In addition, if you are not finding opportunities such as adverse events, near misses or unsafe conditions, just ask your crews. Share with them what the PSO is and how it can support their mission each day on the frontlines. In addition, implementing a Just Culture will offer your providers an improved culture of learning as they become confident to self-report without fearing punitive repercussions.



REMINDER

PSO adverse event reporting cannot be used for comparison with other individual organizations. The purpose of PSO adverse event reporting is to learn what events occur and why, and to use that information to prevent future occurrence and patient harm. The value is in the quantity, quality, and details. The more reports obtained by the PSO containing detailed information about errors, near misses, and unsafe conditions, the greater potential for learning, sharing, and proactively preventing future harm, costs, and liability exposure.



UPCOMING events..

JUNE 10
BENEFITS OF AHRQ PSOS: SUCCESS STORIES
Webinar
REGISTER

JUNE 22
EMS JUST CULTURE TRAINING
Central Jackson County Education Center
Blue Springs, Missouri
REGISTER

JUNE 30
EMS QUALITY MANAGEMENT: IT'S EVERYBODY'S GAME
Webinar
REGISTER

SEPTEMBER 3
EMS SECOND VICTIM: CARING FOR THE CAREGIVER
Webinar
REGISTER

SEPTEMBER 24
SECOND VICTIM TRAIN-THE-TRAINER
Mid-America Transplant Services
Saint Louis, Missouri
REGISTER

OCTOBER 30
EMS PATIENT SAFETY CONFERENCE
Hollywood Hotel & Convention Center & Casino
Saint Louis, Missouri
REGISTER

Have you noticed this icon?

Look for this icon to find additional resources in the articles. You'll find links to downloadable templates, websites and other resources.

Available in the electronic version of this newsletter.

CPS SPEAKERS on the circuit

CPS staff are always on the go, sharing their expertise at national, state, and local conferences, events, and meetings. If you see them at an upcoming event near you, stop and say hello!

- Lee presented at **Chillicothe Fire Department in Chillicothe, Missouri** in February on Patient Safety and the Culture of Safety
- Dr. Michael Handler was a Keynote Speaker at the **UMKC School of Medicine in Kansas City, Missouri** on the importance of patient safety in March
- Becky presented at the **Annual Agency for Healthcare Research and Quality PSO Meeting in Rockville, Maryland** in April
- Becky and Kathy spoke to the **Society of Healthcare Risk Managers in Wisconsin** on "Balancing PSO Protections, Transparency and State Reporting" in April
- Lee presented Protecting Learning and Preventing at the **Zoll Summit in Denver, Colorado** in May
- Becky presented at the **Hospital Association's Strategic Quality 101 Conference in Missouri** in May
- Becky and Kathy will be presenting to students at the UMSL College of Nursing on Safe System Processes and High Reliability Organizations in June
- Kathy will present High Reliability: The Key to Quality and Value for **LeadingAge in St. Louis, Missouri** in June
- Lee will present Protecting Learning and Preventing at the **Kansas EMS Conference in Topeka, Kansas** in August
- Becky and Dr. Handler will be presenting to the **Missouri Chapter of the American College of Physicians in Osage Beach, Missouri** in September
- Kathy presents twice **in Texas** this Fall, first on Patient Safety Organizations and then Just Culture
- Kathy will conduct a half-day pre-conference session for **LeadingAge in St. Louis, Missouri** and again in **Kansas City, Missouri** on Root Cause Analysis: Fertilizer for a Safe and Just Culture
- Becky and Kathy will be presenting, "PSO's: Your Partners for Managed Care Success" at the **Annual Conference of the American Society of Healthcare Risk Managers in Indianapolis, Indianna** in October
- Lee will present Protecting Learning and Preventing at the **Air Medical Transport Conference (AMTC) in Long Beach, California** in October

FOR MORE INFORMATION, CONTACT ANY MEMBER OF OUR PSO TEAM

BECKY MILLER, MHA CPHQ, FACHE, CPPS, *Executive Director,* bmiller@mocps.org
EUNICE HALVERSON, MA, *Patient Safety Specialist,* ehalverson@mocps.org
KATHRYN WIRE, JD, MBA, CPHRM, *Project Manager,* kwire@mocps.org
ALEX CHRISTGEN, BS-BA, *Project/Operations Manager and Analyst,* achristgen@mocps.org
LEE VARNER, BS, EMS, EMT-P, *Project Manager, EMS Services,* lvarner@mocps.org
TINA HILMAS, RN, BSN, *Project Manager,* thilmas@mocps.org
MICHAEL HANDLER, MD, MMM, FACPE, *Medical Director,*
AMY VOGELSMEIER, PHD, RN, GCNS-BC, *Researcher/Data Analyst,*
JENNIFER LUX, *Office Coordinator,* jlux@mocps.org
DIANA PHELPS, *Administrative Assistant,* dphelps@ mocps.org

For additional information on the Center's PSO activities, resources, toolkits, upcoming events, safety culture resources, and more, visit our website at www.centerforpatientsafety.org or follow us on Twitter @ PtSafetyExpert for the most up-to-date news.

NOTE

Some articles contained within this newsletter may reference materials available to Center for Patient Safety PSO participants only. If you have questions about any Center-resources or articles within this newsletter, please contact the Center for Patient Safety at info@mocps.org or call 888.935.8272.

ABOUT THE CENTER:

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.